Ibis Reproductive Health

# Sexual and reproductive health of women in the US military

## Issue brief 6: Contraception and abortion policies in militaries worldwide

## Introduction

Women play an integral role in the US military, comprising 16% of the active-duty force and 19% of the Selected Reserve.*,[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. There is limited public information regarding military coverage of contraception and abortion care for servicewomen globally. In this brief, we provide an overview of the reproductive health coverage policies for women serving in militaries around the world, including their overall health care source, coverage for contraception, and coverage for abortion. We believe that this systematically collected information will help place the US military's reproductive health care model in an international context and shed light on the situation of military women around the globe.

## Methods

We conducted an online survey from August 2014 to February 2016 to determine countries' policies on contraceptive and abortion coverage and provision for servicewomen. Countries were included if they allowed women to play an active role in the military[2] and had liberal or liberally interpreted abortion laws, defined as permitting abortion for economic or social reasons or upon request.[3] Participants were country experts, including defense attachés; international health policy researchers; local health practitioners; and representatives from ministries of health, family planning associations, and health care centers.

We sent a brief email with a link to the survey to these key informants. The survey asked whether medical services were provided for military personnel through a military health system, public health system, or both; whether contraception and abortion were paid for and/or provided by the military and if there were any limitations; and how, if at all, abortion services were provided during deployment. Additionally, previously published data on public funding for abortion in the general population in countries where abortion is broadly legal were used to compare civilian and military policies.[3]

We categorized coverage for both contraception and abortion as either: full coverage, partial coverage, limited coverage, or no coverage. A country was considered to have "full coverage" if contraception or abortion was provided for free at military facilities or fully covered under military health insurance. Countries were categorized as having "partial coverage" if the costs of contraception or abortion were partially covered by the military. Countries were categorized as having "limited coverage" if coverage was only permitted under specific circumstances. In the case of abortion, limited coverage included when services were only covered in cases of rape, incest, fetal impairment, the health/life of the woman, or in other limited cases such as when the servicewoman had a physical or mental disability. For contraception, limited coverage included when contraception was only covered for a medical indication as defined by the health system. Countries were categorized as having "no coverage" if there was no funding for abortion or contraception. Countries were categorized as providing abortion care in military treatment facilities (MTFs) if abortion care was routinely provided in MTFs (countries were considered "N/A" if the military did not have MTFs).

Across these domains, we compared policies, identified common themes, and explored outliers. Additionally, we compared global military coverage trends to those in the United States.

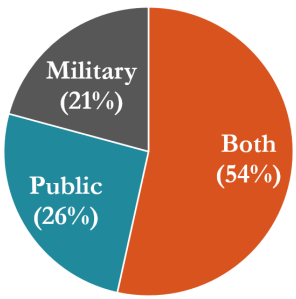
* Selected Reserve members are Guard and Reserve forces who complete annual active-duty training.

## Results

Overall, 71 countries met our inclusion criteria. We were able to obtain complete data for 31 countries and partial data for an additional eight countries (see Table 1). Key informants reported a range of policies related to contraceptive and abortion coverage for servicewomen in these countries.

Of the 39 countries with data on health care source, 54% (n=21) provided servicemembers with health care through both military and public health systems. Roughly a quarter of these countries (26%, n=10) provided health care to servicemembers solely through a public health system, and 21% (n=8) provided health care solely through a military health system.

**Sources of health care coverage for military servicemembers (n=39)**



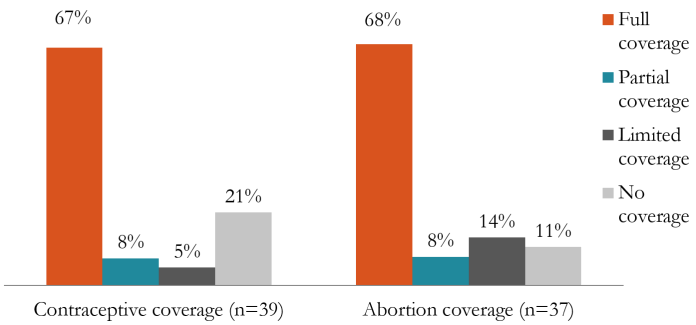

Of the 39 countries with data on contraceptive coverage, 67% (n=26) fully covered contraception for servicewomen, 8% (n=3) partially covered contraception, 5% (n=2) provided coverage only in limited circumstances, and 21% (n=8) did not cover contraception.

