

**U.S. Army FORSCOM Immunizations, Chemoprophylaxis, and Medical  
Screening Requirements for Southwest Asia  
03 March 2000**

**Area of Operations**

Southwest Asia (SWA) for purposes of this document includes Bahrain, Israel, Jordan, Kuwait, Lebanon, Qatar, Iran, Oman, Saudi Arabia, United Arab Emirates, Iraq, Syria, and Turkey.

**Immunizations**

Exercise caution when considering any immunization during pregnancy. Avoid all live virus vaccines (e.g., yellow fever, measles) during pregnancy.

When administered with other live virus vaccines, give **all on the same day**, or **separate the doses by at least 1 month**. Information regarding the concurrent administration of live virus vaccines is contained in the following references available through the Centers for Disease control at [www.cdc.gov](http://www.cdc.gov).

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Recommendations and Reports

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention (CDC)

Atlanta, Georgia 30333

Measles, Mumps, and Rubella—Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps:

Recommendations of the Advisory Committee on Immunization Practices (ACIP)

and

May 04, 1990 / 39(RR-6);1-6

Yellow Fever Vaccine Recommendations of the Immunization Practices Advisory Committee (ACIP)

**Hepatitis A Vaccine**

1.0 cc IM (deltoid); two-shot series, with second shot given between 6-12 months after the first shot. The first shot should be given at least 14 days before departure. If this is not possible and there is a high hepatitis risk immediately after vaccination, consider giving immune globulin (IG) at an alternate site in addition to the vaccine. If this is not possible, and high risk exposure is anticipated within the first month following immunization, consider giving immune globulin (IG) at an alternate site.

**Alternate:** Immune globulin (IG, ISG, GG); 2 ml IM will protect against hepatitis A for three months; 5 cc IM will protect for five months. **Immune globulin is very difficult to obtain; therefore, all efforts should be made to use the Hepatitis A vaccine.**

**Hepatitis B Vaccine**

All medical personnel and those at high risk for contact with blood and body fluids should receive a three-shot series, 1 ml IM (deltoid) at months 0, 1, 6; give complete series before deployment, if possible; otherwise, remaining doses can be given in-country.

### Influenza Vaccine

Current annual vaccine if available; 0.5 ml IM (deltoid)

Current annual vaccine; 0.5 ml IM (deltoid) for AC Forces and for RC Forces on Active Duty in excess of 30 days or as directed by the FORSCOM Surgeon Office. The Influenza Vaccine should be given as soon after notification of deployment as realistically possible to allow immunity to develop. This will help reduce the risk of an influenza outbreak in the unit after it is deployed. **We realize that Influenza Vaccine may vary in availability due to the season of the year. Please make an effort to obtain the vaccine by contacting your medical supply personnel as soon as possible after being notified of a deployment.**

### Measles Vaccine

If the soldier has documented proof of having received a measles vaccination upon entry into the military or at any time since entering the military, then **no** measles vaccination is required. If there is no documentation, then a single booster of measles vaccine (preferably MMR), 0.5 ml (dose may vary by manufacturer) is administered SC if they are an adult born after 1956. When administered with other live virus vaccines, give all on the same day, or separate the doses by at least 1 month. Also, give MMR vaccine at least 2 weeks before IG or at least 3 months after IG. **(Should have been given on entrance into the military.)**

### Inactivated Polio Vaccine (IPV)

Three-dose primary series and one-time dose as an adult. Give the inactivated polio vaccine (IPV) if primary series is begun as adult. Most adults have had the three-dose primary series. If there is any doubt as to the immunization history, give a dose of the inactivated polio vaccine (IPV). **(Should have been given upon entrance into the military.)** The dosing schedule is shown below:

#### **Unimmunized adolescents/adults:**

IPV is recommended - two doses at 4-8 week intervals, third dose 6-12 months after second (can be as soon as 2 months) Dose: 0.5 ml subcutaneous (SC) or intramuscular (IM).

#### **Partially immunized adolescents/adults:**

Complete primary series with IPV (IPV schedule shown above).

### Tetanus-Diphtheria Vaccine

Last dose within 10 years; 0.5 ml IM.

### Typhoid Vaccine - Injectable or oral.

(1) Injectable (Wyeth-Ayerst Typhoid Vaccine, USP). Two-dose primary series, 0.5 ml SC on week 0 and 4; booster every 3 years, 0.5 ml SC.

