

Military Deployment
Periodic Occupational and Environmental Monitoring Summary (POEMS):
Camp Ashraf, Iraq
2001 to 2009

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 Camp Ashraf, Iraq. It presents a qualitative summary of health risks identified at this location and their potential medical implications. The report is based on information collected from 1 January 2001 through 31 December 2009 to include deployment OEHS sampling and monitoring data (e.g., air, water, and soil), field investigation and health assessment reports, as well as country and area-specific information on endemic diseases.

This assessment assumes that environmental sampling at Camp Ashraf 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 1 January 2001 through 21 December 2009.

The POEMS can be useful to inform healthcare providers and others of environmental conditions experienced by individuals deployed to Camp Ashraf 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:

Camp Ashraf is situated north of the Iraqi town of Al-Khalis in Diyala Province, about 44 miles from Iran's western border. There was a motor pool which created lots of dust when the weather was dry. In the soldiers' living area there was a large white board where movies were projected, indicating soldiers spent time outside in the evenings sometimes to watch movies. There was a gym, dining facility and moral welfare and recreation center that was accessed by gravel covered road in the soldiers' living area. Camp Ashraf gets its water supply from wells. Water was temporarily stored in bags before it was treated by Reverse Osmosis Water Purification Unit (ROWPU) and stored in adjacent treated water towers. The source of the water was the Iranian Water System. Primary drinking water was bottle water. The Forward Operating Base was hard piped for water distribution to all structures. There was a parking area available. The soil was covered by gravel in 95% of the area in the basecamp (Reference 4).

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 Camp Ashraf. As indicated in the detailed sections that follow Table 2, controls established to reduce health risk were factored into this assessment. In some cases, e.g., ambient air, specific controls are noted, but not routinely available/feasible.

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

Short-term health risks & medical implications:

The following hazards may be associated with potential acute health effects in some personnel during deployment at Base camp that includes Camp Ashraf:

Food/waterborne diseases (e.g., bacterial diarrhea, hepatitis A, typhoid/paratyphoid fever, diarrhea-cholera, diarrhea- protozoal, brucellosis, hepatitis E); other endemic diseases (cutaneous leishmaniasis (acute), Crimean-Congo hemorrhagic fever, sandfly fever, scrub typhus (mite-borne), leptospirosis, schistosomiasis, 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 (cutaneous leishmaniasis (acute), Crimean-Congo hemorrhagic fever, sandfly fever, scrub typhus (mite-borne)), these diseases may constitute a significant risk due to exposure to biting vectors; risk reduced to 'Low' by proper wear of the treated uniform, application of repellent to exposed skin, bed net use, and appropriate chemoprophylaxis, as well as minimizing areas of standing water and other vector-breeding areas. For water contact diseases (leptospirosis, schistosomiasis), 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 May through October, and greater for susceptible persons including those older than 45, of low fitness level, unacclimatized, or with underlying medical conditions, and those under operational constraints (equipment, PPE, vehicles). Risks from heat stress may have been reduced with preventive medicine controls, work-rest cycles, proper hydration and nutrition, and mitigation.

Air quality: For inhalable coarse particulate matter less than 10 micrometers in diameter (PM₁₀) from environmental dust, the PM₁₀ overall short-term health risk was not evaluated due insufficient data for analysis. For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM_{2.5}) from environmental dust, the PM_{2.5} overall short-term health risk was not evaluated due insufficient data for analysis. However, the Camp Ashraf and vicinity area is a dust-prone desert environment, with a semi-arid climate, also subject to vehicle traffic. Consequently, exposures to PM₁₀ and PM_{2.5} may vary, as conditions may vary, and may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel while at this site, particularly exposures to high levels of dust such as during high winds or dust storms. For PM₁₀ and PM_{2.5}, certain subgroups of the deployed forces (e.g., those with pre-existing asthma/cardio-pulmonary conditions) are at greatest risk of developing notable health effects. Burn pits and/or incinerators might have existed at Camp Ashraf 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. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM₁₀ and the PM_{2.5} overall short-term health risks specifically for burn pits were not evaluated – see Section 10.7. Where burn pits exist, exposures may vary, and exposures to high levels of PM₁₀ and PM_{2.5} from smoke may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups. Although most short-term health effects from exposure to particulate matter and burn pit smoke should have resolved post-deployment, providers should be prepared to consider the relationship between deployment exposures and current complaints. Some individuals may have sought treatment for acute respiratory irritation while at Camp Ashraf 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 Base camp that includes Camp Ashraf:

