UNITED STATES AFRICA COMMAND MANUAL

OPL-MDF
ACM 4200.03

14 April 2010

HEALTH AND MEDICAL
Force Health Protection Procedures for Deployment and Travel

References: See enclosure E

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1. **PURPOSE**. This manual provides minimum Force Health Protection (FHP) requirements and standardized procedures for health surveillance in the United States Africa Command's Area of Responsibility (AOR). This instruction is intended to meet the health requirements outlined in references h and k for deployments. Additionally, this instruction outlines requirements for official travel to Africa or assignment to Headquarters (HQ) U.S. Africa Command.

2. **CANCELLATION**. None.

3. **APPLICABILITY**. In accordance with Department of Defense (DoD) and Service-specific guidance, this directive applies to all DoD military and civilian personnel, to include non-DoD interagency personnel who have been appointed to HQ U.S. Africa Command, and DoD contractor personnel traveling or deploying with U.S. Forces within the U.S. Africa Command AOR. However, DoD contractor personnel are only included to the extent provided in applicable contracts or IAW DoD and Service-specific policy. Shipboard operations that are not anticipated to involve operations ashore are exempt from the deployment requirements of this message except for recording individual daily deployment locations or when potential health threats indicate actions necessary beyond the scope of shipboard occupational health program or per the decision of the commander exercising operational control. In addition to deploying personnel, this instruction applies to personnel on official travel or assignment to HQ U.S. Africa Command and the AOR.

4. **PROCEDURES**. See enclosures A thru D. Failure to comply with the procedures and requirements outlined in this manual may result in administrative, disciplinary, or adverse action.

5. **SUMMARY OF CHANGES**. None. Forward any suggested improvements to HQ U.S. Africa Command, ATTN: OPL-MDF, email address: africom.force.health.protection@africom.mil or meddivchips@africom.smil.mil.

6. **RELEASABILITY**. RESTRICTED. This Instruction is approved for restricted release. Authorized users may obtain copies on the appropriate US Africa Command SJS network portal page. Directors/Special Staff/Component Commanders must ensure that the medical requirements contained in this document are communicated to all inbound TDY and PCS personnel to the command and to personnel inbound to the continent.

7. **EFFECTIVE DATE**. This manual is effective immediately.

MICHAEL A. SNODGRASS
Major General, USAF
Chief of Staff

Enclosures:
A. Procedures for Deployment and Travel Health Surveillance
B. Pre-deployment FHP and Health Surveillance Activities
C. Deployment FHP and Health Surveillance Activities
D. Post-deployment FHP and Health Surveillance Activities
E. References
GL. Glossary of Acronyms and Definitions

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ENCLOSURE A

GENERAL INSTRUCTIONS FOR DEPLOYMENT AND TRAVEL HEALTH SURVEILLANCE

1. OVERVIEW. The procedures contained in this manual pertain to actions to be taken before assignment to HQ U.S. Africa Command or the supporting commands; before official travel to African countries within the U.S. Africa Command AOR; and before, during, and after deployments to African countries within the U.S. Africa Command AOR. For purposes of this manual, the fourth definition of deployment in reference b applies. Deployment is defined as: "The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental U.S., inter-theater, and intra-theater movement legs, staging, and holding areas". Deployment health surveillance requirements based on length of deployment are outlined throughout this manual.

2. FORCE HEALTH PROTECTION. FHP provides a conceptual framework for optimizing health readiness and protecting DoD personnel from occupational and environmental hazards associated with deployment and military service. Health readiness is an ongoing Service and individual responsibility IAW references d, h, and k.

3. SURVEILLANCE. Health surveillance is the regular or repeated collection, analysis, archiving, interpretation, and distribution of health-related data used for monitoring the health of a population or of individuals, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents.

a. Health surveillance is critical to FHP and includes indentifying the population at risk, identifying and assessing potential occupational and environmental health (OEH) hazards, documenting OEH and chemical, biological, radiological, and nuclear (CBRN) risks and exposures; using specific risk management countermeasures, monitoring real time health outcomes (medical surveillance, assessing and ensuring appropriate sanitation and reporting of disease and non-battle injury (DNBI) and battle injury (BI) rates), and other measures in a timely manner.

b. U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) is the repository for operational and deployment health surveillance and reports for locations within the U.S. Africa Command AOR. All operational, deployment, medical, and health surveillance data (including DNBI, BI, pesticide, sanitation/food service, food/water vulnerability assessment reports), OEH surveillance data and reports and associated deployed personnel rosters within the U.S. Africa Command AOR will be submitted to USACHPPM via DoD or Service-specific systems for further disposition and archiving. To the extent possible, electronic copies of all data, data summaries, final reports and investigations will be uploaded, at least monthly, to the Deployment Occupational and Environmental Health Readiness System (DOEHRS) portal. Electronic or hard copies may be emailed to NIPR:

chppm-oehs-data@apg.amedd.army.mil, SIPR: oehsdata@usachppm.army.smil.mil or mailed to USACHPPM-Environmental Surveillance Integration Program; ATTN: MCHB-TS-RDE, 5185 Blackhawk Road, Aberdeen Proving Ground, MD 21010-5403. After uploading or forwarding any surveillance information, medical personnel must notify U.S. Africa Command Medical Division FHP branch (email: meddivchops@ africom. smil.mil or africom.force.health.protection@africom.mil) of the surveillance information.

ENCLOSURE B

PRE-DEPLOYMENT AND PRE-TRAVEL FHP AND HEALTH SURVEILLANCE ACTIVITIES

1. GENERAL. Pre-deployment health activities are based on DoD and Service policies, the health risk assessments for the operations area and the specific deployment location. Pre-travel health activities and those activities required for permanent change of stations moves are based upon health threats, location of travel, and recommendations of the U.S. Africa Command Joint FHP Working Group. The following describes the required pre-deployment and pre-travel health activities.

2. REQUIREMENTS.

a. Prior to departure, all personnel deploying, on official travel orders, or on permanent change of station orders in support of the U.S. Africa Command mission must be assessed and determined to be fully medically ready and psychologically fit for worldwide deployment and travel.

Fit for deployment and travel involves, but is not limited to, the ability to accomplish the tasks and duties unique to a particular operation, and ability to tolerate the environmental and operational conditions of the deployed or travel location, including use of required prophylactic medications.

b. Personnel on permanent change of station or temporary duty (TDY) orders to HQ U.S. Africa Command or component commands in Europe and the U.S. must meet all Service-specific requirements for travel to Europe. Personnel expecting to travel to Africa are highly encouraged to obtain vaccinations listed in paragraph 1.f. of appendix B to enclosure B prior to permanent change of station or TDY assignment.

c. Personnel on permanent change of station orders to HQ U.S. Africa Command in African countries must meet the following minimum FHP requirements:

(1) Be current on immunizations as required in paragraphs 1.e. and 1.f. of appendix B to enclosure B.

(2) Be current on tuberculosis (TB) screening test as required in paragraphs 1.f. of appendix B to enclosure B.

(3) Take malaria chemoprophylaxis as required IAW annex C of appendix B to enclosure B. It is mandatory to verify that a one-time G6PD deficiency screening test has been completed prior to travel to Africa.

(4) Take an appropriate supply of any other personal prescription medications, required medical equipment (glasses, hearing aids, etc) and occupational health personal protective equipment (respiratory and hearing protection, dosimeters, etc.).

(5) Prior to deployment or travel to African countries, receive a health threat and

countermeasures briefing from qualified medical personnel IAW annex D of appendix B to enclosure B.

(6) These FHP requirements can be used as guidance for accompanying family members and other categories of personnel not previously mentioned. Additional immunizations or health screening may be indicated after evaluating an individual's risk factors, medical record, and assignment or travel location to Africa. Health requirements must be addressed by the accompanying family member, other personnel and their primary care provider prior to moving or traveling overseas.

d. All personnel deploying or on official travel for less than 30 days to African countries within the U.S. Africa Command AOR must meet minimum FHP requirements as outlined in paragraph c. (1. - 5.) above.

e. If deployment or official travel is less than 30 days, but is to an area deemed to be of high health risk, U.S. Africa Command, component and subordinate activities commanders may mandate additional requirements IAW reference h and k.

f. All personnel deploying or on official travel for 30 days or more to African countries within the U.S. Africa Command AOR must meet all FHP requirements IAW references h and k as outlined in appendixes A-E of this enclosure.

