

InterFET Pilot Project

Final Report

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Table of Contents

Document Administration.....	3
Document Location.....	3
Revision History	3
Approvals.....	3
Distribution	3
Acknowledgements.....	4
1. EXECUTIVE SUMMARY	5
2. INTRODUCTION	7
3. OBJECTIVES	8
4. NOMINAL ROLL AND SAMPLE SELECTION	9
Methods	9
Findings	10
Recommendations.....	10
5. MORTALITY REVIEW.....	11
Methods	11
Findings	11
Recommendations.....	12
6 SELF-REPORTED QUESTIONNAIRE.....	12
Methods	12
Findings	13
Recommendations.....	15
7 DEFENCE HEALTH DATA.....	16
Methods	16
Findings	16
Recommendations.....	17
8 HAZARD ASSESSMENT	18
Methods	18
Recommendations.....	20
9 DATA INTEGRATION AND MANAGEMENT	20
Methods	20
Findings	20
Recommendations.....	20
10 RESEARCH MANAGEMENT	21
Recommendations.....	21
11 DISCUSSION	21

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Approvals

This document requires the following approvals:

Name	Position	Signature	Date	Version
Prof Annette Dobson	Chair DHSP Scientific Research Team			
CDRE Robyn Walker	Chair DHSP Program Management Board			

Signed approval forms are filed in the Management section of the project file.

Distribution

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1. Executive Summary

1.1 The aim of the Deployment Health Surveillance Program is to provide a systematic, prospective and ongoing means of assessing and understanding the health effects of operational deployment on Australian Defence Force (ADF) personnel and veterans.

1.2 This program is being undertaken by the Centre for Military and Veterans' Health (CMVH). The first stage of the program was to design the methodology and conduct a feasibility study with ADF personnel and veterans deployed to East Timor as part of Australia's commitment to InterFET. It is called the InterFET Pilot Project.

1.3 The purpose of the InterFET Pilot Project was to design and test the proposed methodology for the Deployment Health Surveillance Program. This purpose was achieved and a number of important lessons have been learnt that will strengthen subsequent projects in the program, including operations in the Solomon Islands, Bougainville, East Timor and the Middle East. The study design tested use of data from multiple sources, including Defence health, operational and administrative information, to form a database that can be extended over time and analysed to understand emerging health issues and make recommendations to protect the health of ADF personnel and veterans. The InterFET Pilot Project has demonstrated the critical importance of testing the feasibility of the proposed design for a program of research.

1.4 The major recommendations are:

- a) For future deployment health studies, information identifying ADF personnel and veterans who have been deployed on specific military operations should be obtained from all available sources and should not be not limited to PMKeys;
- b) The surprising result of a very low death rate among personnel deployed to InterFET warrants further investigation of both the "healthy soldier effect" and data matching procedures of the National Death Index;

- c) For future projects a strong communications strategy should be implemented, in consultation with appropriate stakeholders, to raise awareness of the program and improve the response to personnel surveys;
- d) As far as possible best practice survey methods should be used to maximise the response rate to the personnel survey including multiple options for completion – paper-based, internet-based, telephone interview, or face to face interview, and the provision of reimbursement to participants for time spent completing the questionnaire, e.g., film tickets;
- e) Defence Health Services should continue to develop the use of electronic health records and CMVH should continue to endeavour to use electronic and paper based records to capture as much Defence health data as possible for long-term surveillance of health issues for ADF personnel and veterans;
- f) CMVH should support and capitalise on initiatives within Defence Health Services to improve the collection of objective exposure information which could be used to supplement self-reported data on hazard exposure;
- g) The data collection and management systems developed as part of the InterFET pilot project should be extended to provide a fully integrated system for on-going surveillance;
- h) Mechanisms should be strengthened to improve co-ordination between Defence Health Services, CMVH and other major health initiatives especially in relation to communication with ADF personnel and veterans.

