Ibis Reproductive Health

Sexual and reproductive health of women in the US military

Issue brief 5: Former and retired military officers' perspectives on military reproductive health access and policy

Background

Women play an integral role in the US military, comprising 15% of the active-duty force and 19% of the Reserve and Guard.[1] 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 present the findings from interviews we conducted with former and retired military officers on their perceptions and experiences related to reproductive health care access and policy for servicewomen.

We conducted nine semi-structured in-depth phone interviews with former and retired military officers from February to May 2013. We recruited participants through contacts at military and advocacy groups. Participants had served in the Air Force, Army, Marine Corps, and Navy, and included three Captains, one Lieutenant Colonel, one Colonel, one Lieutenant Commander, two Major Generals, and one Lieutenant General; four of the participants were medical personnel. Our interview questions focused on participant perspectives on contraceptive access and use, unintended pregnancy, and abortion in the US military. Interviews were recorded and transcribed, and the data were coded thematically using grounded theory methods. IRB approval was obtained from Allendale Investigational Review Board.

Contraceptive access and use

Participants noted that a wide variety of contraceptive options were available to servicemembers, but also emphasized that not all methods could be obtained in deployment settings. Additionally, they cited the need for standardized contraceptive counseling, including at annual wellness visits, other medical visits, and prior to deploying.

Given the young demographic of servicemembers, several participants expressed concern that some servicemembers have limited knowledge of the range of contraceptive methods upon entering the military, and experience difficulty navigating the military health care system and advocating for their health care needs. Respondents reported that improved, more proactive systems for contraceptive counseling were needed. In addition, one participant noted that contraceptive counseling varied widely between providers, and the information servicewomen received might not include all options. The participant also expressed concern that servicemembers may be unaware that they could request another provider if an individual declined to provide a preferred contraceptive method due to a personal or religious belief.

Respondents noted that some military medical providers had misconceptions about sexual activity during deployment, believing it did not take place and therefore not initiating contraceptive counseling. Participants also reported inaccurate beliefs among some providers about the appropriateness of certain contraceptive methods. One participant reported that some providers declined to provide intrauterine devices (IUDs) to women who have not had children because of an erroneous belief that they were ineligible for them. Since access to contraceptive supplies is often limited for servicemembers once deployed, the respondent further noted that it was particularly troubling when forms of long-acting reversible contraception, like IUDs, were not routinely offered, despite being safe and appropriate for many women.[2]

Respondents described how recruits in training and deployed military members may have a particularly difficult time accessing contraceptive supplies due to impermanent duty locations, rapidly changing schedules, and separation from their supplies. One OB/GYN who screened thousands of servicemembers deploying to Iraq and Afghanistan reported that military medical providers faced "significant problems" ensuring servicemembers were able to bring an adequate supply of contraception for their entire deployment and that they could not always guarantee access to long-acting reversible contraception, refills, or a subsequent contraceptive injection once servicemembers were in theater.

> *There was very little policy about making sure that adequate screening and education and counseling were done for women specifically for their reproductive health care as opposed to things like dental care…. [With dental care for example] there were exams that had to be done, official forms that had to be checked. All that had to be in their record before they could deploy.* **—Navy**

Unintended pregnancy

The unintended pregnancy rate in the United States is estimated to be 45/1,000 women aged 15-44,[3] a rate that is significantly higher than many other developed countries.[4] However, the unintended pregnancy rate in the military is even higher, at 72/1,000 active-duty women aged 18-44.[5] Participants described a variety of factors that they believed contribute to the elevated rate of unintended pregnancy among servicewomen. One participant noted that high stress levels among deployed servicemembers may contribute to increased engagement in risky behaviors (of note, engaging in generally risky behavior was not found to be associated with having had an unintended pregnancy in a recent representative survey of active-duty servicewomen[5]). Several participants reported that there was no standard policy for reproductive health care counseling and that restrictive or prohibitive policies related to sexual activity could result in a lack of discussion about contraception with military medical providers. They noted that servicemembers continued to have sex regardless of these policies and thus needed access to information and counseling. Participants also discussed the role that sexual assault may play in elevating the unintended pregnancy rate, but noted a lack of data on the number of pregnancies resulting from sexual assault.