Of the 37 countries with data on abortion coverage, 68% (n=25) fully covered abortion services for servicewomen, 8% (n=3) partially covered abortion, 14% (n=5) provided coverage only in limited cases, and 11% (n=4) did not cover abortion.

Thirty-five countries provided data on whether abortion was provided at MTFs. Of these, 14% (n=5) provided abortion services at MTFs while 66% (n=23) did not or only provided abortion at MTFs in exceptional circumstances. The remaining seven countries (20%) did not have MTFs.

Finally, of the 32 countries with data on deployment, 66% (n=21) required deployed women to return to their home country to access abortion services,* 3% (n=1) provided abortion services at overseas military facilities, 13% (n=4) covered services provided locally by an external provider with the option of allowing women to return to their home country based on preference and/or the local health system, 9% (n=3) did not deploy servicewomen, and 9% (n=3) had no precedent or set regulation for this circumstance.

**Countries' contraceptive and abortion coverage for military members**




In general, countries that provided full contraceptive coverage also offered full abortion coverage. Twenty-six countries provided full contraceptive coverage for military personnel and 25 countries provided full abortion coverage. Twenty countries provided full coverage of both contraceptive and abortion services to their military personnel; this constitutes 77% of all countries that provided full contraceptive coverage and 80% of all countries that provided full coverage of abortion services. Two countries (Greece and Moldova) offered full abortion coverage but only partial or limited contraceptive coverage, and three countries (Belgium, Bulgaria, and Russia) provided full abortion coverage but did not provide contraceptive coverage.

Of the eight countries that provided health coverage for servicemembers exclusively through military systems, only four (Bulgaria, Nepal, the Netherlands, and South Africa) reported full coverage of abortion; however, Bulgaria and Nepal only fully covered specific abortion methods. Of the remaining countries that only offered health care through a military system, Serbia offered partial coverage for abortion; Germany and United States offered coverage only in limited cases; and Switzerland did not cover any abortion coverage.

* This percentage includes the United Kingdom and United States; UK servicewomen can receive abortion care in country in Germany and the US military provides abortion services at MTFs only in cases of rape, incest, or life endangerment.

## Comparing Civilian and Military Public Funding for Abortion

Almost half (n=17) of the 39 countries in this review provided full public funding for abortion for civilians. Abortion services tended to be covered for military personnel in the same way they were for civilians—all countries that provided full funding for abortion under the civilian public health system offered full abortion coverage to members of the military.*

However, there were a few notable exceptions. Among the remaining nine countries that had full military abortion coverage, seven offered partial funding through the public health system (Bulgaria, Finland, Israel, Moldova, Singapore, Sweden, and Turkey); one offered limited funding under the public health system (Croatia); and one offered no funding for abortion under the public health system (Nepal).

In 13 countries, servicewomen's access to abortion services was restricted through both the military and public health systems:

- In three countries (Bosnia and Herzegovina, Cyprus, and Saint Vincent and the Grenadines), there was no coverage for abortion through either the military or public health systems.
- In eight countries (Estonia, Germany, Lithuania, Montenegro, Mozambique, Serbia, Slovakia, and Switzerland), abortion services were covered partially, in limited circumstances, or not at all through either the military or public health systems.
- In two countries (Latvia and United States), abortion services were covered only in limited circumstances through both the military and public health systems.

* India was missing data for abortion coverage in the military.

## Comparing Reproductive Health Coverage

To make comparisons across countries, each country was assigned a reproductive health coverage score based on the level of abortion and contraception coverage provided to servicewomen. Countries with no coverage received zero points, limited coverage received one point, partial coverage received two points, and full coverage received three points. The maximum score was six points for countries that fully covered both abortion and contraception. Countries with missing coverage data were not scored. Coverage scores were categorized as: exceptional (6 points), good (5 points), below average (3-4 points), poor (1-2 points), or none (0 points).

