

**Military Deployment**  
**Periodic Occupational and Environmental Monitoring Summary (POEMS):**  
**Bella, Afghanistan**  
**Calendar Years: 2001-2008**

**AUTHORITY:** This periodic occupational and environmental monitoring summary (POEMS) has been developed in accordance with Department of Defense (DoD) Instructions 6490.03, 6055.05, and JCSM (MCM) 0017-12 (References 1-3).

**PURPOSE:** This POEMS documents the Department of Defense (DoD) assessment of occupational and environmental health (OEH) risk for Combat Outpost (COP) Bella, Afghanistan. It presents a qualitative summary of OEH risks identified at this location and their potential medical implications. The report is based on information collected from 01 January 2001 through 31 December 2008 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.

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This assessment assumes that environmental sampling at COP Bella 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 01 January 2001 through 31 December 2008.

The POEMS can be useful to inform healthcare providers and others of environmental conditions experienced by individuals deployed to COP Bella 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 record on a Standard Form (SF) 600 (Chronological Record of Medical Care).

**SITE DESCRIPTION:** COP Bella was located near the town of Wanat in the northeastern province of Nuristan. The outpost was a platoon size base in the remote Waygal Valley. It was closed in 2008.

**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 COP Bella. 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.

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S-0757

**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 COP Bella:

Food/waterborne diseases (e.g., bacterial diarrhea, hepatitis A, typhoid/paratyphoid fever, diarrhea-cholera, diarrhea- protozoal, brucellosis, hepatitis E); other endemic diseases (malaria, Crimean-Congo hemorrhagic fever, leishmaniasis-cutaneous (acute), sandfly fever, typhus-miteborne (scrub typhus), leptospirosis, Tuberculosis (TB), rabies, Q fever, soil transmitted helminthes (hookworm, strongyloidiasis, cutaneous larva migrans)); 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, Crimean-Congo hemorrhagic fever, leishmaniasis-cutaneous (acute), sandfly fever, typhus-miteborne (scrub typhus)), 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, Q fever), pose year-round risk. For soil transmitted helminthes (hookworm, strongyloidiasis, cutaneous larva migrans), risk may have been reduced by limiting exposure to soil contaminated with human or animal feces (including not sleeping on bare ground, and not walking barefoot). For heat stress, risk can be greater during months of June through August, 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 (PM<sub>10</sub>) from environmental dust (including any burn pits and/or incinerators, which might have existed), the PM<sub>10</sub> overall short-term health risk was not evaluated due to no data for analysis. For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM<sub>2.5</sub>) from environmental dust (including any burn pits and/or incinerators, which might have existed), the PM<sub>2.5</sub> overall short-term health risk was not evaluated due to no data for analysis. However, the COP Bella and vicinity area is a dust-prone desert environment, with a semi-arid climate, also subject to vehicle traffic. Consequently, exposures to PM<sub>10</sub> and PM<sub>2.5</sub> 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 PM<sub>10</sub> and PM<sub>2.5</sub>, 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 might have existed in the vicinity (e.g., burn pits used by the local population); however, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall short-term health risks specifically for burn pits were not evaluated due to no reports and no environmental samples collected near burn pits provided for analysis— see Section 10.7. Where burn pits exist, exposures may vary, and exposures to high levels of PM<sub>10</sub> and PM<sub>2.5</sub> 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 incinerator and/or 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 while at COP Bella and vicinity. 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 COP Bella:

Air quality: For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM<sub>2.5</sub>) from environmental dust (including any burn pits and/or incinerators, which might have existed), the overall long-term health risk was not evaluated due to no data for analysis. Inhalable coarse particulate matter less than 10 micrometers in diameter (PM<sub>10</sub>) from environmental dust (including any burn pits and/or incinerators, which might have existed) was not evaluated for long-term health risk due to no data for analysis and no available health guidelines. However, the COP Bella and vicinity area is a dust-prone desert environment with a semi-arid climate, also subject to vehicle traffic, and conditions may have varied. Burn pits and/or incinerators might have existed in the vicinity (e.g., burn pits used by the local population); however, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall long-term health risks specifically for burn pits were not evaluated due to no reports and no environmental samples collected near burn pits provided for analysis— see Section 10.7. Where burn pits exist, exposures may vary, as conditions may have varied. For inhalational exposure to high levels of dust containing PM<sub>10</sub> and PM<sub>2.5</sub>, such

as during high winds or dust storms, and for exposures to incinerator and/or 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 –COP Bella<sup>1, 2</sup>**