2. Introduction

2.1 “The vision for the Deployment Health Surveillance Program is to provide a systematic, prospective and ongoing means of assessing and understanding the health effects of operational deployment on ADF personnel.”¹

2.2 This program is being undertaken by the Centre for Military and Veterans’ Health (CMVH). The first stage of the program was to design the methodology and conduct a feasibility study with ADF personnel and veterans deployed to East Timor as part of Australia’s commitment to the InterFET (Operations Spitfire and Warden). This feasibility study is called the InterFET Pilot Project.

2.3 In recent times ADF personnel have deployed on active service overseas in a variety of war-like and non war-like roles. These include peacekeeping, peace enforcement, border protection, humanitarian assistance and offensive military operations in support of coalition agreements. Such deployments have varied in intensity and complexity and have been associated with a wide range of operational, occupational and environmental health threats - physical, physiological and psychological. Identification and documentation of the various health threats encountered has been variable and at times limited and their effects on health are not always well-understood.

2.4 There are continuing controversies and significant public debate about the health effects of deployments on current and former members of the ADF. Concerns have usually been raised by veterans and ex-service organisations as health effects become manifest, often many years after the deployment has been completed. As a consequence, the health effects of operational deployments to date have only been studied retrospectively, with associated difficulty in obtaining relevant data, particularly regarding hazardous exposures. The interpretation of such data is problematic and often inconclusive. Additionally these retrospective studies have been limited to self-reported questionnaires or interviews together with medical

¹ AVM Tony Austin, Head, Defence Health Services, July 2005

assessments and linkage studies to mortality and cancer incidence. They have not used the potentially rich data recorded in Defence health records.

2.5 A program of longitudinal health reviews of personnel who have been operationally deployed has been commissioned by the Director General Defence Health Services (now Head, Defence Health Service) based on government policy espoused by the (then) Minister for Defence Personnel. This is the Deployment Health Surveillance Program. The first stage of the program is the InterFET Pilot Project.

3. Objectives

3.1 The objectives of the InterFET Pilot Project were to:

- Develop and test methods to measure health and risk exposure for ADF personnel and veterans;
- Test the feasibility of using this methodology for long-term surveillance;
- Develop a nominal roll of ADF personnel deployed on Operations Warden and Spitfire (InterFET nominal roll);
- Test the linkage of the InterFET nominal roll with the National Death Index;
- Compare the mortality of those on the InterFET nominal roll with death rates in the comparable national population;
- Select a random sample of the InterFET population (Veterans group) and other ADF personnel who did not deploy on these operations (the Comparison group);
- Test the collection and management of data to describe and compare health and illness of Veterans and Comparison groups;
- Test the access, collection and use of routinely collected Defence health assessment data and vaccine records;
- Test the collection of data on self-reported health and exposures from Veterans and Comparison groups;

- Report on the assessment of hazards encountered during the InterFET operations based on a variety of source documents;
- Link information obtained from all these various sources to establish an integrated data system and test it to a limited extent (but not to the stage of testing hypotheses).

3.2 The InterFET Pilot Project comprised:

- a) the development of a nominal roll and selection of random samples for the Veterans and Comparison groups;
- b) a mortality review using the National Death Index;
- c) a self-completed questionnaire;
- d) retrieval of routinely gathered Defence health assessment and vaccination records;
- e) a hazard assessment based on routinely collected environmental information;
- f) the establishment of an integrated database using information from all these sources.

3.3 Each of these components is described below with an outline of the methods used, the findings and recommendations for the future.

4. Nominal Roll and Sample Selection

Methods

4.1 A nominal roll of ADF personnel deployed on Operations Spitfire and Warden was obtained by the Deployment Health Surveillance Program Office (DHSPO) from the Defence Personnel Executive who extracted it using the PMKeys database.

4.2 Ethics approval was required for CMVH to access the nominal roll. The data were handled by Defence personnel with appropriate security clearance at CMVH and, where possible, within the Defence system. At all times the standards for the handling of restricted information were met.

