

**SERVICE
WOMEN'S
ACTION
NETWORK**



YOUR VOICE, **AMPLIFIED**

**ACCESS TO REPRODUCTIVE HEALTH CARE:
THE EXPERIENCES OF MILITARY WOMEN**

2018 REPORT



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About the Service Women's Action Network

SWAN is a national, nonpartisan organization and member-driven community network advocating for the individual and collective needs of service women and women veterans. To date, SWAN has played a major role in opening all military jobs to service women, holding sex offenders accountable in the military justice system, eliminating barriers to disability claims for those who have experienced military sexual trauma, and expanding access to a broad range of reproductive health and mental wellness services for military women.

YOUR VOICE, AMPLIFIED.

LETTER FROM THE CEO

December 1, 2018

Dear Friends and Colleagues,

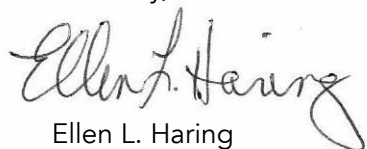
It is with great anticipation that the Board of Directors of the Service Women's Action Network (SWAN) and I present this research report. We are grateful to The Moriah Fund for their support that provided the initial funds to engage in this research. The Moriah Fund's longstanding support of reproductive choice and freedom is well established. Their support of women in the military with this grant is integral to their commitment to highlight the needs of specific groups of women who face unique, additional, or overly burdensome obstacles to reproductive care.

I would also like to deliver a heart-felt thank you to all the military women who responded to SWAN's survey. Answering questions about reproductive choices, options, and challenges can be very difficult. We appreciate the candor and trust that the respondents to this survey have shown to SWAN — and by extension to you, the reader. I look forward to their trust being rewarded with policy changes that will make similar journeys easier for future military women.

There is much that the citizens of the U.S. owe to our military personnel, and one of the most integral components of re-paying them for ensuring our safety and security is to provide them with comprehensive health care and benefits. Women currently comprise 17% of the U.S. military and are the fastest growing demographic within the military and veteran populations. All of these women require — and should expect — the best reproductive health services possible, which includes access to all forms of family planning. In order for SWAN — along with its partner organizations working on reproductive rights of women in the military — to advocate for those services to be improved upon and expanded, we required data to illustrate the scope and depth of the reproductive needs facing women in the military. With this report, we present you with that necessary data.

SWAN looks forward to sharing this data with the Department of Defense, Department of Veterans Affairs, members of Congress, the media, our partner organizations, and Military and Veteran Serving Organizations (MSOs and VSOs), in our shared efforts to ensure that all members of our military get all of their health needs addressed. We are eager to jointly craft comprehensive and fair policy responses to the issues the data show. Together we can make the struggles so candidly shared by the women who responded to SWAN's survey a relic of the past.

Sincerely,

A handwritten signature in black ink, reading "Ellen L. Haring". The signature is fluid and cursive, with the first name "Ellen" being the most prominent.

Ellen L. Haring
SWAN, CEO

EXECUTIVE SUMMARY

There are over 369,000 service women and more than 2 million women veterans. Service women comprise more than 17% of the military force and 10% of the veteran population with predictions that their numbers will increase exponentially in the coming years. Indeed, women veterans under the age of 45 comprise 18.5% of the under 45 veteran population.¹ Reproductive care for service women and women veterans has historically been a neglected area of attention by military and veteran health care providers. A number of organizations have called attention to the lack of women-specific care, particularly in the area of access to reproductive health care. In 2018, SWAN conducted a survey to pinpoint areas of need relative to three categories of reproductive care; access to birth control, infertility services, and abortion care. At the end of the survey period 799 military women² had participated in the survey.

The good news is that care trends show improvement in some areas over time. Today, active duty women report high levels of access to their preferred methods of birth control. However, care is impacted by rank. At a statistically significant rate, enlisted women report not receiving information about reproductive options, lower access to their preferred method of birth control and a higher rate of unintended pregnancies.

