DEPARTMENT OF DEFENSE
UNITED STATES SOUTHERN COMMAND
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SC-COS

16 February 2023

POLICY MEMORANDUM 15-21

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Policy Memorandum 15-21, Force Health Protection (FHP) Guidance for Deployment in United States Southern Command (USSOUTHCOM) Area of Responsibility (AOR).

1. References: See Appendix A

2. Purpose: This message provides guidance for deployment health in the USSOUTHCOM AOR. It synthesizes and supplements DoD and service specific deployment health, force health protection (FHP), and/or medical policy/guidance for military and civilian personnel mobilized and/or deployed across the range of military operations. Additional mission or exercise-specific guidance may be issued separately.

3. Applicability: This guidance applies to military personnel, DoD civilians, DoD contractors, and dependents traveling or deploying to the USSOUTHCOM AOR. Shipboard operations that are not anticipated to involve ashore activities are exempt from the requirements of this memorandum except for recording individual daily deployment locations or when potential health threats indicate actions necessary beyond the scope of shipboard occupational health programs or per the decision of the commander exercising operational control.

4. Policy: The Command Surgeon is the senior medical advisor to the USSOUTHCOM Commander, as well as the command's senior staff for all health service support policy, plans, engagements, and exercises. The Command Surgeon's Office oversees U.S. military medical operations across the USSOUTHCOM AOR. The SOUTHCOM Surgeon's mission is to enable and synchronize health engagement activities utilizing a whole-of-government approach to support national and regional health security, enhance preparedness and strengthen partner nations' military medical capabilities

5. Records Management: Records generated by the implementation of this memorandum will be maintained in accordance with CJCSM 5760.01A, Vol II, Joint Staff Records Schedule. This policy memorandum will be reviewed every three (3) years or sooner, as needed.

6. The Point of contact for this Policy Memorandum is Public Health/Force Health Protection Officer, USSOUTHCOM Command Surgeon Office, commercial telephone: (305) 437-1331.

FOR THE COMMANDER:

SCOTT A. JACKSON
Major General, USA
Chief of Staff

DISTRIBUTION D

1.A. For Purposes of This Guidance, Deployment/Travel Is Defined As:

1.A. (1) Travel to or through the USSOUTHCOM AOR, with time in country (boots on ground) for a period of greater than 30 days IAW with Ref C.

1.A. (2) Travel to or through the USSOUTHCOM AOR, with time in country (boots on ground) for a period of 30 days or less when in support of service component training deployments, USSOUTHCOM joint exercise program deployments, contingency deployments, or TDY/TAD travel under austere and/or field conditions.

1.A. (3). Personnel traveling to and/or transitioning through the USSOUTHCOM AOR for 30 days or less, who are not specifically included in paragraph 1.A(2) such as official travelers in TDY/TAD status conducting brief trips in non-austere, non-field settings should seek travel medicine advice/services from their supporting military treatment facility (MTF) specific to their travel itinerary and tailored to their individual needs. Additionally, personnel must ensure they are medically screened and cleared for travel to USSOUTHCOM AOR IAW Applicable Service Policies, the DoD Foreign Clearance Guide and Ref D.

1.B. Permanent Change of Station (PCS)

1.B. (1) PCS personnel (e.g., security cooperation office personnel and dependents) will coordinate with their respective service component medical personnel and comply with the Individual Medical Readiness (IMR) Guidance in paragraph 2 and Immunization Requirements in paragraph 3.

2. Individual Medical Readiness (IMR)

2.A. Periodic Health Assessments (PHA)

2.A. (1) PHA and special duty exams must be current and remain current throughout the deployment.

2.B. Medical Screening

2.B. (1) Vision Readiness. Service Member (SM) must meet all testing requirements and applicable standards for fully deployable status IAW service policy/guidance. For deployment to JTF-B, SM will arrive with a current refraction for eyewear not older than one year documented in the electronic health record or a handwritten prescription.

2.B. (2) Hearing Readiness. SM must meet all testing requirements and applicable standards for fully deployable status IAW service policy/guidance.

2.B. (3) Dental Readiness. Ensure SM has a current annual dental exam. If

annual dental exam expires 90 days before expected redeployment date, a new exam will be required prior to deployment. Only SM assessed as dental readiness class 1 (I) or 2 (II) are deployable to the USSOUTHCOM AOR. SM assessed as class3 (III) or 4 (IV) are not deployable.

2.B. (4) Deployment-Limiting Conditions (DLC).

2.B. (4)(a) Service components are responsible for medically screening personnel on an individual basis prior to deployment to the USSOUTHCOM AOR IAW Ref D, and Ref E.

2.B. (4)(b) All required medical waivers to DLC will be processed IAW Ref D prior to deployment.

2.C. Immunization Status

2.C. (1) Ensure SM is current for total force/all services, occupational, and USSOUTHCOM AOR location-specific vaccines as per paragraph 3 below.

2.D. Medical Readiness Laboratory Tests

2.D. (1) Blood type and Rh factor. Required IAW service guidance.

2.D. (2) Glucose 6-PhosphateDehydrogenase (G6-PD) deficiency screening.

2.D. (3) Deoxyribonucleic Acid (DNA) specimen. Required IAW DoD/service policy/guidance.

2.D. (4) Tuberculin Skin Test or interferon-gamma release assays (IGRA) testing required for all personnel deploying to Joint Task Force Guantanamo (JTF-GTMO) and JTF-Bravo. Other locations IAW DoD/service policy/guidance.

2.D. (5) HIV screening. Required IAW DoD/service guidance.

2.D. (6) Serum Specimens (pre & post). Required IAW DoD/service guidance.

2.D. (7) Pregnancy Test. Required for all female SM IAW DoD/service guidance.

2.D. (8) Current quantitative Hepatitis B surface antibody level titer. Required complete series for health care workers, emergency medical technicians and correctional facility staff for all services.

2.D. (9) COVID-19 Test. Per specific country entry policy and DoD guidance.

2.E. Women’s Readiness Pre-Deployment Screening

2.E. (1) Female SM must complete all female specific preventive health requirements prior to deployment (e.g.,cervical cancer screening, mammogram screening) and all other applicable standards for fully deployable status IAW service

policy/guidance.

2.F. Individual Medical Equipment

2.F. (1) Corrective Eyewear/Eyeglasses. SM requiring eyewear must deploy and travel with at least two pairs of eyeglasses.

2.F. (2) Contact Lenses. While service policy may allow it, USSOUTHCOM SG recommends personnel not use contact lenses in field conditions or austere operational environments. Contact lenses have been identified during USSOUTHCOM deployments as an operational hazard. Personnel deploying may encounter field conditions that may not allow for proper contact lens hygiene, which leads to an increase in eye abrasions, infections, and ulcers.

2.F. (3) Protective Mask Eyeglass Inserts. Based on occupational and environmental health(OEH) and operational risks.

2.F. (4) Ballistic Protection Optical Inserts. Based on OEH and operational risks.

2.F. (5) Hearing aids/batteries. As required by individual. Note: assume no resupply will be available at deployment location.

2.F. (6) Dental Orthodontic Equipment. As issued pre-deployment and required by individual. Note: assume no orthodontic services will be available at deployment location.

2.F. (7) Medical Warning Tags. As required as per service policy.

2.F. (8) Automatic positive airway pressure (APAP), continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP) IAW Ref D.

3. Immunizations

3.A Immunizations required for all personnel entering the USSOUTHCOM AOR (do not delay deployment if immunization series has been initiated but not completed):

3.A. (1) Hepatitis A. Documented immunity, series complete, or dose one prior to departure.

3.A. (2) Influenza. Current annual vaccine. All Active Duty (AD) and Reserve Component (RC) (including National Guard) personnel are required to receive a seasonal influenza vaccine or obtain an exemption (i.e., medical, or administrative), IAW Ref GGG.

3.A. (2)(a) Northern Hemisphere (NH) influenza vaccination is required for all AD and RC (and recommended for all other beneficiaries), permanently or temporarily assigned in the NH influenza zone for at least 14 continuous days or more, between 1 October and 30 March, as designated by the World Health Organization (WHO), IAW

Appendix 5, Ref GGG.

3.A. (2)(b) Southern Hemisphere (SH) influenza vaccination is required for all AD and RC (and recommended for all other beneficiaries), permanently or temporarily assigned for at least 14 continuous days or more, between 1 April through the 30 September, and in the SH influenza zone as designated by the WHO IAW Appendix 5, Ref GGG.