APPENDIX A TO ENCLOSURE B

HEALTH RISK ASSESSMENT

1. HEALTH RISK ASSESSMENT AND RISK MANAGEMENT. Risk management is an essential element of military doctrine. Therefore, health risk assessments shall be conducted as part of the risk management processes of all Service components and subordinate activities. The risk management process shall be institutionalized and be an inherent part of all deployment and travel health operations (before, during, and after deployment/travel) to address health threats. The general content of a health risk assessment and example checklists may be found on the U.S. Africa Command/ Medical Division/FHP SIPR portal home page and/or in reference a.

2. COMPONENTS AND SUBORDINATE ACTIVITIES SHALL:

a. Establish procedures to ensure health risk assessments and risk management decisions are documented, archived, and periodically reevaluated.

b. Ensure health risk assessments are conducted to anticipate, identify, and assess health threats; develop controls and countermeasures; make risk decisions; and implement controls to mitigate unavoidable health threats.
Health risk assessments use information from sources such as OEH site assessments, Preliminary Hazard Assessments (PLHA), industrial hazard assessments, environmental baseline surveys, health surveillance activities, medical intelligence products, lessons learned, and other available data for the deployment/travel area.

c. Consult the Services' deployment health surveillance support hubs such as the U.S. Air Force School of Aerospace Medicine (USAFSAM), Navy and Marine Corps Public Health Center, and USACHPPM for deployment OEH historical exposure and monitoring data, and mission and site information; National Center for Medical Intelligence (NCMI) for current intelligence on foreign medical capabilities, infectious disease threats, environmental health risks, toxic industrial chemical threats, and developments in biotechnology and biomedical subjects of military importance; DoD Veterinary Service Activity for food and bottled water sanitation audit information; and the Armed Forces Pest Management Board (AFPMB) for information on animals and plants that may impact the DoD mission. Other sources of information to be considered include the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH).

d. Ensure health risk communication plans are developed as part of the health risk assessment and risk management process before, during, and after deployments.

3. HEALTH RISK ASSESSMENT AND RISK MANAGEMENT.

a. An overall health risk assessment for the joint operations area or area of operations must be accomplished before extended travel and before each deployment

to identify the specific health threats and appropriate protective measures, and determine the content of health risk communication messages and materials, including pre-deployment or pre-travel health threat briefings. Specific health risk countermeasures (e.g. immunizations, prophylactic medications, or personal protective equipment (PPE)) will be based on the health threats or potential health threats as well as DoD, Service, and U.S. Africa Command guidance.

b. If U.S. Africa Command has not completed a health risk assessment within three years of an operational location, then the Service component or subordinate activity must coordinate accomplishment through the operational chain of command. Health risk assessment will be developed to identify deployment and travel-specific health threats and determine appropriate protective measures and health risk communication requirements.

(1) Components and subordinate activities will incorporate health risk assessment and surveillance requirements into the operational plan FHP appendix, annex Q (medical) and into operational orders.

(2) Components and subordinate activities will ensure health risks are reflected in the overall risk summary evaluation and will communicate this health risk information to operational planners.

(3) Health risk assessments should also be integrated into operational plan annex B (intelligence) as appropriate.

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) <u>Enclosures (include only if these have any bearing on deployability)</u>:

(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.

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. CHEMICAL WARFARE (CW) ANTIDOTES

a. Units and individuals traveling or deploying for more than 30 days to the CJTF-HOA AOR (Djibouti, Eritrea, Ethiopia, Kenya, Seychelles, Somalia, and Sudan) with a requirement to bring C/C-1 bag and/or D/D-1 bag must bulk ship, with the deploying unit, the following CW antidotes: atropine and pralidoxime chloride (2-PAM Cl) auto injectors (three of each injector per deploying individual); pyridostigmine bromide (PB) tabs (two 18 or 21 tablet blister pack per deploying individual); and convulsive antidote

nerve agent (CANA) auto injectors (one each per deploying individual). If individuals are deploying without a troop commander, they should hand-carry these items, and if flying commercial, should place them in checked baggage. Upon arrival, all CW antidotes will be turned into the medical unit at the deployed location. If no medical unit is attached, CW antidotes will be turned into the unit command section for accountability.

b. When required, the above paragraph will be included on all orders to the CJTF-HOA AOR.

c. Units and individuals traveling or deploying for less than 30 days to CJTF-HOA AOR and units and individuals deploying or traveling, regardless of length, to the rest of Africa will not hand-carry CW antidotes unless required by Service and/or subordinate activity policy.

4. 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.

ENCLOSURE C

FHP REQUIREMENTS AND PROCEDURES DURING DEPLOYMENT AND TRAVEL

1. GENERAL. The deployment phase begins when advanced party or initial cadre personnel arrive into the deployment area. Deployment health activities are based on the pre-deployment health risk assessment of the health threats for the joint operations area or area of operations and the specific deployment location and should be updated as the deployment proceeds.

2. For any land-based deployment or travel, for 30 days or more, to an African country/location within U.S. Africa Command AOR, commanders and/or medical personnel must conduct daily disease and injury surveillance, disease and injury reporting, and other activities to detect any trends in health of deployed personnel as outlined below.

a. Medical personnel must conduct ongoing health surveillance [DNBI, battle injury (BI), pesticide, sanitation and food service surveillance], location specific OEHSA assessment and systemic OEH hazard surveillance. Ensure surveillance data is reported and archived according to DoD, U.S. Africa Command and Service-specific policies. During deployment, medical personnel will:

(1) Validate and update preliminary hazard assessment.

(2) Ensure environmental monitoring of air, water, soil, disease vectors, and radiation based on assessment of actual and/or potential medical threats at deployed locations.

(3) Ensure deployment health surveillance and OEH reporting and data submission to USACHPPM via DoD or Service-specific systems for further disposition and archiving. To the extent possible, electronic copies of all data, data summaries, final reports and investigations will be uploaded, at least monthly, to DOEHRS IAW references a, h, k. Alert U.S. Africa command, service chain of command, Armed Forces Health Surveillance Center (AFHSC), and NCMI to any newly identified health threats, negative health trends or adverse events.

(4) Investigate, report and document all OEH and chemical, biological, radiological and nuclear (CBRN) exposure incidents.

(5) Document OEH surveillance and monitoring summaries on a SF 600 for each permanent or semi-permanent basing location and update at least annually. File the OEH summaries in the medical records of each individual for which exposure applies or archive the summaries so that they are readily available to health care providers and redeployed personnel.

(a) The OEH monitoring summaries will provide monitoring results, estimated

personnel exposures, assessment on whether estimated exposures are acceptable or unacceptable, and the criteria used for the estimate, along with any anticipated acute, chronic, and latent health effects.

(b) The summaries will also include references to monitoring data that indicates little or no health risks associated with ambient monitoring conditions falling below military exposure guidelines.

b. Deployed medical personnel at each operating location must conduct ongoing DNBI and BI surveillance through DoD and Service specific automated systems that feed into the Joint Medical Workstation (JMeWS).

c. Medical personnel must document all patient encounters.

(1) It is mandatory that copies of all inpatient and original outpatient medical encounter documentation (including medical treatment records provided to deployed personnel by allies and coalition partners of the U.S.) be incorporated into the deployment health record (automated or hardcopy; DD Form 2766 or equivalent).

(2) Document all patient encounters and ensure Service-specific procedures are maintained for appropriate archiving of health documents and records.

(3) Commanders must ensure personnel comply with any and all required medical follow-up.

d. Commanders must ensure appropriate storage, use and disposal of hazardous materials.

e. Commanders must ensure the integrity of field hygiene and sanitation, occupational health and safety programs.

f. Commanders must enforce the use of all required countermeasures including the use of DoD Approved Sources of food and bottled water IAW references jj, pp, and qq. When requesting DoD Approved Source Audits of food establishments ensure enough lead time (typically 3-6 months) in order to meet the operational and logistical requirements of the mission. Audit requests will meet requirements set forth by the U.S. Army Veterinary Service Activity and may be found at www.veterinaryservice.army.mil/food.html.

g. Commanders must ensure food and water vulnerability assessments are conducted IAW Service Standards to validate potential or actual vulnerabilities and determine courses of action to control or reduce the vulnerabilities. Food and water vulnerability assessments must be done in collaboration with security, medical, and anti-terrorism personnel.

h. Commanders will conduct pest control operations using the integrated pest management program described in reference q, current AFPMB recommendations, and

IAW any Service policy. Vector surveillance and control must be a part of all operational planning.

i. Commanders and/or medical personnel will provide health information, during all phases of deployment, to educate, maintain fit forces, and change health related behaviors for the prevention of disease, illness, and injury due to risky practices and unprotected exposures.