Air quality: For inhalable fine particulate matter less than 2.5 micrometers in diameter (PM_{2.5}) from environmental dust, the overall long-term health risk was not evaluated due insufficient data for analysis. Inhalable coarse particulate matter less than 10 micrometers in diameter (PM₁₀) from environmental dust was not evaluated for long-term health risk due to insufficient data for analysis and no available health guidelines. However, the Camp Ashraf 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 near Camp Ashraf and vicinity (for example, burn pits used by the local population); however, there are no reports or sampling data to indicate their effect. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM₁₀ and the PM_{2.5} overall long-term health risks specifically for burn pits were not evaluated – see Section 10.7. However, burn pit exposures may vary, as conditions may have varied. For inhalational exposure to high levels of dust containing PM₁₀ and PM_{2.5}, such as during high winds or

dust storms, and for exposures to burn pit smoke, it is considered possible that some otherwise healthy personnel, who were exposed for a long-term period to dust and particulate matter, could develop certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions. While the dust and particulate matter exposures and possible 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 - Camp Ashraf^{1, 2}

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
AIR			
Particulate matter less than 10 micrometers in diameter (PM ₁₀)	Short-term: Not enough 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: Not enough 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 _{2.5})	Short-term: Not enough data were available for analysis to characterize short-term health risk. Because Camp Ashraf 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: Not enough data were available for analysis to characterize short-term health risk. Because Camp Ashraf 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: Insufficient 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).
Water			
Consumed Water (Water Used for Drinking)	Short-term: Low	U.S. Army Public Health Center (USAPHC) former U.S. Army Veterinary Command (VETCOM) approved bottled water and potable water only from approved water sources	Short-term: Low
	Long-term: Low		Long-term: Low
Water for Other Purposes	Short-term: Not an identified source of health risk	Water treated in accordance with standards applicable to its intended use	Short-term: Not an identified source of health risk
	Long-term: Not an identified source of health risk		Long-term: Not an identified source of health risk
ENDEMIC DISEASE			

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
Food borne/Waterborne (e.g., diarrhea-bacteriological)	Short-term: Variable, (bacterial diarrhea, hepatitis A, typhoid fever) to Moderate (diarrhea-cholera, diarrhea-protozoal, brucellosis and hepatitis E). If local food/water were consumed, the health effects can temporarily incapacitate personnel (diarrhea) or result in prolonged illness (Hepatitis A, Typhoid fever, Brucellosis, Hepatitis E).	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, Moderate for leishmaniasis-cutaneous, Crimean-Congo hemorrhagic fever, and sandfly fever; Low for West Nile fever, sindbis, rickettsioses-tickborne and typhus-fleaborne	Preventive measures include proper wear of treated uniform, application of repellent to exposed skin, and bed net use, minimizing areas of standing water and appropriate chemoprophylaxis.	Short-term: Low
	Long-term: Low (Leishmaniasis-visceral infection)		Long-term: No data available
Water-Contact (e.g., wading, swimming)	Short-term: Moderate for leptospirosis and schistosomiasis.	Control measures implemented: Avoid water contact and recreational water activities, properly wear of the uniform (especially footwear), and utilize protective coverings for cuts/abraded skin.	Short-term: Moderate for leptospirosis and schistosomiasis.
	Long-term: No data available		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; vaccination	Short-term: Low
	Long-term: No data available		Long-term: No data available
Animal Contact	Short-term: Variable; Moderate for rabies and Q-fever, and 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	Short-term: Moderate for soil transmitted helminthes (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
VENOMOUS ANIMAL/			

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
INSECTS			
Snakes, scorpions, and spiders	Short-term: Low; If encountered, effects of venom vary with species from mild localized swelling to potentially lethal effects	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 to potentially lethal
	Long-term: No data available		Long-term: No data available
HEAT/COLD STRESS			
Heat	Short-term: Variable; Risk of heat injury is High for May-October, and Low for all other months.	Work-rest cycles, proper hydration and nutrition, and Wet Bulb Globe Temperature (WBGT) monitoring.	Short-term: Variable; Risk of heat injury in unacclimatized or susceptible personnel is High for May – October, and Low for all other months.
	Long-term: Low, The long-term risk was 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, The long-term risk is Low. However, the risk may be greater to certain susceptible persons—those older (i.e., greater than 45 years), in lesser physical shape, or with underlying medical/health conditions.
Cold	Short-term: Low risk of cold stress/injury.	Risks from cold stress reduced with protective measures such as use of the buddy system, limiting exposure during cold weather, proper hydration and nutrition, and proper wear of issued protective clothing.	Short-term: Low risk of cold stress/injury.
	Long-term: Low; Long-term health implications from cold injuries are rare but can occur, especially from more serious injuries such as frost bite.		Long-term: Low; Long-term health implications from cold injuries are rare but can occur, especially from more serious injuries such as frost bite.
NOISE			
Continuous (Flightline, Power Production)	Short-term: Low	Hearing protection used by personnel in higher risk areas	Short-term: Low
	Long-term: Low		Long-term: Low
Impulse	Short-term: Low		Short-term: Low
	Long-term: Low		Long-term: Low
UNIQUE INCIDENTS/ CONCERNS			
Pesticides/Pest Control	Short-term: Low	See Section 10.4	Short-term: Low
	Long-term: Low		Long-term: Low
Burn Pits	Short-term: Burn pits and/or incinerators might have existed at Camp Ashraf 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. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM ₁₀ and the PM _{2.5} overall short-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 ₁₀ and PM _{2.5} from smoke may result	Risks reduced by limiting strenuous physical activities when air quality was especially poor; and action 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.	Short-term: Burn pits and/or incinerators might have existed at Camp Ashraf 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. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM ₁₀ and the PM _{2.5} overall short-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 ₁₀ and PM _{2.5} from smoke may result