3.A. (2)(c) AD and RC members traveling between the NH and SH for 14 continuous days or more during that hemisphere's influenza season are required to receive the respective hemisphere's influenza vaccine unless the strains in both vaccines are identical. AD and RC members with 14 or more days asynchronous travel to the NH or SH influenza zones during that hemisphere's influenza season may elect to obtain the vaccination for that zone when it is available.

3.A. (2)(d) The SH or NH vaccine should be administered at least 2 weeks prior to entry into the respective AOR if possible.

3.A. (2)(e) Short notice travel or travel of an unspecified length will be handled on a case-by-case basis. If SH influenza vaccination is not possible before travel begins, personnel should seek vaccination from the closest OCONUS medical activity upon arrival in the AOR.

3.A. (2)(f) Administration of the SH or NH influenza vaccine should be separated by at least 30 days from any previous dose of influenza vaccine.

3.A. (2)(g) It is possible for an individual to receive a maximum of three different influenza vaccines in a single calendar year (e.g., a person was immunized with the 2019-2020 NH influenza vaccine in January 2020, then was administered the 2020 SH influenza vaccine in preparation for a temporary duty to Australia in June 2020, and then returned to the United States and received the 2020-2021 NH influenza vaccine in October 2020.).

3.A. (3) Measles/Mumps/Rubella (MMR). Required documentation of one of the following: born before 1957, immunity by titer, or administration of 2 lifetime doses of MMR vaccine.

3.A. (4) Poliovirus. One adult dose.

3.A. (5) Tetanus-Diphtheria and Pertussis. Tetanus / diphtheria. Receive a one-time dose of TDAP if no previous dose recorded. ReceiveTetanus (TD) if ≥ 10 years since last TDAP or TD booster.

3.A. (6) Hepatitis B. Documented immunity, series complete, or dose one prior to departure.

3.A. (7) Typhoid. Booster dose of if ≥ 2 years since vaccination with inactivated / injectable vaccine or ≥ 5 years since receipt of live / oral vaccine.

3.A. (8) Varicella. Required documentation of one of the following: documented immunity with titers, proof of series completion, or one dose prior to departure.

3.A. (9) Coronavirus Disease 2019 (COVID-19). It is strongly recommended for all, especially high-risk individuals, to be up to date with COVID-19 vaccines prior to entering USSOUTHCOM AOR.

3.B. Location-specific/risk-based/policy-specified/occupational immunizations

3.B. (1) Pneumococcal. Required for all personnel who are in a high–risk category due to age or underlying health conditions as per ACIP recommendations (for example, persons without spleens).

3.B. (2) Rabies (pre-exposure). Required for all high-risk individuals (e.g., veterinarians, veterinary technicians, animal handlers, security personnel who have animal control duties, special operations personnel and personnel who cannot receive prompt medical evaluation and risk-based post-exposure prophylaxis or be medically evacuated within 72 hours of being bitten). May be considered for other personnel at risk of animal contact (e.g., civil affairs personnel). For previously vaccinated personnel, booster dose is required every two years if titers are below acceptable level.

3.B. (3) Yellow Fever (YF).

3.B. (3)(a) Required for personnel deploying, and/or TDY to JTF-B. A single life-time dose is sufficient per ACIP recommendation.

Exception: Additional doses of Yellow Fever vaccine are recommended for:

a. Women who were pregnant (regardless of trimester) when they received their initial dose of yellow fever vaccine should receive 1 additional dose of Yellow Fever vaccine before their next travel that puts them at risk for Yellow Fever virus infection.

b. Persons who received a hematopoietic stem cell transplant after receiving a dose of Yellow Fever vaccine and who are sufficiently immunocompetent to be safely vaccinated should be revaccinated before their next travel that puts them at risk for Yellow Fever virus infection.

c. Persons who were infected with human immunodeficiency virus when they received their last dose of Yellow Fever vaccine should receive a dose every 10 years if they continue to be at riskfor yellow fever virus infection.

d. Laboratory workers who routinely handle wild-type Yellow Fever virus should have Yellow Fever virus–specific neutralizing antibody titers measured at least every 10 years to determine if they should receive additional doses of the vaccine. For laboratory workers who are unable to have neutralizing antibody titers measured, Yellow Fever vaccine should be given every 10 years if they remain at risk.

e. A booster dose shall be given to travelers who received their last dose of

Yellow Fever vaccine at least 10 years previously and who will be in a higher-risk setting based on season, location, activities, and duration of their travel. This would include travelers who plan to spend a prolonged period in endemic areas or those traveling to highly endemic areas such as the Amazon basin during peak transmission season or an area with an ongoing outbreak. Commander's discretion is allotted to determine whether travelers' deployment location meets the definition of a higher risk setting IAW USSOUTHCOM FHP guidance section 3.B (3) Yellow Fever.

3.B. (3)(b) The vaccination is required for Yellow Fever endemic countries: Argentina, Bolivia, Brazil, Colombia,Ecuador, French Guiana, Guyana, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Venezuela (review CDC guidance for updated list of endemic countries at www.cdc.gov/yellowfever/maps/south_america.html

3.B.(3)(c) Yellow Fever vaccination required for the following countries if you are traveling from a country listed in 3.B.(3)(b): South America (Chile, Uruguay), Central America (Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, Honduras) Caribbean islands (Antigua and Barbuda, Aruba, Bahamas, Barbados, Dominica, Dominican Republic, Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Monserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines.

3.B. (3)(d) If traveling to and from a Yellow Fever endemic country listed in 3.B.(3)(b), carry a copy ofyour SF 601, Health Record Immunization Record; CDC 731, International Certificate of Vaccination; DD form 2766c, Adult Preventive and Chronic Care Flow Sheet to prevent revaccination by health authorities.

3.B. (3)(e) SM travel itinerary must be carefully reviewed and considered (countries visited/airports transited prior to entry). Please contact USSOUTHCOM SG office if further guidance is needed.

3.C. Immunization Tracking

3.C. (1) Tracking of immunizations for all SM deploying to USSOUTHCOM AOR will be IAW DoD-approved systems as per Ref G and service policy/methods.

3.D. Proof of Immunization Documentation

3.D. (1) When travelling to the USSOUTHCOM AOR, all DoD personnel must carry an updated official paper immunization record. This official record must be in any of the DoD-approved formats that qualify as a valid certificate of vaccination for international travel and that comply with world health organization's international health regulations requirements. These include SF 601, Health Record Immunization Record; CDC 731, International Certificate of Vaccination; DD form 2766c, Adult Preventive and Chronic Care Flow Sheet.

4. Personal Protective Equipment (PPE) and Medications

4. A. DoD insect repellent system components.

4.A. (1) All personnel deployed to the USSOUTHCOM AOR must strictly adhere to the concurrent use of all three components of the DoD insect repellent system which are: permethrin treated civilian clothes or uniforms, DEET on exposed skin, and properly worn uniform.

4.A. (2) Field uniforms. Personnel will deploy with at least 2 Operational Camouflage Pattern (OCP) uniforms (each permethrin treated OCP is good for 25 washes).

4.A. (3) Permethrin uniform treatment methods. Uniform treatment with permethrin must be accomplished prior to deployment. The four DoD-approved permethrin uniform treatment methodsare: 1) IDA kit; 2) aerosol spray can; 3) two-gallon sprayer; 4) factory treatment.

4.A. (3)(a) Individuals authorized to deploy or travel in civilian clothes will treat clothing worn during operations with DoD permethrin aerosol spray (NSN: 6840-01-278-1336) IAW the label instructions. Field clothing includes civilian attire which is defined as all exterior clothing, and any trousers and collared shirt worn in an operational setting. Any fabric may be treated. However, the ability of permethrin to bind to clothing fabrics and be retained for 6 weeks or 6 washings may vary by fabric type. Individuals should deploy with a minimum two sets of permethrin-treated civilian clothes (long sleeves and pants). Do not use any permethrin product on hats, headgear, underwear, PT uniforms,t-shirts, or NOMEX uniforms. Spray only the outer surfaces.

4.A.(3)(b) Do not dry clean permethrin treated uniforms or civilian clothes as this will remove the permethrin.

