

Military Deployment
Periodic Occupational and Environmental Monitoring Summary (POEMS):
FOB Clark and vicinity, Afghanistan
Calendar Years: (2006 to 2014)

AUTHORITY: This POEMS has been developed in accordance with Department of Defense Instructions (DoDI) 6490.03, 6055.05, and Joint Chiefs of Staff memorandum MCM 0017-12 (References 1-3).

PURPOSE: This POEMS documents the Department of Defense (DoD) assessment of occupational and environmental health (OEH) risk for FOB Clark and vicinity that includes: Combat Outpost (COP) Chergatah, COP Narizah, and COP Spera. It presents a qualitative summary of OEH risks identified at these locations and their potential medical implications. The report is based on information collected from 10 September 2006 through 07 August 2014 to include deployment OEH surveillance sampling and monitoring data (e.g., air, water, and soil), field investigation and health assessment reports, as well as country and area-specific information on endemic diseases.

This assessment assumes that environmental sampling at FOB Clark and vicinity during this period was performed at representative exposure points selected to characterize health risks at the population-level. Due to the nature of environmental sampling, the data upon which this report is based may not be fully representative of all the fluctuations in environmental quality or capture unique occurrences. While one might expect health risks pertaining to historic or future conditions at this site to be similar to those described in this report, the health risk assessment is limited to 10 September 2006 through 07 August 2014.

The POEMS can be useful to inform healthcare providers and others of environmental conditions experienced by individuals deployed to FOB Clark and vicinity during the period of this assessment. However, it does not represent an individual exposure profile. Individual exposures depend on many variables such as; how long, how often, where and what someone is doing while working and/or spending time outside. Individual outdoor activities and associated routes of exposure are extremely variable and cannot be identified from or during environmental sampling. Individuals who sought medical treatment related to OEH exposures while deployed should have exposure/treatment noted in their medical records on a Standard Form (SF) 600 (Chronological Record of Medical Care).

SITE DESCRIPTION:

FOB Clark was located in the Khost Province of Eastern Afghanistan near the town of Khost. Vehicle emissions are considered a major contributor to air pollution in the town of Khost. COP Chergatah is located on a rugged mountaintop bordering Pakistan less than two miles from Northern Waziristan. There was limited information on COP Narizah and COP Spera which are both located near the Pakistan border.

SUMMARY: Conditions that may pose a Moderate or greater health risk are summarized in Table 1. Table 2 provides population based risk estimates for identified OEH conditions at FOB Clark and vicinity. As indicated in the detailed sections that follow Table 2, controls established to reduce health risk were factored into this assessment. In some cases, e.g., ambient air, specific controls are noted, but not routinely available/feasible.

Table 1: Summary of Occupational and Environmental Conditions with MODERATE or Greater Health Risk

Short-term health risks & medical implications:

The following hazards may be associated with potential acute health effects in some personnel during deployment at FOB Clark and vicinity:

Food/waterborne diseases (e.g., bacterial diarrhea, hepatitis A, typhoid/paratyphoid fever, diarrhea-cholera, diarrhea- protozoal, brucellosis, hepatitis E); other endemic diseases (malaria, cutaneous leishmaniasis (acute), Crimean-Congo hemorrhagic fever, sandfly fever, scrub typhus(mite-borne), leptospirosis, Tuberculosis (TB), rabies, anthrax, Q fever); and heat stress. For food/waterborne diseases (e.g., bacterial diarrhea, hepatitis A, typhoid/paratyphoid fever, diarrhea-cholera, diarrhea- protozoal, brucellosis, hepatitis E), if ingesting local food and water, the health effects can temporarily incapacitate personnel (diarrhea) or result in prolonged illness (hepatitis A, typhoid/paratyphoid fever, brucellosis, hepatitis E). Risks from food/waterborne diseases may have been reduced with preventive medicine controls and mitigation, which includes hepatitis A and typhoid fever vaccinations and only drinking from approved water sources in accordance with standing CENTCOM policy. For other vector-borne endemic diseases (malaria, cutaneous leishmaniasis (acute), Crimean-Congo hemorrhagic fever, sandfly fever, scrub typhus (mite-borne), these diseases may constitute a significant risk due to exposure to biting vectors; risk reduced to 'Low' by proper wear of the treated uniform, application of repellent to exposed skin, bed net use, and appropriate chemoprophylaxis, as well as minimizing areas of standing water and other vector-breeding areas. For water contact diseases (leptospirosis) activities involving extensive contact with surface water increase risk. For respiratory diseases (TB), personnel in close-quarter conditions could have been at risk for person-to-person spread. Animal contact diseases (rabies, anthrax, Q fever), pose year-round risk. For heat stress, risk can be greater during months of March through October, and greater for susceptible persons including those older than 45, of low fitness level, unacclimatized, or with underlying medical conditions, and those under operational constraints (equipment, PPE, vehicles). Risks from heat stress may have been reduced with preventive medicine controls, work-rest cycles, proper hydration and nutrition, and mitigation.

Air quality: For inhalable coarse particulate matter less than 10 micrometers in diameter (PM₁₀), the PM₁₀ overall short-term health risk was not evaluated due to insufficient data. For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM_{2.5}), the PM_{2.5} overall short-term health risk was not evaluated due to insufficient data. However, the entire FOB Clark and vicinity area is an arid and dust-prone desert environment, also subject to vehicle traffic. Consequently, exposures to PM₁₀ and PM_{2.5} may vary, as conditions may vary, and may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel while at this site, particularly exposures to high levels of dust such as during high winds or dust storms. For PM₁₀ and PM_{2.5}, certain subgroups of the deployed forces (e.g., those with pre-existing asthma/cardio-pulmonary conditions) are at greatest risk of developing notable health effects. Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. For FOB Clark and vicinity, the PM₁₀ and the PM_{2.5} overall short-term health risks specifically for burn pits and incinerators were not evaluated due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis'; samples identified with burn pits were assessed with base wide assessment.— see Section 10.7. Where burn pits, incinerators, and/or open burning of solid waste exist, all exposures may vary, and exposures to high levels of PM₁₀ and PM_{2.5} from smoke may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups. Although most short-term health effects from exposure to particulate matter and burn pit smoke should have resolved post-deployment, providers should be prepared to consider the relationship between deployment exposures and current complaints. Some individuals may have sought treatment for acute respiratory irritation. Personnel who reported with symptoms or required treatment while at site(s) with burn pit activity should have exposure and treatment noted in medical record (e.g., electronic medical record and/or on a Standard Form (SF) 600 (*Chronological Record of Medical Care*)).

Long-term health risks & medical implications:

The following hazards may be associated with potential chronic health effects in some personnel during deployment at FOB Clark and vicinity:

Air quality: For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM_{2.5}), the overall long-term health risk was not evaluated due to insufficient data. Inhalable coarse particulate matter less than 10 micrometers in diameter (PM₁₀) was not evaluated for long-term health risk due to no available health guidelines. However, the entire FOB Clark and vicinity area is an arid and dust-prone desert environment, also subject to vehicle traffic, and conditions may have varied. Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. The PM₁₀ and PM_{2.5} overall long-term health risks were not evaluated at the burn pit/incinerator and open burning locations at FOB Clark and vicinity due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis' and due to no available health guidelines for PM₁₀. Samples identified with burn pits were assessed with base wide assessment - see Section 10.7. However, burn pit, incinerator and/or open burning of solid waste exposures all may vary, as conditions may have varied. For inhalational exposure to high levels of dust containing PM₁₀ and PM_{2.5}, such as

during high winds or dust storms, and for exposures to burn pit smoke, it is considered possible that some otherwise healthy personnel, who were exposed for a long-term period to dust and particulate matter, could develop certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions. While the dust and particulate matter exposures and exposures to burn pits are acknowledged, at this time there were no specific recommended, post-deployment medical surveillance evaluations or treatments. Providers should still consider overall individual health status (e.g., any underlying conditions/susceptibilities) and any potential unique individual exposures (such as burn pits/barrels, incinerators, occupational or specific personal dosimeter data) when assessing individual concerns. Certain individuals may need to be followed/evaluated for specific occupational exposures/injuries (e.g., annual audiograms as part of the medical surveillance for those enrolled in the Hearing Conservation Program; and personnel covered by Respiratory Protection Program and/or Hazardous Waste/Emergency Responders Medical Surveillance).