Source of Identified Health Risk ³	Unmitigated Health Risk Estimate ⁴	Control Measures Implemented	Residual Health Risk Estimate ⁴
	<p>in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups.</p> <p>Long-term: Burn pits and/or incinerators might have existed at Camp Ashraf 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. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM₁₀ and the PM_{2.5} 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 PM₁₀ and PM_{2.5} in the smoke may be associated with some otherwise healthy personnel, who were exposed for a long-term period, possibly developing certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions.</p>		<p>in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel and certain subgroups.</p> <p>Long-term: Burn pits and/or incinerators might have existed at Camp Ashraf 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. There was only mention of smoke from a burn pit appearing near the common area, but no other information. Consequently, the PM₁₀ and the PM_{2.5} 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 PM₁₀ and PM_{2.5} in the smoke may be associated with some otherwise healthy personnel, who were exposed for a long-term period, possibly developing certain health conditions (e.g., reduced lung function, cardiopulmonary disease). Personnel with a history of asthma or cardiopulmonary disease could potentially be more likely to develop such chronic health conditions.</p>

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

² This assessment is based on specific environmental sampling data and reports obtained from 1 January 2001 through 31 December 2009. Sampling locations are assumed to be representative of exposure points for the camp population but may not reflect all the fluctuations in environmental quality or capture unique exposure incidents.

³This Summary Table is organized by major categories of identified sources of health risk. It only lists those sub-categories specifically identified and addressed at Camp Ashraf. 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 though a potential exposure is identified, and no health risks of either a specific acute or chronic health effects are determined. More detailed descriptions of OEH exposures that are evaluated but determined to pose no health risk are discussed in the following sections of this report.

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

1 Discussion of Health Risks at Ashraf and Vicinity, Iraq by Source

The following sections provide additional information about the OEH conditions summarized above. All risk assessments were performed using the methodology described in the U.S. Army Public Health Command Technical Guide 230, *Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel* (Reference 5). All OEH risk estimates represent residual risk after accounting for preventive controls in place. Occupational exposures and exposures to endemic diseases are greatly reduced by preventive measures. For environmental exposures related to airborne dust, there are limited preventive measures available, and available measures have little efficacy in reducing exposure to ambient conditions.

The ProUCL version 5.0 software package was used for statistical analyses (Reference 6). 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

Camp Ashraf is situated in a dusty semi-arid desert environment. There was a motor pool which created a lot of dust when the weather was dry. There was a gym, dining facility and moral Welfare and recreation center that was accessed by gravel covered road in the soldiers living area. There was a burn pit, unknown location, which produced smoke near the common area, indicated in the exposure notes with sample 00001LQM in DOEHRs. Inhalational exposure to high levels of dust and particulate matter, such as during high winds or dust storms, may result in mild to more serious short-term health effects (e.g., eye, nose or throat and lung irritation) in some personnel. Additionally, certain subgroups of the deployed forces (e.g., those with pre-existing asthma/cardio pulmonary conditions) are at greatest risk of developing notable health effects.

2.2 Particulate matter

Particulate matter (PM) is a complex mixture of extremely small particles suspended in the air. The PM includes solid particles and liquid droplets emitted directly into the air by sources such as: power plants, motor vehicles, aircraft, generators, construction activities, fires, and natural windblown dust. The PM can include sand, soil, metals, 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: PM₁₀, which includes coarse particles with a diameter of 10 micrometers or less, and fine particles less than 2.5 micrometers (PM_{2.5}), which can reach the deepest regions of the lungs when inhaled. Exposure to excessive PM is linked to a variety of potential health effects.

2.3 Particulate matter, less than 10 micrometers (PM₁₀)

2.3.1 Exposure Guidelines:

Short-term (24-hour) PM₁₀ (micrograms per cubic meter, µg/m³):

- Negligible MEG = 250
- Marginal MEG = 420
- Critical MEG = 600

Long-term PM₁₀ MEG (µg/m³):

- Not defined and not available.

2.3.2 Sample data/Notes:

A total of 15 valid and four invalid, PM₁₀ air samples were collected from 4 August 2003 to 6 August 2008. The range of 24-hour PM₁₀ concentrations was 18 µg/m³ – 620 µg/m³ with an average concentration of 185 µg/m³ with a standard deviation (SD) of 171.