4.A. (4) DEET skin repellant: insect/ arthropod repellent lotion, NSN: 6840-01-284-3982. All personnel will deploy with four tubes for initial issue or any other DoD-approved DEET-based skin repellant product on the NSN list containing between 30-35% DEET.

4.B. Other Vector Countermeasures

4.B. (1) Bed net, pop-up, self-supporting low profile bed net (SSLPB), treated with permethrin repellent, green camouflage, NSN: 3740-01-516-4415 or coyote brown, NSN: 3740-01-518-7310. If the pop-up bed nets are not readily available, obtain any other military or commercially available bednet. These are critical for protecting SMs. Bed nets are not required for personnel deploying to Guantanamo Bay, Cuba (GTMO).

4.B. (2) Non-authorized products. Personnel must only use products authorized by Armed Forces Pest Management Board (AFPMB) for personal protection. Unauthorized products may be less effective or hazardous when used in a manner not approved by the label or hazardous to use on humans (e.g., Flea collars).

4.C. General Health Care Individual Issued Items

4.C. (1) Sunscreen SPF-15 or greater. Especially important for personnel taking doxycycline for malaria prophylaxis.

4.C. (2) Lip balm (NSN: 6508-01-265-0079). Especially important for personnel taking doxycycline for malaria prophylaxis.

4.C. (3) Double-sided combat arms earplugs (NSN: 6515-01-466-2710) or single or triple flange earplugs.

4.C. (4) Water purification tablet iodine (NSN: 6850-00-985-7166) or other service-approved individual water purification method for emergency use.

4.C. (5) Waterless hand sanitizer (NSN: 8520-01-490-7358).

4.D. Additional Recommended Items. Improved first aid kit (NSN: 545-01-530-0929).

4.E. Occupational Personal Protective Equipment (PPE)

4.E. (1) Pre-deployment mission analysis must consider occupational PPE requirements for providing SM with adequate protection from all types of workplace hazards during the conduct of operations in the deployment setting, including chemical, biological, mechanical, radiological, environmental noise, particulate matter, air pollutant, climatic, and COVID-19. The required PPE should be available in sufficient quantities to provide protection to everyone with potential exposure to pre-identified hazards. On-site commanders and personnel should also evaluate the need to update PPE, based on their continuing reevaluation of operational risks.

4.F. Occupational personal Monitoring Devices & Exposure Dosimeters. As per service policy.

4.G. Prescription Medications

4.G. (1) Ensure personnel deploy with a 90-day supply of any required personal prescription medications. SM deploying to JTF-B must submit prescription to Tricare mail order Pharmacy (TMOP) and have approval for 9 months prior to deployment. Inability to obtain medication via theTMOP requires JTF-B medical commander clearance prior to deployment/assignment.

4.H. Durable Medical Equipment. As per service policy

4.I. Personal Durable Medical Equipment

4.I. (1) Other than items listed in paragraph 2.F., durable medical equipment is not permitted in USSOUTHCOM austere deployment settings (e.g., CPAP, tens, etc.).

4.J. Deployment Health Record (DD form 2766 Adult Preventive and Chronic Care Flow Sheet)

4.J. (1) All deploying personnel (military and DoD civilian) will deploy with a deployable medical record (DD form 2766) updated with blood type, medication/ allergies, special duty qualifications, immunization record, pre-deployment health assessment form, and summary sheet of past medical problems. Units deploying to JTF-GTMO will deploy with dental records and tuberculosis test resultsdocumentation.

4.J. (2) All SM requiring deployment medical waivers (paragraph 2.B.(4)) will have a copy of the approved waiver in the deployable health record.

4.J. (3) Deployment health records will be returned to the demobilization station for review during medical out-processing and then returned to home station following mobilization/deployment processing. Upon return to home station, the DA form 2766 will be integrated into the SM's permanent medical record.

5. Force Health Protection Prescription Products (FHPPP)

5.A. Malaria Chemoprophylaxis

5.A. (1) Malaria is a health risk in most countries in the USSOUTHCOM AOR. However, specific risks and chemoprophylaxis requirements vary by location and operational circumstances. Review the malaria country table and specific country's baseline infectious disease risk assessment from the National Center for Medical Intelligence (NCMI) for individual Malaria risk assessments at https://www.ncmi.detrick.army.mil/ or http://www.ncmi.dia.smil.mil; CDC travelers health website at http://www.cdc.gov/malaria/travelers/index.html prior to deployment.

5.A. (2) Leaders at all levels must ensure all personnel deployed in the USSOUTHCOM AOR strictly adhere to all malaria countermeasures (DoD insect repellant system, permethrin-treated bed nets),not just FHPPP.

5.A. (2)(a) In some Malaria-endemic countries in the USSOUTHCOM AOR, the Malaria risk may be significantly lower in capitals and major cities, particularly in locations where Malaria vectors are rare and human infection rates are very low. Upon careful preventive medicine (PM) analysis, Commanders may decide not to employ malaria chemoprophylaxis for/in personnel on short-durationTDY/TAD travel to such cities if overnight stays are in air-conditioned lodging. This same chemoprophylaxis decision making process may apply to transiting aircraft personnel (remain over night or stage).

5.A. (2)(b) Primary malaria chemoprophylaxis. Ref G provide guidelines and best practices in the choice of primary malaria prophylaxis medications. In chloroquine-resistant malaria areas, first-line prophylactic medication choices are doxycycline and atovaquone-proguanil. Mefloquine should be reserved for individuals with intolerance or contraindications to first-line choices. Contact service component surgeon or USSOUTHCOM Surgeon FHP division for further guidance in chemoprophylaxisdrug choice decisions.

5.A. (3) Presumptive anti-relapse therapy (terminal chemoprophylaxis):

5.A. (3)(a) Generally recommended for all individuals who were put on primary malaria chemoprophylaxis and had prolonged exposure to relapsing forms of malaria (p. Vivax in USSOUTHCOM AOR). Terminal chemoprophylaxis should begin once the potential for diseasetransmission ends, such as departure from the risk area or AOR.

5.A. (3)(b) Confirm all deployed personnel have a G6PD test. G6PD deficient individuals must not begiven primaquine due to the risk of hemolytic anemia.

5.A. (4) In areas where malaria is endemic and deployed medical support can diagnose malaria, they should carry malaria treatment medications.

6. Preliminary Hazard Assessment

6.A. General

6.A. (1) Units deploying to the USSOUTHCOM AOR must conduct a preliminary hazard assessment as a first step in the pre-deployment health risk assessment.

6.A. (2) Unit and/or supporting Preventive Medicine (PM) personnel should consult NCMI, USAPHC, NMCPHC, USAFSAM,CDC, AFPMB, Pan-American Health Organization (PAHO), host nation MOH and other sources of endemic disease information for the area of operations (AO). In addition, units should review past hazard assessments, recent exercise, or operation AAR, and/or other available data to identify potential OEH/endemic disease (ED) threats and hazards to deploying personnel.

6.A. (3) The PHA is a key action in establishing PM requirements, allocating and assigning appropriate medical resources to conduct pre-deployment OEH/ED site assessments, establishingOEH/ED baseline conditions, employing effective pm countermeasures, developing health risk communication strategies, and planning for deployment health/medical surveillance.

6.A. (4) Based on mission planning; commanders will be responsible for tasking their unit intelligence personnel to gather finished OEH/ED threat assessments produced by the NCMI. Depending on the mission type or criticality of information for mission assurance, production of such assessments when non-existent or out-of-date should be requested. Tasking for collection or requesting collectionof information will also be a unit commander’s responsibility.

6.A. (5) The following are hazards of importance in the USSOUTHCOM AOR. As such they should be analyzed before any deployment to the AOR.

6.B. Foodborne and Waterborne

6.B. (1) Acute diarrheal diseases

6.B. (1)(a) Bacterial and protozoal diarrhea, Hepatitis A, Typhoid/Paratyphoid fever, Brucellosis, Cholera, and Hepatitis E constitute the greatest potential infectious disease threat to DoD members during deployments where local food, water or ice are consumed. To counter this threat, no food or water (including ice) should be consumed unless an appropriate risk assessment is performed by U.S. Military medical authorities and is reviewed/approved by the unit commander. Field sanitation and hygiene will be continually emphasized, and requirements followed.