3. For any land-based deployment or travel, for less than 30 days, to an African country/location within U.S. Africa Command AOR, commanders and/or medical personnel must:

a. Document all patient encounters.

b. Ensure appropriate storage, use and disposal of hazardous materials.

c. Ensure the integrity of field hygiene and sanitation, occupational health and safety programs.

d. Enforce the use of all required countermeasures including the use of DoD approved Sources of food and bottled water and personal protective equipment to protect the health of personnel, balanced with mission needs.

e. Consider completing an OEH site assessment as they are highly recommended for travel and deployment to sites with high-risk health threat estimates or for long-standing locations where exercises and other activities routinely occur.

f. Provide health information to educate, maintain fit forces, and change health related behaviors for the prevention of disease, illness, and injury due to risky practices and unprotected exposures.

APPENDIX A TO ENCLOSURE C

DISEASE AND INJURY EVENT SURVEILLANCE

1. GENERAL. Disease and injury (D&I) event trends, whether counts or rates, are an important type of surveillance for use at all levels and must be monitored and evaluated at least once daily. Abnormal patterns or trends may indicate a problem that could negatively impact mission accomplishment and indicate the need for additional investigations, and if validated, the need to implement appropriate FHP countermeasures.

2. D&I PROCESS. Daily D&I event surveillance is required for all deployment and travel for more than 30 days to locations within the U.S. Africa Command AOR. For deployment and travel less than 30 days, daily D&I, surveillance is at the discretion of the component commander or commander exercising operational control, based on the health risks.

a. Component and subordinate activities surgeons are responsible for ensuring that units within the U.S. Africa Command AOR are collecting the prescribed D&I data and reporting that data through the joint medical workstation (JMeWS).

(1) To the extent possible, electronic health event data collection systems that populate JMeWS will used at all levels of medical care within the U.S. Africa Command AOR. Refer to paragraph c below for more information on JMeWS.

(a) For sites without patient electronic data collection systems, medical personnel will need to revert to manual surveillance procedures and submit a weekly summary report of D&I surveillance rates via secure communication to their command chain and to U.S. Africa Command Medical Division FHP branch. An example summary report spreadsheet may be found in annex A of appendix A to enclosure C.

(b) For sites without patient electronic data collection systems, but with SIPRNET access to JMeWS, the annex Q reporting portion of JMeWS is available for input of local data for review by command chain and U.S. Africa Command.

(2) D&I surveillance derives from electronic patient records, sick call logs, safety mishap reports or other sources. Medical person must ensure capture of the following information, at a minimum, on every patient encounter:

(a) Patient's name, SSN, gender, unit, unit identifier code, and duty location

(b) Type of visit - new vs. follow-up. Providers must be trained to use the ICD 9 V-code (V67.9) to identify follow-up visits

(c) Primary (chief) complaint, the reason for seeking care

(d) Final diagnosis (es), in order of importance related to the primary complaint

(e) Injuries, which must be classification into recreation/sports, motor vehicle accidents, work/training, or other

(f) Final projected disposition, such as full duty, limited duty, transfer

(g) D&I category (case definitions in annex A to appendix A to enclosure C)

(3) At least daily, medical personnel at all levels will analyze the D&I data from their unit and the units subordinate to them and make changes and recommendations as required to reduce D&I and mitigate the effects of D&I upon operational readiness.

(4) The list of D&I reporting categories, their definitions, and the essential elements of the standard D&I report can be found in appendix B of enclosure C found in reference k.

b. Component and subordinate activities surgeons are responsible for ensuring that units within the U.S. Africa Command AOR are collecting the appropriate reportable medical event (RME) data and reporting that data through their Service-specific reporting mechanisms. Suspected or confirmed RMEs should be reported to Africa Command Medical Division FHP branch as appropriate.

(1) The Tri-service RME List is at reference jj.

(2) RME reporting is to occur as soon as reasonably possible after the event has occurred, but not more than 24 hours.

c. Joint Medical Workstation (JMeWS). JMeWS will be used as the primary data entry point for D&I reporting within the U.S. Africa Command AOR.

(1) Component and subordinate activities surgeons will ensure all subordinate units apply for JMeWS access prior to deploying and complete on-line training available at https://fhp.osd.mil//index.jsp. Units may also coordinate training with Army Medical Communications for Combat Casualty Care (MC4) at http://www.MC4.army.mil.

(2) Component and subordinate activities surgeons will ensure that deployed medical unit submits a joining and exiting report via the JMeWS portal to establish and disestablish the deployed unit and to ensure medical records are assigned correctly.

d. Medical personnel will keep their chain of command and U.S. Africa Command Surgeon informed of any significant disease outbreaks, negative health trends or adverse events.

e. Component and subordinate activity surgeons will submit, at least annually and as required, a summary report and trend analysis of D&I surveillance within the U.S. Africa

Command AOR to the U.S. Africa Command FHP Working Group.

f. D&I surveillance and reporting should begin with the start of health care delivery. However, it is not required in the absence of deployed medical personnel.

ANNEX A TO APPENDIX A TO ENCLOSURE C

SPREADSHEET FOR REPORTING D&I SURVEILLANCE

1. A working copy of this D&I Surveillance spreadsheet may be found on the U.S. Africa Command Medical Division FHP branch portal page or obtained from U.S. Africa Command Medical Division FHP branch personnel.

Daily/Weekly DNBI Report This worksheet is classified SECRET once troop strength and location is entered

Unit / MTF Name:
Location this Week: Area of Operation:
Period Covered by this Report (Sat-Fri) NOTE: The following diagnosis
Preparer's Name Preparer'
Sr. Enlisted Name: Sr.
Total Strength this Week:
Female Strength this Week: (Required for rate calculation.)

CATEGORY	Sat. New Visits	Sun. New Visits	Mon. New Visits	Tues. New Visits	Wed. New Visits	Thur. New Visits	Fri. New Visits	Total for week	Rate - % per week	Suggested Reference Rate	Days of Light Duty	Lost Work Days	Admits
Dental								0	#DIV/0!	NA			
Dermatologic Clear cause								0	#DIV/0!	0.5%			
Dermatologic, Unclear cause								0	#DIV/0!	0.5%			
DERM TOTAL								0	#DIV/0!	[illegible]	0	0	0
Fever, Unexplained								0	#DIV/0!	0.0%			
GI - Infectious								0	#DIV/0!	0.5%			
Gynecologic								0	#DIV/0!	0.5%			
Cold Injuries								0	#DIV/0!	0.5%			
Heat Cramps								0	#DIV/0!	0.5%			
Heat Exhaustion ICD-9 Code 992.3								0	#DIV/0!	0.5%			
Heat Stroke								0	#DIV/0!	0.5%			
HEAT/COLD INJURIES TOTAL								0	#DIV/0!	[illegible]	0	0	0
Injury, Rec./Sports								0	#DIV/0!	1.0%			
Injury, MVA								0	#DIV/0!	1.0%			
Injury, Work/Training								0	#DIV/0!	1.0%			
Injury, Other								0	#DIV/0!	1.0%			
NON-BATTLE INJURIES (NBI)								0	#DIV/0!	[illegible]	0	0	0
Neurological, Unexplained								0	#DIV/0!	0.1%			
Ophthalmologic								0	#DIV/0!	0.1%			
Operational/Combat Stress Reactions								0	#DIV/0!	0.1%			
Psychiatric, Mental Disorders								0	#DIV/0!	0.1%			
Respiratory, Upper								0	#DIV/0!	0.4%			
Respiratory, Lower								0	#DIV/0!	0.4%			
RESPIRATORY TOTAL								0	#DIV/0!	0.4%	0	0	0
Sexually Transmitted								0	#DIV/0!	0.5%			
All Other Medical-Surgical								0	#DIV/0!	NA			
TOTAL JCS-DNBI								0	#DIV/0!	4.0%	0	0	0
Battle Injury								0	#DIV/0!	NA			
Admin, Misc., Follow-up								0	#DIV/0!	NA			
Malaria								0	#DIV/0!	NA			
Viral Illness								0	#DIV/0!	NA			
Other								0	#DIV/0!	NA			
TOTAL DNBI	0	0	0	0	0	0	0	0	#DIV/0!	NA	0	0	0

Notes: 1. Count only the initial visit. Do not count follow-up visits.
2. Count ONLY US Military Personnel.
3. Call your HQs Preventive Medicine if you have questions

Problems Identified:

Corrective Actions:

APPENDIX B TO ENCLOSURE C

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE

1. GENERAL. Occupational and environmental health surveillance assessments (OEHSA) are required in order to document environmental exposures that may pose short or long term health risks. Exposures of interest are anything that may adversely impact a service member's future health, including but not necessarily limited to chemical contamination of soil, water, and/or air; microbial contamination of water; noise; harmful fibers or particulates.

a. The OEHSA is an iterative evaluation used to identify actual or potential completed exposure pathways for chemical, biological, and radiological agents in the environment that may affect the short or long-term health of deployed personnel. In order to optimize the overall effort to accomplish required surveillance, this appendix outlines the essential parts of the process required of deployed units involved in the OEHSA process.

b. IAW references h and k, OEHSAs are required for operating locations occupied for 30 days or longer. Periodic sampling based on the Conceptual Site Model (CSM) provides data that will be used to update the Periodic Occupational Environmental Model.

c. This appendix is not exhaustive in its treatment of the OEHSA process, but should rather be seen as a baseline guide for required common elements in OEHSAs.