Stigma around unintended pregnancy was reported by participants, particularly as a result of both perceived and real effects that the removal of pregnant servicemembers has on deployed military troops. The standard protocol dictates that pregnant servicemembers be evacuated from deployment settings, which can have significant impact on their units. Respondents noted that each member of a unit is critical to operations, and there were potentially severe consequences of any member leaving. Most agreed that the costs of evacuation placed a burden on military resources. However, they also felt it was important to keep these financial and operational costs in perspective, noting that similar numbers of servicemembers were sent home due to accidents incurred while playing sports or for other reasons. One participant clarified that although it is rarely the case, many servicemembers assume that active-duty servicewomen become pregnant intentionally in order to avoid deployment, reduce physical labor and training requirements, or to move out of the barracks or into off-base housing.

> *We're willing to die for the country. They're not willing to provide us the same level of healthcare they provide for citizens.* **—Army**

Abortion access

The Shaheen Amendment, passed in January 2013 as part of the 2013 National Defense Authorization Act, amended federal law to mandate that military health insurance cover abortion in cases of rape or incest, in addition to the previously covered circumstance of life endangerment of a servicewoman.[6] Federal law allows for the provision of abortion at military treatment facilities (MTF) under these same three circumstances.[7] If a pregnancy does not fall within this narrow scope, a servicemember has to pay out-of-pocket for an abortion and obtain the procedure outside the military system. Military medical personnel are permitted to opt out of abortion provision if they have moral or religious objections, unless it is required to save a woman's life.[8]

These interviews were conducted just after passage of the Shaheen Amendment, but prior to its implementation. As a result, participants were aware of the amendment's specific provisions, but had doubts about how it would be implemented, particularly whether it would allow abortion provision at MTFs in instances of rape or incest. Many participants expressed concerns that not providing abortion at MTFs could potentially be associated with unsafe abortion, increased unwanted pregnancy, and challenges navigating foreign medical environments while deployed. No respondents could recall hearing of abortions being provided at an MTF other than a limited number of cases of life endangerment several decades ago, and most doubted that abortion would be provided at MTFs now despite the amendment. Participants reported widespread confusion about the military's abortion law due, in part, to a lack of communication of the military's policies to medical providers and servicemembers. This leaves military providers uncertain as to whether they can provide abortion and servicemembers unsure whether they can obtain an abortion through military facilities, even under permissible circumstances.

A few participants indicated that a conservative ideology held by some military personnel may also contribute to inadequate education about abortion policy and availability. Additionally, as one respondent explained, a woman's medical chart may be viewed by dozens of people before she gets to a medical appointment, and fear of a confidentiality breach, gossip, or a negative impact on her career may prompt her to seek services elsewhere rather than disclose her need for an abortion to a military medical provider. Respondents also noted that a lack of disclosure may make it difficult for providers to adequately measure how frequently military servicewomen seek and obtain abortions outside of the military system. As a retired Navy member stated, "Nobody talks about [abortion] anymore. And because it was driven out of the system, they don't have any statistics…so you basically have no idea how many women might have had to resort to an abortion outside the military medical system."

Participants also discussed that the absence of abortion training in military medical residencies and a resultant lack of providers trained to provide abortions constituted a barrier to provision within the military medical system. The lack of providers could be especially problematic for servicemembers deployed in areas where abortion is legally restricted or unavailable, and where accessing services at an MTF may be the only viable option. One respondent suggested that the lack of training could readily be addressed if abortion provision were included in existing miscarriage management training. Respondents also noted that smaller bases with limited facilities may face additional challenges that could make abortion provision or other specialty care more difficult.

Discussion

Despite robust health insurance coverage, there is a disproportionately high rate of unintended pregnancy among servicemembers. Gaps in contraceptive counseling and provision may be contributing factors. Participants reported a widespread lack of knowledge about contraceptive options and abortion services throughout all levels of the military, and noted a need to address this lack of knowledge through policy and improved communication. Stigma about unintended pregnancy and abortion needs to be addressed through outreach, education, and policy changes.