6.B. (1)(b) Recent Cholera outbreaks have been confirmed on Caribbean islands and is expected to spread to other countries in the region. Because cholera is an acute diarrheal disease that can kill within hours if left untreated, personnel with sudden onset of profuse, watery stools should report to medical authorities immediately. If going to a cholera-present or areas of low public health infrastructure, units are recommended to deploy with stocks of oral rehydration salts (NSN: 6S05-01-197-8809) and appropriate antibiotics if self-supported by medical personnel and reliable access to a safe water source.

6.C. Vector-Borne Diseases

6.C. (1) Vector-borne diseases are transmitted in the AOR by mosquitoes, sandflies, ticks, triatomines, lice, and fleas. Vector-borne diseases can significantly impact force health unless preventive measures are enforced. Avoidance of vectors (24 - hrs./day) is key and can be accomplished through habitat awareness and use of preventive measures.

6.C. (2) Chikungunya/ Dengue Fever/Zika risk are widespread across the AOR with outbreaks routinely reported in most countries in the region. The mosquitoes that transmit Chikungunya/Dengue/Zika are known to bite during the day. Personal protective measures are required 24hrs a day throughout the AOR and must be given the highest priority (see para 5.A. Forminimal personal issue PPE). Another method of prevention is the regular elimination of standing pools of water in the area since these habitats serve as mosquito breeding grounds.

6.C. (3) Malaria risk is regional with outbreaks occurring frequently in endemic areas. Malaria- carrying mosquitoes bite from dusk to dawn. Symptoms typically develop one to two weeks after the initial bite of an infected mosquito. However, symptoms can also present as late as several months or more following departure from the malaria-endemic region. Personnel who are currently or have been recently deployed in high-risk areas must be briefed on the importance of seeking medical evaluation as soon as possible in the event fever is experienced while in the area or upon return. At risk SM should employ protection measures against mosquitoes (see para 4.A.) In conjunction with the proper use of malaria chemoprophylaxis (see para 5.A.).

6.C. (4) Leishmaniasis occurs in three forms: cutaneous, mucosal, and visceral. All forms are transmitted by sandflies, and the risk of being bitten is greatest from dusk to dawn and in rural areas. Cutaneous Leishmaniasis (CL) is the most common form of the disease. Most CL cases occur in Bolivia, Brazil, Colombia, and Peru. Although CL primarily affects the skin, the parasite that causes the characteristic skin lesions can

also spread to the mucosal surfaces of the nose and mouth. Visceral Leishmaniasis's (VL) is found primarily in Brazil, and to a lesser extent in other parts of central and South America. Personnel deployed to areas of higher risk should avoid sandfly bites using the DoD insect repellent system. No vaccine exists for any form of the disease.

6.C. (5) American trypanosomiasis (also known as Chagas disease) is endemic in Central and South America. Chagas disease is transmitted through the feces of Triatomine insects (such as the Kissing Bug), which can be introduced to the skin/mucosa of the eyes, nose, or mouth when an insect bite is rubbed or through the consumption of contaminated food and beverages. Symptoms of acute infection usually develop approximately one week after exposure, and last up to 90 days. This stage is treatable but then is followed by an untreatable chronic stage which has the potential to cause permanent damage to your heart and intestinal tract. No vaccine exists, and personnel should avoid infection through use of protective measures and compliance with food and water consumption guidelines. (See para 8.E).

6.D. Water Contact Diseases

6.D. (1) Leptospirosis. Risk is limited to personnel with freshwater contact such as boating, wading, immersed or swimming in bodies of water contaminated by animal urine. Leptospira enter the body through cut or abraded skin and mucous membranes, such as the eyes or nose. Direct contact with the infected bodily fluids of animals can also result in disease. Leptospirosis causes debilitating febrile illness, which typically requires one to seven days of inpatient care. Personnel should avoid contact with fresh surface water. Flooding can increase risk of transmission. Rescue personnel operating in flooded areas and evacuees may suffer cuts or abrasions that increase the risk for infection. Persons at an increased risk for disease should minimize contact with potentially contaminated water and wear protective equipment including face shield or goggles, waterproof boots, gloves, and aprons. Cuts and abrasions should be appropriately covered with waterproof dressings. There is no vaccine available.

Note: Swimming in hotel or public swimming pools is not advised during official travel in many parts of the AO.

6.D. (2) Schistosomiasis is endemic to Brazil, Suriname, Venezuela, and some Caribbean islands. Infection occurs through direct contact with contaminated water. The acute form of the disease has an incubation period 14 to 84 days, while the chronic form has the potential to remain for years. Severe health complications can develop because of chronic infection. To prevent infection, personnel should avoid direct contact with bodies of freshwater in endemiccountries and wear protective clothing and footwear if such contact is unavoidable. Personnel should also adhere to all water consumption guidelines (see para 7.E.). There is currently no vaccine available.

6.E. Sexually Transmitted Infections

6.E. (1) Sexually transmitted infections (STI) include Gonorrhea, Chlamydia, HIV/AIDS, Hepatitis B,and Syphilis. Abstinence is the only way to ensure prevention of an STI. Detection of an STI in a potential partner is often impossible. Latex condoms

should be made available and used by all who choose to be sexually active. Synthetic, non-Latex condoms should be used by those who are or whose partners are latex allergic or sensitive. Proper use includes placement prior to sexual contact, use of non-petroleum lubricant to decrease condom breakage, and use of a new condom with each sexual contact. Personnel should seek prompt medical treatment for STI symptoms.

6.F. Aerosolized Dust or Soil-Contact Diseases

6.F. (1) Hantaviruses. Humans may be infected with Hantaviruses by breathing air contaminated with the feces, urine, and/or saliva of certain species of wild rodents, or by direct contact with such rodents or their feces, or through their bites. The primary route of infection, inhalation, is almost always associated with indoor environments where infected rodent excreta is present. These indoor environments also limit dissipation of aerosolized and favor virus viability due to restricted air movement and lack of direct sunlight respectively.

6.F. (2) Travel to and within all areas where Hantavirus infection has been reported is safe. The possibility of exposure to Hantavirus in field environments is very small and reduced even more if steps are taken to minimize rodent contact. However, the disease's high fatality rate is ample reason for concern. It is prudent to assume a "worst case scenario" when dealing with wild rodents or rodent-contaminated buildings. Personnel in the field for short periods are at minimal risk if the procedures listed below are followed. However, if personnel are required to use seasonal buildings or shelters, then an initial inspection for rodents or signs of rodent contamination should be made before troops enter and begin to disturb dust and furnishings inside. If evidence of rodents (live or dead animals, droppings, urine, or nesting material) is found inside the building, then entry and use should be prohibited until rodent contamination is removed or personnel wear equipment that protects them against Hantavirus infection.

6.F. (3) The best currently available approach for disease control and prevention is risk reduction through environmental modification and hygiene practices that prevent or deter rodents from colonizing building structures. Building surveys should be performed on a regular basis, and any indication of rodent activity should be addressed immediately. Sanitation practices are essential in deterring rodents from entering buildings. All sources of food and water available to rodents should be eliminated. Please consult Ref H for safe cleanup operations and procedures for rodent waste and nesting materials including required PPE.

6.G. Animal Contact Diseases

6.G. (1) Animals are carriers and reservoirs for multiple diseases to include Rabies, Q Fever, Brucellosis, Hantavirus, and Avian/Swine Influenza. Dog, cats, bats, and wild carnivores represent the greatest risk to personnel deployed to the USSOUTHCOM AOR. Personnel must avoid contact with local animals in the operational setting and must not attempt to feed, adopt, or interact with them in any way. Personnel must not keep mascots and pets. Uncured hides present an anthrax risk and must be avoided.

6.G. (2) Rabies

6.G. (2)(a) Rabies is a viral infection that can be transmitted to humans through the saliva of infected animals. Because the disease is prevalent in the Caribbean, Central and South America, it constitutes a health threat to SM deployed/TDY to the USSOUTHCOM AOR.

6.G. (2)(b) Other than U.S. military working dogs, animals must not be considered rabies-free when deployed. Animals infected with rabies may not look sick or act strangely, enabling a seemingly healthy animal to spread the disease to humans. Personnel must never assume local animals are vaccinated against rabies. Despite efforts of countries in the USSOUTHCOM AOR to institute vaccination programs for dogs, cases of dog-transmitted human-rabies continue to be regularly reported. Dogs, cats, bats, foxes, skunks, raccoons, mongooses, and jackals are among the most likely animals to transmit rabies. In certain rural areas or tropical forest locations, personnel may be at increased risk of bat bites. Bat bites may occur at night during personnel sleeping hours and thus may go unnoticed. In 2010 and 2011 outbreaks of bat-transmitted human rabies were reported in several South American countries and continues to be reported by local health authorities throughout theUSSOUTHCOM AOR.