4.3 The definition of the Veterans and Comparison groups, using the same proportions as on the nominal roll, was undertaken by CMVH. A sample of 100 Veterans was randomly selected to meet these criteria. Also a table of required numbers from each service and gender was provided to DHSPO for random selection of another sample of ADF personnel who did not deploy on these operations (Comparison group). However, identification of individuals for the Comparison group was not supervised by CMVH.

Findings

4.4 In the original Statement of Works for the InterFET Pilot Project, the number of ADF personnel deployed on the operations was said to be 5500. The nominal roll of the two operations was estimated to be in excess of 7000 names. However, the actual nominal roll received included only 4124 veterans with very small numbers of RAAF and RAN personnel.

4.5 From the list of 200 names selected for the Veterans and Comparison groups, two Veterans were incorrectly placed in the Comparison group and 23 of the Comparison group were found to be ineligible because they were not in the ADF at the time specified for inclusion in the study (the onset of InterFET).

4.6 The deficiencies in the Nominal Roll particularly for RAAF and RAN personnel significantly limited the representation from these services in the pilot project. Inclusion and exclusion criteria were not uniformly applied in selection of the samples. This level of retrospectively identified ineligibility is not sustainable for the program as a whole.

Recommendations

- For future deployment health studies, information identifying ADF personnel who have been deployed on specific operations should be obtained from all credible sources and not be limited to PMKeys;
- Data from these sources should be made available to CMVH for generation of a project nominal roll;
- CMVH should provide DHSPO with precise specifications of data items and formats required from PMKeys;

- CMVH should provide DHSPO with clear instructions for the selection of the Comparison group by PMKeys personnel.
- The time between the provision of contact details of people in the Veterans and the Comparison groups and subsequent mail out of the questionnaire should be short, and not bridge a posting cycle. If a posting cycle falls within the period of mailout of questionnaire reminders, updated addresses should be provided by DHSPO.

5. Mortality Review

Methods

5.1 A list of all names on the nominal roll and those selected for the Comparison group was submitted to the Australian Institute of Health and Welfare (AIHW) for comparison with the National Death Index (NDI) using probabilistic matching. The NDI is a list of all confirmed deaths which have occurred in Australia since 1980. A confirmed death requires a burial certificate, medical certificate and death certificate.

5.2 Attempts were made to validate deaths identified from matching with the NDI using other sources such as obituaries.

5.3 Next, the validated deaths from the nominal roll were compared with the expected number of deaths based on Australian population data, and the number of deaths in the Veterans and Comparison groups were compared.

Findings

5.4 There were 4124 personnel on the nominal roll. Checks of the roll revealed that two personnel who were deployed to InterFET and were known to have died were not included. These known deaths could not be added to this analysis because their date of birth was unknown. Linkage to the NDI yielded just two deaths.

5.5 The mortality statistics for the InterFET nominal roll were based on a total of 25,375 person-years, an average of 6.2 years per person. Based on death rates for the Australian population for the same age and sex distribution, the expected number of deaths by 2006 for the entire nominal roll is 32.0, compared to an observed number of

just two. This is a very large difference and is statistically significant. Possible reasons for this difference could be:

- Personnel eligible for inclusion on the nominal roll and who have died were not included on the nominal roll;
- ADF personnel are a group that is generally more mobile than the Australian population, and hence may be more likely to have unregistered deaths because, for example, they died overseas;
- The National Death Index failed to find real matches because of surname changes or misspellings on the nominal roll or death register; or
- The healthy soldier effect - ADF personnel may well be healthier than the general population, and hence we might expect to see fewer deaths in the short term.

5.6 The largest differences between observed and expected deaths were in men aged 25 to 34. This difference could support the hypotheses of either a more mobile population or a healthy soldier effect.

Recommendations

- The accuracy of the nominal roll should be improved - as discussed above;
- The surprising result of a very low death rate among personnel deployed to InterFET warrants further investigation of both the “healthy soldier effect” and data matching procedures of the National Death Index.

