



### BACKGROUND

Women play an integral role in the US military, comprising 15% of the active-duty force and 19% of the Reserve and Guard.<sup>1</sup> Servicewomen face unique challenges when it comes to accessing contraception and abortion services, especially during deployment when these services may be limited. Furthermore, policies prohibiting or discouraging sexual activity may prevent women from seeking the care to which they are entitled. Unintended pregnancy and access to reproductive health services are not only public health and reproductive justice concerns, but also impact troop readiness, deployment, and military health care costs.

Ibis Reproductive Health launched a program of work in 2010 to fill the gaps in knowledge about servicewomen's sexual and reproductive health needs and experiences. In this brief, we outline the restrictions and barriers affecting servicewomen's ability to access abortion care. To respond to these challenges, we highlight the potential of telemedicine to provide a feasible, cost-effective solution to improve access to abortion.

### ABORTION RESTRICTIONS AFFECTING SERVICEWOMEN

Servicewomen have limited options when faced with an unwanted pregnancy. Under US Code §1093, a woman serving in the military may only obtain an abortion at a military treatment facility if continuing the pregnancy would threaten her life or if the pregnancy is a result of rape or incest.<sup>2</sup> Due to this policy, servicewomen must invest significant time and resources to obtain abortion care, which can result in delays that increase the cost and complexity of the procedure.<sup>3</sup>

For deployed women, the challenges of obtaining abortion care are particularly acute. Abortion is legally restricted in the countries where most US troops are deployed, which presents an obstacle to locating abortion services in theater.<sup>4</sup> Even if a provider is available, it may be unsafe and/or unfeasible to travel off-base to obtain abortion care, and if a deployed servicewoman is unable to access care locally, she must request leave and be evacuated.<sup>4</sup> The process of evacuation is expensive for the military, increases the woman's time away from her job, and jeopardizes her confidentiality.

Finally, unless continuing the pregnancy threatens the woman's life or is a result of rape or incest, she must pay for her procedure out of pocket.<sup>4</sup> Taken together, these financial and logistical challenges result in a time-consuming and expensive process for both the woman and the military and present numerous barriers to care.<sup>4</sup> Furthermore, by requiring women to take leave and obtain services off-base, this law not only burdens servicewomen, but can negatively affect military operations and troop readiness.



## CURRENT BARRIERS TO INCREASING ACCESS TO ABORTION CARE

Increasing numbers of legislators and organizations are calling for a change to federal policy to ensure that abortion for all legal indications is available and covered at military treatment facilities, and at a minimum is available if paid for with private funds.<sup>5-7</sup> However, if abortion coverage and provision are expanded, considerable barriers to care in the military may remain. Military medical residency programs typically offer limited or no abortion training,<sup>8-10</sup> which may limit the number of providers who are able to perform the service in the military. A study surveying OB/GYN residency program directors found that military residency programs were significantly less likely to provide routine training in abortion care compared to university-affiliated and community-based training programs.<sup>10</sup> Furthermore, military medical staff have the right to refuse to provide abortion care in the case of religious or moral objections.<sup>11</sup> Limited research suggests that there may be challenges to finding an adequate number of willing providers.<sup>8</sup>

## TELEMEDICINE PROVISION OF MEDICATION ABORTION

Telemedicine may provide a solution for women in the military seeking early abortion care (see text box on p. 3). Telemedicine refers to the use of technology and electronic communications, such as video conferencing, to provide medical care and counseling at a distance.<sup>12</sup> Medication abortion (the abortion pill) is an abortion method using mifepristone taken with another medication, misoprostol, to induce abortion up to 70 days gestation. Because it does not involve surgery, medication abortion can be offered by a wide range of providers, including certified nurse midwives, physician assistants, and nurse practitioners, and does not require a surgical facility. Medication abortion provided by telemedicine offers the opportunity to expand the reach of providers and enhance access for women in remote locations, including deployed settings.

## TELEMEDICINE IN THE MILITARY

TRICARE, the health insurance program for military servicemembers and their families, covers the use of interactive audio/video technology to provide clinical consultations and office visits when appropriate and medically necessary.<sup>13</sup> We conducted a literature search to better understand the ways in which telemedicine has been utilized by the US military. Between December 2011 and January 2012, we searched Pubmed and Google Scholar for articles published in 2001 or later that pertained to use of telemedicine in the US military. These articles were categorized based on how telemedicine technology was used, and for which clinical discipline.

Through this literature review, we identified 104 published articles relating to the use of telemedicine in the US military. Direct patient care and provider-to-provider consultation were the most common applications of telemedicine, although we also found several examples of telemedicine being used for education and training, radiology, and laboratory medicine (see Table 1 on p. 4). We found examples of telemedicine being used in the military in 16 different clinical disciplines, with emergency medicine, mental health, and dermatology being most common. Of the 104 articles identified, 49 referred to the use of telemedicine in a deployment setting.