6.G. (2)(c) The time between human exposure to rabies virus and onset of symptoms varies but averages two to twelve weeks. In rare cases, symptoms may not appear for over one year. Once the signs and symptoms of rabies occur, the disease is almost always fatal. However, if medical evaluation and treatment is commenced promptly following a potential rabies exposure, nearly all cases of rabies will be prevented.

6.G. (2)(d) Unit commanders must ensure personnel compliance with this guidance and all prevention and post-exposure evaluation and care actions IAW Ref I and Ref J. Commanders must mandate a “no mascot” policy; personnel will be instructed to not feed, handle, or otherwise contact local animals outside of directed operational missions. Commanders will mandate reporting of all animal bite wounds and scratches to include any broken skin contact with animal saliva. This includes wounds or lacerations that occur even without a known animal exposure. Some rabies carrying animals (i.e., vampire bats) can produce wounds when sleeping that are not perceived due to anesthetic properties of the animal’s saliva. All human-animal contact incidents must be reported immediately to ensure the safety and well-being of personnel. In the case of a reportable human-animal contact event, an immediate review of unreported injuries to unit personnel caused by animals must be conducted for the preceding 18-month period. All personnel with injuries caused by animals must be identified and evaluated by medical personnel to ensure proper treatment is provided. Medical personnel will document all animal bites and scratches on DD form 2341 report of animal bite – potential rabies exposure. The DD form 2341 will be properly routed and completed in its entirety through final case disposition, to include the multi-disciplinary review of the circumstances of each potential rabies exposure by the rabies advisory team/board.

6.H. Respiratory Diseases

6.H. (1) Tuberculosis (TB) is endemic in the USSOUTHCOM AOR. The risk may be elevated for those personnel with significant close contact with local populations. As with many regions of the world, drug resistant strains are present in the USSOUTHCOM AOR. To mitigate the threat, avoid prolonged contact in crowded or enclosed areas and ensure TB testing is accomplished IAW para 2.D.(4).

6.I. Natural Physical Threats to Health

6.I. (1) Weather Hazards. Deployed personnel must take appropriate precautions about lightning, sun exposure, heat/humidity, exposure to rain, wind, and cold temperatures. Exercise caution when conducting operations in times of limited visibility. Follow the evacuation plan in the event of severe weather (tornados, hurricanes, or storm surge).

6.I. (2) Heat/Cold/Solar Injuries/Illness.

6.I. (2)(a) In the USSOUTHCOM AOR, heat injuries may constitute the greatest environmental threat to deployed personnel. The tropics pose health risks related both to extreme temperatures, humidity, and sun exposure. Injuries can include dehydration, heat exhaustion, heat stroke, and sunburn. Certain FHPPP, such as doxycycline, may increase susceptibility. Personnel should gain familiarity with the temperature range in the intended destination, noting any potential for severe fluctuations between daytime and nighttime temperatures. Acclimatization may take 10-14 days or more. Ensure proper work-rest cycles, adequate hydration. Command emphasis of heat injury prevention is paramount. Units will make available and enforce use of individual protection supplies, such as sunscreen, lip balm, covers (hats), and sun goggles/glasses. Ensure personnel are capable of recognizing signs related to heat illness and responding with proper methods.

6.I. (2)(b) 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.

6.J. (3) Altitude

6.J. (3)(a) Operations at high altitude (over 8000 ft.) are at special risk; approximately 20 percent of personnel may be susceptible to altitude sickness at these altitudes. High altitudes can cause illness or death. High altitude medical threats include acute mountain sickness, high altitude bronchitis, high altitude cerebral edema, and high-altitude pulmonary edema. High altitude-regions exist in the following AOR countries: Peru, Bolivia, Chile, Argentina, Venezuela, Ecuador, Colombia, Guatemala, and Costa Rica. Specialty equipment and medications may be necessary for personnel deploying or traveling to locations at high altitude. All ascents should be performed gradually, if possible. Going directly from low altitude to >9,000 ft. (2,750 m) in one day should be avoided. Use acetazolamide (Diamox) to speed acclimatization if abrupt ascent is unavoidable. Treat altitude headaches with simple analgesics. High altitude illnesses can constitute a medical emergency and require immediate treatment and

descent to save the SM's life.

6.J. (3)(b) Sun exposure at high altitudes may also produce adverse health effects associated with the eyes (cataracts) and skin (skin cancer, sunburn) (see https://www.cdc.gov/cancer/skin/basic_info/sun-safety.htm) Wraparound sunglasses that provide 100 percent UV ray protection should be worn for eye protection. A broad-spectrum (protection against both UVA and UVB rays) sunscreen and lip screen with at least SPF 15 should be used.

6.K. Dangerous Flora and Fauna

6.K. (1) Various species of poisonous animals, including reptiles and arthropods are present. A current list of venomous animals by country is available at https://www.acq.osd.mil/eie/afpmb/docs/lhd/venomous_animals_bycountry.pdf Education/awareness and avoidance are required to prevent snakebite incidents.

6.K. (2) Displaced reptiles, such as snakes, are likely to be found following flooding and other natural disasters. The venom of a small or immature snake can be even more concentrated than that of larger ones; therefore, all snakes should be left alone. Medical attention should be immediately sought any time a bite wound breaks the skin. For treatment procedures, personnel should seek medical advice/services from their supporting MTF.

6.K. (3) There are numerous plants that are hazardous to human health in the USSOUTHCOM AOR. Plant hazards are present in the form of mechanical injury, contact dermatitis and poisonous when consumed. Personnel need to be briefed on specific AO hazards.

6.L. Industrial Hazards

6.L. (1) General. During natural or man-made disasters, industrial facilities may release hazardous materials (e.g., toxic industrial chemicals (TICS)/toxic industrial materials (TIMS)) resulting in air, soil,food, and water pollution or cause the release of biologic contaminants.

6.L. (2) Contamination and pollution. Contamination of surface and ground water with raw sewage and industrial wastes, urban air pollution and food sources contaminated with agricultural chemicals or pesticides pose localized threats. Consult NCMI or USAPHC for location-specific information.

6.L. (3) Other. Occupational/operational health threats must be evaluated in mission analyses. Preliminary hazard assessments (PLHA) should be accomplished as part of the OEH site assessment (OEHSA) as early as possible (preferably during pre-deployment site survey (PDSS)) to identify and quantify OEH threats and to determine the scope of deployment health activities. Assume that occupational hazards will not significantly differ from those at home station. If the job at home station requires use of PPE, so will the job while deployed. Home station engineering controls may not be available while deployed. Therefore, use of PPE may be required even if not required at home station.

6.L. (4) Submit completed PLHA to military exposure surveillance library (MESL).

6.M. Psychological Factors

6.M. (1) Mental health information, to include deployment-related stressors, suicide risk, and traumatic stress should be provided to all personnel prior to and during deployment. All personnel should be aware of deployment-related stress and injuries, their signs/symptoms, and how to seek final help for themselves or their fellow Service Members to include methods for mental health referral. Personnel should be cognizant of sleep discipline and the impact of alcohol misuse.

6.M. (2) Because of the tremendous loss of life, serious injuries, missing and separated families, and destruction of whole areas often associated with disasters, it is important that personnel involved in relief operations recognize the situation they encounter may be extremely stressful.

6.M. (3) Pre-existing behavioral health problems can be a very significant factor and must be considered in the assignment of individuals to high stress positions. Treatment for Behavioral Health conditions in the AOR is very limited. This includes pre-existing conditions such as current substance abuse and suicidal ideations.