6 Self-Reported Questionnaire

Methods

6.1 A self administered questionnaire was developed and included items which covered potential exposures and hazards to which ADF personnel may have been exposed as part of their deployment, and potential health outcomes. The choice of questions was based on instruments used in previous Australian defence health studies, data collected in similar UK and US studies, and the exposures identified in the hazard assessment part of this project.

6.2 The questionnaire was divided into 14 main areas of investigation:

- A list of various symptoms that could be experienced by participants, informed by studies of Gulf War veterans and DVA compensation claims;
- General health, psychosocial health and disability;
- Anxiety and depression, and disability;
- Oral health, using the Oral Health Impact Profile (OHIP-14);
- A list of possible conditions for which participants could have received a diagnosis;
- Items regarding hospitalisation, family history of selected psychological conditions and malignancies;
- Medications currently being taken by the participant;
- Smoking and alcohol intake;
- Post traumatic stress disorder (using Post Traumatic Stress Disorder Checklist – Civilian Version);
- Reproductive and child health outcomes;
- General demographic items to check date of birth, gender, marital status and the highest educational qualification obtained;
- Civilian occupational history;
- Deployment details, including vaccinations and medications, chemical and environmental exposures, sun protection behaviour, traumatic and other major stressors, post deployment experiences; and
- A final section allowing participants the opportunity to provide details of any exposures or outcomes not already covered.

6.3 A bulk mail house distributed the packages of questionnaire and other study material to Veterans and Comparison group members in February 2006. An informed consent process was available for subjects to withdraw their names from further involvement in the study.

Findings

6.4 Incorrect addresses were subsequently identified for 58 of the sample of 200 (35 from the Veterans group and 23 from the Comparison group) among the ADF personnel still serving at the time of the study. These addresses are presumed to be

incorrect due to the posting cycle that occurred immediately after the nominal roll was provided to CMVH. It was not possible to determine how many addresses provided for civilians by DHSPO (from discharge documents) were also incorrect.

6.5 Dead mail was received back for 11 packages including six identified as having incorrect addresses and five not previously known to be to incorrect addresses. From a total of 137 (200 - 58 - 5) mail-outs not known to be sent to incorrect addresses, there was a total of 19 responses (14%); seven from each of the Veteran and Comparison group and five telephoned refusals.

6.6 Before the project could continue to the follow-up procedures and second mail-out, Defence Health directed that the project should be stopped because of the response rate. The self-reported data collection component of the InterFET Pilot Project was closed and the direction submitted to ADHREC as the reason for breach of protocol.

6.7 Because of termination of the recruitment stage of the survey, some aspects of the self-reported questionnaire were not trialled.

6.8 Following the low response, a review of recent literature on response rates was conducted. A Cochrane review has provided a summary of the literature on response-enhancing strategies for mail-out surveys. The review covered 372 trials that involved at least one randomised assessment of survey design, and found that the odds of response:

- were at least doubled using financial reimbursements (the amounts in the examples involved was as little as a dollar);
- were 1.5 times higher with pre-notification;
- increased with shorter questionnaires;
- increased if the more interesting questions were placed towards the front and the general questions to the back;
- increased if a second questionnaire was included in the reminder;
- increased if the study was sponsored by a university;
- increased if an obligation to respond was mentioned.

6.9 The current British Op Telic study recently published initial findings indicating that with media promotion, pre-notification, financial incentives, enclosed letters of support, within two years of the Operation and at the height of public debate regarding Gulf War Syndrome and involvement in the war, only a 35% response rate was received from an equivalent first mail-out of questionnaires (Hotopf et al, 2006).

6.10 While the response rate for mail-out of the self-report questionnaire was very low, this aspect of the study still achieved some of the desired aims in terms of:

- developing an appropriate questionnaire;
- trialling the questionnaire;
- developing and trialling a recruitment strategy.

6.11 Factors considered to have contributed to the low response rate for the self-reported questionnaire included:

- no pre-recruitment media strategy;
- no endorsement by highly respected Defence and/or veteran community figures;
- incorrect addresses for potential participants;
- no participant reimbursement or other incentives;
- size and structure of the questionnaire.