Table 2. Population-Based Health Risk Estimates - FOB Clark and vicinity that includes COP Chergatah, COP Narizah, and COP Spera ^{1, 2}

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
AIR			
Particulate matter less than 10 micrometers in diameter (PM ₁₀)	Short-term: Insufficient data to assess risk. Daily levels vary; acute health effects (e.g., upper respiratory tract irritation) more pronounced during peak days. More serious effects are possible in susceptible persons (e.g., those with asthma/existing respiratory diseases).	Limiting strenuous physical activities when air quality is especially poor; and actions such as closing tent flaps, windows, and doors.	Short-term: Insufficient data to assess risk. Daily levels vary; acute health effects (e.g., upper respiratory tract irritation) more pronounced during peak days. More serious effects are possible in susceptible persons (e.g., those with asthma/existing respiratory diseases).
	Long-term: No health guidelines		Long-term: No health guidelines
Particulate matter less than 2.5 micrometers in diameter (PM _{2.5})	Short-term: Insufficient data to assess risk. A majority of the time mild acute (short term) health effects are anticipated; certain peak levels may produce mild eye, nose, or throat irritation in some personnel and pre-existing health conditions (e.g., asthma, or cardiopulmonary diseases) may be exacerbated.	Limiting strenuous physical activities when air quality is especially poor; and actions such as closing tent flaps, windows, and doors.	Short-term: Insufficient data to assess risk. A majority of the time mild acute (short term) health effects are anticipated; certain peak levels may produce mild eye, nose, or throat irritation in some personnel and pre-existing health conditions (e.g., asthma, or cardiopulmonary diseases) may be exacerbated.
	Long-term: Insufficient data to assess risk. A small percentage of personnel may be at increased risk for developing chronic conditions, particularly those more susceptible to acute effects (e.g., those with asthma/existing respiratory diseases).		Long-term: Insufficient data to assess risk. A small percentage of personnel may be at increased risk for developing chronic conditions, particularly those more susceptible to acute effects (e.g., those with asthma/existing respiratory diseases).
PM ₁₀ Metals	Short-term: Insufficient data to assess risk.		Short-term: Insufficient data to assess risk.
	Long-term: Insufficient data to assess risk.		Long-term: Insufficient data to assess risk.
PM _{2.5} Metals	Short-term: Insufficient data to assess risk.		Short-term: Insufficient data to assess risk.
	Long-term: Insufficient data to assess risk.		Long-term: Insufficient data to assess risk.
Volatile Organic Compounds (VOC)	Short-term: Insufficient data to assess risk.		Short-term: Insufficient data to assess risk.
	Long-term: Insufficient data to assess risk.		Long-term: Insufficient data to assess risk.
SOIL			
Metals	Short-term: Not an identified source of health risk.		Short-term: Not an identified source of health risk.
	Long-term: No data available		Long-term: No data available
Organic Compounds	Short-term: Not an identified source of health risk.		Short-term: Not an identified source of health risk.
	Long-term: No data available		Long-term: No data available
Inorganic Compounds	Short-term: Not an identified source of health risk.		Short-term: Not an identified source of health risk.
	Long-term: No data available		Long-term: No data available
WATER			
Consumed Water (Water Used for Drinking)	Short-term: Insufficient data to assess risk.	Use of U.S. Army Public Health Center (Provisional) (APHC (Prov)) [former Army	Short-term: Insufficient data to assess risk.
	Long-term: Insufficient data to assess risk.		Long-term: Insufficient data to assess risk.

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
		Institute of Public Health (AIPH) and U.S. Army Veterinary Command] approved bottled water and potable water only from approved water sources.	
Water for Other Purposes	Short-term: Insufficient data to assess risk.	Water treated in accordance with standards applicable to its intended use.	Short-term: Insufficient data to assess risk.
	Long-term: Insufficient data to assess risk.		Long-term: Insufficient data to assess risk.
ENDEMIC DISEASE			
Food borne/Waterborne (e.g., diarrhea-bacteriological)	Short-term: Variable; High (bacterial diarrhea, hepatitis A, typhoid fever) to Moderate (diarrhea-cholera, diarrhea- protozoal, brucellosis, hepatitis E) to Low (polio) if ingesting local food/water, the health effects can temporarily incapacitate personnel (diarrhea) or result in prolonged illness (hepatitis A, Typhoid fever, hepatitis E, brucellosis).	Preventive measures include Hepatitis A and Typhoid fever vaccination and consumption of food and water only from approved sources.	Short-term: Low to none
	Long-term: none identified		Long-term: No data available
Arthropod Vector Borne	Short-term: Variable; High for malaria, Moderate for leishmaniasis - cutaneous (acute), Crimean-Congo hemorrhagic fever, sandfly fever, typhus-miteborne; and Low for, the plague and West Nile fever.	Preventive measures include proper wear of treated uniform, application of repellent to exposed skin, bed net use, minimizing areas of standing water.	Short-term: Low
	Long-term: Low for Leishmaniasis-visceral infection.		Long-term: No data available
Water-Contact (e.g., wading, swimming)	Short-term: Moderate for leptospirosis	Recreational swimming in surface waters not likely in this area of Afghanistan during this time period.	Short-term: Low for leptospirosis.
	Long-term: No data available		Long-term: No data available
Respiratory	Short-term: Variable; Moderate for tuberculosis (TB) to Low for meningococcal meningitis.	Providing adequate living and work space; medical screening; vaccination.	Short-term: Low
	Long-term: No data available		Long-term: No data available
Animal Contact	Short-term: Variable; Moderate for rabies, anthrax, Q-fever to Low for H5N1 avian influenza.	Prohibiting contact with, adoption, or feeding of feral animals in accordance with U.S. Central Command (CENTCOM) General Order (GO) 1B. Risks are further reduced in the event of assessed contact by prompt post-exposure rabies prophylaxis in accordance with The Center for Disease Control's Advisory Committee on Immunization Practices guidance.	Short-term: No data available
	Long-term: Low (Rabies)		Long-term: No data available
VENOMOUS ANIMALS			