Of the 37 countries with complete coverage data, the average score was 4.5 points. Among these countries, 54% (n=20) had exceptional reproductive health coverage, 5% (n=2) had good coverage, 24% (n=9) had below average coverage, 5% (n=2) had poor coverage, and 11% (n=4) had no coverage (see Table 1).

## NATO Countries

Of the 29 countries in the North American Treaty Organization (NATO), which includes the United States,[4] 27 met our inclusion criteria and 22 responded. Of the countries that provided data regarding contraceptive coverage for servicewomen, 73% (n=16) provided full coverage for contraception while 5% (n=1) provided partial and 5% (n=1) provided limited coverage for contraception; four countries did not provide contraceptive coverage for servicewomen. Seventy-seven percent of countries provided full (n=15) or partial (n=2) abortion coverage for servicewomen, while 23% (n=5) provided limited coverage.

## Discussion

In recent decades, female participation in the military has increased around the world.[1,5] The United States has one of the largest militaries in the world, which includes 200,000 female active-duty members.[6] A lack of attention to servicewomen's needs could affect troop readiness and deployment.

# Country profiles at a glance

*Contraception and abortion policies for military personnel varied throughout the world. The following case studies were chosen to highlight the range of coverage offered.*

**Belgium:** Belgian military personnel received medical care through both military and public health systems. Belgium was one of two countries that did not cover the cost of contraception for military personnel but did fully cover abortion care. Servicewomen could obtain coverage for abortion through the government's health insurance program. Belgian civilians typically paid small personal contributions to access a refund for the cost of abortion, but servicewomen referred by a military provider were not required to pay that amount. If deployed, Belgian servicewomen had to return to Belgium for the procedure in order to receive government support.

**Bosnia/Herzegovina:** Military personnel in Bosnia and Herzegovina received medical care through both military and public health systems; however, contraceptive and abortion coverage were not provided to servicewomen, nor was public funding available for abortion. There were no regulations in place for women who may need an abortion while deployed.

**Canada:** Members of the Canadian military received medical care through both military and public health systems. Servicewomen had full coverage for both contraceptive and abortion care; however, services for abortion were not offered at MTFs in Canada. In the event of deployment, Canadian servicewomen had to return to Canada in order to access full military coverage for abortion.

**Denmark:** Danish servicemembers received medical care through the country's public health system. Under this system, contraception and abortion were free for all women. Abortions were provided in public hospitals. If deployed, female troops had to return to Denmark in order to obtain abortion care.

**France:** Military personnel in France received medical care through the public health system and coverage through military health insurance. Contraceptive and abortion care were covered through these systems. If deployed, female troops had to return to France in order to obtain abortion care.

**Germany:** German military personnel received medical care through a military health system, which did not provide coverage for contraception and only covered abortion care in cases of medical emergency. Abortion services were not provided at German MTFs, so servicewomen had to seek care from outside providers. If deployed, the same regulations applied. When an abortion was deemed medically necessary during deployment, the location of the procedure was dependent on the health condition of the servicewoman and quality of care provided in the country of deployment.

**Nepal:** Servicemembers in Nepal received medical care through the military. Although there was neither a public health system nor public funding for abortion in Nepal at the time of the study, abortion and contraception were both covered by the military and abortion was provided at MTFs. Nepalese servicemembers who were deployed had to return to Nepal in order to obtain abortion care.

**Netherlands:** Military personnel in the Netherlands received medical care through a military health system and had full coverage for contraception and abortion. Dutch servicewomen received care from military general practitioners who referred them to licensed hospitals and clinics where abortion was provided. If deployed, a woman had to return to the Netherlands regardless of her decision about continuing the pregnancy, since pregnant women were not cleared for duty outside of the country.

**Saint Vincent and the Grenadines:** Servicemembers in Saint Vincent and the Grenadines received medical care through the public health system. There was no public funding for abortion, the military did not have MTFs, and neither abortion nor contraception were covered by the military. There were no regulations for servicemembers who become pregnant while deployed.