2. RESPONSIBILITIES

a. <u>HQ U.S. Africa Command Commander</u> has overall responsibility for this program in the U.S. Africa Command AOR. Key tasks include:

(1) Ensure adequate staffing is provided in the AOR to accomplish the mission in accordance with reference a.

(2) Provide technical and management guidance for this program

(3) Track OEHSA and Field Data Sheet (FDS) completion status of sites in the AOR.

(4) To prevent duplication of effort, maintain a list of all locations in the AOR which indicates OEHSA and FDS completion.

(5) Develop training and education materials suitable for use to ensure deploying and traveling personnel are aware of the risks, preventive measures, and individual responsibility to adhere to FHP policies and procedures.

b. Components and other subordinate activities shall:

(1) Ensure preventive medicine assets are properly positioned in the AOR to accomplish the mission and help establish priorities.

(2) Provide technical support and consultation to preventive medicine assets as necessary to complete OEHSA mission

(3) Conduct DOEHRS queries to determine what sampling is needed.

(4) Ensure all OEHSAs are coordinated with U.S. Africa Command Medical Division, FHP Branch prior to being forwarded to USACHPPM.

(5) Coordinate for sampling media and equipment as required and for analysis through USACHPPM or other DoD certified lab. Components will request funding for and providing funding to Preventive Medicine (PM) assets as part of their contingency and operational planning.

c. PM Assets:

(1) Coordinate with existing and requested PM assets as to who is working on which FDS/OEHSA.

(2) Conduct OEHSA sampling as needed (focusing effort on those areas not previously sampled).

(3) Conduct OEHSAs as outlined below in references h, k, and v, and paragraph 5 below. Emphasis should be given to those sites not previously done with sites camps scheduled for closure as the highest priority among these sites.

(4) Complete FDSs and CSM.

(5) Review basing data for and imagery of all sites in the AOR requiring completed OEHSA FDS to CHPPM.

(6) Update FDS when significant changes such as expansions, renovations, and etc. occur on sites with previously completed FDS.

(7) Obtain sampling media and equipment as required and coordinate for analysis through USACHPPM or other DoD certified lab.

(8) Send samples to USACHPPM or other DoD certified labs and forward results to the component surgeon's office.

(9) Will draft the OEHSA once all FDS, CSM, drawing, pictures, and etc., are completed.

(10) Send clean first draft of OEHSA to component surgeon's office for review.

(11) Will make final changes to OEHSA after review process and publish. Published copies will be provided to the component surgeon's office to be uploaded to DOEHRS or forwarded to USACHPPM. Component medical personnel will notify U.S. Africa Command Medical Division FHP Branch that a completed OEHSA has been uploaded/forwarded.

(12) ICW USACHPPM/USAFSAM/Navy and Marine Public Health Center, review sampling data for U.S. Africa Command AOR and provide recommendations to U.S. Africa Command Medical Division FHP Branch for further sampling strategies.

3. OEHSA PROCESS. Risk assessment is an operational commander responsibility. Working in coordination, U.S. Africa Command, components, and subordinate activities will determine OEHSA priorities of sites based on hazards, population served, closure dates, and will determine who will conduct the initial site visit of which areas. OEHSAs are required for any deployment/exercise/operation/activity exceeding 30 days in length. Areas with long term recurrent short duration occupation such as air crew refueling points, ports of call, exercise locations, or similar areas should have OEHSAs conducted to develop an occupational exposure database and document existing conditions to support the EBS process. OEHSAs should be conducted at Embassy sites where possible to develop an occupational database for defense attaché and office of security cooperation personnel. All data and OEHSA reports are to be submitted to USACHPPM via DoD or Service-specific systems for further archiving. Notification of uploaded date or electronic copies should also be forwarded to U.S. Africa Command Medical Division FHP branch (email: africom.force.health.protection@africom.mil or meddivchops@africom.smil.mil).

a. For all site occupied by U.S. personnel for greater than 30 days, OEHSAs should be conducted as early as possible to identify existing and potential hazards, develop and refine sampling plans, document potential and existing exposures, develop FHP recommendations, and generate FHP force support requirements. Whenever possible, OEHSAs should be conducted as part of the initial planning conference or PDSS.

b. Pre-visit planning. Pre-visit planning is crucial. The assessment team shall review existing documentation on bases of interest. Existing surveys, sampling, and documentation are available on the USACHPPM SIPR website and the DOEHRS SIPR and NIPR portals. These survey reports contain significant information on the base that will save effort on the part of the assessment team. Often available are aerial images of the base that can be used for diagrams placing conceptual site models in the context of the base.

(1) Review existing documentation. Various sources of information are available at the following locations.

(a) NCMI. NCMI is the single source medical intelligence repository for the identification and assessment of environmental risks that can degrade force health or effectiveness including: chemical and microbial contamination of the environment, toxic industrial, chemical, and radiation accidents and environmental terrorism. Environmental health risk assessments are available at:

1. SIPR: http://www.afmic.dia.smil.mil/index.php

2. NIPR: https://www.intelink.gov/ncmi/index.php

(b) USACHPPM. USACHPPM retains copies of completed Global Threat Assessment Program (GTAP) phase 1 assessments, completed OEHSAs, and on-site environmental sampling documents. These are maintained only on the SIPR portal at: https://usachppm1.army.smil.mil/. Points of contact to request assistance with phase 1 assessments are located on the USACHPPM website.

(c) DOEHRS. DOEHRS is an Automated Information System (AIS) designed to support the Occupational Health (OH) program within the Deployment Data Archiving & Polity Integration Program (DDAPI). The portal will also allow appropriate personnel the ability to search, view and download OEHS documents.

a. SIPR: https://doehsportal.csd.disa.smil.mil/doehrs-oehs/

b. NIPR: https://doehrswww.apgea.army.mil/front.htm/

(d) The DOEHRS database should be searched by the surveyor to determine if samples needed have previously been collected. If not, sampling equipment should be prepared to collect needed samples at time of site visit. If air, water, and soil samples have been collected previously, then there may not need to collect more at this time. During the site visit, new hazards may be identified or existing hazards may have significantly changed enough to warrant additional samples.

(e) Sampling media and kits can be obtained through USACHPPM or other approved lab sources. Current costs estimates for sampling media and analysis are available from USACHPPM or the approved lab source. These costs must be included in the estimated mission funding requirements. Additionally, sampling media must be held and shipped under controlled conditions. For specific shipment requirements, contact USACHPPM or review Technical Guide 251. Information on sampling may be also found at http://chppm-www.apgea.army.mil/desp/default/aspx.

c. Site Visit.

(1) Complete the field datasheets to document all of the potential health risks on site. The assessment team should obtain MGRS or equivalent GPS coordinates of the corners of the site.

(2) Use the pre-existing aerial photos obtained during the Pre-visit planning to document and identify significant features.

(3) Sampling. The purpose of sampling is to provide quantifiable data in order to determine the risk to personnel due to environmental exposures, document that exposure, and develop mitigating messages to reduce cost where possible. Sampling should be planned, if possible, based on documents reviewed prior to the visit. If such pre-planning is not possible, extemporaneous sampling will be necessary, with the objective of obtaining a representative picture of the exposures within the base. Composite samples are acceptable for initial screening. Positive hits for analytes above one year military exposure guidelines (MEG) shall result in plans for targeted sampling in subsequent updates for the base where the analyte was found.