6.N. Other Non-Battle Injury

6.N. (1) Crime, terrorism, and chemical, biological, radiological, and nuclear (CBRN) threats. The risk of deliberate use of force, violence, or CBRN agents is intrinsically difficult to quantify or predict. Personnel awareness of current threat situation isparamount to prevent and/or rapidly contain deliberate actions against the health of U.S. forces. Prior to deployment, units should contact the embassy regional security officer or equivalent to obtain the latest location-specific threat information. Although NCMI assesses the risk as low, operational medical personnel should be aware that several diseases endemic in the USSOUTHCOM AOR constitute pathogens potentially suitable for deliberate attacks. Deployed medical personnel should be trained on the signs, symptoms, medical countermeasures, and post-exposure treatments associated with CBRN health threats. Medical personnel should review disease and injury (D&I) data to identify potential CBRN exposures and detect any trends of concern and report through the appropriate command channels.

6.N. (2) Injuries (work and recreational).

6.N. (2)(a) Work-related injuries as well as sports and other recreational injuries can have a significant negative impact on mission effectiveness. Command emphasis of safety awareness is important.

6.N. (2)(b) Poor road conditions combined with variable driving experience of foreign nationals significantly increase the risk of motor vehicle accidents. Personnel should drive defensively, must always wear seat belts, and ensure vehicles are in good working order. Personnel should drive only during daylight hours and never alone.

6.N. (2)(c) The risk of physical trauma during and after a natural disaster is high. Persons who anticipate the need to travel to disaster areas should wear appropriate PPE in these areas.

6.N. (3) Other conditions

6.N. (3)(a) Community-acquired methicillin-resistant staphylococcus aureus (CA-MRSA). In forward-deployed settings, high-density living environments may result in prolonged close person-to-person contact and lapses in personal hygiene. These living conditions create ideal conditions for MRSA transmission. Primarily transmitted person to person through direct contact. The sharing of clothing, personal hygiene items or training equipment may also transmit MRSA.

6.N. (3)(b) Mold. Flooding, water intrusion, lack of adequate ventilation and moisture control are conditions that could lead to mold growth. Extensive water damage after major hurricanes and floods increases the likelihood of mold contamination in buildings. Commanders should take necessary actions recommended by PM personnel to limit exposure to mold and to identify and prevent mold- related health effects. Excessive exposure to mold-contaminated materials can cause adverse health effects in susceptible persons regardless of the type of mold or the extent of contamination. When mold growth is present, the removal and cleaning of contaminated materials must be handled IAW Ref X or service guidance for proper procedures.

7. Pre-Deployment Health Activities

7.A. General

7.A. (1) Service component and JTF surgeons will ensure units conduct all deployment health requirements IAW Ref B, service-specific policy, and other applicable guidance.

7.A. (2) Commanders must ensure unit medical planners and PM personnel carefully review all FHP relevant to the mission to obtain additional guidance and ensure full compliance with applicable policy and requirements.

7.A. (3) Service components and subordinate units will ensure PM assets are properly utilized/positioned in the AO to meet pre-deployment health risk assessment (HRA) requirements,support the mission, and help establish priorities pre, during, and post deployment.

7.B. Pre-Deployment Health Risk Assessments

7.B. (1) OEH/ED threats can seriously impact a commander’s mission. This guidance considersOEH/ED hazards to be integrally related and addresses them consistently.

7.B. (2) An overall HRA for the AO must be accomplished before deployment in the USSOUTHCOMAOR.

7.B. (3) PM personnel will conduct a preliminary hazard assessment as per para 6 and integrate such data to the composite risk management (CRM) process to identify OEH/ED hazards, assess their risks, determine appropriate countermeasures, and develop effective risk communication messages and materials.

7.B. (4) As part of the pre-deployment HRA, units will conduct OEH/ED studies at potential deployment sites to establish baseline conditions. These studies may include environmental baseline surveys, OEHSA, industrial hygiene site assessments, PHLA, pre-deployment site surveys, and base camp assessments.

7.B. (5) PM personnel completing HRA must evaluate all information obtained and prepare a written and verbal HRA for the commander to include findings, conclusions, opinions, and recommendations.

7.C. Occupational and Environmental Health Site Assessments (OEHSA)

7.C. (1) IAW Ref B and Ref I, OEHSA are required for all operating locations occupied for 30 days or longer to identify, evaluate, and document deployment health threats and countermeasures per Ref L and Ref M. An exposure of interest is anything that may adversely impact individual personnel'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.

7.C. (2) Commanders must consider completing an OEHSA for deployment sites with high-risk health threat estimates or for longstanding locations where exercises and other activities routinely occur, regardless of deployment duration.

7.C. (3) OEHSA focus on collecting site-specific data to identify potential or actual exposure pathways during bed down, employ, and sustainment of deployed forces.

7.C. (4) OEHSA provide a baseline to identify where future periodic sampling will be required based on the conceptual site model (CSM). Sampling data will be used to update the periodic occupational environmental model (POEM) (see para 8.G).

7.C. (5) The OEHSA shall be documented in the Defense Occupational and Environmental Health Readiness System (DOEHRS) database. If DOEHRS is not available, theOEHSA will be documented using DOEHRS standard templates to facilitate DOEHRS entry post deployment. Additionally, OEHSA shall be documented in the MESL.

7.C. (6) Components and subordinate activities should:

7.C. (6)(a) Provide technical support and consultation to PM assets as necessary to completeOEHSA mission.

7.C. (6)(b) Query the MESL and DOEHRS to determine what sampling is needed at a given deployment site.

7.C. (6)(c) Ensure all OEHSA are coordinated with USSOUTHCOM SG, public health division prior to being forwarded to USAPHC.

7.C. (6)(d) Coordinate for sampling media and equipment as required and for analysis through USAPHC or another DoD certified lab. Components will request funding for and provide funding to PM assets part of their contingency and operational planning.

7.D. Endemic Disease Site Assessments

7.D. (1) Conditions in the USSOUTHCOM AOR, such as poverty, underdevelopment, malnutrition, crowded living conditions, rudimentary public health infrastructure, and limited availability of healthcare, often result in ideal conditions for infectious disease (ID) spread.

7.D. (2) Since USSOUTHCOM primary missions include non-combat roles such as security cooperation,humanitarian civic assistance exercises, humanitarian assistance/disaster relief (HA/DR), and peace support operations, ID will be the predominant enemy for U.S. military deployed in the USSOUTHCOM AOR.

7.D. (3) Units must identify diseases endemic to the AO and estimate the potential operational impact of such threats on overall unit readiness. Diseases with potential operational impact and/or health consequences to the deployed force must be addressed.

7.D. (4) During site assessments, units should consult embassy and host nation health authorities to obtain further/latest information on local ED threats and validate preliminary hazard assessment findings. ED assessments must consider time frame of operations. Assessment prioritization should be based on seasonal prevalence, incubation period, and likelihood of exposure based on the natureof the mission.

7. E. Food and Water Safety

7.E. (1) Safe food/water sources, storage, preparation, handling, distribution, and consumption are critical in preventing and/or controlling food-borne/water-borne diseases in deployed settings. For purposes of this guidance, the term food and water include food, drinks, food ingredients, ice, and drinking water to include bottled individual and bulk containers. It also includes water in piped distribution systems to the point of use to include related internal water storage and treatment.

7.E. (2) Tactical commanders on the ground must enforce the use of all required countermeasures including the use of DoD approved sources of food and drinking water IAW Ref U, Ref V, and Ref W.

7.E. (3) No source of drinking water (including ice) will be considered potable until properly tested and approved by qualified DoD medical/veterinary personnel IAW

DoD and service-specific guidance. The same applies to food. No food source will be utilized unless properly inspected and approved by qualified personnel IAW DoD and service-specific guidance.

7.E. (4) The USPHC has a world-wide directory of approved commercial food suppliers/sources. Audits of these facilities have been conducted by USAPHC veterinary personnel. If audit compliant, facilities are placed on USAPHC Circular 40-1 “worldwide directory of sanitarily approved food establishments for armed forces procurement”. See https://phc.amedd.army.mil/topics/foodwater/ca/Pages/DoDApprovedFoodSources.aspx for a listing of approved sites in the USSOUTHCOM AOR.

7.E. (5) When requesting commercial audits of food establishments ensure enough lead time (typically 3-6 months) to meet the operational and logistical requirements of the mission.Request must be made through USSOUTHCOM SCSG or delegated to the appropriate component.