**United Kingdom (excluding Northern Ireland):** In the United Kingdom, British military personnel received medical care through both military and public health systems. Contraception and abortion were fully covered and women could seek these services through military providers and the National Health Service or independent providers where appropriate. To access military coverage for abortion during deployment, servicewomen had to return to the United Kingdom unless they were stationed in Germany, where they could seek fully-covered care through a German abortion provider.

**United States:** In the United States, military personnel received medical care through a military health system. While military women did have full coverage for contraception, abortion was only covered by the military and offered at MTFs in cases of rape, incest, and life endangerment. The Shaheen Amendment changed policies in 2013[7] so that abortion may be performed at MTFs in these limited cases; however, data indicate that few abortions are performed at MTFs even in cases when it is allowed.[8] Since the Shaheen Amendment passed, abortion statistics from MTFs have not been reported. In all other circumstances, women must pay for the procedure on their own and go to facilities outside of military command.

## Policy Recommendations

### *Worldwide*

1. **Countries should provide full contraceptive and abortion coverage for servicewomen.** By fully covering contraception and abortion care, servicewomen will have access to the full range of family planning options. This could promote troop readiness, reduce unintended pregnancies, and ensure that women do not face additional hardships if they need to access these services.

2. **Countries should provide and/or cover abortion services for servicewomen during deployment in the country where they are serving. When this is not possible, countries should provide and/or cover abortion when servicewomen return to their home country.** A pregnancy can disrupt a servicewoman's tour of duty if she has to return to her home country for an abortion. Countries should provide abortion services locally at their MTFs or cover them through private services in country, if feasible. If abortion is not provided in the country of deployment, servicewomen should be able to return to their home country or remote duty station where their abortion should be covered through their military health insurance system.

### *In the United States*

1. **Abortion for all indications should be covered by TRICARE**. In the United States, only women whose pregnancies are a result of rape or incest or whose lives are endangered are allowed to access an abortion at an MTF and coverage through TRICARE. In order to ensure timely care and access to an abortion without additional hardship for women, their families, and their units, abortion services should be provided at MTFs and covered by TRICARE.
2. **Ensure the successful implementation of the Shaheen Amendment.** The Shaheen Amendment, passed in January 2013,[7] allows for coverage of abortion services by TRICARE in cases of rape, incest, or life endangerment of the woman. Lessons learned from the Hyde Amendment, which prohibits federal Medicaid coverage for abortion except in these limited circumstances, show that operationalizing abortion coverage for exceptions can be challenging.[9] Women must be informed of their right to abortion coverage after rape/incest and be assured access to timely, confidential care. Streamlined processes for reporting and determining eligibility are critical. If abortions are provided outside of the military, claim processing procedures must be in place. If at least some care will be provided at MTFs, it is imperative that health care providers be trained in the provision of evidence-based abortion care.
3. **Establish abortion referral and support guidelines.** While abortion is only currently provided and covered in the US military in cases of rape, incest, and life endangerment, the majority of unintended pregnancies among servicewomen do not fall under these categories. Routinized counseling on and referrals for the full range of pregnancy options are needed to ensure that servicemembers have access to safe and high-quality care.