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
Snakes, scorpions, and spiders	Short-term: Low; If encountered, effects of venom vary with species from mild localized swelling (e.g., widow spider) to potentially lethal effects (e.g., <i>Androctonus baluchicus</i>).	Risk reduced by avoiding contact, proper wear of uniform (especially footwear), and proper and timely treatment.	Short-term: Low; If encountered, effects of venom vary with species from mild localized swelling (e.g., widow spider) to potentially lethal effects (e.g., <i>Androctonus baluchicus</i>).
	Long-term: No data available		Long-term: No data available
HEAT/COLD STRESS			
Heat	Short-term: Low to High, Risk of heat injury is Extremely High from April – September, High in October, Moderate in March, and Low from October – February.	Work-rest cycles, proper hydration and nutrition, and Wet Bulb Globe Temperature (WBGT) monitoring.	Short-term: Low to High, mitigated to Low. Risk of heat injury in unacclimatized or susceptible personnel is Extremely High from April – September, High in October, Moderate in March, and Low from October – February.
	Long-term: Low. However, the risk may be greater to certain susceptible persons—those older (i.e., greater than 45 years), in lesser physical shape, or with underlying medical/health conditions.		Long-term: Low. However, the risk may be greater to certain susceptible persons—those older (i.e., greater than 45 years), in lesser physical shape, or with underlying medical/health conditions.
Cold	Short-term: Low risk of cold stress/injury.	Risks from cold stress reduced with protective measures such as use of the buddy system, limiting exposure during cold weather, proper hydration and nutrition, and proper wear of issued protective clothing.	Short-term: Low risk of cold stress/injury.
	Long-term: Low; Long-term health implications from cold injuries are rare but can occur, especially from more serious injuries such as frost bite.		Long-term: Low; Long-term health implications from cold injuries are rare but can occur, especially from more serious injuries such as frost bite.
Unique Incidents/Concerns			
Pesticides/Pest Control	Short-term: Error! Reference source not found.	See Section 10.4	Short-term: Error! Reference source not found.
	Long-term: Error! Reference source not found.		Long-term: Error! Reference source not found.
Burn Pits PM _{2.5} and PM ₁₀	Short-term: Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. For FOB Clark and vicinity, the PM ₁₀ and the PM _{2.5} overall short-term health risks specifically for burn pits, incinerators, and open burning sites were not evaluated due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis'; samples identified with burn pits were assessed with base wide assessment.— see Section 10.7. Exposure to burn pit (or incinerator or open burning site) smoke is variable. Exposure to high levels of PM ₁₀ and PM _{2.5} from smoke may result in mild to	Control measures may have included locating burn pits downwind of prevailing winds, increased distance from living and working areas when possible, and improved waste segregation and management techniques.	Short-term: Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. For FOB Clark and vicinity, the PM ₁₀ and the PM _{2.5} overall short-term health risks specifically for burn pits, incinerators, and open burning sites were not evaluated due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis'; samples identified with burn pits were assessed with base wide assessment.— see Section 10.7. Exposure to burn pit (or incinerator or open burning site) smoke is variable. Exposure to high levels of PM ₁₀ and PM _{2.5} from smoke may result in mild to

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
	<p>more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups.</p> <p>Long-term: Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. The PM₁₀ and the PM_{2.5} overall long-term health risks were not evaluated at the burn pit locations at FOB Clark and vicinity due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis' and due to no available health guidelines for PM₁₀. Samples identified with burn pits were assessed with base wide assessment – see Section 10.7. Exposure to burn pit (and incinerator and open burning site) smoke is variable. Exposure to high levels of PM₁₀ and PM_{2.5} in the smoke may be associated with some otherwise healthy personnel, who were exposed for a long-term period, possibly developing certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions.</p>		<p>more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups.</p> <p>Long-term: Burn pits and/or incinerators were reported in operation at COP Narizah, and open burning of solid waste was reported occurring adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp. The PM₁₀ and the PM_{2.5} overall long-term health risks were not evaluated at the burn pit locations at FOB Clark and vicinity due to 'insufficient environmental samples collected near burn pits (or incinerators or open burning sites) provided for analysis' and due to no available health guidelines for PM₁₀. Samples identified with burn pits were assessed with base wide assessment – see Section 10.7. Exposure to burn pit and incinerator and open burning site smoke is variable. Exposure to high levels of PM₁₀ and PM_{2.5} in the smoke may be associated with some otherwise healthy personnel, who were exposed for a long-term period, possibly developing certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions.</p>

¹This Summary Table provides a qualitative estimate of population-based short- and long-term health risks associated with the occupational and environmental conditions at FOB Clark and vicinity that includes COP Chergatah, COP Narizah, and COP Spera. It does not represent an individual exposure profile. Actual individual exposures and health effects depend on many variables. For example, while a chemical may have been present in the environment, if a person did not inhale, ingest, or contact a specific dose of the chemical for adequate duration and frequency, then there may have been no health risk. Alternatively, a person at a specific location may have experienced a unique exposure which could result in a significant individual exposure. Any such person seeking medical care should have their specific exposure documented in an SF600.

² This assessment is based on specific environmental sampling data and reports obtained from 10 September 2006 through 07 August 2014. Sampling locations are assumed to be representative of exposure points for the camp population but may not reflect all the fluctuations in environmental quality or capture unique exposure incidents.

³This Summary Table is organized by major categories of identified sources of health risk. It only lists those sub-categories specifically identified and addressed at FOB Clark and vicinity. The health risks are presented as Low, Moderate, High or Extremely High for both acute and chronic health effects. The health risk level is based on an assessment of both the potential severity of the health effects that could be caused and probability of the exposure that would produce such health effects. Details can be obtained from the APHC (Prov). Where applicable, "None Identified" is used when though a potential exposure is identified, and no health risks of either a specific acute or chronic health effects are determined. More detailed descriptions of OEH exposures that are evaluated but determined to pose no health risk are discussed in the following sections of this report.

⁴Health risks in this Summary Table are based on quantitative surveillance thresholds (e.g., endemic disease rates; host/vector/pathogen surveillance) or screening levels, e.g., Military Exposure Guidelines (MEGs) for chemicals. Some previous assessment reports may provide slightly inconsistent health risk estimates because quantitative criteria such as MEGs may have changed since the samples were originally evaluated and/or because this assessment makes use of all historic site data while previous reports may have only been based on a select few samples.

1 Discussion of Health Risks at FOB Clark and vicinity, Afghanistan by Source

The following sections provide additional information about the OEH conditions summarized above. All risk assessments were performed using the methodology described in the U.S. Army Public Health Command Technical Guide 230, *Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel* (Reference 4). All OEH risk estimates represent residual risk after accounting for preventive controls in place. Occupational exposures and exposures to endemic diseases are greatly reduced by preventive measures. For environmental exposures related to airborne dust, there are limited preventive measures available, and available measures have little efficacy in reducing exposure to ambient conditions.

2 Air

2.1 Site-Specific Sources Identified

FOB Clark and vicinity were situated in a dusty semi-arid desert environment. Inhalational exposure to high levels of dust and particulate matter, such as during high winds or dust storms, may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel. Additionally, certain subgroups of the deployed forces (e.g., those with pre-existing asthma/cardio pulmonary conditions) are at greatest risk of developing notable health effects.

2.2 Particulate matter

Particulate matter (PM) is a complex mixture of extremely small particles suspended in the air. The PM includes solid particles and liquid droplets emitted directly into the air by sources such as: power plants, motor vehicles, aircraft, generators, construction activities, fires, and natural windblown dust. The PM can include sand, soil, metals, VOC, allergens, and other compounds such as nitrates or sulfates that are formed by condensation or transformation of combustion exhaust. The PM composition and particle size vary considerably depending on the source. Generally, PM of health concern is divided into two fractions: PM₁₀, which includes coarse particles with a diameter of 10 micrometers or less, and fine particles less than 2.5 micrometers (PM_{2.5}), which can reach the deepest regions of the lungs when inhaled. Exposure to excessive PM is linked to a variety of potential health effects.

2.3 Particulate matter, less than 10 micrometers (PM₁₀)

2.3.1 Exposure Guidelines:

Short Term (24-hour) PM ₁₀ (micrograms per cubic meter, $\mu\text{g}/\text{m}^3$):	Long-term PM ₁₀ MEG ($\mu\text{g}/\text{m}^3$):
<ul style="list-style-type: none"> • Negligible MEG = 250 • Marginal MEG = 420 • Critical MEG = 600 	<ul style="list-style-type: none"> • Not defined and not available.