Source of Identified Health Risk <sup>3</sup>	Unmitigated Health Risk Estimate <sup>4</sup>	Control Measures Implemented	Residual Health Risk Estimate <sup>4</sup>
<b>AIR</b>			
Particulate matter less than 10 micrometers in diameter (PM <sub>10</sub> )	Short-term: No data were available for analysis to characterize short-term health risk. Daily levels vary; acute health effects (e.g., upper respiratory tract irritation) more pronounced during days with elevated PM levels. More serious effects are possible in susceptible persons (e.g., those with asthma/pre-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: No data were available for analysis to characterize short-term health risk. Daily levels vary; acute health effects (e.g., upper respiratory tract irritation) more pronounced during days with elevated PM levels. More serious effects are possible in susceptible persons (e.g., those with asthma/pre-existing respiratory diseases).
	Long-term: No health guidelines		Long-term: No health guidelines
Particulate matter less than 2.5 micrometers in diameter (PM <sub>2.5</sub> )	Short-term: No data were available for analysis to characterize short-term health risk. Because COP Bella is situated in a dusty semi-arid desert environment, a majority of the time mild acute (short term) health effects are anticipated. Elevated 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: No data were available for analysis to characterize short-term health risk. Because COP Bella is situated in a dusty semi-arid desert environment, a majority of the time mild acute (short term) health effects are anticipated. Elevated 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: No data were available for analysis to characterize long-term health 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/pre-existing respiratory diseases).		Long-term: No data were available for analysis to characterize long-term health 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/pre-existing respiratory diseases).
<b>ENDEMIC DISEASE</b>			
Food borne/Waterborne (e.g., diarrhea-bacteriological)	Short-term: Variable; High (bacterial diarrhea, hepatitis A, typhoid/paratyphoid 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/paratyphoid 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, scrub typhus (mite-borne); 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, and appropriate chemoprophylaxis.	Short-term: Low
	Long-term: Low for Leishmaniasis-visceral infection.		Long-term: No data available
	Short-term: Moderate for leptospirosis		Short-term: Low for leptospirosis.

Source of Identified Health Risk <sup>3</sup>	Unmitigated Health Risk Estimate <sup>4</sup>	Control Measures Implemented	Residual Health Risk Estimate <sup>4</sup>
Water-Contact (e.g., wading, swimming)	Long-term: No data available	Recreational swimming in surface waters not likely in this area of Afghanistan during this time period.	Long-term: No data available
Respiratory	Short-term: Variable; Moderate for tuberculosis (TB) to Low for meningococcal meningitis and Middle East respiratory syndrome coronavirus (MERS-CoV).	Providing adequate living and work space; medical screening.	Short-term: Low
	Long-term: No data available		Long-term: No data available
Animal Contact	Short-term: Variable; Moderate for rabies and Q-fever to Low for anthrax and avian influenza.	Prohibiting contact with, adoption, or feeding of feral animals IAW U.S. Central Command (CENTCOM) General Order (GO) 1C. Risks are further reduced in the event of assessed contact by prompt post-exposure rabies prophylaxis IAW The Center for Disease Control's (CDC) Advisory Committee on Immunization Practices guidance.	Short-term: No data available
	Long-term: Low (Rabies)		Long-term: No data available
Soil-transmitted helminths	Short-term: Moderate for soil transmitted helminths (hookworm, strongyloidiasis, cutaneous larva migrans).	Risk was reduced to Low by limiting exposure to soil contaminated with human or animal feces (including sleeping on bare ground and walking barefoot).	Short-term: Low
	Long-term: No data available		Long-term: No data available
<b>VENOMOUS ANIMAL/ INSECTS</b>			
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. Haly's Pit Viper).	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. Haly's Pit Viper).
	Long-term: None identified		Long-term: None identified
<b>HEAT/COLD STRESS</b>			
Heat	Short-term: Variable; Risk of heat injury is Moderate for months of June, July, and August, and Low all the other months from September to May.	Work-rest cycles, proper hydration and nutrition, and Wet Bulb Globe Temperature (WBGT) monitoring.	Short-term: Variable; Risk of heat injury is Moderate for months of June, July, and August, and Low all the other months from September to May.
	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	Short-term: Low risk of cold stress/injury.
	Long-term: Low; Long-term health implications from cold injuries are rare		Long-term: Low; Long-term health implications from cold injuries are rare