| Region and country[α] | Source of health coverage | Contraception coverage | Abortion coverage | Abortion provision at military facilities | Abortion services while deployed | Public funding for abortion | Reproductive health coverage score |
|---|---|---|---|---|---|---|---|
| **Africa** | | | | | | | |
| Mozambique | Both | ◆ | – | – | – | ◈ | – |
| South Africa | Military | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| **Asia** | | | | | | | |
| Cyprus | Both | ◇ | ◇ | ◇ | N/A | ◇ | None |
| India | Public | ◆ | – | – | – | ◆ | – |
| Israel | Both | ◆ | ◆ | ◇ | N/A | ◈ | Exceptional |
| Nepal[β] | Military | ◆ | ◆ | ◆ | Return to home country | ◇ | Exceptional |
| Singapore | Public | ◆ | ◆ | ◇ | Return to home country | ◈ | Exceptional |
| Turkey | Both | ◆ | ◆ | ◆ | – | ◈ | Exceptional |
| **Australia and Oceania** | | | | | | | |
| Australia | Both | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| New Zealand | Both | ◆ | ◆ | ◇ | Local facility/return home | ◆ | Exceptional |
| **Europe** | | | | | | | |
| Belgium | Both | ◇ | ◆ | ◇ | Return to home country | ◆ | Below average |
| Bosnia & Herzegovina | Both | ◇ | ◇ | N/A | There are no regulations | ◇ | None |
| Bulgaria[γ] | Military | ◇ | ◆ | ◆ | Return to home country | ◈ | Below average |
| Croatia | Both | ◆ | ◆ | ◇ | – | ◈ | Exceptional |
| Denmark | Public | ◆ | ◆ | N/A | Return to home country | ◆ | Exceptional |
| Estonia | Both | ◆ | ◈ | ◇ | Local facility/return home | ◈ | Good |
| Finland | Both | ◆ | ◆ | N/A | Return to home country | ◈ | Exceptional |
| France | Both | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| Germany | Military | ◇ | ◈ | ◇ | Local facility/return home | ◈ | Poor |
| Greece | Both | ◈ | ◆ | ◇ | Return to home country | ◆ | Below average |
| Italy | Public | ◆ | ◆ | ◇ | – | ◆ | Exceptional |
| Latvia | Both | ◈ | ◈ | – | – | ◈ | Poor |
| Lithuania | Public | ◆ | ◈ | ◇ | Military facility | ◈ | Below average |
| Luxembourg | Both | ◆ | ◆ | ◇ | Local facility/return home | ◆ | Exceptional |
| Moldova | Both | ◈ | ◆ | ◆ | Return to home country | ◈ | Good |
| Montenegro | Public | ◆ | ◈ | N/A | Return to home country | ◈ | Below average |
| Netherlands | Military | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| Norway | public | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| Portugal | Both | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| Russian Federation | Both | ◇ | ◆ | ◆ | Return to home country | ◆ | Below average |
| Serbia | Military | ◈ | ◈ | – | – | ◇ | Below average |
| Slovakia | Both | ◈ | ◈ | ◇ | Return to home country | ◈ | Below average |
| Slovenia | Public | ◆ | ◆ | N/A | There are no regulations | ◆ | Exceptional |
| Sweden | Public | ◆ | ◆ | ◇ | Return to home country | ◈ | Exceptional |
| Switzerland | Military | ◇ | ◇ | ◇ | N/A | ◈ | None |
| United Kingdom[δ] | Both | ◆ | ◆ | N/A | Return to home country unless based in Germany | ◆ | Exceptional |
| **Latin America and Caribbean** | | | | | | | |
| St Vincent & the Grenadines | Public | ◇ | ◇ | N/A | There are no regulations | ◇ | None |
| **Northern America** | | | | | | | |
| Canada | Both | ◆ | ◆ | ◇ | Return to home country | ◆ | Exceptional |
| United States of America[ϕ] | Military | ◆ | ◈ | ◇ | Return to home country/ MTF for rape, incest, or life endangerment | ◈ | Below average |

**Table 1. Reproductive health coverage for servicewomen from countries with liberal or liberally interpreted abortion laws.**

[α] Includes eligible countries that provided usable data. Eligible countries with no usable data: Albania, Armenia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belarus, Cape Verde, China, Cuba, Czech Republic, Fiji, Ghana, Guyana, Hong Kong, Hungary, Japan, Kyrgyzstan, Macedonia, Mongolia, North Korea, Romania, Spain, South Korea, Taiwan, Tajikistan, Tunisia, Turkmenistan, Ukraine, Vietnam, and Zambia.

[β] All contraceptive methods fully covered except the levonorgestrel intrauterine system, implant, and diaphragm, which were reported to be unavailable; only medication abortion fully covered.

[γ] Only surgical abortion fully covered.

[δ] Excludes Northern Ireland.

[ϕ] Abortion covered and provided at MTFs only in cases of rape, incest, or life endangerment.

**KEY: ◆ Yes (full); ◇ No; ◈ Partial; ◈ Limited; – Missing**; N/A **Not applicable (no military hospitals or no deployment)**

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

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