Policy Recommendations

- **Ensure successful implementation of Section 718 of the 2016 National Defense Authorization Act.** In the fall of 2015, the 2016 National Defense Authorization Act (NDAA) was approved, which contained a provision that called for access to comprehensive contraceptive counseling for members of the Armed Forces and the establishment and dissemination of clinical practice guidelines for those services.[9] While operationalizing such procedures can be challenging, it is imperative that implementation move forward as planned to guarantee servicemembers access to consistent and comprehensive contraceptive counseling.
- **Establish and implement standardized, evidence-based reproductive health care policies and programming**. Servicemembers should have access to comprehensive sexual and reproductive health information and services so that they can make informed decisions regarding their health. Reproductive health care should be consistent across military branches and include routine annual wellness visit and pre-deployment reproductive health care screening, including contraceptive counseling as specified in the 2016 NDAA amendment.[9]
- **Guarantee access to adequate contraceptive supplies for the entirety of deployment.** Not only should servicemembers have comprehensive, evidence-based counseling on appropriate contraceptive methods for deployment, but they should also have access to all methods of contraception at MTFs, with referral as needed, and receive adequate supplies for deployment.
- **Provide and cover abortion care in all circumstances in military treatment facilities.** In the general US population, 42% of unintended pregnancies end in abortion.[3] However, women in the military have limited pregnancy options, especially when deployed. Servicewomen deserve the same access to care as civilian women. Alternatively, women should be able to pay out of pocket to receive abortion care in MTFs.
- **Proactively educate military medical providers, leadership, and servicemembers about contraceptive methods and abortion care**. To enable servicemembers access to reproductive health care, they must be aware of the availability, permissibility, and coverage of contraceptive methods and abortion services and the processes for accessing care. In addition, proactive referral systems must be put in place so that the personal beliefs of medical providers and commanding officers do not prevent servicemembers from accessing contraception or abortion services.
- **Incorporate abortion into military medical residency training.** In order to ensure that safe and confidential abortion services are available at all MTFs or from referral sites when necessary, it is important that medical providers receive abortion training. Telemedicine provision of medication abortion may also be an appropriate care model to improve access to abortion care at MTFs. For more information, see our brief, *Sexual and reproductive health of women in the US military: The potential of telemedicine to improve abortion access.*
- **Monitor the implementation of the Shaheen Amendment.** The Shaheen Amendment, codifying abortion coverage in cases of rape and incest, became law in 2013.[6] Servicewomen must be informed of their right to abortion coverage in these circumstances, and be ensured timely access to confidential care. Evaluating implementation efforts could help to identify service barriers, improve quality, and target education efforts and ensure that abortion coverage for rape and incest is enforced.

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. Curtis KM et al. US medical eligibility criteria for contraceptive use, 2016. Morbidity and Mortality Weekly Report 2016; 65(2): 1-104.
3. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008-2011. New England Journal of Medicine 2016; 374(9): 843-52.
4. Singh S, Sedgh G, Hussain R. Unintended pregnancy: worldwide levels, trends, and outcomes. Studies in Family Planning 2010; 41(4): 241-50.
5. Grindlay K, Grossman D. Unintended pregnancy among active-duty women in the United States military, 2011. Contraception 2015; 92(6): 589–95.
6. One Hundred Twelfth Congress of the United States of America. H.R. 4310: National Defense Authorization Act for fiscal year 2013.
7. Legal Information Institute. U.S. Code § 1093. Performance of abortions: restrictions. http://www.law.cornell.edu/uscode/10/1093.html.
8. Boonstra HD. Off-base: the US military's ban on privately funded abortions. Guttmacher Policy Review. Summer 2010; 13(3).
9. One Hundred Fourteenth Congress of the United States of America. S.1356: National Defense Authorization Act for fiscal year 2016.

Ibis Reproductive Health

Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health

(617) 349-0040
admin@ibisreproductivehealth.org
www.ibisreproductivehealth.org

Issued February 2017

This research was supported by grants from The Wallace Alexander Gerbode Foundation and The William and Flora Hewlett Foundation.