(4) Soil. For small sites, a composite sample may not only be sufficient for initial screening, but may be considered representative of the base. For larger bases, composite samples may be used to divide the base into sections. Positive hits on analytes above MEGs should prompt more focused sampling on subsequent sampling iterations. Sites covered in gravel or pavement are exempt from soil sampling if there is deemed no exposure risk after completion of the CSM.

(5) Air. Air samples are highly variable in the materials captured for analysis and are the most likely samples to yield results that, in isolation, indicate exposures that are hazardous to health. Air samples also provide long term exposure date due to airborne contaminants. The assessment team should not attempt to characterize risk from airborne exposures based on small numbers of samples. It is not helpful to estimate that risk is in a particular range, however because the sample(s) taken are not representative, confidence in the risk estimate is low.

(6) Water. For austere sites, collect raw water samples and treated water samples if possible. For built up locations such as cities, bases, or urban areas, collect treated water samples for characterization. For teams with limited space or time, treated water kits may be utilized until raw water kits can be obtained and transported to the site.

(7) Noise. Noise surveys may also be appropriate if personnel must live, work, or walk close to significant noise sources, such as diesel electrical generators. Noise survey data should either have MGRS or equivalent GPS coordinates taken or have their location annotated on a map, providing spatial information on the sample.

(8) Other hazardous materials as appropriate.

(9) When there is a known source (spill) of contamination for which a concentration gradient with respect to distance is important in ascertaining exposure above MEG, the sampling plan shall determine the range limit of exposure above MEGs. Samples shall be collected at intervals to establish contaminant concentrations at increasing distances from the source. The distance interval shall be at the discretion of the sampling team but shall be stated in the sampling report.

d. The CSM is the first of two essential steps in localizing environmental exposures within a base. Abstractly, an exposure pathway is completed if the following elements are present: 1) source, 2) environmental medium, 3) mechanism of exposure, and 4) route of dose acquisition [inhalation, ingestion, dermal absorption]. A completed pathway results in an absorbed dose of the substance in question.

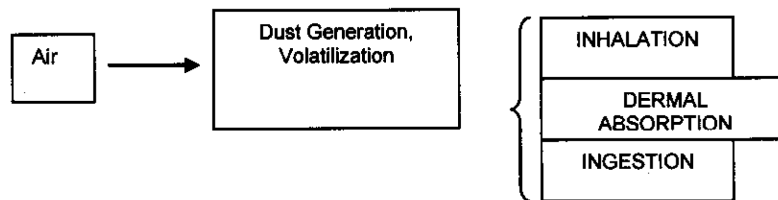


Figure 1. Generic CSM Template

(1) The CSM is drafted while on-site. Units with organic OEHSA sampling capability such as Preventive Medicine Detachments (PM Det), Forward Deployed Preventive Medicine Units (FDPMU), Preventive Aerospace Medicine (PAM) teams, and Brigade Combat Team PM (BCT-PM) sections will collect samples as indicated by the CSM. Units without organic sampling capability will coordinate for follow-on sampling as needed.

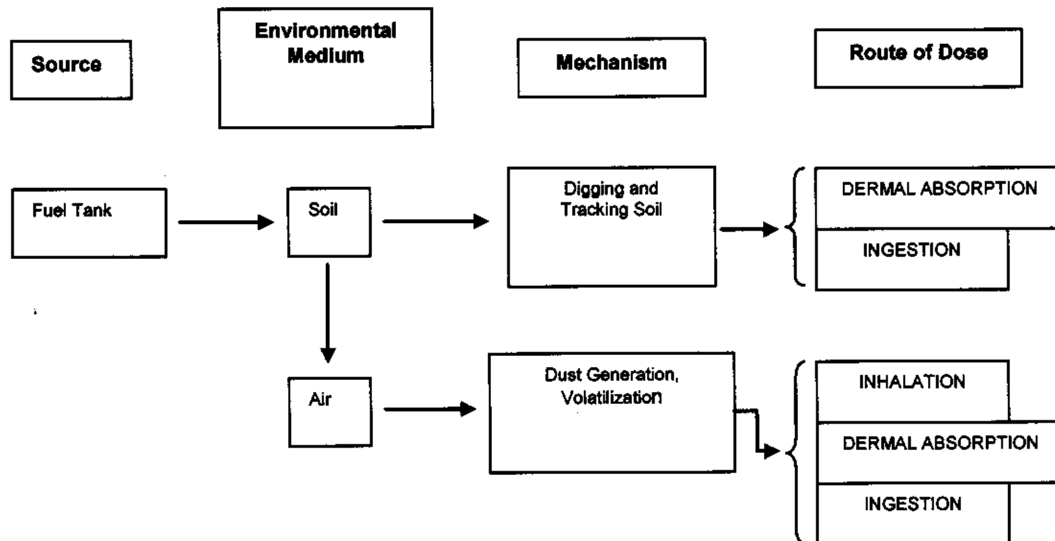


Figure 2. Completed CSM

(2) For complete or potentially complete exposure pathways identified in the CSM, the location on the base where the exposure pathway is substantiated must be identified. Use of diagrams or annotated maps to localize the exposure pathway within the base is expected. Failure to do this may show that an exposure will be attributed to the entire base, resulting in inaccurate assumptions of exposure.

(3) For very small sites, it may be reasonable that all CSM exposure pathways be attributed to the entire location. For larger sites, where an exposure pathway is held to be uniform across the site, e.g., particulate in ambient air not caused by burning, the exposure pathway may also be stated to apply to the entire site. In either case, the assessment team shall explicitly state that the exposure pathway applies to the entire site, and justify why this attribution is appropriate.

(4) For larger sites where an exposure is more localized, e.g. noise, asbestos in buildings, localized spills onto soil, the use of diagrams or annotated maps shall be used to locate an exposure within a location. Samples shall be localized within the base using either MGRS coordinates or notations on maps.

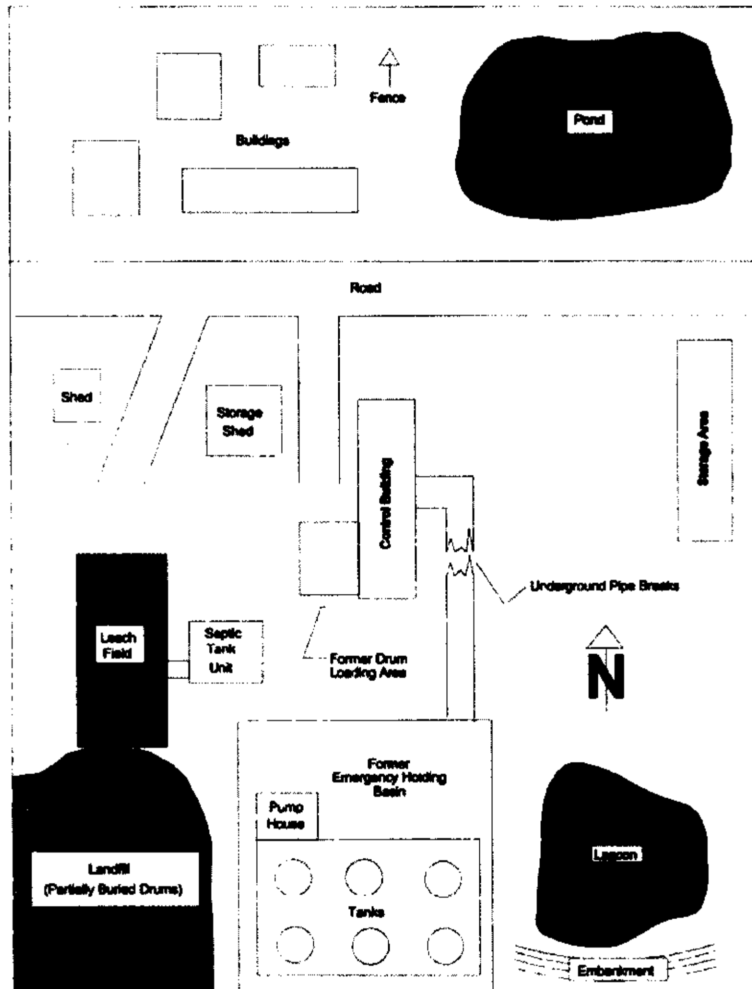


Figure 3. Example Site Map

4. OEHSA WRITING PROCESS:

a. FDS forms are used to detail characterizations of a base. If one exists, much of the information required for the FDS may be obtained from the U.S. Army Corps of Engineers' (USACE) Environmental Baseline Survey (EBS). An example FDS may be found on the SIPR portal/Medical Division FHP home page.