6.12 A more thorough investigation of non-response was not possible, because approval was not given by ADHREC to discuss these issues with individuals who declined to participate in the study.

6.13 The low response rate led to several changes in study methodology for the Defence Deployed Solomon Islands Health Study, which is the next study to be conducted as part of the program.

Recommendations

- For future projects a strong communications strategy should be implemented, in consultation with appropriate stakeholders, to raise awareness of the program and improve the response to personnel surveys;

- As far as possible best practice survey methods should be used to maximise the response rate to the personnel survey including multiple options for completion – paper-based, internet-based, telephone interview, or face to face interview, and the provision of reimbursement to participants for time spent completing the questionnaire, e.g., film tickets.

7 Defence Health Data

Methods

7.1 After allocation of study numbers, the lists of all 200 ADF personnel, (Veterans and Comparison groups) were forwarded to DHSPO for de-identified copies of the last medical assessment (Annual Health Assessment (AHA), Discharge Medical, Specialist AHA, or Comprehensive Preventive Health Evaluation (CPHE)) and vaccination record. Source documents retrieved were de-identified (temporarily) for copying, therefore, copies stored securely by the CMVH are de-identified and no identified copy exists outside the source documents held by Defence.

7.2 Data extraction was tested using firstly a medically trained civilian researcher transcribing data from Defence health documents and then by an ex-Defence clinician. Significant deficiencies were identified in the first extraction particularly related to abbreviations and the meanings of findings. This experience suggests that the data extraction from these sources should be conducted or at least supervised by a clinician familiar with the Defence health system or a similarly qualified researcher.

7.3 The linkage of Defence health and self-reported information from the 14 completed questionnaires was readily conducted using the study numbers allocated. Specifically, linkages between self-reported information and Defence assessed alcohol and tobacco use, perceived stress, deployment history among other variables were all readily made.

Findings

7.4 Linkage of the nominal roll and archived routine health assessments produced documents on 96% of Veterans group and 93% of the Comparison group; however, vaccine records were located for only 1% of subjects. Of those records collated,

almost 90% were from the two years immediately before the date of sampling (end of 2005). The Defence health records are clearly a rich and contemporary source of health data. Vaccine records will need to be obtained from different sources. It is proposed to explore using HealthKeys directly for this purpose in addition to sourcing the missing health records from the archives.

7.5 There was a disproportionate representation of discharge medicals collected from the Veterans group. This may represent a higher rate of discharge among Veterans of the InterFET operations and warrants further investigation.

7.6 The confirmed Medical Employment Category (MEC) was analysed and a higher proportion of Veterans than Comparison group personnel were found to be MEC2. The MEC2 standard is a deployable standard for most employment categories in the ADF and for most deployments. Nevertheless fewer Veterans than the Comparison group reported undertaking recent deployments. Longitudinal surveillance will provide much more detailed assessment of this information.

7.7 The rates of current illnesses, injuries and medication use reported were high for an otherwise healthy population; however, these data were drawn from health assessments which were conducted routinely for illness, injury and medications as well as to determine fitness to perform duties. A greater level of illness was reported from Veterans than the Comparison group which is consistent with an overall higher prevalence of illness reported in other veterans' health studies. Similarly, Veterans' perceptions of stress in their lives were higher than the Comparison group and that stress was perceived to occur more frequently.

Recommendations

- Defence Health Services should continue to develop the use of electronic health records and CMVH should continue to endeavour to use electronic and paper based records to capture as much Defence health data as possible for long-term surveillance of health issues for ADF personnel and veterans;

- Possible evidence from the InterFET Pilot Project that there may be higher proportions of discharge medicals and Medical Employment Category (MEC) 2 classifications in InterFET Veterans than in the Comparison group warrants further investigation.