Source of Identified Health Risk <sup>3</sup>	Unmitigated Health Risk Estimate <sup>4</sup>	Control Measures Implemented	Residual Health Risk Estimate <sup>4</sup>
	but can occur, especially from more serious injuries such as frost bite.	and nutrition, and proper wear of issued protective clothing.	but can occur, especially from more serious injuries such as frost bite.
<b>Unique Incidents/ Concerns</b>			
Burn Pits	<p>Short-term: Burn pits and/or incinerators might have existed at COP Bella and vicinity (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their presence or absence. Consequently, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall short-term health risks specifically for burn pits were not evaluated – see Section 10.7. Because COP Bella and vicinity is situated in a dusty semi-arid desert environment, 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.</p> <p>Long-term: Burn pits and/or incinerators might have existed at COP Bella and vicinity (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their presence or absence. Consequently, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall long-term health risks specifically for burn pits were not evaluated – see Section 10.7. Exposure to burn pit smoke is variable. Exposure to high levels of PM<sub>10</sub> and PM<sub>2.5</sub> 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>	Risks reduced by limiting strenuous physical activities when air quality was especially poor, and actions such as closing tent flaps, windows, and doors. Other control measures included locating burn pits downwind of camps, increased distance from troop populations, and improved waste segregation and management techniques.	<p>Short-term: Burn pits and/or incinerators might have existed at COP Bella and vicinity (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their presence or absence. Consequently, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall short-term health risks specifically for burn pits were not evaluated – see Section 10.7. Because COP Bella and vicinity is situated in a dusty semi-arid desert environment, 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.</p> <p>Long-term: Burn pits and/or incinerators might have existed at COP Bella and vicinity (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their presence or absence. Consequently, the PM<sub>10</sub> and the PM<sub>2.5</sub> overall long-term health risks specifically for burn pits were not evaluated – see Section 10.7. Exposure to burn pit smoke is variable. Exposure to high levels of PM<sub>10</sub> and PM<sub>2.5</sub> 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>

Source of Identified Health Risk <sup>3</sup>	Unmitigated Health Risk Estimate <sup>4</sup>	Control Measures Implemented	Residual Health Risk Estimate <sup>4</sup>
<p><sup>1</sup>This Summary Table provides a qualitative estimate of population-based short- and long-term health risks associated with the occupational environment conditions at COP Bella. 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.</p> <p><sup>2</sup> This assessment is based on specific environmental sampling data and reports obtained from 1 January 2001 through 31 December 2008. 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.</p> <p><sup>3</sup>This Summary Table is organized by major categories of identified sources of health risk. It only lists those sub-categories specifically identified and addressed at COP Bella. 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 Army Public Health Center (APHC). Where applicable, "None Identified" is used when 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.</p> <p><sup>4</sup>Health 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.</p>			

## 1 Discussion of Health Risks at Bella, 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 Center (USAPHC) 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, which have little efficacy in reducing exposure to ambient conditions.

The ProUCL version 5.0 software package was used for statistical analyses (Reference 5). Means are followed by standard deviation (SD). Risk characterization was based on the 95 percent upper confidence level of the arithmetic mean (95% UCL) or the arithmetic mean depending on the quality and quantity of the data being evaluated. The sample mean is an uncertain estimate of the true mean of the population exposure point concentration (PEPC). The 95% UCL reduces the uncertainty inherent in the sample mean and states with a higher level of confidence that the mean PEPC is no greater than the 95% UCL.