2.3.3 Short- and Long-term health risks:

There was not enough data to perform a health risk assessment. For PM₁₀ there were only three samples collected in 2003 on three consecutive days. In 2008, 11 samples were collected, seven of which were on the same day, which are considered replicates, and one outlier sample, bringing the total of samples collected to six. The rest of the samples only covered January - August with single samples in each month, therefore a risk assessment could not be completed that would be representative of the entire year. There was one sample above the Critical MEG of 600 µg/m³, however the other five samples were below the Negligible MEG of 250 µg/m³.

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

2.4.1 Exposure Guidelines:

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

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

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

- Negligible MEG = 15
- Marginal MEG = 65.

2.4.2 Sample data/Notes:

Camp Ashraf: A total of seven valid PM_{2.5} air samples were collected from 7 August 2009 to 13 November 2009. The range of 24-hour PM_{2.5} concentrations was 32 µg/m³ – 67 µg/m³ with an average concentration of 53 µg/m³ (SD 12).

2.4.3 Short- and Long-term health risks:

There was not enough data to perform a health risk assessment. Samples for PM_{2.5} were collected in 2009 and there were no samples taken during any other previous years. There were a total of seven samples taken, four from the pavilion and three from the common area where the soldiers were living. For these seven samples, four were taken on consecutive days in September and three were taken on consecutive days in November, it is not representative of an entire year. However the average and maximum concentration for 2009 were below the Marginal MEG of 250 µg/m³.

2.5 Airborne Metals

2.5.1 Sample data/Notes:

A total of 22 valid PM₁₀ and PM_{2.5} airborne metal samples were collected at Camp Ashraf from 4 August 2003 to 13 November 2009. Five analytes were detected in the samples, lead, manganese, nickel, zinc and chromium. All concentrations were below the one year Negligible MEG.

2.5.2 Short- and Long-term health risks:

There was not enough data to perform a health risk assessment. For PM₁₀ there were only three samples collected in 2003 on three consecutive days and there were only five samples collected in 2008. The rest of the samples only covered January - August with single samples in each month therefore a risk assessment could not be completed that would be representative of the entire year. Lastly there were seven PM_{2.5} samples collected in 2009 but the samples were only taken in September and November. However all 22 samples were below the short- and long-term MEGs for the five analytes detected.

2.6 Volatile Organic Compounds (VOC)

2.6.1 Sample data/Notes:

The health risk assessment is based on one valid volatile organic chemical (VOC) air sample collected on the 8 March 2008, and the likelihood of exposure. None of the three analyzed VOC chemicals, benzene, hexane and toluene, were found at concentrations above short- or long-term MEGs.

2.6.2 Short- and long-term health risks:

Only one valid sample was collected which is not enough data to perform a health risk assessment. However all three detected chemicals were below their corresponding 1 year Negligible MEG.

3 Soil

3.1 Site-Specific Sources Identified

3.2 Sample data/Notes:

A total of 14 valid surface soil samples were collected from 4 August 2003 through 11 September 2009, to assess OEH health risk to deployed personnel. The primary soil contamination exposure pathways are dermal contact and dust inhalation. Typical parameters analyzed for included semi volatile organic compounds (SVOCs), heavy metals, polychlorinated biphenyls (PCBs), pesticides, and herbicides. If the contaminant was known or suspected, other parameters may have been analyzed for (i.e., total petroleum hydrocarbons (TPH) and polycyclic aromatic hydrocarbons (PAH) near fuel spills). For the risk assessment, personnel are assumed to remain at this location for 6 months to 1 year. For the 14 samples nine analytes were detected, however all analytes were below the long-term MEGs.

3.3 Short-term health risk:

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

3.4 Long-term health risk:

None identified based on available sample data. No parameters exceeded 1-year Negligible MEGs.

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, all untreated water samples were associated with source water for treatment and no exposure pathways were associated with those samples. Therefore, untreated samples are not assessed as potential health hazards. It is assumed that 100% of all U.S. personnel at Camp Ashraf will be directly exposed to reverse osmosis water purification unit (ROWPU) treated, municipal, and bottled water since this classification of water is primarily used for personal hygiene, showering, cooking, and for use at vehicle wash racks. Field data sheets indicate that bottled water is the primary source of drinking water.

4.1 Drinking Water: Bottled or ROWPU/Municipal

4.1.1 Site-Specific Sources Identified

There was a single bottled water brand sampled at Camp Ashraf. This sample was Oasis® brand bottled water. Identification of a trademarked product does not imply endorsement by the Army. Camp Ashraf used reverse osmosis purified water as their primary source of potable water for DFAC operations, recreation, showering and personal hygiene. Bottled water was the primary source of water for drinking. Samples of reverse osmosis purified water were periodically collected and analyzed to ensure potability. There were nine drinking water samples, one of them being bottled water. Seven out of the nine samples were collected throughout January - November 2008. There were 26 analytes detected in the nine water samples, but only boron was detected above the MEG. Boron was found at a maximum concentration of 2 µg/m³, with an average of 2 µg/m³ (SD 0.89). The MEG value for boron is 0.93 µg/m³, so a health risk assessment was performed.