8 Hazard Assessment

Methods

8.1 The InterFET health hazard assessment was compiled from information known prior to the InterFET deployment, reports and observations made during deployment and retrospective findings from later information and analysis. The following methods and sources were used:

- Search of the ADF website for relevant health related documents relating to InterFET/East Timor;
- Search of medical and public health literature on InterFET and East Timor;
- Findings from the Australian National Audit Office report ‘Management of Australian Defence Force Deployments to East Timor’;
- Review of routine health intelligence gathered, collated and prepared by ADF in support of these and subsequent operations in East Timor;
- Post Operation Reports – focusing on key findings of vulnerabilities;
- Review of health files and databases prepared by the Medical and Health staff of Headquarters InterFET (held at Deployable Joint force Headquarters);
- Review of health surveillance reports submitted by Headquarters InterFET and summarized in ADF Health Status Report 2000;
- Review of hazard exposure assessment information held by Defence Safety Management Agency;
- Review of de-identified AC563 (Defence Occupational Health Incident reports).

A review of health records and interviews with military personnel were not conducted as ethical approval had not been granted to source health related information.

Findings

8.2 The ADF personnel deployed to East Timor as part of Australia's commitment to the InterFET were exposed to a wide variety of operational, environmental and occupational health hazards. Overall, the principal health threat to the deployed force was environmental, with a large number of health care attendances for conditions related to the tropical environment of East Timor.

8.3 A feature of InterFET was the initial rapid force preparation and deployment into war-like conditions in a harsh tropical climate. There was limited opportunity to gather health information locally or for health intelligence to be incorporated extensively into force preparation at all levels. Consequently, there was a lack of detailed information on the health threat available to commanders once in theatre. The early deployment of health threat assessment personnel and equipment as a tool to define the health threat for commanders has gained greater acceptance in subsequent operations (OP ANODE, OP SUMATRA ASSIST). While a health threat assessment team was not deployed on those operations, environmental health personnel were specifically tasked on OP SUMATRA ASSIST to gather all available information and prepare a basic health threat assessment using a framework which has been in use since 1997. This document and reports from the HAZMAT team and the psychology team provided timely health intelligence to the commander and formed the basis of post deployment medical insert slips and health briefings. Subsequently, health threat assessment teams have been deployed to other area of operations to complete specific hazard assessments.

8.4 This report highlights that adequate health hazard assessment is critical to the early phases of any deployment. The timely identification of risk, communicated to the appropriate levels of command is essential to effectively mitigate health risks to personnel. A mechanism for rapidly identifying and quantifying expected and unanticipated hazards and exposures is also essential to effective prevention and management of perceived risks.

Recommendations

- CMVH should explore the potential to use, enhance and evaluate the framework of physical, psychological and social exposure factors developed for the Nature of Service Review in future projects;
- CMVH should support and capitalise on initiatives within Defence Health Services to improve the collection of objective exposure information which could be used to supplement self-reported data on hazard exposure.

9 Data Integration and Management

Methods

9.1 A commercial mailing company, Security Mail, was employed to manage the self-reported questionnaire survey. The Data Management and Analysis Centre at the University of Adelaide were employed to manage the data obtained from Defence health records.

Findings

9.2 As far as was possible to establish from this limited pilot project both of these arrangements have provided effective logistic support at a reasonable cost and this has meant that CMVH has not had to employ staff with the specific technical capabilities to perform these functions.

Recommendations

- The model for outsourcing specific data collection and data management activities through a partnership with expert providers should be continued for other projects in the program, subject to meeting Defence security requirements.
- The prototype data collection and data management systems developed as part of the InterFET pilot project should be developed and enhanced to provide the capability for a fully integrated data collection and management system for surveillance of health of ADF personnel and veterans.

10 Research Management

Management of the project

10.1 This project suffered from initial confusion in governance. This resulted in loss of focus on the aims of the project and time delays. In July 2005 a new governance arrangement was established by Defence Health Services and the Prince 2 project management methodology was adopted.