7.E. (6) Food & water risk assessments (FWRA) are conducted to support short-term events and exercises outside the continental United States (OCONUS) in locations where no or insufficient DoD approved food sources are available and/or a logistics support tail is not available or feasible. FWRA are conducted primarily by veterinary service personnel. When veterinary service personnel are not available, an experienced and trained preventive medicine officer (Army MOS 72D, Navy PMO, or USAF PHO) may conduct FWRA for troop feeding in these areas. A FWRA does not yield an approved source; it is a health risk assessment and mitigation tool for tactical commanders to decide whether to allow troop feeding from non-approved caterers, restaurants, foreign military dining facilities, etc.

7.E. (7) When requesting FWRA ensure enough lead time (typically 90 days) to meet the operational and logistical requirements of the mission. Request must be made through USSOUTHCOM SCSG or delegated to the appropriate component.

7.E. (8) Tactical commanders on the ground will ensure the necessary security to protect against intentional tampering or unintentional contamination of drinking water, food supplies, and food service operations under DoD control. Continual verification of quality and periodic inspection of storage and preparation facilities are required and will be carried out onsite by a U.S military medical authority IAW service-specific guidelines.

7.E. (9) As a standard measure, consumption or individual purchase of local food and water is prohibited. However, it is recognized that at times, U.S. forces may need to eat local foods with community leaders and residents.

7.E. (9)(a) Although eating local foods may be good for building relationships, it frequently carries significant risk. Tactical commanders on the ground are responsible to consult with supporting preventive medicine and/or veterinary personnel about health risks that may result from eating local foods available at a particular location/event.

7.E. (9)(b) If after weighing risks the tactical commander on the ground, approves consumption, then personnel should be briefed on risks involved and provided with information on making educated choices regarding the types of local food they can eat to help reduce their risk of foodborne illness. A variety of downloadable training resources regarding consumption of local foods during deployment are available on the USAPHC website (http://phc.amedd.army.mil/topics/foodwater/pages/default.aspx)

7.E. (10) During disaster or emergency response, local foods are in short supply and need to be made available to fulfill the need of local civilians. As a result, local procurement of food is prohibited unless authorized by higher HQ.

7.F. Pre-Deployment Health Threat Briefing

7.F. (1) All personnel deploying or traveling to the USSOUTHCOM AOR must receive a pre-deployment health threat and countermeasures briefing within 30 days of expected date of arrival in theater.

7.F. (2) Qualified medical personnel must brief all deployers and travelers on anticipated locationspecific health threats and exposures, relevant countermeasures, and their employment, plannedhealth surveillance monitoring, and the overall operational risk management program.

7.F. (3) At a minimum, content of brief will include endemic diseases, vector-borne disease countermeasures, food and water borne disease prevention, STI, endemic flora and fauna hazards,environmental conditions, OEHS, personal/dental hygiene, motor vehicle and general safety, personal health and fitness, and operational stress control.

7.G. Health Risk Communications Plan

7.G. (1) Units will develop a plan to communicate to commanders, health professionals, and personnel the nature, magnitude, and significance of potential OEH/ED health risks (including actual and potential exposures) adequately and accurately in the AO. Plan should specify the means of delivery and development of key messages and describe the potential or anticipated impact of possible threats on force health.

7.G. (2) During all phases of deployment, units will 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.

7.G. (3) Continual HRA’s are essential elements of the health risk communication process during the deployment phase. Medical personnel at all levels will provide written and oral risk communication products for medical threats, countermeasures to those threats, and the need for any medical follow-up.

8. During Deployment Health Activities

8.A. General

8.A. (1) During deployment health, activities should be based on the pre-deployment risk assessmentof the health threats for the AO and the specific deployment location.

8.A. (2) During deployment health, activities begin when the advanced party or initial cadre personnel arrive at the deployment area. Activities should be updated as the deployment proceeds based on HRA's, OEHSA, routine and incident-driven monitoring and sampling, and other health surveillance activities.

8.A. (3) 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.

8.A. (4) Commanders must ensure the integrity of field hygiene and sanitation and occupational health and safety programs.

8.B. Health Surveillance

8.B. (1) Unit commanders must ensure medical personnel conduct daily D&I surveillance, disease and injury reporting, pesticide, sanitation and food service surveillance, location specific OEHSA and systemic OEH hazard surveillance and other activities to detect any trends in the health of deployed personnel.

8.B. (2) During deployment, medical personnel will:

8.B. (2)(a) Validate and update preliminary hazard assessments.

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

8.B. (2)(c) Ensure deployment health surveillance and OEH reporting, and data is entered into DOEHRS, if DOEHRS is not available, ensure submission to DoD or service-specific systems for further disposition and archiving IAW DoD, USSOUTHCOM and service specific policies. To the extent possible, electronic copies of all data, data summaries, final reports and investigations will be uploaded, at least monthly, to MESL IAW Ref B.

8.B. (2)(d) Alert USSOUTHCOM, service chain of command, Armed Forces Health Surveillance Center (AFHSC), and NCMI (ncmiops@ncmi.detrick.army.mil) to any newly identified health threats, negative health trends or adverse events.

8.B. (2)(e) Investigate, report, and document all OEH and CBRN exposure incidents within the incident reporting module of DOEHRS when available.

8.C. Disease and Injury (D&I) Surveillance

8.C. (1) Daily D&I event surveillance is required for all deployment for more than 30 days to locations within the USSOUTHCOM AOR. For deployment 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.

8.C. (2) D&I surveillance and reporting should begin at the time that health care delivery is initiated. However, D&I surveillance is required even in the absence of deployed U.S. medical personnel. Units will continuously capture data about individual and population health status, instances of D&I, medical interventions (such as immunizations and treatments), stress-induced casualties, combat casualties,and medical evacuations.

8.C. (3) D&I event counts, rates, and trends are an important type of surveillance for use at all levels. Deployed medical personnel at each operating location must monitor and evaluate D&I event data at least once daily. Data for D&I surveillance derives from electronic patient records, sick call logs, safety mishap reports or other sources. 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.

8.C. (4) The list of D&I reporting categories, their definitions, and the essential elements of the standard D&I report can be found in Ref K.

8.C. (5) Service component and JTF surgeons are responsible for ensuring subordinate units are collecting the prescribed D&I data and reporting that data on a weekly basis, preferably through DoD and service specific automated systems that feed into the joint medical workstation (JMEWS).

8.C. (6) 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. Units must email D&I report in excel format to chain of command and USSOUTHCOM Surgeon (USSOUTHCOM.miami.sc-cc.mesg.uscsg@mail.mil or USSOUTHCOM.miami.sc-cc.mesg.sg@mail.smil.mil). MEDSITREP in pdf or word format that include D&I reporting data are also acceptable.

8.C. (7) 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 and mitigate D&I.

8.C. (8) Service component and subordinate activity surgeons will submit to the USSOUTHCOM SG FHP division, at least monthly or more frequently as required, a summary report and trend analysis of D&I surveillance of service component activities within the USSOUTHCOM AOR.

8.D. Reportable Medical Event (RME) Surveillance

8.D. (1) Units must report all occurrences of diseases and conditions listed in the

armed forces reportable medical events (RME's) guidelines & case definitions IAW Ref N.

8.D. (2) Units must all comply with the RME requirement IAW established service-specific systems.

8.D. (3) Adverse medical events related to immunizations should be reported through RME if case definitions are met. All immunization related adverse events are to be reported through the vaccine adverse events reporting system (VAERS) at http://www.vaers.hhs.gov.

8.D. (4) RME reporting is to occur as soon as reasonably possible after the event has occurred. Certain events are considered urgent RME, and immediate reporting is required.

8.D. (5) Units are required to copy USSOUTHCOM SG for the following RME at (USSOUTHCOM.miami.sc- cc.mesg.uscsg@mail.mil: Anthrax; Botulism; CBRN and TIC/TIM OEH exposure; cold weather/heatinjuries; Chikungunya, Dengue Fever; Hantavirus disease; Hemorrhagic Fever; Hepatitis B or C, HIV; Malaria; Measles; Meningococcal disease; Norovirus; Plague; Pneumonia, Eosinophilic; Rabies, Human; Streptococcus, Invasive Group A; Tetanus; Tuberculosis, Pulmonary; TyphoidFever; Varicella.

8.D. (6) Service component and JTF surgeons are responsible for ensuring subordinate units are collecting the appropriate RME data and reporting that data through their service specific reportingmechanisms.

8.E. Patient Encounter Documentation/Deployment Health Record

8.E. (1) Deployed medical personnel must document all patient encounters and ensure service- specific procedures are maintained for appropriate archiving of health documents and records.