## 2 Air

### 2.1 Site-Specific Sources Identified

COP Bella was 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, might 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, volatile organic compounds (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: PM<sub>10</sub>, which includes coarse particles with a diameter of 10 micrometers or less, and fine particles less than 2.5 micrometers (PM<sub>2.5</sub>), 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 (PM<sub>10</sub>)

#### 2.3.1 Exposure Guidelines:

Short Term (24-hour) PM<sub>10</sub> MEG (micrograms per cubic meter, µg/m<sup>3</sup>):

- Negligible MEG = 250

Long-term PM<sub>10</sub> MEG (µg/m<sup>3</sup>):

- Not defined and not available.

- Marginal MEG = 420
- Critical MEG = 600

#### 2.3.2 Sample data/Notes:

No PM<sub>10</sub> samples were taken at COP Bella.

#### 2.3.3 Short-term health risks:

**Not evaluated.** No samples taken.

#### 2.3.4 Long-term health risk:

**Not Evaluated- no samples and no available health guidelines.** The U.S. Environmental Protection Agency (EPA) has retracted its long-term standard (National Ambient Air Quality Standards, NAAQS) for PM<sub>10</sub> due to an inability to clearly link chronic health effects with chronic PM<sub>10</sub> exposure levels.

### 2.4 Particulate Matter, less than 2.5 micrometers (PM<sub>2.5</sub>)

#### 2.4.1 Exposure Guidelines:

Short Term (24-hour) PM<sub>2.5</sub> MEG (µg/m<sup>3</sup>):

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

Long-term (1 year) PM<sub>2.5</sub> MEGs (µg/m<sup>3</sup>):

- Negligible MEG = 15
- Marginal MEG = 65

#### 2.4.2 Sample data/Notes:

No PM<sub>2.5</sub> samples were taken at COP Bella.

#### 2.4.3 Short and long-term health risks:

**Not evaluated.** No samples taken.

### 2.5 Airborne Metals

#### 2.5.1 Exposure Guidelines:

#### 2.5.2 Sample data/Notes:

No airborne metal samples were taken at COP Bella.

#### 2.5.3 Short and long-term health risks:

**Not evaluated.** No samples taken.

### 2.6 Volatile Organic Compounds (VOC)

#### 2.6.1 Sample data/Notes:

No VOC samples were taken at COP Bella.

## 2.6.2 Short and long-term health risks:

**Not evaluated.** No samples taken.

### 3 Soil

#### 3.1 Sample data/Notes:

One discrete soil sample was taken near the helipad at COP Bella on 29 April 2008.

#### 3.2 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.

#### 3.3 Long-term health risk:

**None identified based on available sample data.** The collected sample was below the short and long-term Negligible MEGs. However, only one sample was taken, and this may not be indicative of conditions during the entire length of the outpost operations.

### 4 Water

In order to assess the health risk to U.S. personnel from exposure to water in theater, the APHC 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. Based on the information provided from the field, a sample of untreated water was provided that was used for hygiene and laundry. Therefore, this untreated sample was assessed as a potential health hazard. It is assumed that 100% of all U.S. personnel at COP Bella will be directly exposed to reverse osmosis water purification unit (ROWPU) treated, disinfected fresh bulk water and bottled water. Field data sheets indicate that bottled water was the only approved source of drinking water.

#### 4.1 Drinking Water: Bottled or Packaged 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 L/day of bottled water for up to 365 days (1-year). It was further assumed that control measures were not used.

No drinking water samples were taken at COP Bella.

##### 4.1.3 Short-term and long-term health risk:

**Not evaluated.** No samples taken.

#### 4.2 Non-Drinking Water: Untreated

#### 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. One sample of untreated river water was taken on 22 January 2008. As this water was used for laundry and showering, it was evaluated. No chemicals were detected at levels above the short or long-term MEGs.

#### 4.2.3 Short and long-term health risks:

**None identified based on available sample data.** The collected sample was below the short and long-term Negligible MEGs. However, only one sample was taken, and this may not be indicative of conditions during the entire length of the outpost operations.

## 5 Military Unique

### 5.1 Chemical Biological, Radiological Nuclear (CBRN) Weapons

No specific hazard sources were documented in the Defense Occupational and Environmental Health Readiness System (DOEHRS) from 1 January 2001 to 31 December 2008 (Reference 1).