2.3.2 Sample data/Notes:

COP Narizah: A total of three valid PM₁₀ air samples were collected in 2012. The range of 24-hour PM₁₀ concentrations was 28 $\mu\text{g}/\text{m}^3$ – 153 $\mu\text{g}/\text{m}^3$ with an average concentration of 82 $\mu\text{g}/\text{m}^3$. There were not enough samples to assess risk.

2.3.3 Short-term health risks:

Insufficient data to assess risk.

2.3.4 Long-term health risk:

Not Evaluated-no available health guidelines. The U. S. Environmental Protection Agency (EPA) has retracted its long-term standard (National Ambient Air Quality Standards, NAAQS) for PM₁₀ due to an inability to clearly link chronic health effects with chronic PM₁₀ exposure levels.

2.4 Particulate Matter, less than 2.5 micrometers (PM_{2.5})

2.4.1 Exposure Guidelines:

Short Term (24-hour) PM_{2.5} (µg/m³):

- Negligible MEG = 65
- Marginal MEG = 250
- Critical MEG = 500

Long-term (1-year) PM_{2.5} MEGs (µg/m³):

- Negligible MEG = 15
- Marginal MEG = 65

2.4.2 Sample data/Notes:

FOB Clark and vicinity: There were only three valid PM_{2.5} air samples collected from 2012-2014. The range of 24-hour PM_{2.5} concentrations was 11 µg/m³ – 39 µg/m³ with an average concentration of 24 µg/m³. There were not enough samples to assess risk.

COP Narizah: There were only two valid PM_{2.5} air samples collected in 2012. The range of 24-hour PM_{2.5} concentrations was 113 µg/m³ – 546 µg/m³ with an average concentration of 330 µg/m³. There were not enough samples to assess risk.

2.4.3 Short-term health risks:

Insufficient data to assess risk.

2.4.4 Long-term health risks:

Insufficient data to assess risk.

2.5 Airborne Metals

2.5.1 Airborne Metals from PM₁₀

2.5.1.1 Sample data/Notes:

COP Narizah: A total of three valid PM₁₀ airborne metal samples were collected in 2012. None of the analyzed metals in the collected samples were found at concentrations above the 1-year negligible MEGs. There were not enough samples to assess risk.

2.5.1.2 Short-term health risks:

Insufficient data to assess risk.

2.5.1.3 Long-term health risks:

Insufficient data to assess risk.

2.5.2 Airborne Metals from PM_{2.5}

2.5.2.1 Sample data/Notes:

FOB Clark and vicinity: There were only three valid PM_{2.5} airborne metal samples collected from 2012-2014. None of the analyzed metals in the collected samples were found at concentrations above the 1-year negligible MEGs. There were not enough samples to assess risk.

COP Narizah: There were only two valid PM_{2.5} airborne metal samples collected in 2012. None of the analyzed metals in the collected samples were found at concentrations above the 1-year negligible MEGs. There were not enough samples to assess risk.

2.5.2.2 Short-term health risks:

Insufficient data to assess risk.

2.5.2.3 Long-term health risks:

Insufficient data to assess risk.

2.6 Volatile Organic Compounds

2.6.1 Sample data/Notes:

FOB Clark and vicinity: There was only one valid VOC air sample collected in 2013. Acrolein was detected above the long term MEG but there were not enough samples to assess chronic risk. There were not enough samples to assess risk.

2.6.2 Short-term health risks:

Insufficient data to assess risk.

2.6.3 Long-term health risk

Insufficient data to assess risk.

3 Soil

3.1 Site-Specific Sources Identified

3.2 Sample data/Notes:

A total of two valid surface soil samples were collected at FOB Clark and vicinity, six valid surface soil samples were collected at COP Chamkani, and one valid surface soil sample was collected at COP Spera to assess OEH health risk to deployed personnel. The primary soil contamination exposure pathways are dermal contact and dust inhalation. Typical parameters analyzed for included semi volatile organic compounds, heavy metals, polychlorinated biphenyls, pesticides, and herbicides. If the contaminant was known or suspected, other parameters may have been analyzed for (i.e., total

petroleum hydrocarbons and polycyclic aromatic hydrocarbons near fuel spills). For the risk assessment, personnel are assumed to remain at this location for 6 months to 1 year.

3.3 Short-term health risk:

Not an identified source of health risk. Currently, sampling data for soil are not evaluated for short term (acute) health risks.

3.4 Long-term health risk:

None identified based on available sample data. No parameters exceeded 1-year Negligible MEGs for dermal contact. The dust inhalation exposure pathway is addressed in Section 2 above.

4 Water

In order to assess the health risk to U.S. personnel from exposure to water in theater, the APHC (Prov) identified the most probable exposure pathways. These are based on the administrative information provided on the field data sheets submitted with the samples taken over the time period being evaluated. It is assumed that 100% of all U.S. personnel at FOB Clark and vicinity were directly exposed to reverse osmosis water purification unit (ROWPU) treated, disinfected fresh bulk water, bottled water, and untreated well water since this classification of water is primarily used for personal hygiene, showering, cooking, and for use at vehicle wash racks. There is a possibility that personnel, particularly at small outlying camps, may use water that is not regularly disinfected for showering, personal hygiene, or cleaning. Field data sheets indicate that bottled water is the only approved source of drinking water, however, in instances where bottled water was unavailable, ROWPU treated water was used.

4.1 Drinking Water: Bottled or Treated Water

4.1.1 Site-Specific Sources Identified

4.1.2 Sample data/Notes:

To assess the potential for adverse health effects to troops, the following assumptions were made about dose and duration: A conservative (protective) assumption was that personnel routinely ingested 5 liters per day (L/day) of bottled water for up to 365 days (1-year). It was further assumed that control measures were not used. Drinking water samples were only collected at FOB Clark but there were not enough samples collected to assess risk for each year. A total of two valid drinking water samples were collected in 2009, two valid drinking water samples were collected in 2010, one valid drinking water sample was collected in 2012, two valid drinking water samples were collected in 2013, and one valid drinking water sample was collected in 2014. No parameters exceeded their respective MEGs in any of the available drinking water samples.

4.1.3 Short-term health risk:

Insufficient data to assess risk.

4.1.4 Long-term health risk:

Insufficient data to assess risk.

4.2 Non-Drinking Water: Disinfected

4.2.1 Site-Specific Sources Identified

Although the primary route of exposure for most microorganisms is ingestion of contaminated water, dermal exposure to some microorganisms, chemicals, and biologicals may also cause adverse health effects. Complete exposure pathways would include drinking, brushing teeth, personal hygiene, cooking, providing medical and dental care using a contaminated water supply or during dermal contact at vehicle or aircraft wash racks.

4.2.2 Sample data/Notes:

To assess the potential for adverse health effects to troops the following assumptions were made about dose and duration: All U.S. personnel at this location were expected to remain at this site for approximately 1 year. A conservative (protective) assumption is that personnel routinely consumed less than 5L/day of non-drinking water for up to 365 days (1-year). It is further assumed that control measures and/or personal protective equipment were not used. A total of two disinfected bulk water (Non-Drinking) samples were collected at FOB Clark and vicinity in 2006 and 2013, one non-drinking water sample was collected at COP Chergatah in 2012, and six non-drinking water samples were collected at COP Narizah from 2009-2010 and 2012 were evaluated for this health risk assessment. No parameters exceeded their respective MEGs in any of the available drinking water samples.

4.2.3 Short-term health risks:

Insufficient data to assess risk.

4.2.4 Long-term health risks:

Insufficient data to assess risk.