8.E. (2) It is mandatory that copies of all inpatient and original outpatient medical encounter documentation (including medical treatment records provided to deployed personnel by allies andcoalition partners of the U.S. be incorporated into the deployment health record (automated or hardcopy; DD form 2766 or equivalent).

8.E. (3) Individual dosimeter data and/or medical treatment information must be documented in individual medical records using the SF form 600 (medical record – chronological record of medical care, rev. 6/97).

8.E. (4) Deployment health data will be collected and maintained in DoD-approved automated health information management systems.

8.E. (5) Deployed medical personnel must ensure capture of the following information, at a minimum,on every patient encounter: patient's name, DoD ID#, gender, unit, unit identifier code, and duty location; type of visit (i.e. new vs. follow-up); primary (chief) complaint; final diagnosis (es), in order of importance related to the primary complaint injuries, which must be classification into recreation/sports, motor

vehicle accidents, work/training, or other; final projected disposition, such asfull duty, limited duty, transfer; D&I category.

8.E. (6) Medical personnel should use ICD-10 codes to best support medical event surveillance. Use of ICD-10 codes assists in the search for cases of reportable diseases in healthcare encounter databases. Other ICD-10 codes may also be needed to find additional RME's (occupational injuries) in these databases.

8.E. (7) Health surveillance records are protected information and must be maintained.

8.E. (8) Electronic health event data collection systems that populate JMEWS will be used at all levels of medical care within the USSOUTHCOM AOR. Refer to para below for more information on JMEWS.

8.F. Joint Medical Workstation (JMEWS)

8.F. (1) Deployed units will use JMEWS as the primary data entry point for weekly D&I reporting within the USSOUTHCOM AOR. Shipboard units should utilize SAMS or TMIP-M for D&I reporting and fixed MTF's should utilize AHLTA or MHS GENESIS.

8.F. (2) 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 USSOUTHCOM.

8.F. (3) Service component and subordinate surgeons will ensure all units apply for JMEWS access prior to deploying and complete on-line training. Units may also coordinate training with army medical communications for combat casualty care (MC4) athttp://www.mc4.army.mil .

8.F. (4) Component and subordinate activities surgeons will ensure that deployed medical unit submit a joining and exiting report via the JMEWS portal to establish and disestablish the deployed unit and to ensure medical records are assigned correctly.

8.G. Periodic Occupational and Environmental Monitoring Summary (POEMS)

8.G. (1) Authority. POEMS is a joint approved product used to address environmental exposure documentation requirements.

8.G. (2) Timeframe. POEMS will be created and validated for every major deployment site at least annually. In general, POEMS are a summary of information reflecting a year or more of OEH data to ensure adequate collection of exposure information.

8.G. (3) Classification/publication/access. POEMS will be unclassified but posted on the password protected MESL where joint OEH surveillance data and reports are stored. The POEMS template can be found at http://phc.amedd.army.mil.

8.G. (4) Responsibilities. Service components and JTFs are responsible for ensuring POEMS are completed for sites in their respective AOR. They should develop site prioritization lists and enlist the support of service public health organizations (e.g., USAPHC) to draft the content of a site POEMS. The USAPHC oversees the data archival website for publication of final POEMS and associated documents; however, approval of "final" POEMS must come from the service component/JTF FHP officer with input from PM resources in direct or general area support.

8.H. Incident Response & Reporting (OEH Exposures/Outbreaks, Disease Outbreak, CBRN)

8. H. (1) Medical personnel will keep their chain of command and USSOUTHCOM surgeon informed of any significant disease outbreaks, negative health trends or adverse events. Please note that all illnesses requiring hospitalization and/or evacuation must be reported to their chain of command and USSOUTHOM surgeon.

8.I. Field Sanitation

8.I. (1) Not all potential sources of infection or illness can be countered with vaccinations or prophylactic medications. The best defense against these threats is strict discipline in proper field hygiene and sanitation practices by personnel, leaders, and units.

8.I. (2) Units must ensure their own health and disease prevention by strict enforcement of proper field sanitation and hygiene. Units are responsible for field sanitation routine requirements unless such services are contracted.

8.J. Pest Control Operations

8.J. (1) Commanders will conduct pest control operations using the integrated pest management program IAW Ref S.

8.J. (2) Vector surveillance and control must be a part of all operational planning.

8.L. Waste control and disposal

8.L. (1) Commanders must ensure appropriate storage, use and disposal of hazardous materials (human, hazardous, medical) IAW DA Pamphlet 710–7.

9. Post Deployment Health Activities

9.A. Post-Deployment Health Assessment (DD form 2796)

9.A. (1) All personnel who were required to complete a pre-deployment health assessment will complete a post-deployment health assessment on a DD form 2796 as close to the redeployment date as possible, but not earlier than 30 days before

expected redeployment date or no later than 30 days after redeployment.

9.A. (2) Individuals who were not required to complete a pre-deployment health assessment, but who completed one due to multiple trips to theater each of 30 days or less duration, should complete a post-deployment health assessment at least once a year to document any potential exposures of concern resulting from any such travel and the potential need for medical follow-up.

9.A. (3) All redeploying personnel must undergo a face-to-face health assessment with an independent practitioner (physician, physician assistant, nurse practitioner, advanced practice nurse,independent duty corpsman, independent duty medical technician, or special forces medical sergeant). The original completed copy of the DD form 2796 must be placed in the individual's medical record and transmit an electronic copy to the DMSS at the AFHSC.

9.B. Post-Deployment Health Re-Assessment (PDHRA) (DD form 2900)

9.B. (1) All personnel who were required to complete a pre- and post-deployment health assessment must complete a PDHRA (DD form 2900) 90 to 180 days after return to home station. See www.pdhealth.mil

9.C. Additional Individual/Unit Requirements

9.C. (1) Post-deployment TB screening. Required for all personnel deployed to USSOUTHCOM AOR.

9.C. (2) Post-deployment serum specimens. Required for all service members (NOT Civilians) deployed to USSOUTHCOM AOR. Individuals must be informed if the post-deployment serum sample will be tested for HIV.

9.C. (3) Biomonitoring. Required based on the deployment health threats, possible exposures, and available bioassays.

9.C. (4) Post-deployment health debriefings and risk communications. A health threat de-briefing must be provided to redeploying or redeployed DoD personnel during in-theater medical out- processing or following a deployment to the USSOUTHCOM AOR.

9.C. (5) Post-deployment medical surveillance. Commanders are responsible to ensure appropriate medical surveillance should be conducted to detect emerging (latent) health conditions on redeployed personnel.

9.D. Post-Deployment OEH Activities

9.D. (1) Units will submit any remaining OEH reports and data including monitoring and sampling results for air, water, soil, and noise; vector surveillance; toxic industrial chemicals or materials; and veterinary public health including food safety data that were not submitted previously to MESL for archiving. This includes but it is not limited to environmental sampling reports, industrial hygiene reports, PM unit

SITREPS, veterinary service food and bottled water sanitation audit reports, veterinary laboratory test results, disease vector surveillance reports, pest management records, health surveillance data, monitoring/sampling data, field monitoring data, specific reports/documents,reports of investigations/evaluations pertaining to potential OEH exposure hazards, field water quality assurance surveys and monitoring data, pest surveillance surveys/reports, noise surveys, radiation surveys/monitoring data, entomological surveys, infectious/endemic disease reports, polymerase chain reaction (PCR) results.

9.D. (2) Ensure all OEH sample results are analyzed for the potential medical follow-up and to contribute to lessons learned and future operational reports.

9.D. (3) Medical follow-up must be appropriately documented to address OEH concerns related to the review of responses on the DD form 2796 in the health record.

9.E. After Action Reports

9.E. (1) Commanders must comply with operation-specific guidance to document any OEH exposures during the deployment and any health lessons learned during the deployment. Documentation is in the form of official after-action reports such as the joint uniform lessons learned system, cruise reports, etc.

9.E. (2) This timely feedback allows medical personnel to provide health risk assessments that are based on the most accurate and up-to-date information and intelligence available.

9.E. (3) These reports should be submitted within 60 days of the conclusion of a deployment via the operational chain of command IAW theater information policy. Copies should be forwarded to NCMI, Joint Lessons Learned Information System (JLLIS), service-specific medical lessons learned, future plans, and knowledge management as required.

APPENDIX A

References

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