Boron is widely distributed in surface water and groundwater. Boron is a common element in minerals found in the earth's crust and is mined for use in glass, ceramics, soaps, fire retardants and pesticides. Humans exposed to large amounts of boron by ingestion (about 30 g of boric acid) over short periods of time can be affected through the stomach, intestines, liver, kidney and brain and symptoms can eventually lead to death. Animal studies of dogs, rats and mice indicate that the male reproductive organs, especially the testes, are affected if large amounts of boron are ingested for short or long periods of time. The doses that produced these effects in animals are more than 1800 times higher than the average daily intake of boron in food by adults in the U.S. population (reference 8).

4.1.2 Sample data/Notes:

To assess the potential for adverse health effects to troops, the following assumptions were made about dose and duration: A conservative (protective) assumption was that personnel routinely ingested 5 (liters per day (L/day) of bottled water for up to 365 days (1-year). It was further assumed that control measures were not used.

One valid bottled water sample was collected on 29 January 2008. There were nine drinking water samples taken and a health risk assessment was performed.

4.1.3 Short-term health risk:

Low: The short-term Boron health risk assessment is Low based on average and peak Boron sample concentrations, and the likelihood of exposure at these hazard severity levels. A Low health risk is expected to have little or no impact on accomplishing the mission (Reference 5, Table 3-2). Confidence in the short-term Boron health risk assessment was Low (Reference 5, Table 3-6).

For the highest observed Boron exposure, the hazard severity was negligible. During peak exposures at the negligible hazard severity level, few exposed personnel are expected to have noticeable health effects during mission. Exposed personnel are expected to be able to effectively perform all critical tasks during mission operations. Minimal to no degradation of abilities to conduct complex tasks are expected (Reference 5, Table 3-4).

4.1.4 Long-term health risk

None identified based on available sample data. Boron concentrations did not exceed 1-year Negligible MEGs.

4.2 Non-Drinking Water: Disinfected

4.2.1 Site-Specific Sources Identified

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

4.2.2 Sample data/Notes:

To assess the potential for adverse health effects to troops the following assumptions were made about dose and duration: All U.S. personnel at this location were expected to remain at this site for approximately 1 year. A conservative (protective) assumption is that personnel routinely consumed less than 5L/day of non-drinking water for up to 365 days (1-year). It is further assumed that control measures and/or personal protective equipment were not used. A total of three disinfected bulk water (Non-Drinking) samples collected from 29 January 2008 - 14 November 2009 were evaluated for this health risk assessment. No chemicals were detected at levels above the short- or long-term MEGs.

4.2.3 Short- and long-term health risks:

Not enough data to evaluate short- or long-term health risks. No chemicals were detected at levels above the short- or long-term MEGS

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), or the Military Exposure Surveillance Library (MESL) from 1 January 2001 through 31 December 2009 timeframe (References 1 and 7).

5.2 Depleted Uranium (DU)

No specific hazard sources were documented in the DOEHRS, or MESL from 1 January 2001 through 31 December 2009 timeframe (References 1 and 7).

5.3 Ionizing Radiation

No specific hazard sources were documented in the DOEHRS, or MESL from 1 January 2001 through 31 December 2009 timeframe (References 1 and 7).

5.4 Non-Ionizing Radiation

No specific hazard sources were documented in the DOEHRS, or MESL from 1 January 2001 through 31 December 2009 timeframe (References 1 and 7).

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. USCENTCOM MOD 11 (1C lists deployment requirements, to include immunizations and chemoprophylaxis, in effect during the timeframe of this POEMS.

6.1 Food borne and Waterborne Diseases

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

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

6.1.1 Diarrheal diseases (bacteriological)

High, mitigated to Low: Diarrheal diseases are expected to temporarily incapacitate a very high percentage of personnel (potentially over 50% per month) within days if local food, water, or ice is consumed. 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 Short-term Health Risks:

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

6.1.4 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. 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

Low: Between 2001-2007 malaria cases were on a sustained decline. Indigenous transmission of malaria in Iraq was eliminated as of 2008 reducing risk among personnel exposed to mosquito bites to none (Reference 10).

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 sand flies. A small number of cases (less than 1% per month attack rate) 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 disease can cause severe febrile illness which typically requires hospitalization with convalescence over 7 days.

6.2.3 Crimean-Congo hemorrhagic fever

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

5% to 50%.