Our review demonstrated that the military has a history of being on the forefront of telemedicine technologies. By the 1980s, the military had developed a teleradiology system to transmit images from deployment settings to specialists in the United States for diagnosis and consultation.<sup>14</sup> In 1990, the US Army founded the Telemedicine and Advanced Technology Research Center (TATRC) to identify new applications of telemedicine, such as mobile medical robots and virtual environments for training and treatment.<sup>15</sup>

**TELEMEDICINE** is already used to provide medication abortion in settings where there is no abortion provider and where patients would otherwise have to travel long distances for care.<sup>16</sup>

In June 2008, Planned Parenthood of the Heartland in Iowa began providing medication abortion via telemedicine at clinics without an on-site physician in order to improve access to early abortion and reduce physician and patient travel. In this program, women seeking medication abortion meet with staff in a clinic where they have an ultrasound performed by a trained technician, receive information about the procedure from a medical assistant or nurse, and undergo standard informed consent. A remote physician then reviews the patient's medical history and ultrasound images, and meets with the woman using video teleconference equipment. The physician answers questions and determines whether the woman is eligible for medication abortion. If she is eligible, the physician enters a computer password to remotely unlock and open a drawer in front of the patient containing the medications, observes the woman swallow the mifepristone, and, as is done during an in-person visit, gives her instructions for taking the remaining tablets 24-48 hours later.<sup>16</sup> Other medication abortion telemedicine models involve a simpler process for administering the medication, where the doctor gives verbal instructions to a clinic staff member present with the woman, who then hands her the medication.

The telemedicine model in Iowa was evaluated and shown to be equally safe and effective as an in-person physician visit.<sup>16</sup> Ninety-nine percent of telemedicine patients had a successful abortion compared to 97% of in-person patients, and there was no significant difference in ongoing pregnancy or serious complications between telemedicine patients and face-to-face patients. The vast majority of both telemedicine (94%) and in-person (88%) patients reported being very satisfied with their experience. Notably, significantly more telemedicine patients than in-person patients (90% vs. 83%) reported that they would recommend the service they received to a friend. Nearly all telemedicine patients (99%) reported that they could easily see and hear the doctor during the videoconference and that they were comfortable asking the doctor questions (89%).<sup>16</sup>

In-depth interviews with telemedicine patients and clinic staff in Iowa confirmed that the service was acceptable to women, particularly because it improved the timeliness and proximity of abortion care. The majority of patients felt neutral about speaking with a physician via videoconference and some felt more comfortable with this model instead of an in-person visit. Staff involved with telemedicine also responded positively, noting that procedures for a telemedicine appointment were not significantly different from an in-person visit with the doctor, and that the transition to providing care via videoconference was easy.<sup>17</sup> A study of provider perspectives on telemedicine for medication abortion provision in Alaska had similar findings.<sup>18</sup>

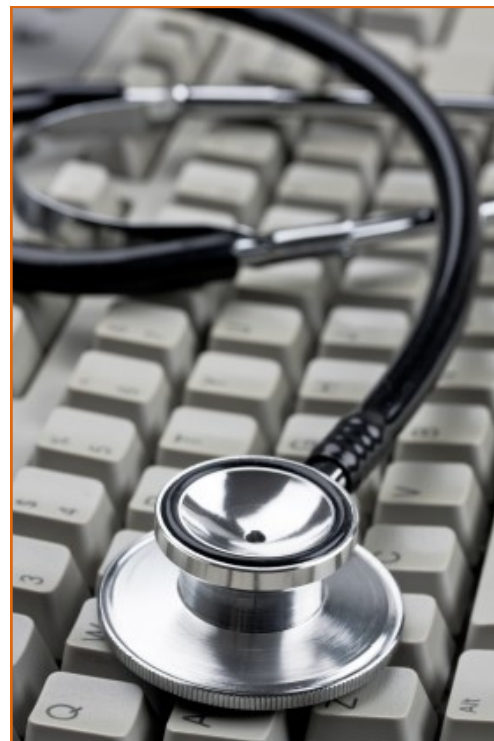
The telemedicine model was shown to help clinics maximize limited resources, reduce travel for patients and providers, and accommodate a need for early abortion care.<sup>17,18</sup> Another study of this model showed that telemedicine improved women's access to early abortion. After telemedicine was introduced, women were significantly more likely to have their abortion earlier in pregnancy.<sup>19</sup> Together, these studies demonstrate that medication abortion through telemedicine improves access to early abortion services and is an effective and highly acceptable option for women.