Recommendations

- The structure for research governance comprising the Program Management Board (PMB), Scientific Advisory Committee (SAC) with some stakeholder liaison devolved to CMVH should remain in place for other projects in the program;
- Mechanisms should be strengthened to improve co-ordination between Defence Health Services, CMVH and other major health initiatives especially in relation to communication with ADF personnel and veterans.

11 Discussion

11.1 The main achievements of this pilot project have been the development of the overall design for the program piloting the use of multiple data sources forming a relational database describing the health of ADF personnel and veterans. Elements of this design have been challenging individually in addition to the overall concept. Establishing a nominal roll for Operations Spitfire and Warden has been a significant achievement since nominal rolls of these operations were not previously available. The roll produced for this project was shown to be inaccurate and incomplete; however, the means of developing accurate nominal rolls for deployments has been developed. This is an essential foundation for the program.

11.2 Questionnaires and medical examinations have been used previously for veterans' health studies but not the large quantity of routinely collected health data owned by Defence. This is a rich source of data, and its use for this program requires no additional effort by Defence health workers so that there is no requirement upon existing health services for supplementary medical examinations or the need to hire an

additional health workforce to undertake medical examinations. Transparency of a data source for surveillance is of great value in times of minimal staffing of health services and survey fatigue among soldiers, sailors and airmen.

11.3 Clearly, civilian data sources are necessary to complement Defence-owned health data. Accessing civilian databases was piloted in this project by comparison of the nominal roll with the National Death Index (NDI). On-going NDI comparisons will identify deceased veterans in the longitudinal program and provides the model for other database comparisons such with as the cancer registries and data from the Department of Veterans' Affairs (DVA) to obtain additional civilian data on veterans' health.

11.4 Major management achievements arising from this project are the establishment of the Deployment Health Surveillance Unit and the Scientific Research Team by CMVH and the Program Office, the Program Management Board (PMB) and Scientific Advisory Committee (SAC) by Defence and DVA. The new Governance arrangements have been enhanced by including Prince 2 Project Management methodology used now in Defence health research. All of these structures have been developed to address issues that arose during the InterFET Pilot Project.

11.5 The project was developed to act as a foundation for a prospective longitudinal surveillance program. The design is a significant innovation from previous retrospective veterans' health studies. All aspects of the design are capable of being repeated and used to obtain longitudinal information. Key elements have been designed to immediately permit longitudinal comparisons with Defence data collected before and after operations and to articulate with tools presently employed by Defence for health assessments.

11.6 Other programmatic features tested in this project have been the inclusion of health assessments not previously used in veterans' health studies. One example is the inclusion of oral health assessment as an outcome of interest. Another innovation is for self-reported health information to be linked to general medical and psychological assessments conducted by Defence. Investigation of issues around

exposure to malaria, dengue and ultraviolet light, recognising the issues confronting ADF personnel on the recent deployments, are also of interest in this program. These considerations recognise the increase in claims for DVA treatment and pensions arising from these exposures despite the limited evidence regarding attribution (based on Table 18 of the DVA Annual Report 2005 using a denominator of 8000 East Timor veterans).

11.7 Finally, the design features not previously used in veterans' health studies and developed in this project have been tailored for ready use across operations beyond those of InterFET, for the differing nature of operational conditions from service assisted evacuations and humanitarian assistance operations to war-like peace-making. In particular they recognise the need to consider the health effects of multiple deployments which are the usual experience of ADF personnel nowadays.

11.8 The resolution of issues and solutions developed in the InterFET Pilot Project are a foundation for the Deployment Health Surveillance Program. This will remain an iterative process as the Program develops. The next project in this program (the Defence Deployment Solomon Islands Health Study) will benefit from many of the lessons learnt in the InterFET Pilot Project and has been built on the infrastructure created for this project. The Solomon Islands project has been approved by the Australian Defence Human Research Ethics Committee (ADHREC), supporting the value of the pilot process and infrastructure from the InterFET Pilot Project. These will be enduring aspects for the Deployment Health Surveillance Program.