5 Military Unique

5.1 Chemical Biological, Radiological Nuclear Weapons

No specific hazard sources were documented in the Defense Occupational and Environmental Health Readiness System (DOEHRS) or the Military Exposure Surveillance Library (MESL) from 10 September 2006 through 07 August 2014 timeframe (References 1 and 5).

5.2 Depleted Uranium

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe (References 1 and 5).

5.3 Ionizing Radiation

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe (References 1 and 5).

5.4 Non-Ionizing Radiation

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe (References 1 and 5).

6 Endemic Diseases

This document lists the endemic diseases reported in the region, its specific health risks and severity and general health information about the diseases. CENTCOM Modification (MOD) 12 (Reference 6) lists deployment requirements, to include immunizations and chemoprophylaxis, in effect during the timeframe of this POEMS.

6.1 Food borne and Waterborne Diseases

Food borne and waterborne diseases in the area are transmitted through the consumption of local food and water. Local unapproved food and water sources (including ice) are heavily contaminated with pathogenic bacteria, parasites, and viruses to which most U.S. Service Members have little or no natural immunity. Effective host nation disease surveillance does not exist within the country. Only a small fraction of diseases are identified or reported in host nation personnel. Diarrheal diseases are expected to temporarily incapacitate a very high percentage of U.S. personnel within days if local food, water, or ice is consumed. Hepatitis A and typhoid fever infections typically cause prolonged illness in a smaller percentage of unvaccinated personnel. Vaccinations are required for DoD personnel and contractors. In addition, although not specifically assessed in this document, significant outbreaks of viral gastroenteritis (e.g., norovirus) and food poisoning (e.g., *Bacillus cereus*, *Clostridium perfringens*, *Staphylococcus*) may occur. Key disease risks are summarized below:

Mitigation strategies were in place and included consuming food and water from approved sources, vaccinations (when available), frequent hand washing and general sanitation practices.

6.1.1 Diarrheal diseases (bacteriological)

High, mitigated to Low: Diarrheal diseases are expected to temporarily incapacitate a very high percentage of personnel (potentially over 50% per month) within days if local food, water, or ice is consumed. Mitigation strategies in place include consumption of approved food, water, and ice; hand washing; and applied food/water safety mechanisms. Field conditions (including lack of hand washing and primitive sanitation) may facilitate person-to-person spread and epidemics. Typically diarrheal diseases are a mild disease treated in an outpatient setting with recovery and return to duty in less than 72 hours with appropriate therapy. A small proportion of infections may require greater than 72 hours limited duty, or hospitalization.

6.1.2 Hepatitis A, typhoid/paratyphoid fever, and diarrhea-protozoal

High, mitigated to Low: Unmitigated health risk to U.S. personnel is high year round for hepatitis A and typhoid/paratyphoid fever, and Moderate for diarrhea-protozoal. Mitigation strategies in place include immunization, consumption of approved food, water, and ice; hand washing; and applied food/water safety mechanisms. U.S. Personnel did not drink untreated water, and vaccination for Hepatitis A is required for deployment into the CENTCOM Area of Responsibility (AOR). Hepatitis A, typhoid/paratyphoid fever, and diarrhea-protozoal disease may cause prolonged illness in a small percentage of personnel (less than 1% per month). Although much rarer, other potential diseases in this area that are also considered a Moderate risk include: hepatitis E, diarrhea-cholera, and brucellosis.

6.1.3 Polio

Low: Potential health risk to U.S. personnel is Low. Despite a concerted global eradication campaign, poliovirus continues to affect children and adults in Afghanistan. Polio is a highly infectious disease that invades the nervous system. The virus is transmitted by person-to-person, typically by hands, food

or water contaminated with fecal matter or through direct contact with the infected person's saliva. An infected person may spread the virus to others immediately before and about 1 to 2 weeks after symptoms appear. The virus can live in an infected person's feces for many weeks. About 90% of people infected have no symptoms, and about 1% have a very severe illness leading to muscle weakness, difficulty breathing, paralysis, and sometimes death. People who do not have symptoms can still pass the virus to others and make them sick.

6.1.4 Short-term Health Risks:

Variable, unmitigated; Low, mitigated: The overall unmitigated short-term risk associated with food borne and waterborne diseases are considered High (bacterial diarrhea, hepatitis A, typhoid/paratyphoid fever) to Moderate (diarrhea-cholera, diarrhea-protozoal, brucellosis, hepatitis E) to Low (polio) if local food or water is consumed. Preventive Medicine measures reduced the risk to Low. Confidence in the health risk estimate is high.

6.1.5 Long-term Health Risks:

None identified based on available data.

6.2 Arthropod Vector-Borne Diseases

During the warmer months, the climate and ecological habitat support populations of arthropod vectors, including mosquitoes, ticks, mites, and sandflies. Significant disease transmission is sustained countrywide, including urban areas. Malaria, the major vector-borne health risk in Afghanistan, is capable of debilitating a high percentage of personnel for up to a week or more. Mitigation strategies were in place and included proper wear of treated uniforms, application of repellent to exposed skin, and use of bed nets and chemoprophylaxis (when applicable). Additional methods included the use of pesticides, reduction of pest/breeding habitats, and engineering controls.

6.2.1 Malaria

High, mitigated to Low: Potential unmitigated risk to U.S. personnel is High during warmer months (typically April through November) but reduced to low with mitigation measures. Malaria incidents are often associated with the presence of agriculture activity, including irrigation systems and standing water, which provide breeding habitats for vectors. A small number of cases may occur among personnel exposed to mosquito (*Anopheles* spp.) bites. Malaria incidents may cause debilitating febrile illness typically requiring 1 to 7 days of inpatient care, followed by return to duty. Severe cases may require intensive care or prolonged convalescence. Mitigation strategies in place include Individual Protective Measure practices, taking Malaria chemoprophylaxis, permethrin treated uniforms, pesticides, reduction of pest/breeding habitats, and engineering controls.

6.2.2 Leishmaniasis

Moderate, mitigated to Low: The disease risk is Moderate during the warmer months when sandflies are most prevalent, but reduced to low with mitigation measures. Mitigation strategies in place include Individual Protective Measures (IPM) practices, permethrin treated uniforms, pesticides, reduction of pest/breeding habitats, and engineering controls. Leishmaniasis is transmitted by sand flies. There are two forms of the disease; cutaneous (acute form) and visceral (a more latent form of the disease). The leishmaniasis parasites may survive for years in infected individuals and this infection may go unrecognized by physicians in the U.S. when infections become symptomatic years later. Cutaneous infection is unlikely to be debilitating, though lesions may be disfiguring. Visceral leishmaniasis disease can cause severe febrile illness which typically requires hospitalization with convalescence over 7 days.

6.2.3 Crimean-Congo hemorrhagic fever

Moderate, mitigated to Low: Unmitigated risk is moderate, but reduced to low with mitigation measures. Crimean-Congo hemorrhagic fever occurs in rare cases (less than 0.1% per month attack rate in indigenous personnel) and is transmitted by tick bites or occupational contact with blood or secretions from infected animals. The disease typically requires intensive care with fatality rates from 5% to 50%.

6.2.4 Sandfly fever

Moderate, mitigated to Low: Sandfly fever has a Moderate risk with potential disease rates from 1% to 10% per month under worst case conditions. Mitigation measures reduced the risk to low. The disease is transmitted by sandflies and occurs more commonly in children though adults are still at risk. Sandfly fever disease typically results in debilitating febrile illness requiring 1 to 7 days of supportive care followed by return to duty.