### 5.2 Depleted Uranium (DU)

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

### 5.3 Ionizing Radiation

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

### 5.4 Non-Ionizing Radiation

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

## 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 Foodborne and Waterborne Diseases

Foodborne 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 disease surveillance has been improved to cover the majority of the country since 2009. There is still underreporting of specific disease incidence. 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.

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

Key disease risks are summarized below:

#### 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. Field conditions (including lack of hand washing and primitive sanitation) may facilitate person-to-person spread and epidemics. Typically mild disease treated in outpatient setting; 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 was in place to reduce the risks to low. 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 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 up to 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 reaction 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:

**Low:** The overall unmitigated short-term risk associated with foodborne 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 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.

### 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. Leishmaniasis is transmitted by sandflies. A small number of cases (less than 1% per month) could occur among personnel exposed to sandfly bites in areas with infected people, rodents, dogs, or other reservoir animals. In groups of personnel exposed to heavily infected sandflies in focal areas, attack rates can be very high (over 50%). 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 can cause severe febrile illness, which typically requires hospitalization with convalescence over 7 days.

### 6.2.3 Crimean-Congo hemorrhagic fever

**High, mitigated to Low:** Unmitigated risk is High, but reduced to Low with mitigation measures.

Crimean-Congo hemorrhagic fever occurs in a small number of cases (less than 1% per month) 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 disease rates can be as high as 50%. 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 typically resulted 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) 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.

#### 6.2.9 Short -term health risks:

**Low:** The unmitigated health risk estimate is High for malaria and Crimean-Congo hemorrhagic fever (infection rate of less than 1% per month), Moderate for leishmaniasis-cutaneous (acute), 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.

#### 6.2.10 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 (e.g. 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. 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,

measles, 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, and implementation of proper personal protective equipment (PPE), when necessary, for healthcare providers and detention facility personnel.

#### 6.4.1 Tuberculosis (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 can also occur with more incidental contact. Individuals with prolonged indoor exposure to the local population are at increased risk for latent TB infection.

#### 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 Middle East respiratory syndrome coronavirus (MERS-CoV)

**Low:** Although no cases have been reported in Afghanistan, Middle East respiratory syndrome coronavirus (MERS-CoV) is known to occur within the region. Most MERS patients developed severe acute respiratory illness with symptoms of fever, cough, and shortness of breath. MERS-CoV has spread from ill people to others through close contact, such as caring for or living with an infected person. The incubation period for MERS-CoV is usually about 5 to 6 days, but can range from 2 to 14 days. Currently, there is no vaccine to prevent MERS-CoV infection.

#### 6.4.4 Short-term health risks:

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

#### 6.4.5 Long-term health risks:

**None identified based on available data.** Tuberculosis is evaluated as part of the post deployment health assessment (PDHA). 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 8). 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 1C, 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 Avian influenza

**Low:** Potential health risk to U.S. personnel is Low. Although 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) 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 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.

### 6.6 Soil-transmitted helminths (hookworm, strongyloidiasis, cutaneous larva migrans)

**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. A small number of cases (less than 1% per month) could occur among

personnel with direct skin exposure to soil contaminated with human or animal feces (including sleeping on bare ground and walking barefoot). Initial skin symptoms typically are mild and are not debilitating. However, systemic symptoms of fever, cough, abdominal pain, nausea, and diarrhea may develop weeks to months after initial infection with hookworm or *Strongyloides*. More severe infections with high worm burden may be debilitating in some cases. Rates of infection in U.S. personnel will be highly variable, depending on specific local environmental conditions. Rates of infection in U.S. personnel are expected to be less than 1 percent per month in most locations. However, rates in some focal areas with heavily contaminated soil could exceed 1 percent per month.

#### 6.6.1 Short-term health risks:

**Low:** Moderate for soil transmitted helminthes. Overall risk was reduced to Low with mitigation measures. Confidence in the health risk estimate is high.