6.2.4 Sandfly fever

Moderate, mitigated to Low: Sandfly fever has a Moderate risk with potential disease rates from 1% to 10% per month; under worst case conditions 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 disease typically resulted in debilitating febrile illness requiring 1 to 7 days of supportive care followed by return to duty.

6.2.5 Sindbis (and Sindbis-like viruses)

Low: Sindbis and sindbis-like viruses are maintained in a bird-mosquito cycle in rural areas and occasionally caused limited outbreaks among humans. The viruses are transmitted by a variety of *Culex* mosquito species found primarily in rural areas. A variety of bird species may serve as reservoir or amplifying hosts. Extremely rare cases (less than 0.01% per month attack rate) could have occurred seasonally (April - November). Debilitating febrile illness often accompanied by rash, typically requires 1 to 7 days of supportive care; significant arthralgia may persist for several weeks or more in some cases. This disease is associated with a Low health risk estimate.

6.2.6 Rickettsioses, tickborne (spotted fever group)

Low: Rare cases (less than 0.1% per month) of rickettsioses disease are possible among personnel exposed to tick bites. Rickettsioses are transmitted by multiple species of hard ticks, including *Rhipicephalus* spp., which are associated with dogs. Other species of ticks, including *Ixodes* are also capable of transmitting rickettsial pathogens in this group. In addition to dogs, various rodents and other animals also may serve as reservoirs. Ticks are most prevalent from April through November. Incidents can result in debilitating febrile illness, which may require 1 to 7 days of supportive care followed by return to duty. The health risk of rickettsial disease is Low.

6.2.7 Typhus-murine (fleaborne)

Low: Typhus-murine has a Low risk estimate and is assessed as present, but at unknown levels. Rare cases are possible among personnel exposed to rodents (particularly rats) and flea bites. Incidents may result in debilitating febrile illness typically requiring 1 to 7 days of supportive care followed by return to duty.

6.2.8 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 risk is moderate for leishmaniasis - cutaneous (acute), Crimean-Congo hemorrhagic fever, and sandfly fever; Low for, sindbis, rickettsioses-tickborne, typhus-fleaborne, and West Nile fever. No hazard from malaria (post 2008), Low (2001-2008). 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.

6.2.10 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

Tactical operations or recreational activities that involve extensive contact with surface water such as lakes, streams, rivers, or flooded fields may result in significant exposure to leptospirosis and schistosomiasis. Arid portions of Iraq without permanent or persistent bodies of surface water do not support transmission of leptospirosis or schistosomiasis. Risk was restricted primarily to areas along rivers and lakes. These diseases can debilitate personnel for up to a week or more. Leptospirosis 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 exposure to enteric diseases including 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 including 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* spp. present in the soil passes directly into surface waters. *Leptospira* spp. can enter the body through cut or abraded skin, mucous membranes, and conjunctivae. Infection may also occur from ingestion of contaminated water. The acute, generalized illness associated with infection may mimic other tropical diseases (for example, dengue fever, malaria, and typhus), and common symptoms include fever, chills, myalgia, nausea, diarrhea, cough, and conjunctival suffusion. Manifestations of severe disease can include jaundice, renal failure, hemorrhage, pneumonitis, and hemodynamic collapse. Recreational activities involving extensive water contact may result in personnel being temporarily debilitated with leptospirosis. This disease is associated with a Moderate health risk estimate.

6.3.2 Schistosomiasis

Moderate, mitigated to Low: Humans are the principal reservoir for schistosomes; humans shed schistosome eggs in urine or feces. Animals such as cattle and water buffalo may also be significant reservoirs. Rare cases (less than 0.1% per month attack rate) may occur seasonally (typically April through November) among personnel wading or swimming in lakes, streams, or irrigated fields which were frequently contaminated with human and animal waste containing schistosome eggs. In groups with prolonged exposure to heavily contaminated foci, attack rates may exceed 10%. Exceptionally heavy concentrations of schistosomes may occur in discrete foci, which were difficult to distinguish from less contaminated areas. In non-immune personnel exposed to such foci, rates of acute schistosomiasis may be over 50%. Mild infections are generally asymptomatic. In very heavy acute infections, a febrile illness (acute schistosomiasis) may occur, especially with *Schistosoma japonicum* and *S. mansoni*, requiring hospitalization and convalescence over 7 days. This disease is associated with a Moderate health risk estimate.

6.3.3 Short-term health risks:

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

6.3.4 Long-term health risks:

None identified based on available data.

6.4 Respiratory Diseases

Although not specifically assessed in this document, deployed U.S. Forces may be exposed to a wide variety of common respiratory infections in the local population. These include influenza, pertussis, viral upper respiratory infections, viral and bacterial pneumonia, and others. The U.S. military populations living in close-quarter conditions are at risk for substantial person-to-person spread of respiratory pathogens. Influenza is of particular concern because of its ability to debilitate large numbers of unvaccinated personnel for several days. Mitigation strategies were in place and included routine medical screenings, vaccination, enforcing minimum space allocation in housing units, implementing head-to-toe sleeping in crowded housing units, implementation of proper personal protective equipment (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 also can occur with more incidental contact. Rates of latent TB (LTBI) may be elevated for personnel with prolonged indoor exposure to local populations. Tuberculin skin tests (TST) screening or blood test may be warranted in personnel with a history of prolonged close exposure to local populations.