6.2.5 Plague

Low: Potential health risk to U.S. personnel is Low year round. Bubonic plague typically occurred as sporadic cases among people who come in contact with wild rodents and their fleas during work, hunting, or camping activities. Outbreaks of human plague are rare and typically occur in crowded urban settings associated with large increases in infected commensal rats (*Rattus rattus*) and their flea populations. Some untreated cases of bubonic plague may develop into secondary pneumonic plague. Respiratory transmission of pneumonic plague is rare but has the potential to cause significant outbreaks. Close contact is usually required for transmission. In situations where respiratory transmission of plague is suspected, weaponized agent must be considered. Extremely rare cases (less than 0.01% per month attack rate) could occur. Incidence could result in potentially severe illness which may require more than 7 days of hospitalization and convalescence.

6.2.6 Typhus-miteborne (scrub typhus)

Moderate, mitigated to Low: Potential health risk to U.S. personnel is Moderate during warmer months (typically March through November) when vector activity is highest. Mitigation measures reduced the risk to low. Mite-borne typhus is a significant cause of febrile illness in local populations with rural exposures in areas where the disease is endemic. Large outbreaks have occurred when non-indigenous personnel such as military forces enter areas with established local transmission. The disease is transmitted by the larval stage of trombiculid mites (chiggers), which are typically found in areas of grassy or scrubby vegetation, often in areas which have undergone clearing and regrowth. Habitats may include sandy beaches, mountain deserts, cultivated rice fields, and rain forests. Although data are insufficient to assess potential disease rates, attack rates can be very high (over 50%) in groups of personnel exposed to heavily infected "mite islands" in focal areas. The disease can cause debilitating febrile illness typically requiring 1 to 7 days of inpatient care, followed by return to duty.

6.2.7 West Nile fever

Low: West Nile fever is present. The disease is maintained by the bird population and transmitted to humans via mosquito vector. Typically, infections in young, healthy adults were asymptomatic although fever, headache, tiredness, body aches (occasionally with a skin rash on trunk of body), and swollen lymph glands can occur. This disease is associated with a low risk estimate.

6.2.8 Short-term health risks:

Low: The unmitigated health risk estimate is High for malaria (infection rate of less than 1% per month), Moderate for leishmaniasis-cutaneous (acute), Crimean-Congo hemorrhagic fever, sandfly fever, typhus-miteborne; and Low for, the plague and West Nile fever. Health risk is reduced to low by proper wear of the uniform, application of repellent to exposed skin, and appropriate chemoprophylaxis. Confidence in health risk estimate was high.

6.2.9 Long-term health risks:

Low: The unmitigated risk is moderate for leishmaniasis-visceral (chronic). Risk is reduced to Low by proper wear of the uniform and application of repellent to exposed skin. Confidence in the risk estimate is high.

6.3 Water Contact Diseases

Operations or activities that involve extensive water contact may result in personnel being temporarily debilitated with leptospirosis in some locations. Leptospirosis health risk typically increases during flooding. In addition, although not specifically assessed in this document, bodies of surface water are likely to be contaminated with human and animal waste. Activities such as wading or swimming may result in exposures to enteric diseases such as diarrhea and hepatitis via incidental ingestion of water. Prolonged water contact also may lead to the development of a variety of potentially debilitating skin conditions such as bacterial or fungal dermatitis. Mitigation strategies were in place and included avoiding water contact and recreational water activities, proper wear of uniform (especially footwear), and protective coverings for cuts/abraded skin.

6.3.1 Leptospirosis

Moderate, mitigated to Low: Human infections occur seasonally (typically April through November) through exposure to water or soil contaminated by infected animals and is associated with wading, and swimming in contaminated, untreated open water. The occurrence of flooding after heavy rainfall facilitates the spread of the organism because as water saturates the environment *Leptospira* present in the soil passes directly into surface waters. *Leptospira* can enter the body through cut or abraded skin, mucous membranes, and conjunctivae. Infection may also occur from ingestion of contaminated water. The acute, generalized illness associated with infection may mimic other tropical diseases (for example, dengue fever, malaria, and typhus), and common symptoms include fever, chills, myalgia, nausea, diarrhea, cough, and conjunctival suffusion. Manifestations of severe disease can include jaundice, renal failure, hemorrhage, pneumonitis, and hemodynamic collapse. Recreational activities involving extensive water contact may result in personnel being temporarily debilitated with leptospirosis. Incidence could result in debilitating febrile illness typically requiring 1 to 7 days of inpatient care, followed by return to duty; some cases may require prolonged convalescence. Mitigation strategies in place include avoiding water contact and recreational water activities; proper wear of uniform, especially footwear, and protective coverings for cuts/abraded skin. This disease is associated with a Moderate health risk estimate.

6.3.2 Short-term health risks:

Low: Unmitigated Health risk of leptospirosis is Moderate during warmer months. Mitigation measures reduce the risk to Low. Confidence in the health risk estimate is high.

6.3.3 Long-term health risks:

None identified based on available data.**6.4 Respiratory Diseases**

Although not specifically assessed in this document, deployed U.S. forces may be exposed to a wide variety of common respiratory infections in the local population. These include influenza, pertussis, viral upper respiratory infections, viral and bacterial pneumonia, and others. The U.S. military populations living in close-quarter conditions are at risk for substantial person-to-person spread of respiratory pathogens. Influenza is of particular concern because of its ability to debilitate large numbers of unvaccinated personnel for several days. Mitigation strategies were in place and included routine medical screenings, vaccination, enforcing minimum space allocation in housing units, implementing head-to-toe sleeping in crowded housing units, implementation of proper personal protective equipment when necessary for healthcare providers and detention facility personnel.

6.4.1 TB

Moderate, mitigated to Low: Potential health risk to U.S. personnel is Moderate, mitigated to Low, year round. Transmission typically requires close and prolonged contact with an active case of pulmonary or laryngeal TB, although it also can occur with more incidental contact. Individuals with prolonged indoor exposure to the local population are at increased risk for latent TB infection. Additional mitigation included active case isolation in negative pressure rooms, where available.

6.4.2 Meningococcal meningitis

Low: Meningococcal meningitis poses a Low risk and is transmitted from person to person through droplets of respiratory or throat secretions. Close and prolonged contact facilitates the spread of this disease. Meningococcal meningitis is potentially a very severe disease typically requiring intensive care; fatalities may occur in 5-15% of cases.

6.4.3 Short-term health risks:

Low: Moderate (TB) to Low (for meningococcal meningitis). Overall risk was reduced to Low with mitigation measures. Confidence in the health risk estimate is high.

6.4.4 Long-term health risks:

None identified based on available data: Tuberculosis is evaluated as part of the post deployment health assessment. A TB skin test is required post-deployment if potentially exposed and is based upon individual service policies.

6.5 Animal-Contact Diseases**6.5.1 Rabies**

Moderate, mitigated to Low: Rabies posed a year-round moderate risk. Occurrence in local animals was well above U.S. levels due to the lack of organized control programs. Dogs are the primary reservoir of rabies in Afghanistan, and a frequent source of human exposure. Rabies is transmitted by exposure to the virus-laden saliva of an infected animal, typically through bites, but could occur from scratches contaminated with the saliva. A U.S. Army Soldier deployed to Afghanistan from May 2010 to May 2011 died of rabies in New York on 31 August 2011 (Reference 7). Laboratory results indicated the Soldier was infected from contact with a dog while deployed. Although the vast majority (>99%) of persons who develop rabies disease will do so within a year after a risk exposure, there have been rare

reports of individuals presenting with rabies disease up to six years or more after their last known risk exposure. Mitigation strategies included command emphasis of CENTCOM GO 1B, reduction of animal habitats, active pest management programs, and timely treatment of feral animal scratches/bites.