When women deploy to remote locations or are on board ships, access is significantly degraded across all categories of service women but has improved relative to what now retired service women experienced when they deployed. While some of the reduced access is unavoidable, most of it is easily remedied. The primary reason for reduced access is that some service women are not prescribed enough birth control to cover their entire deployment and when refills are required, they are not available at the deployed location. Some providers prescribe enough to cover an entire deployment while others don't. A second, easily remedied reason, is that some providers continue to deny prescriptions to service women during deployment citing General Orders that prohibit sexual activity during deployment. However, most women report that they are not using birth control to prevent pregnancy during deployments. They are using it to control or suppress their menstrual cycles or for other health related reasons. Providers should not deny service women birth control because of General Orders that govern sexual activity.

The data on unintended pregnancies reveals a significant percentage of unintended pregnancies in military women. In the four groups of military women surveyed the highest rate occurred among now retired women at 32%. Unfortunately, the medical options available to military women who have unintended pregnancies are limited to just one option; carry to term, unless the pregnancy is the result of rape, incest or the life of the mother is in danger. Four of the ten women who reported that their unintended pregnancies were the result of rapes had their pregnancies terminated in military treatment facilities (MTF). In total, 81 military women reported terminating their pregnancies and they did so with little or no assistance from MTF or Veteran Health Administration (VHA) providers even after seeking assistance from them.

¹Department of Defense, Defense Manpower Data Center, unpublished data current as of February 28, 2018.

²Terms in this report. "Military women" refers to all women who have ever served or are currently serving in the US Armed Forces. "Service women" refers to women who are currently serving on Active Duty, in the National Guard or in the Reserve components. Women veterans are women who have served but are no longer serving and do not receive a military pension. Retirees are women who served a full career and receive a military pension.

EXECUTIVE SUMMARY CONTINUED

The most surprising data revealed in this survey is the high percentage of military women who report having trouble getting pregnant when actively trying to do so. In all four categories of military women examined in the study over 30% report having problems getting pregnant when actively trying to do so with the highest percentage (37%) coming from currently serving service women. This is dramatically higher than the national average. According to the Centers for Disease Control (CDC) approximately 12% of US women have “impaired fecundity” which is defined as difficulty in either getting pregnant after actively trying for one year or the inability to carry a pregnancy to live birth.³

Unfortunately for military women, treatment options are limited by location, accessibility and cost. Only five military hospitals offer the full range of infertility treatments but at those hospitals there are long wait lists and service women have to pay some of the costs of their treatment. A service woman who is not able to get care at one of the five designated treatment facilities must use Tricare insurance at a civilian provider. However, Tricare limits coverage to some tests and procedures and completely excludes in vitro fertilization (IVF). Service women report paying approximately \$15,000 to \$20,000 for just one round of IVF treatment.

Women veterans are even more limited in their options. In order to get any kind of VHA infertility care a woman veteran must be able to show that her infertility is service connected. If a woman veteran is able to establish service connected infertility she will be referred to a civilian provider for care. Women veterans who don't know the source of their infertility seem to be treated on a random basis depending on the VHA hospital and the provider that they see. Some are totally denied care while others receive limited care.

Finally, women who are not in a heterosexual marriage seem to receive very mixed infertility care. While it is official policy to provide infertility services regardless of sexual orientation or marital status, our research found that reality does not match policy. Several women reported that they were denied infertility treatments because they were gay or not married.

In follow-up interviews women who reported infertility believe that their infertility may be the result of military service and is related to exposure to toxins on the job, during deployments and on military installations where they live. One infertile woman officer with 3 deployments to Iraq believes contaminated water, overheated plastic water bottles, and poor air quality due to burn pits and other air pollutants may be to blame. Another woman says that as a fuel handler she was exposed to many toxins that may have caused her infertility. Finally, ill-fitting equipment in the form of oversized body armor, designed for men but issued to women, was linked to another woman's infertility. She reports that she wore heavy plates that pressed into her abdomen while riding for extended periods in moving vehicles in Iraq that caused abdominal hernias and have resulted in her inability to carry a baby to term. This data clearly cries out for more research to pinpoint the high levels of infertility. In the interim, military women who present with fertility problems, which are likely a result of military service should be afforded access to *all* available infertility testing and procedures at *no* cost.