(2) Oral (Vivotif-Berna). Four-dose oral series, taken on days 0, 2, 4, and 6. Booster every 5 years. Do not give on same day as mefloquine or with antibiotics. Keep tablets refrigerated.

(3) Injectable (Typhim Vi). A one-injection primary series, 0.5 ml IM. Booster required every 2 years.

### **Yellow Fever Vaccine**

One dose every 10 years, 0.5 ml subcutaneous.

### **Other Vaccines**

#### **Anthrax**

**Anthrax Immunization is REQUIRED for ALL U.S. Military personnel, Department of Defense (DoD) emergency essential civilian employees, and emergency essential contractor personnel assigned, deployed or on temporary duty in the high threat areas and contiguous waters of Southwest Asia (Kuwait, Saudi Arabia, Bahrain, Jordan, Qatar, Oman, UAE, Yemen, and Israel) for any period of time to initiate vaccination against anthrax in accordance with the prescribed immunization schedule.**

The recommended schedule for vaccination is 6 subcutaneous 0.5 ml doses given at day 0 (D-0), 2 weeks (D+14D), 4 weeks (D+28D), 6 months (D+6M), 12 months (D+12M), and 18 months (D+18M). Annual booster doses of 0.5 ml are required to maintain immunity.

For personnel who have not completed a minimum of three shots, the antibiotic Cipro must be available for administration in the event of imminent biological warfare attack. In the event of imminent biological warfare attack, these personnel will be administered a Cipro 500 mg tablet orally every 12 hours until the person has received the third shot or if the use of anthrax as an attack agent has been excluded.

#### **Meningococcal Vaccine**

Quadrivalent (A, C, Y, W-135); personnel should have proof of 0.5 ml subcutaneous within last 5 years or be reimmunized.

#### **Pneumococcal Vaccine**

For all asplenic (personnel with no spleen) personnel. 0.5 ml IM or subcutaneous every 6 years.

### **Malaria Risk and Prophylaxis**

#### **Bahrain, Israel, Jordan, Kuwait, Lebanon, Qatar**

No risk of malaria.

#### **Iran, Oman, Saudi Arabia, United Arab Emirates, Yemen**

**Recommended Regimen:** Mefloquine 250 mg/week begun 2 weeks before entering country and continued weekly until 4 weeks after departure.

**Note: Personnel on flight status must use doxycycline.**

**Alternate Regimen:** Doxycycline 100 mg/day begin 2 days before entering risk area; continue daily while in country and for 28 days after departure.

**Terminal Prophylaxis (both regimens):** Primaquine 15 mg/day for 14 days starting on the day of departure.

**Iraq, Syria, Turkey**

**Recommended Regimen:** Chloroquine 500 mg/week begun 2 weeks before entering country and continued weekly until 4 weeks after departure from the foreign country.

**Alternate Regimen:** Doxycycline 100 mg/day begin 2 days before entering risk area; continue daily while in country and for 28 days after departure from the foreign country.

**Terminal Prophylaxis (both regimens):** Primaquine 15 mg/day for 14 days starting on the day of departure from the foreign country.

**Special Note:**

**If personnel are deploying very rapidly (less than 2 weeks), Malaria Prophylaxis can begin with doxycycline and chloroquine or mefloquine (depending on the area of operations) until they have had at least two doses of either chloroquine or mefloquine. This is accomplished by the following regimen:**

**If you cannot start the Chloroquine or Mefloquine regimen 2 weeks prior to departing due to rapid deployment, begin Chloroquine or Mefloquine immediately and take Doxycycline 100 mg/day until it is time to take the second Chloroquine or Mefloquine (7 days after the first Chloroquine or Mefloquine). Then stop taking the Doxycycline, but continue the Chloroquine or Mefloquine as instructed by the above regimen.**

**Flight Personnel should use doxycycline in place of mefloquine. Flight Personnel can use chloroquine in areas where it is effective.**

**For Personnel who are making multiple trips in and out of country:** Personnel who are making multiple visits from the United States to the foreign country should continue to take Mefloquine, Chloroquine or Doxycycline during the entire period of time they would be involved with the operation.