6.5.2 Anthrax

Low: Anthrax cases are rare in indigenous personnel, and pose a Low risk to U.S. personnel. Anthrax is a naturally occurring infection; cutaneous anthrax is transmitted by direct contact with infected animals or carcasses, including hides. Eating undercooked infected meat may result in contracting gastrointestinal anthrax. Pulmonary anthrax is contracted through inhalation of spores and is extremely rare. Mitigation measures included consuming approved food sources, proper food preparation and cooking temperatures, avoidance of animals and farms, dust abatement when working in these areas, vaccinations, and proper PPE for personnel working with animals.

6.5.3 Q-Fever

Moderate, mitigated to Low: Potential health risk to U.S. personnel is Moderate, but mitigated to Low, year round. Rare cases are possible among personnel exposed to aerosols from infected animals, with clusters of cases possible in some situations. Significant outbreaks (affecting 1-50%) can occur in personnel with heavy exposure to barnyards or other areas where animals are kept. Unpasteurized milk may also transmit infection. The primary route of exposure is respiratory, with an infectious dose as low as a single organism. Incidence could result in debilitating febrile illness, sometimes presenting as pneumonia, typically requiring 1 to 7 days of inpatient care followed by return to duty. Mitigation strategies in place as listed in paragraph 6.5.2 except for vaccinations.

6.5.4 H5N1 avian influenza

Low: Potential health risk to U.S. personnel is Low. Although H5N1 avian influenza (AI) is easily transmitted among birds, bird-to-human transmission is extremely inefficient. Human-to-human transmission appears to be exceedingly rare, even with relatively close contact. Extremely rare cases (less than 0.01% per month attack rate) could occur. Incidence could result in very severe illness with fatality rate higher than 50 percent in symptomatic cases. Mitigation strategies included avoidance of birds/poultry and proper cooking temperatures for poultry products.

6.5.5 Short-term health risks:

Low: The short-term unmitigated risk is Moderate for rabies, and Q-fever, to Low for anthrax, and H5N1 avian influenza. Mitigation measures reduced the overall risk to Low. Confidence in risk estimate is high.

6.5.6 Long-term health risks:

Low: A Low long term risk exists for rabies because, in rare cases, the incubation period for rabies can be several years.

7 Venomous Animals

All information was taken directly from the Armed Forces Pest Management Board (Reference 8) and the Clinical Toxinology Resources web site from the University of Adelaide, Australia (Reference 9). The species listed below have home ranges that overlap the location of FOB Clark and vicinity, and may present a health risk if they are encountered by personnel. See Section 9 for more information

about pesticides and pest control measures.

7.1 Spiders

- *Latrodectus dahlia* (widow spider): Severe envenoming possible, potentially lethal. However, venom effects are mostly minor and even significant envenoming is unlikely to be lethal.

7.2 Scorpions

- *Androctonus amoreuxi*, and *Androctonus baluchicus*: Severe envenoming possible, potentially lethal. Severe envenoming may produce direct or indirect cardio toxicity, with cardiac arrhythmias, cardiac failure. Hypovolaemic hypotension possible in severe cases due to fluid loss through vomiting and sweating.
- *Compsobuthus rugosulus*, *Mesobuthus caucasicus*, *Mesobuthus eupeus*, *Mesobuthus macmahoni*, *Orthochirus afghanus*, *Orthochirus bicolor*, *Orthochirus Jalalabadensis*, *Orthochirus pallidus*, *Orthochirus samrchelsis*, and *Orthochirus scrobiculosus*: There are a number of dangerous Buthid scorpions, but there are also some known to cause minimal effects only. Without clinical data it is unclear where these species fit within that spectrum.
- *Hottentotta alticola*, and *Hottentotta saulcyi*: Moderate envenoming possible but unlikely to prove lethal. Stings by these scorpions are likely to cause only short lived local effects, such as pain, without systemic effects.
- *Scorpiops afghanus*: Mild envenoming only, not likely to prove lethal. Stings by these scorpions are likely to cause only short lived local effects, such as pain, without systemic effects.

7.3 Snakes

- *Echis carinatus sochureki* (Sochurek's saw-scaled viper), *Gloydius halys* (Haly's pit viper): Severe envenoming possible, potentially lethal. Bites may cause moderate to severe coagulopathy and haemorrhagins causing extensive bleeding.
- *Macrovipera lebetina obtuse* (Levantine viper, and *Macrovipera lebetina turanica* (Levantine viper): Severe envenoming possible, potentially lethal. Bites may cause mild to severe local effects, shock & coagulopathy.
- *Bungarus caeruleus* (Common krait): Severe envenoming likely, high lethality potential. Krait bites can cause moderate to severe flaccid paralysis, respiratory failure, requiring intubation & ventilation in severe cases. Most victims bitten while asleep in huts at night. Bites may produce invisible or barely perceptible puncture marks. Human mortality rate is high without use of antivenom. Antivenom may prevent worsening of paralysis, but may not reverse established paralysis.

7.4 Short-term health risk:

Low: If encountered, effects of venom vary with species from mild localized swelling (e.g., widow spider) to potentially lethal effects (e.g., *Androctonus baluchicus*). See effects of venom above. Mitigation strategies included avoiding contact, proper wear of uniform (especially footwear), and timely medical treatment. Confidence in the health risk estimate is low (Reference 4, Table 3-6).

7.5 Long-term health risk:

None identified.

8 Heat/Cold Stress

8.1 Heat

Summer (June - September) monthly mean temperatures range from 86 degrees Fahrenheit (°F) to 94°F with an average temperature of 91°F based on historical climatological data from the U.S. Air Force Combat Climatology Center, 14th Weather Squadron. The health risk of heat stress/injury based on temperatures alone is Low (< 78°F) from November – February, Moderate (78-81.9°F) in March, high (82-87.9°F) in October, and extremely high (≥ 88°F) from April – September. However, work intensity and clothing/equipment worn pose greater health risk of heat stress/injury than environmental factors alone (Reference 10). Managing risk of hot weather operations included monitoring work/rest periods, proper hydration, and taking individual risk factors (e.g., acclimation, weight, and physical conditioning) into consideration. Risk of heat stress/injury was reduced with preventive measures

8.1.1 Short-term health risk:

Low to High, mitigated to Low. Risk of heat injury in unacclimatized or susceptible populations (older, previous history of heat injury, poor physical condition, underlying medical/health conditions), and those under operational constraints (equipment, PPE, vehicles) is Extremely High from April – September, High in October, Moderate in March, and Low from October – February. The risk of heat injury was reduced to low through preventive measures such as work/rest cycles, proper hydration and nutrition, and monitoring WBGT. Confidence in the health risk estimate is low (Reference 4, Table 3-6).

8.1.2 Long-term health risk:

Low. However, the risk may be greater for certain susceptible persons—those older (i.e., greater than 45 years), in lesser physical shape, or with underlying medical/health conditions. Long-term health implications from heat injuries are rare but may occur, especially from more serious injuries such as heat stroke. It is possible that high heat in conjunction with various chemical exposures may increase long-term health risks, though specific scientific evidence is not conclusive. Confidence in these risk estimates is medium (Reference 4, Table 3-6).

8.2 Cold

8.2.1 Short-term health risks:

Winter (December - March) temperatures range from 34°F to 58°F with an average temperature of 62°F based on historical climatological data from the U.S. Air Force Combat Climatology Center, 14th Weather Squadron. Because even on warm days a significant drop in temperature after sunset by as much as 40°F can occur, there is a risk of cold stress/injury from November – February. The risk assessment for Non-Freezing Cold Injuries, such as chilblain, trench foot, and hypothermia, is Low based on historical temperature and precipitation data. Frostbite is unlikely to occur because temperatures rarely drop below freezing. However, personnel may encounter significantly lower temperatures during field operations at higher altitudes. As with heat stress/injuries, cold stress/injuries are largely dependent on operational and individual factors instead of environmental factors alone (Reference 10).