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 Iraq, 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 were the primary reservoir of rabies in Iraq, and a frequent source of human exposure. In June 2008, the New Jersey Health department in the United States reported a confirmed case of rabies in a mixed-breed dog recently imported from Iraq. 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. No cases of rabies acquired in Iraq have been identified in U.S. Service Members to date. 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 attack rate) could occur. Incidence could result in very severe illness with fatality rate higher than 50 percent in symptomatic cases. Mitigation strategies included avoidance of birds/poultry and proper cooking temperatures for poultry products.

6.5.5 Short-term health risks:

Low: The short-term unmitigated risk is Moderate for rabies, and Q-fever, too 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)

Low: Potential health risk to U.S. personnel is Low during warmer months (typically April through November) when vector activity is highest. Risk reduced with mitigation measures. A small number of cases (less than 0.1% per month attack rate) could occur among personnel with direct skin exposure to soil contaminated with human or animal feces (including sleeping on bare ground, 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 spp.* 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: Low for soil transmitted helminthes. Overall risk was further reduced 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 11) and the Clinical Toxinology Resources web site from the University of Adelaide, Australia (Reference 12). The species listed below have home ranges that overlap the location of Camp Ashraf and vicinity, and may present a health risk if they are encountered by personnel. See Section 9 for more information about pesticides and pest control measures.

7.1 Spiders

- *Latrodectus pallidus*: Clinical effects uncertain, but related to medically important species, therefore major envenoming cannot be excluded.

7.2 Scorpions

- *Androctonus crassicauda* (black scorpion): Severe envenoming possible and potentially lethal, however most stings cause only severe local pain.
- *Buthacus leptochelys*, *Buthacus macrocentrus*, *Compsobuthus matthiesseni*, *Compsobuthus*

wernerii, *Mesobuthus caucasicus*, *Mesobuthus eupeus*, *Odontobuthus doriae*, and *Orthochirus scrobiculosus*: Clinical effects unknown; 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 this species fits within that spectrum.

- *Scorpio maurus*, *Scorpio maurus palmatus*: Mild envenoming only, not likely to prove lethal.
- *Hemiscorpius lepturus*: Severe envenoming possible, potentially lethal.
- *Hottentotta saulcyi*, *Hottentotta scaber*, and *Hottentotta schach*: Moderate envenoming possible but unlikely to prove lethal.

7.3 Snakes

- *Cerastes gasperettii* (Gasperetti's horned viper): Potentially lethal envenoming, though unlikely.
- *Malpolon moilensis* (Hooded Malpolon), *Malpolon monspessulanus* (Montpellier snake), *Pseudocerastes persicus* (Persian Horned Viper), and *Pseudocerastes persicus fieldi* (Field's horned viper): Clinical effects varies, but unlikely to cause significant envenoming.
- *Macrovipera lebetina* subspecies *euphratica* and subspecies *obtuse* (Levantine viper), *Vipera albicornuta* (white-horned viper), and *Walterinnesia aegyptia* (black desert cobra): Severe envenoming possible, potentially lethal.

7.3.1 Short-term health risk:

Low: If encountered, effects of venom vary with species from mild localized swelling to potentially lethal effects. 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 5, Table 3-6).

7.3.2. Long-term health risk:

None identified.

8 Heat/Cold Stress

8.1 Heat

The information was taken from Weather Spark for Baghdad which is approximately 50 miles south of Camp Ashraf. This was the closest weather information available. Summer (June - September) monthly mean daily maximum temperatures range from 76 degrees Fahrenheit (°F) to 112 °F with an average temperature of 102 °F based on historical climatological data. The health risk of heat stress/injury based on temperatures alone is Low (< 78 °F) from December - March, Moderate (78-81.9°F) in April, High (82-87.9°F) in November, and Extremely High (≥ 88°F) from May-October. However, work intensity and clothing/equipment worn pose greater health risk of heat stress/injury than environmental factors alone (Reference 13). Managing risk of hot weather operations included monitoring work/rest periods, proper hydration, and taking individual risk factors (e.g., acclimation, weight, and physical conditioning) into consideration. Risk of heat stress/injury was reduced with preventive measures.

8.1.1 Short-term health risk:

Low to High, mitigated to Low: 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 Extremely High May - October, High in November, Moderate in April, and Low from December - March. Confidence in the health risk estimate is Low.

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.

8.2 Cold

8.2.1 Short-term health risks:

Winter (December - March) monthly mean daily minimum temperatures range from 41 °F to 80 °F with an average temperature of 43 °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 December - 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 13).