**Table 1. Use of Telemedicine in the Military**

	<b>Articles Identified (#)</b>
Total	104
Deployment setting	49
<b>Application*</b>	
Direct care to patient	45
Provider-to-provider consultation	40
Education/training	23
Radiology	11
Laboratory	7
<b>Clinical Discipline*</b>	
Emergency medicine	25
Mental health	20
Dermatology	14
Infectious diseases	11
Cardiology	9
Ophthalmology	8
Pediatrics	7
Surgery	7
Neurology	6
Pathology	6
General practice	5
Internal medicine	5
Otolaryngology	4
Orthopedics	2
Gynecology	1
Oncology	1

\*Articles may include more than one application and/or clinical discipline

One of the more common uses of telemedicine in the military is for psychiatric care of soldiers and veterans with mental health concerns, such as post-traumatic stress disorder. Grady and Melcer (2005) evaluated a telemental health care (TMHC) service, in which psychiatrists provided evaluation and treatment, including medication management and psychotherapy, to remote military personnel via videoconferencing. The study found TMHC patients were more likely to fully comply with medication and follow-up appointments and experienced a greater improvement in Global Assessment of Functioning scores (a combined assessment of the patient's current social, occupational, and psychological functioning) compared to patients receiving in-person care.<sup>20</sup> In a cost analysis, telemedicine was lower cost than all other models for providing mental health services to Navy personnel in remote locations, including local civilian health care in the remote setting, patient travel to a non-local military treatment facility, and travel of a mental health specialty provider to the patient.<sup>21</sup>





## DISCUSSION

Currently, deployed servicewomen face significant barriers to safe, timely, confidential, and affordable abortion care. The reasons for this are varied and include domestic and international abortion policies and the challenging logistics of accessing abortion services in theater. Prior research on the use of telemedicine for early medication abortion care paired with a review of the literature on telemedicine utilization by the US military demonstrate that not only does telemedicine represent a safe, acceptable method of abortion provision, but it is also a technology widely used in the military for other purposes. Although not all servicewomen seeking abortion services will choose or qualify for medication abortion, many will, given evidence that the majority of abortions performed in the United States take place at eight weeks of gestational age or less.<sup>22</sup> Furthermore, the most common complications associated with early medication abortion are similar to those experienced with spontaneous miscarriage, which military treatment facilities should be equipped to treat in theater.

Given the US military's experience developing and implementing technologies to improve medical care for military personnel at home and overseas and the demonstrated safety, effectiveness, and acceptability of telemedicine provision of medication abortion, telemedicine appears to be an appropriate solution for servicewomen seeking abortion services. This technology can also overcome barriers to deployed women's abortion access such as long distances from providers, limited number of staff trained to provide abortion, and challenges to maintaining patient confidentiality in the event of obtaining medical leave and/or evacuation.



MILITARY

## POLICY RECOMMENDATIONS >

- **Provide and cover abortion care in all circumstances in military treatment facilities.**

In the general US population, 42% of unintended pregnancies end in abortion.<sup>23</sup> However, women in the military have limited pregnancy options, especially when deployed. Servicewomen deserve the same access to care as civilian women in the United States. Alternatively, women should be able to pay out of pocket to receive abortion care in military treatment facilities.

- **Increase the availability of abortion training in military residencies.**

Although not all military physicians come from military residencies, it is particularly important that comprehensive training in abortion care be included in these programs to ensure an adequate supply of skilled providers. Military residencies would benefit from making abortion care training routine or opt-out, rather than optional or not part of the curriculum.

- **Expand the role of nurses and other Advance Practice Clinicians (APCs) in abortion care provision.**

Organizations governing the training and education of nurses and allied health professionals should ensure these providers are able to perform abortion care. The military would benefit from recruiting APCs trained in abortion services and providing current APCs with training opportunities. Evidence from the literature demonstrates that non-physician clinicians have the necessary skills to provide medication abortion services and that military APCs in particular already perform a range of complex services for servicemembers and their families.<sup>24</sup> This expanded pool of providers could enable women to obtain abortion care either from an in-person provider or remotely via telemedicine.<sup>25</sup> Adding abortion services to the skill set of APCs in the military would go far in promoting military women's access to care.

- **Cultivate a supportive environment for training in and provision of abortion care in the military.**

Military medical programs and staff within military treatment facilities should create dialogue about abortion care in the military to promote a supportive environment. The military should prioritize the hiring of medical staff with the willingness and appropriate skill set to provide abortion care. Research suggests that tailored “values clarification” workshops can help health care providers understand and empathize with women who need abortion services, and even promote behavior change for expanding and improving abortion care.<sup>26</sup> This may be an important tool in overcoming provider discomfort with abortion provision and promoting safe, accessible pregnancy termination services on-site at military treatment facilities.

- **Expand telemedicine services within the military to include medication abortion.**

The military currently has telemedicine systems in place that could be expanded to include telemedicine provision of medication abortion. Adding medication abortion to the array of telemedicine services available through the military would not only reduce the burdens faced by servicewomen seeking abortion services but also lower the costs and lost duty time incurred by the military when evacuating these women from theater.