Low. The health risk of cold injury is Low. Confidence in the health risk estimate is medium.

8.2.2 Long-term health risk:

Low. The health risk of cold injury is Low. Confidence in the health risk estimate is high.

9 Noise

9.1 Continuous

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

9.1.1 Short-term health risks:

Not evaluated.

9.1.2 Long-term health risks:

Not evaluated.

9.2 Impulse

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

9.2.1 Short-term health risks:

Not evaluated.

9.2.2 Long-term health risks:

Not evaluated.

10 Unique Incidents/Concerns

10.1 Potential environmental contamination sources

DoD personnel are exposed to various chemical, physical, ergonomic, and biological hazards in the course of performing their mission. These types of hazards depend on the mission of the unit and the operations and tasks which the personnel are required to perform to complete their mission. The health risk associated with these hazards depends on a number of elements including what materials are used, how long the exposure last, what is done to the material, the environment where the task or operation is performed, and what controls are used. The hazards can include exposures to heavy metal particulates (e.g., lead, cadmium, manganese, chromium, and iron oxide), solvents, fuels, oils, and gases (e.g., carbon monoxide, carbon dioxide, oxides of nitrogen, and oxides of sulfur). Most of these exposures occur when performing maintenance task such as painting, grinding, welding, engine repair, or movement through contaminated areas. Exposures to these occupational hazards can occur through inhalation (air), skin contact, or ingestion; however exposures through air are generally associated with the highest health risk.

10.2 Waste Sites/Waste Disposal

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

10.3 Fuel/petroleum products/industrial chemical spills

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

10.4 Pesticides/Pest Control:

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

10.5 Asbestos

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

10.6 Lead Based Paint

No specific hazard sources were documented in the DOEHRS or MESL from 10 September 2006 through 07 August 2014 timeframe.

10.7 Burn Pit

Only one PM₁₀ sample and one PM_{2.5} sample were collected in 2012 at COP Narizah and vicinity that listed a burn box or incinerator was active during sampling but there were not enough samples to assess risk. The PM₁₀ sample and PM_{2.5} sample were similar to the base wide samples therefore they were analyzed as part of the base wide assessment in section 2.3. A base camp assessment (BCA) listed that there was a burn pit at COP Narizah and according to U.S. Army Central Command (ARCENT) Engineers, open burning of solid waste occurs adjacent to FOB Clark in the Afghanistan National Army's (ANA) camp but no further information was given and closure dates were unavailable.

While not specific to FOB Clark and vicinity, the consolidated epidemiological and environmental sampling and studies on burn pits that have been conducted as of the date of this publication have been unable to determine whether an association does or does not exist between exposures to emissions from the burn pits and long-term health effects (Reference 11). The Institute of Medicine committee's (Reference 11) review of long-term health consequences of exposure to burn pits in Iraq and Afghanistan suggests that service in Iraq or Afghanistan (i.e., a broader consideration of air pollution than exposure only to burn pit emissions) may be associated with long-term health effects, particularly in susceptible (e.g., those who have asthma) or highly exposed subpopulations, such as those who worked at or near the burn pit. Such health effects would be due mainly to high ambient concentrations of PM from both natural and anthropogenic sources, including military sources. If that broader exposure to air pollution turns out to be relevant, potentially related health effects of concern are respiratory and cardiovascular effects and cancer. Susceptibility to the PM health effects could be exacerbated by other exposures, such as stress, smoking, local climatic conditions, and co-exposures to other chemicals that affect the same biologic or chemical processes. Individually, the chemicals measured at burn pit sites in the study were generally below concentrations of health concern for general populations in the U.S. However, the possibility of exposure to mixtures of the chemicals raises the potential for health outcomes associated with cumulative exposure to combinations of the constituents of burn pit emissions and emissions from other sources.

11 References¹

1. Defense Occupational and Environmental Health Readiness System (referred to as the DOEHRSEH Module) at <https://doehrs-ih.csd.disa.mil/Doehrs/>. Department of Defense (DoD) Instruction 6490.03, *Deployment Health*, 2006.
2. DoDI 6055.05, Occupational and Environmental Health, 2008.
3. Joint Chiefs of Staff. Procedures for Deployment Health Surveillance, MCM 0017-12, 7 December 2012.
4. USAPHC Technical Guide 230, June 2013 Revision.
5. DoD MESL Data Portal: <https://mesl.apgea.army.mil/mesl/>. Some of the data and reports used may be classified or otherwise have some restricted distribution.
6. Modification 12 to United States Central Command Individual Protection and Individual Unit Deployment Policy, 02 December 2013.
7. CDC. 2012. Morbidity and Mortality Weekly Report. Imported Human Rabies in a U.S. Army Soldier. May 4, 2012. 61(17); 302-305.
8. Armed Forces Pest Management Board: <http://www.afpmb.org/content/venomous-animals-country#Afghanistan>. U.S. Army Garrison - Forest Glen, Silver Spring, MD.
9. Clinical Toxinology Resources: <http://www.toxinology.com/>. University of Adelaide, Australia.
10. Goldman RF. 2001. Introduction to heat-related problems in military operations. In: Textbook of military medicine: medical aspects of harsh environments Vol. 1, Pandolf KB, and Burr RE (Eds.), Office of the Surgeon General, Department of the Army, Washington DC.
11. Institute of Medicine. 2011. Long-term health consequences of exposure to burn pits in Iraq and Afghanistan. Washington, DC: The National Academies Press.

¹ NOTE. The data are currently assessed using the 2013 TG230. The general method involves an initial review of the data which eliminates all chemical substances not detected above 1-yr negligible MEGs. Those substances screened out are not considered acute or chronic health hazards so are not assessed further. For remaining substances, acute and chronic health effects are evaluated separately for air water (soil is only evaluated for long term risk). This is performed by deriving separate short-term and long term population exposure level and estimates (referred to as population exposure point concentrations (PEPC)) that are compared to MEGs derived for similar exposure durations. If less than or equal to negligible MEG the risk is Low. If levels are higher than negligible then there is a chemical-specific toxicity and exposure evaluation by appropriate SMEs, which includes comparison to any available marginal, critical or catastrophic MEGs. For drinking water 15 L/day MEGs are used for the screening while site specific 5-15 L/day are used for more detailed assessment. For nondrinking water (such as that used for personal hygiene or cooking) the 'consumption rate' is limited to 2 L/day (similar to the EPA) which is derived by multiplying the 5 L/day MEG by a factor of 2.5. This value is used to conservatively assess non drinking uses of water.

12 Where Do I Get More Information?

If a provider feels that the Service member's or Veteran's current medical condition may be attributed to specific OEH exposures at this deployment location, he/she can contact the Service-specific organization below. Organizations external to DoD should contact Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight (HRP&O).

Army Public Health Center (Provisional) Phone: (800) 222-9698. <http://phc.amedd.army.mil/>

Navy and Marine Corps Public Health Center (NMCPHC) (formerly NEHC) Phone: (757) 953-0700. <http://www.med.navy.mil/sites/nmcphc/Pages/Home.aspx>

U.S. Air Force School of Aerospace Medicine (USAFSAM) (formerly AFIOH) Phone: (888) 232-3764. <http://www.wpafb.af.mil/afrl/711hpw/usafsam.asp>

DoD Health Readiness Policy and Oversight (HRP&O) Phone: (800) 497-6261. <http://fhpr.dhhq.health.mil/home.aspx>