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

8.2.2 Long-term health risk:

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

9 Noise

9.1 Continuous

Two reports were found on the MESL from 1 January 2001 through 31 December 2009 timeframe. The report, titled General Sanitation Form Camp Ashraf - Generators, written 31 May 2004, stated “there are 24 generators throughout Ashraf with no hearing protection. Recommended using sandbags to muffle the sound of the generator, move generators further away from living conditions and wearing hearing protection while working near generators.” These actions were completed and noted in a second report, titled General Sanitation Form Generators, written 12 July 2004 (Reference 7).

9.1.1 Short- and long-term health risks:

Not evaluated

9.2 Impulse

No specific hazard sources were documented in the DOEHRS or MESL from 1 January 2001 through 31 December 2009 timeframe (Reference 1 and 7).

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 the DOEHRS or MESL from 1 January 2001 through 31 December 2009 timeframe (Reference 1 and 7).

10.3 Fuel/petroleum products/industrial chemical spills

No specific hazard sources were documented in the DOEHRS or MESL from 1 January 2001 through 31 December 2009 timeframe (Reference 1 and 7).

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. A total of 52 monthly pesticide application reports in the MESL data portal for Camp Ashraf (October 2001 to August 2009) list the usage of

pesticides on the site (Reference 7).

10.4.1 Rodenticides

Brodifacoum, *Bromadiolone* were used to control rodents. Naphthalene, Sulfur was used to control snakes and a pellet gun was used to keep birds away.

10.4.2 Insecticides

Insecticides used to control ants, filth flies, mosquitoes, sandflies, and scorpions include: *Pyrethrins*, *Piperonyl Butoxide*, *Lambda-cyhalothrin*, *Cypermethrin*, and *(S)-Methoprene*.

10.4.3 Herbicides

An herbicide was used to control weeds. However, it is unknown which herbicide was used.

10.4.4 Short-term and Long-term health risks

Low: Long term health risk is Low. Confidence in the health risk assessment is Medium.

10.5 Asbestos

No specific hazard sources were documented in the DOEHRS or MESL from 1 January 2001 through 31 December 2009 timeframe (Reference 1 and 7).

10.6 Lead Based Paint

No specific hazard sources were documented in the DOEHRS or MESL from 1 January 2001 through 31 December 2009 timeframe (Reference 1 and 7).

10.7 Burn Pit

A single PM_{2.5} sample referenced the presence of a burn pit in the vicinity, saying that smoke from the burn pit was visible near the common area. No other information was given to indicate if the burn pit was part of Camp Ashraf or in the vicinity. While not specific to Camp Ashraf, 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 14). The Institute of Medicine committee's (Reference 14) 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.

10.7.1 Short-term health risk:

No data to evaluate short-term health risks.

10.7.2 Long-term health risk:

Not evaluated-no available health guidelines. The EPA has retracted its long-term NAAQS for PM₁₀ due to an inability to clearly link chronic health effects with chronic PM₁₀ exposure levels.

11 References

1. Defense Occupational and Environmental Health Readiness System (referred to as the DOEHRSEH database) at <https://doehrs-ih.csd.disa.mil/Doehrs/>. Department of Defense (DoD) Instruction 6490.03, *Deployment Health*, 2006.
2. DoDI 6055.05, Occupational and Environmental Health, 2008.
3. Joint Staff Memorandum (MCM) 0017-12, Procedures for Deployment Health Surveillance, 2012.
4. National Council of Resistance of Iran, Camp Ashraf & Liberty, 2016, <http://ncr-iran.org/en/about/camp-ashraf-liberty>
5. USAPHC TG230, June 2013 Revision.
6. 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*.
7. DoD MESL Data Portal: <https://mesl.apgea.army.mil/mesl/>. Some of the data and reports used may be classified or otherwise have some restricted distribution.
8. Toxicological Profile for Boron at <https://www.atsdr.cdc.gov/toxprofiles/tp26.pdf>, U.S. Department of Health and Human Services, November 2010.
9. Impact of Malaria Control at http://www.who.int/malaria/world_malaria_report_2009/mal2009_rep_chap4_v2.pdf, World Malaria Report, Center for Disease Control, 2009
10. Modification 11 to United States Central Command Individual Protection and Individual Unit Deployment Policy, 2 December 2011.
11. Armed Forces Pest Management Board: <http://www.afpmb.org/content/venomous-animals-country-i#Iraq>. U.S. Army Garrison - Forest Glen, Silver Spring, MD.
12. Clinical Toxinology Resources: <http://www.toxinology.com/>. University of Adelaide, Australia.
13. Average Weather in Baghdad: <https://weatherspark.com/y/103217/Average-Weather-in-Baghdad-Iraq>. Weather Spark
14. 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/afri/711hpw/usafsam/>

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