**Example:** If you will be visiting the operation on the first and last day of the operation you would begin the Mefloquine, Chloroquine or Doxycycline using the regimen shown above. You would continue taking it even after returning to the United States awaiting your return visit at the end of the operation. Upon your final return to the United States you would continue either the Chloroquine or Doxycycline for the four weeks and start the Primaquine Terminal Prophylaxis for 14 days.

## **Medical Screening**

### **Tuberculosis Screening**

**Prior to Deployment** - History of a negative Intradermal Purified Protein Derivative (IPPD) reaction within **12 months** of deploying. If no IPPD within **12 months** the person must have an IPPD performed and read between 48-72 hours prior to deploying. Personnel who have a history of a positive IPPD and have been evaluated and treated, then had a negative chest x-ray within the previous 2 years, do not need any further evaluation prior to deployment unless complaining of respiratory symptoms. **Do not administer an IPPD to those persons who have a history of a positive IPPD.** Personnel who have recently converted their IPPD to positive must be evaluated medically and placed on the appropriate treatment before being considered for deployment.

**After Re-deployment** – Administer an IPPD within a **3 to 6 month** period after re-deploying to personnel who had a negative IPPD from Pre-deployment testing. Personnel with a history of a positive IPPD should have a chest x-ray within **six months** of returning. Personnel who convert their post-deployment IPPD to positive must be evaluated medically.

### **Human Immunodeficiency Virus (HIV)**

**HIV testing is done in accordance with AR 600-110 dated 22 April 1994 and with the changes to AR 600-110 Change 1 Effective 01 July 1996. The testing requirements are summarized in the following paragraphs. Please see AR 600-110 and Change 1 for specific information regarding testing procedures.**

#### **Active Component (AC) (Including AGR) Surveillance Testing (AR 600-110 para 2-7.a.)**

All soldiers on **active duty** are required to be tested for the presence of HIV antibodies (HIV test) at least biennially (once every two years).

#### **Reserve Component (RC) Surveillance Testing (AR 600-110 para 2-1.i.(1) and para 2-8.b.)**

ARNG and USAR Selected Reserve screening will be conducted every 5 years.

Soldiers assigned to the Individual Ready Reserve (IRR) and Individual Mobilization Augmentation (IMA) programs will be tested during annual training (AT) or active duty for training (ADT), if their last HIV antibody test is older than 4 years, and during periodic routine physical examinations, including flight physicals. IRR and IMA soldiers' physical examinations that are performed by civilian contract will be considered "interim complete" if the soldier has a documented HIV test no older than 5 years. Under this circumstance, an HIV test will be required within 48 hours of reporting for **any** active duty period to ensure the physical examination is updated.

### **Deployment HIV Testing Requirements**

**The HIV Testing Requirements for Deployment are different from the Active Component and Reserve Component Surveillance Testing. The requirements for AC and RC Components are as follows:**

**Active Component (AC) (Including AGR) HIV Testing for Deployment**

All AC/AGR personnel scheduled for temporary duty (TDY) or deployments on exercises overseas that **will not exceed 179 days** must have tested negative for HIV infection within the **24 months** prior to departure. (AR 600-110 para 2-2.k.(1))

All AC/AGR personnel scheduled for overseas deployment or TDY that **will exceed 179 days** must have tested negative for HIV infection within **6 months** prior to the departure date.

**Reserve Component (RC) HIV Testing for Deployment**

RC personnel scheduled for overseas duty (to include Guam, American Samoa, and the Virgin Islands) of **30 days or less** must have a negative HIV test within the **5 years** prior to departure date. All RC personnel performing active duty of **more than 30 days** require a negative HIV test **within the 6 months prior to reporting date, regardless of whether the duty is overseas or in the United States.**

**There currently is no requirement for testing following redeployment unless the soldier meets one of the categories listed in AR 600-110 para 2-2.b.-g. These categories include history of suspicious illness, patients with sexually transmitted diseases (STD), blood transfusion/blood product recipients (see the regulations for specific requirements), have a sexual partner that is HIV infected, is an intravenous (IV) drug user, or requests voluntary screening.**

**All personnel should be warned of the dangers of contracting HIV through sexual contact with (American Military personnel, American Civilians, and Foreign Local Population), intravenous injection of illegal drugs, other high-risk behavior, and through blood from wounds.**

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