b. CSM, with amplifying diagrams and/or maps to localize any completed or potentially completed exposure pathways within the base, as appropriate. Attribution of an exposure pathway to the entire site is acceptable where specified and justified.

c. Samples. Sample collection shall be driven by the CSM as localized within the site. If the completed exposure pathway is considered to apply uniformly across the base, composite samples or samples attributed to the entire base are acceptable.

d. Draft Report. The surveying unit is responsible for the draft report. The draft report will follow the template included in Tab A to this attachment. Draft reports are forwarded to the requesting component surgeon's office for review and comments prior to completion of the final report.

e. Final Report. Once the draft report has been reviewed, the comments will be used to generate a final report. The final report will use the same template as the draft report. The completed report will be forwarded to the requesting component for archiving and submitted to USACHPPM for archiving in the DOEHRS system.

f. Servicing components will notify the U.S. Africa Command Medical FHP Branch of all completed and submitted/forwarded OEHSAs.

g. Units will conduct AARs after each OEHSA identify shortfalls, costs, and lessons learned. These AARs will be submitted to the servicing component and a copy furnished to the U.S. Africa Command Medical FHP Branch for situational awareness.

5. FOLLOW-ON ACTIONS

a. Updates to OEHSA. OEHSAs will be updated on an as needed basis. At a minimum, an OEHSA update will be conducted during the following:

(1) Significant change in the exposure conditions of the surveyed site, including new pollution sources, changes in environment, or other significant actions.

(2) During operations on site 30 days or greater in length.

(3) If the last OEHSA is over 1 year old in high use, minimal stay areas.

b. Updates can be in the form of an appendix, attachments, or memorandum for record, depending on the amount of information required for the update.

c. U.S. Africa Command Medical Division FHP branch will use completed OEHSAs to determine information gaps and site evaluation prioritization in support of U.S. Africa Command objectives.

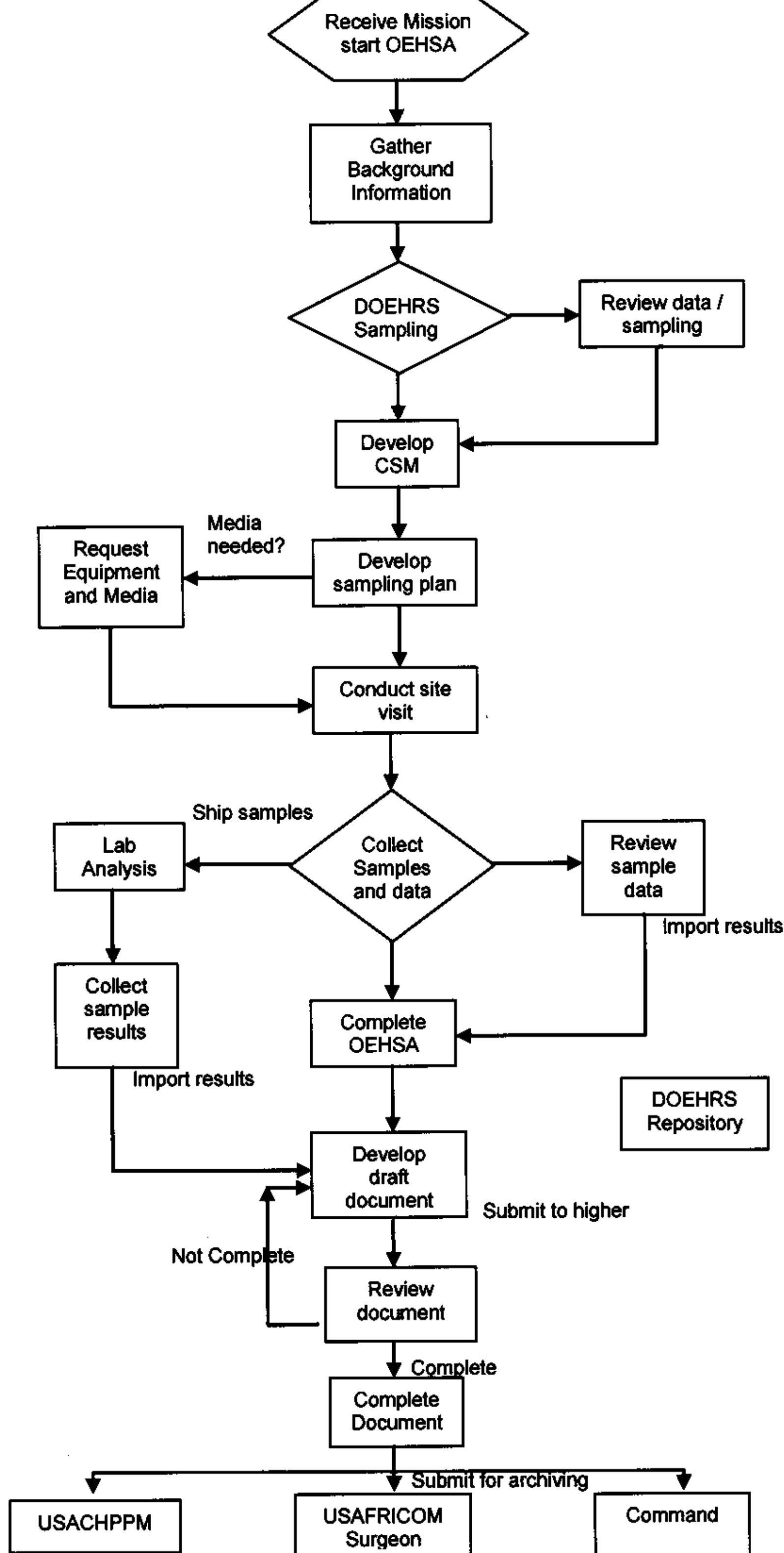
ANNEX A TO APPENDIX B TO ENCLOSURE C

EXAMPLE OEHSA REPORT

1. Executive Summary
2. Introduction
3. Site Description
4. Information Sources
5. Information from Site Reconnaissance
6. Environmental Sampling Data
7. Conceptual Site Model(s)
8. Findings
9. Conclusions
10. Recommendations
11. Technical Assistance
12. Key Appendices, including:
    (a) References
    (b) Site Maps
    (c) Photographs
    (d) Vector Surveillance

ANNEX B TO APPENDIX B TO ENCLOSURE C

OEHSA FLOWCHART



ANNEX C TO APPENDIX B TO ENCLOSURE C

OEHSA CHECKLIST

1. The following is an OEHSA Checklist table of contents. A working copy of an OEHSA checklist may be found on the U.S. Africa Command Medical Division FHP branch SIPR portal page or obtained from U.S. Africa Command Medical Division FHP branch personnel.

a. Administrative Data

b. Survey Background

c. Site Description

d. Site Infrastructure

e. Hazardous Materials

(1) Storage Containers

(2) Petroleum Distribution Points

(3) Past Releases (petroleum, oils, and lubricants (POL))

(4) Hazardous / Unidentified Substances (other than POL)

(5) Hazardous Material Storage

(6) Hazardous Material Disposal

(7) Hazardous Materials Migration

f. Waste Management

(1) Solid/Hazardous Waste

(2) Landfills

(3) Incinerators/Burn Pits

(4) Waste Water (including Storm Water)

g. Entomology

(1) Disease Threats

(2) Entomological Assessment

(3) Vectors Present

(4) Environmental Health Assessment (Facility Inspections)

(5) Countermeasures / Pest Management Control

(6) Pesticide Use

h. Physical Hazards

(1) Non-Ionizing Radiation Sources

(2) Ionizing Radiation Sources

(3) Camp Background Dose Rate

(4) Environmental Noise Sources / Controls

i. Air Quality

(1) Ambient (outside) Air Quality

(2) Indoor Air Quality

j. Water

(1) Water Treatment

(2) Municipal Water

(3) Well Water

(4) Surface Water

(5) Reverse Osmosis Water Purification Unit /Ultraviolet Water, Tactical Water Purification System/Lightweight Water Purifier