#### 6.6.2 Long-term health risks:

**None identified based on available data.**

## 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 COP Bella, 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 afghanus*, *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 tofti*, *Mesobuthus caucasicus*, *Mesobuthus eupeus*, *Mesobuthus macmahoni*, *Orthochirus afghanus*, *Orthochirus bicolor*, *Orthochirus danielleae*, *Orthochirus erardi*, *Orthochirus jalalabadensis*, *Orthochirus monodi*, *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* and *Scorpiops lindbergi*: 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) and *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* (Levant blunt-nosed viper) and *Macrovipera lebetina turanica* (Turan blunt-nosed viper): Severe envenoming possible, potentially lethal. Bites may cause mild to severe local effects, shock & coagulopathy.
- *Naja oxiana* (Oxus cobra): Severe envenoming possible, potentially lethal. Bites can cause systemic effects, principally flaccid 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., Haly's Pit Viper). 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 daily maximum temperatures range from 85 degrees Fahrenheit (°F) to 98 °F, with an average temperature of 79 °F, based on historical climatological data. The health risk of heat stress/injury based on temperatures alone is Low (< 78 °F) from September to May and Moderate (78-81.9°F) from June to August. 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 Moderate, mitigated to Low:** The risk of heat injury was reduced to Low through preventive measures such as work/rest cycles, proper hydration and nutrition, and monitoring Wet Bulb Globe Temperature (WBGT). 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 Low from September to May and Moderate (78-81.9°F) from June to August. Confidence in the health risk estimate is low (Reference 4, Table 3-6).

#### 8.1.2 Long-term health risk:

**Low:** The long-term risk is 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) daily minimum temperatures range from 28 °F to 41 °F, with an average temperature of 44 °F, based on historical climatological data. 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 – March. The risk assessment for Non-Freezing Cold Injuries (NFCI), 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 (Reference 4, Table 3-6).

### 8.1.2 Long-term health risk:

**Low:** The health risk of cold injury is Low. Confidence in the health risk estimate is medium (Reference 4, Table 3-6).

## 9 Noise

### 9.1 Continuous

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

#### 9.1.1 Short and long-term health risks:

**Not evaluated.**

### 9.2 Impulse

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

#### 9.2.1 Short-term and 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 DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

## 10.3 Fuel/petroleum products/industrial chemical spills

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

## 10.4 Pesticides/Pest Control:

The health risk of exposure to pesticide residues is considered within the framework of typical residential exposure scenarios, based on the types of equipment, techniques, and pesticide products that have been employed, such as enclosed bait stations for rodenticides, various handheld equipment for spot treatments of insecticides and herbicides, and a number of ready-to-use (RTU) methods such as aerosol cans and baits. The control of rodents required the majority of pest management inputs, with the acutely toxic rodenticides staged as solid formulation lethal baits placed in tamper-resistant bait stations indoors and outdoors throughout cantonment areas. Nuisance insects, including biting and stinging insects such as bees, wasps, and ants, also required significant pest management inputs. Use of pesticides targeting against these pests generally involved selection of compounds with low mammalian toxicity and short-term residual using pinpoint rather than broadcast application techniques. No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1). No pesticide application reports were available in the MESL data portal for COP Bella.

### 10.4.1 Rodenticides, Insecticides and Herbicides

Not evaluated.

## 10.5 Asbestos

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

## 10.6 Lead Based Paint

No specific hazard sources were documented in DOEHRS from 1 January 2001 to 31 December 2008 (Reference 1).

## 10.7 Burn Pits

Burn pits and/or incinerators might have existed at COP Bella (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their presence or absence. While not specific to COP Bella, 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 the literature and the data 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 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 United States. 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 References

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2. DoDI 6055.05, Occupational and Environmental Health, 2008.
3. Joint Staff Memorandum (MCM) 0017-12, Procedures for Deployment Health Surveillance, 2012.
4. USAPHC TG230, June 2013 Revision.
5. Singh, A. and Singh, A.K. 2013. ProUCL Version 5.0. 00 Technical Guide-Statistical Software for Environmental Applications for Data Sets with and without Nondetect Observations. EPA: Washington, WA, USA.
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. IOM (Institute of Medicine). 2011. Long-term health consequences of exposure to burn pits in Iraq and Afghanistan. Washington, DC: The National Academies Press.

## 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** 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, Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight (HRP&O)** Phone: (800) 497-6261. <http://fhpr.dhhq.health.mil/home.aspx>