## REFERENCES

1. Department of Defense. 2014 demographics: profile of the military community. Office of the Deputy Assistant Secretary of Defense (Military Community and Family Policy); 2014.
2. Legal Information Institute. 10 USC § 1093 - Performance of abortions: restrictions. <http://www.law.cornell.edu/uscode/text/10/1093>.
3. Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics & Gynecology* 2004;103(4):729-37.
4. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the U.S. military: voices from women deployed overseas. *Women's Health Issues* 2011;21(4):259-64.
5. Gillibrand, colleagues introduces legislation lifting ban on use of private funds for abortions in military hospitals. 2013. <https://www.gillibrand.senate.gov/newsroom/press/release/gillibrand-colleagues-introduces-legislation-lifting-ban-on-use-of-private-funds-for-abortion-in-military-hospitals>.
6. Service Women's Action Network. Support the repeal of the ban on private funding of abortion in the FY 2011 National Defense Authorization Act. <https://www.aclu.org/other/service-womens-action-network-swan-letter-private-funding-abortion-2011-national-defense?redirect=reproductive-freedom/service-womens-action-network-swan-letter-private-funding-abortion-2011-national>.
7. American Civil Liberties Union (ACLU). Lift the bans: U.S. servicewomen denied essential abortion care. <http://www.aclu.org/reproductive-freedom/lift-bans-us-servicewomen-denied-essential-abortion-care>.
8. Burrelli DF. Abortion services and military medical facilities. Washington, DC: Library of Congress; 2002.
9. Almeling R, Tews L, Dudley S. Abortion training in U.S. obstetrics and gynecology residency programs, 1998. *Family Planning Perspectives* 2000; 32(6):268-71,320.
10. Eastwood KL, Kacmar JE, Steinauer J, Weitzen S, Boardman LA. Abortion training in United States obstetrics and gynecology residency programs. *Obstetrics & Gynecology* 2006;108(2):303-8.
11. ACLU. U.S. armed forces flag officers in support of the Shaheen Amendment to the FY12 National Defense Authorization Act. 2011. [http://www.aclu.org/files/assets/shaheen\\_amendment-\\_flag\\_officers\\_support\\_letter-11-29-11.pdf](http://www.aclu.org/files/assets/shaheen_amendment-_flag_officers_support_letter-11-29-11.pdf).
12. American Telemedicine Association. What is telemedicine? <http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-faqs>.
13. TRICARE Management Activity. See what's covered. <http://www.tricare.mil/CoveredServices.aspx>.
14. Barneveld Binkhuysen FH, Ranschaert ER. Teleradiology: evolution and concepts. *European Journal of Radiology* 2011;78(2):205-9.
15. Blanchet K. The U.S. Army Telemedicine and Advanced Technology Research Center (TATRC). *Telemedicine Journal and E-Health* 2006; 12(4):390-5.
16. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics & Gynecology* 2011;118(2 Pt 1):296-303.
17. Grindlay K, Lane K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. *Women's Health Issues* 2013;23(2):e117-22.
18. Grindlay K, Grossman D. Telemedicine provision of medical abortion in Alaska: through the provider's lens. *Journal of Telemedicine and Telecare* 2016 Epub ahead of print.
19. Grossman D, Grindlay K, Buchacker T, Potter J, Schmertmann C. Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa. *American Journal of Public Health* 2013;103(1):73-8.
20. Grady BJ, Melcer T. A retrospective evaluation of telemental healthcare services for remote military populations. *Telemedicine Journal and E-Health* 2005;11(5):551-8.
21. Grady BJ. A comparative cost analysis of an integrated military telemental healthcare service. *Telemedicine Journal and E-Health* 2002; 8(3):293-300.
22. Jatlaoui TC, Ewing A, Mandel MG, Simmons KB, Suchdev DB, Jamieson DJ, et al. Abortion surveillance - United States, 2013. *Morbidity and Mortality Weekly Report Surveillance Summaries* 2016;65(12):1-44.
23. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. *New England Journal of Medicine* 2016;374(9):843-52.
24. Dargis J, Horne T, Tillman-Ortiz S, Scherr D, Yackel EE. Expanding the role of the nurse practitioner in the deployed setting. *Military Medicine* 2006;171(8):770-3.
25. Yarnall J, Swica Y, Winikoff B. Non-physician clinicians can safely provide first trimester medical abortion. *Reproductive Health Matters* 2009; 17(33):61-9.
26. Mitchell EM, Trueman K, Gabriel M, Bock LB. Building alliances from ambivalence: evaluation of abortion values clarification workshops with stakeholders in South Africa. *African Journal of Reproductive Health* 2005;9(3):89-99.



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MULTIARY