(6) Water Distribution System

(7) Water Surveillance Program

(8) Water Storage Tanks

(9) Bottled Water

(10) Non-Potable Water

k. General Sanitation

(1) General Facilities

(2) Dining Facilities

l. Personnel Contacted

m. Other Environmental Health Concerns

n. CSMs Consolidated

o. On-Site Sampling Results

p. Direct-Reading Instrumentation and Associated Calibrations

q. Samples Collected for Off-Site Analysis

r. Executive Summary Findings

s. Executive Summary Recommendations

ENCLOSURE D

POST DEPLOYMENT FHP AND HEALTH SURVEILLANCE ACTIVITIES

1. GENERAL. Services are responsible for ensuring post deployment activities are accomplished.

2. REQUIREMENTS. The following must be accomplished for personnel who deployed or traveled for 30 or more days to a land-based location within the U.S. Africa Command AOR.

a. Individuals indicated for terminal primaquine prophylaxis (those deployed to malaria risk area and exposed to relapsing forms of malaria such as *P. vivax* or *P. ovale*) will see a licensed medical provider prior to starting on primaquine. The provider will review the person's G6PD test status and result, and then prescribe a primaquine dosing regimen IAW current CDC, FDA and clinical practice guidelines that is tailored to that person.

b. When required, receive a medical threat debrief and complete USD-HA approved post-deployment health assessment questionnaire (DD Form 2796) within 30 days on either side of redeployment, and for reserve component members, before they are released from active duty; and complete the additional post-deployment health reassessment (PDHRA) 90-180 days after redeployment using DD Form 2900 (or automated equivalent) IAW reference k.

(1) Medical personnel must review each questionnaire with a face to face encounter and ensure appropriate medical follow-up, as indicated (especially, for responses denoted by an asterisk).

(2) Place the original DD Form 2796 and PDHRA (DD Form 2900) forms in the individual's permanent medical record.

(3) Ensure electronic copies of each are transmitted to the deployment medical surveillance system (DMSS) at the AFHSC.

(4) Ensure appropriate medical follow-up as required.

c. Conduct risk based TB screening at home station IAW Service guidance.

d. Draw post-deployment serum samples at home station for storage in the serum repository IAW current DoD and Service-specific policy.

e. Conduct additional health assessments and or health debriefs if indicated by health threats or events occurring in theater.

f. Integrate all deployed medical encounter documentation into the medical record.

g. Ensure all health surveillance and OEH monitoring data and reports have

been submitted to the AFHSC and DOEHRS data portal.

h. Medical personnel will conduct and submit all lessons learned and after action reports IAW Service-specific and subordinate activity policy. All lessons learned and AARs will be submitted to the servicing component and a copy furnished to the U.S. Africa Command Medical Division FHP Branch for situational awareness.

2. For personnel who deployed or traveled for less than 30 days to a land-based location within the U.S. Africa Command, the requirements listed in paragraphs a., c., e., and h. above must be accomplished.

ENCLOSURE E

REFERENCES

a. Joint Publication 4-02, 31 October 2006, "Health Services Support"

b. Joint Publication 1-02, 12 April 2001 as amended through 19 August 2009, "Department of Defense Dictionary of Military and Associated Terms"

c. AR 40-562/BUMEDINST 6230.15a/AFJI 48-110, 29 October 2006, "Immunization and Chemoprophylaxis"

d. DoD USD (P&R) Instruction 6025.19, 03 January 06, "Individual Medical Readiness (IMR)"

e. DoD ASD (HA) Memorandum, 16 February 2008, "Periodic Health Assessment Policy for Active Duty and Selected Reserve Members"

f. DoD USD (P&R) Memorandum, 09 February 2006, "Policy Guidance for Medical Deferral Pending Deployment to Theater of Operations"

g. DoD USD (HA) Memorandum, 14 March 2006, "Policy for Pre-and Post-deployment Serum Collection"

h. DoD USD (P& R) Instruction 6490.03, 11 August 2006, "Deployment Health"

i. DoD ASD (HA) Memorandum, 07 November 2006, "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications"

j. DoD ASD (HA) Memorandum, 28 May 2008, "Baseline Pre-deployment Neurocognitive Functional Assessment - Interim Guidance"

k. CJCS MCM 0028-07, 02 November 2007, "Procedures for Deployment Health Surveillance"

l. DoD USD (P&R) Instruction 6200.05, 16 February 2007, "Force Health Protection Quality Assurance (QA) Program"

m. DoD USD (P&R) Directive, 6200.04, 09 October 2004, certified current as of 23 April 2007, "Force Health Protection (FHP)"

n. DoD USD (P&R) Directive 6490.02E, 21 October 2004, certified current as of 23 April 2007, "Comprehensive Health Surveillance"

o. DoD USD (HA) Memorandum, 18 May 2007, "Updated Policy for Prevention of Arthropod-borne Diseases Among Department of Defense Personnel Deployed to Endemic Areas"

p. Armed Forces Pest Management Board Technical Information Manual 36, 18 April 2002, "Personal Protective Measures Against Arthropods"

q. DoDI USD (AT&L) 4150.7, 22 April 1996, "DoD Pest Management Program"

r. DoD USD (HA) Memorandum, 17 October 2002, "Anti-Malarial Medications"

s. DoD USD (P&R) Instruction 6200.02, 27 February 2008, "Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs"

t. DoD ASD (HA) Memorandum, 08 March 2007, "Traumatic Brain Injury Question for the Post-Deployment Health Assessment"

u. DoD ASD (HA) Memorandum, 28 May 2008, "Baseline Pre-deployment Neurocognitive Functional Assessment Interim Guidance"

v. DoD USD (AT&L) Instruction 6055.05, 11 November 2008, "Occupational and Environmental Health (OEH)"

w. DoD USD (AT&L) Instruction 6055.12, 05 March 2004, "Department of Defense Hearing Conservation"

x. DoD USD (AT&L) Instruction 4715.13, 15 November 2005, "Department of Defense Noise Program"

y. DoD USD (AT&L) Instruction 4715.5G, 15 March 2000, "Overseas Environmental Baseline Guidance Document"

z. DoD USD (AT&L) Instruction 4715.18, 11 June 2009, "Emerging Contaminants"

aa. American Society for Testing and Materials (ASTM) International E 2318-03, December 2003, "Standard guide for Environmental Health Site Assessment Process for Military Deployments"

bb. (U) Navy and Marine Corps Public Health Center, 7 February 2008, " Standard Operating Procedures for Environmental Health Site Assessments"

cc. (U) USACHPPM Technical Guide 251, August 2001, "A Soldier's Guide to Environmental and Occupational Field Sampling for Military Deployment"

dd. DoD ASD (HA) Instruction 1322.24, 12 July 2002, "Medical Readiness Training"

ee. DoD USD (P&R) Directive 1410, 10, 23 January 2009, "DoD Civilian Expeditionary Workforce"

ff. DoD USD (AT&L) Instruction 3020.41, 03 October 2005, "Contractor Personnel Authorized to Accompany U.S. Armed Forces"

gg. DoD USD (I) Instruction 6420.01, 20 March 2009, "National Center for Medical Intelligence"

hh. Armed Forces Health Surveillance Center (AFHSC), June 2009, "Tri-Service Reportable Event Guidelines & Case Definitions"

ii. DoD USD (HA) Directive 6400.4, 22 August 2003, certified current as of 24 November 2003, "DoD Veterinary Services Program"

jj. Army Medical Surveillance Activity, June 2009, "Tri-Service Reportable Events Guidelines & Case Definitions"

kk. HQ US Africa Command Surgeon Policy, 24 February 2009, "Delegation of Waiver Authority for Medical Deferral Pending Deployment to Theater of Operations"

ll. National Center for Medical Intelligence, Health Risk Assessments, www.intelink.gov/ncmi/index.php or http://www.afmic.dia.smil.mil/index.php

mm. Centers for Disease Control and Health Promotion, Traveler's Health Information, www.cdc.gov

nn. Military Vaccines (MILVAX), www.vaccines.mil or http://www.vaccines.army.smil.mil/

oo. US Army Center for Health Promotion and Preventive Medicine, www.usachppm.apgea.army.mil or https://usachppm1.army.smil.mil/

pp. AR 40-657/NAVSUP 4355.4H/MCO P 10110.31H, 21 February 2005, Veterinary/Medical Food Safety, Quality Assurance, and Laboratory Service

qq. AFI 48-116, 17 March 2004, Food Safety Program

rr. DoD USD (P&R) Instruction 6490.07, 05 February 2010, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilians Employees"

GLOSSARY OF ACRONYMS AND DEFINITIONS

PART I - ACRONYMS

AAR After Action Report
AOR Area of Responsibility
ACIP Advisory Committee in Immunization Practice
AFPMB Armed Forces Pest Management Board
AFHSC Armed Force Health Surveillance Center
AIS Automated Information System

BCT-PM Brigade Combat Team-Preventive Medicine
BI Battle Injury

CANA Convulsive Antidote Nerve Agent
CBRN Chemical, Biological, Radiological, and Nuclear
CDC Centers for Disease Control and Prevention
CJTF-HoA Combined Joint Task Force - Horn of Africa
CSM Conceptual Site Model
CW Chemical Warfare

D&I Disease and Injury
DMSS Deployment Medical Surveillance System
DNBI Disease and Non-battle Injury
DoD Department of Defense
DOEHRS Deployment Occupational and Environmental Health Readiness System

EBS Environmental Baseline Survey

FDA Food and Drug Administration
FDPMU Forward Deployed Preventive Medicine Unit
FDS Field Data Sheet
FHP Force Health Protection
FHPPP Force Health Protection Prescription Products

GPS Global Positioning System
GTAP Global Threat Assessment Program

HX History
HIV Human Immunodeficiency Virus
HIPAA Health Insurance Portability and Accountability Act

IAW In Accordance With
IDA Individual Dynamic Absorption

IND	Investigational New Drugs
JMeWS	Joint Medical Work Station
MEG	Military Exposure Guideline
MGRS	Military Grid Record System
NCMI	National Center for Medical Intelligence
NIH	National Institutes of Health
NIPR	Non-secure Internet Protocol Router
OEH	Occupational and Environmental Health
OEHSA	Occupational and Environmental Health Site Assessment
OEF-TS	Operation ENDURING FREEDON – TRANS SAHAL
OASD	Office of Assistant Secretary of Defense
PAM	Preventive Aerospace Medicine
PB	Pyridostigmine Bromide
PDHRA	Post Deployment Health Re-assessment
PDSS	Pre Deployment Site Survey
PLHA	Preliminary Hazard Assessments
POL	Petroleum, Oils, and Lubricants
PPE	Personal Protective Equipment
PM	Preventive Medicine
PPM	Personal Protective Measures
RME	Reportable Medical Event
SIPR	Secure Internet Protocol Router
SOCAF	Special Operations Command Africa
STI	Sexually Transmitted Infection
TAD	Temporary Additional Duty
TB	Tuberculosis
TDY	Temporary Duty
TG	Technical Guide
USACE	U.S. Army Corps of Engineers
USACHPPM	U.S. Army Center for Health Promotion and Preventive Medicine
USAFSAM	U.S. Air Force School of Aerospace Medicine
USAMMCE	U.S. Army Medical Material Center Europe
USD/HA	Under Secretary of Defense Health Affairs
USSOCCOM	U.S. Special Operations Command
WHO	World Health Organization
2-PAM CL	Atropine and Pralidoxime Chloride

PART II - DEFINITIONS

1. Chemical, Biological, Radiological, and Nuclear agents. For the purposes of this Instruction, specific warfare agents that pose health threats such as toxic chemicals intended for use in military operations; microorganisms that cause disease in personnel, plants, or animals or causes the deterioration of material; toxins; or agents that emit radiation, generally alpha or beta particles, often accompanied by gamma rays, from the nuclei of an unstable isotope.

2. Deployment Health Activities. The regular collection, analysis, archiving, interpretation, and distribution of health-related data used for monitoring the health of individuals or a deployed population, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury. It includes OEH and medical surveillance subcomponents.

3. Exposure. Human contact due to a completed exposure pathway with a hazardous or potentially hazardous chemical, physical, or biological agent. Exposure may be short-term, of intermediate duration, or long-term. Assessment of individual health risk is dependent on the exposure concentration (how much), the frequency and duration of exposure (how long), and the multiplicity of exposures with other similar exposure agents.

4. Exposure Pathway. Occurs when five elements: source of contamination, environmental media and transport mechanism, point of exposure, route of exposure, and receptor population link the contaminant source to the receptor population by inhalation, dermal contact, or ingestion. If a completed or potentially completed exposure pathway exists, the receptor population is considered at risk for exposure.

5. Food and Water Vulnerability Assessments. Assessments of the susceptibility of food and water (from the point of manufacture/packaging, through distribution, storage, preparation, and serving), including ice and bottled water supplies, to natural or intentional contamination or destruction including terrorist attacks.

6. Force Health Protection Prescription Products. Certain drugs, vaccines, and other medical products that are useful for protecting the health of deployed personnel that may be used only under a physician's prescription. Examples of such products are atropine and/or 2-PAMchloride auto-injectors, certain antimicrobials, antimalarials, and pyridostigmine bromide. The use of investigational new drugs for force health protection must be prescribed according to DoD Directive 6200.2, "Use of Investigational New Drugs for Force Health Protection.

7. Health Effects. For the purposes of hazard severity categorization, health effects are broken into acute effects and chronic effects.

a. Acute effects: have relatively immediate onset. While acute effects are typically

reversible, chronic effects may occur secondarily.

b. Chronic effects: typically have a delayed onset (e.g., months to years) and are generally considered irreversible and/or can lead to varying degrees of disability.

8. Health Hazard. A composite of ongoing or potential environmental, occupational, psychological, geographic, and meteorological conditions; endemic diseases; and employment of chemical, biological, radiological, or nuclear weapons that reduce the effectiveness of joint forces through wounds, injuries, illness, and psychological stressors.

9. Health Risk Communications. The timely process of effectively communicating the nature of health and safety hazards and risks (probability and severity), their countermeasures, health outcomes, necessary medical follow-up, and other health-related information to commanders, service members, family members, and others in an honest and understandable manner that fosters trust.

10. Health Risk Communications Plan. A document that specifies the means of delivery and development of key messages on deployment health and safety threats and risks (including actual and potential exposures), associated countermeasures, and any necessary medical follow-up for deployed personnel.

11. Health Surveillance. The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents.

12. Health Threat and Countermeasures Briefing. A health briefing to deploying Service members, government civilians, and contractors deploying with the force that identifies potential health and safety hazards, including operational stress, hazardous and nuisance noise, and endemic diseases expected to be encountered during or as a result of the deployment; identifies countermeasures to be used to reduce risks; and reinforces safety, health, and field hygiene and sanitation procedures. The briefing addresses topics such as endemic diseases, hazardous plants and animals, entomological hazards, CBRN agents, toxic industrial chemicals and materials (agricultural and industrial), deployment-related stress, and climatic or environmental extremes (e.g., heat, cold, high altitude, wind-blown sand and/or other particulates).

13. Medical Surveillance. The ongoing, systematic collection, analysis and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance.

14. Occupational and Environmental Health Activities. The regular collection, analysis,

archiving, interpretation, and dissemination of OEH-related data for the purposes of monitoring the health of or potential health hazard impact on a population or an individual, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury, and to assess the effectiveness of controls.

15. Occupational and Environmental Health Site Assessment. Documents the OEH conditions found at a site (base camp, bivouac site or outpost, or other permanent or semi-permanent basing location) beginning at or near the time it is first occupied. The assessment, done by Service preventive medicine personnel, includes site history; environmental health survey results for air, water, soil, and noise; entomological surveys; occupational and industrial hygiene surveys; and ionizing and non-ionizing radiation hazard surveys, if indicated. Its purpose is to identify hazardous exposure agents with complete or potentially complete exposure pathways that may affect the health of deployed personnel.

16. Occupational and Environmental Health Surveillance. The regular or repeated collection, analysis, archiving, interpretation, and dissemination of OEH-related data from monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat or control the occurrence of disease or injury when determined necessary.

17. Population at Risk. The deployed population or a subset of the deployed population that is at risk of experiencing an event or being exposed to the health threat during a specified period and at a specified location.

18. Preliminary Hazard Assessment. For the purposes of this Instruction, PLHA is the process of reviewing relevant intelligence data, past hazard assessments, and/or other available pre-deployment data for the area of deployment to identify potential OEH threats to deploying personnel.

19. Reportable Medical Event. An event that meets the Tri-service case definitions found the Army Medical Surveillance Activity Tri-Service Reportable Event, June 2009. In addition, a reportable medical event may be defined by the supported combatant command or subordinate organization.

20. Toxic Industrial Chemicals and Materials. For the purposes of this Instruction, any chemicals or materials used or produced in an industrial process (raw material, final products, or by-products, including solid and liquid wastes and air pollutants) that pose a health hazard due to their toxic properties.