³National Health Statistics Report. 2013. <https://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf>

INTRODUCTION

In early 2018 the Service Women's Action Network conducted a research effort to determine the needs of military women relative to access to three reproductive health services. We sought to determine if military women have access to their preferred method of birth control, to abortion and infertility services.

The survey was funded by a grant from the Moriah Fund. Survey questions were developed in consultation with medical research experts from the University of Washington and the University of California, San Francisco. From February 1 until April 6, 2018, SWAN distributed the online survey via internet snowball survey methods utilizing Survey Monkey software.

At the end of the survey period 799 military women had participated in the survey. The survey asked a common set of demographic questions and then a logic tree sorted respondents by their service status. Because medical care is different depending on service status the survey was designed to sort military women into four categories; active duty, reserve and guard, veteran, and retired. After demographic data was collected and respondents were sorted by service status they were all asked a similar set of questions. However, response options were tailored to reflect the health care options available to each group of respondents. For example, active duty service women generally receive their care from the Department of Defense at military treatment facilities (MTF) while veterans go to Department of Veteran Health Administration (VHA) clinics and hospitals or to civilian providers.

All respondents were asked questions about where they receive their reproductive health care services; if they are able to access their preferred method of birth control; if they have ever had an unintended pregnancy; and, if they have ever had trouble conceiving while actively trying to get pregnant. Depending on how they answered each question they were asked additional questions or were logically routed to the next section of questions. For example, women who answered affirmatively to questions about unintended pregnancy and problems with conception were asked a set of additional questions to determine where they received their care, the quality and the cost of the care.



Lt. Tasha Gallegos talks to a patient about contraceptive care. (Photo by Jason Bortz)

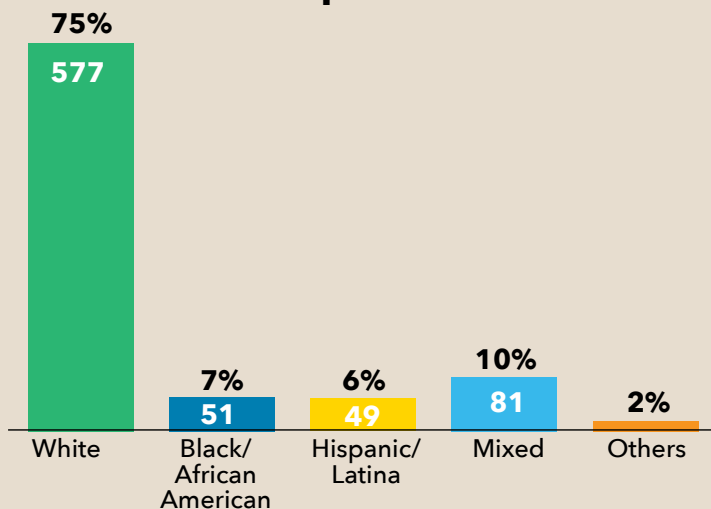
DEMOGRAPHIC DATA OVERVIEW

According to 2018 DoD data there were 216,650 Active Duty service women; 170,070 Reserve and National Guard service women; and over 2 million women veterans. Minority women make up a significantly larger portion of the military and veteran women population than in the general population.⁴ In the Army, minority women comprise 66% of enlisted women and 43% of women officers. The demographic data from the SWAN survey reveals that it is not fully representative of military women and is skewed toward the experiences of white officers. Despite the skewed sample there are some important and consistent findings.

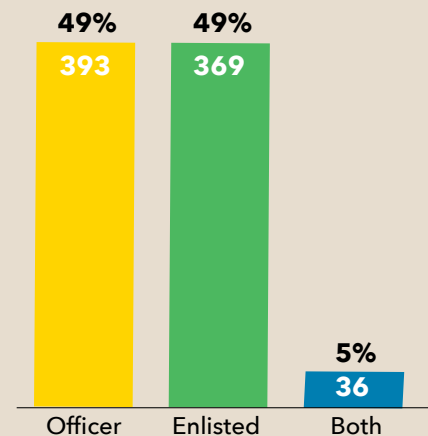
DEMOGRAPHIC DATA

Average Age: 41.33 ± 11.67 N: 795

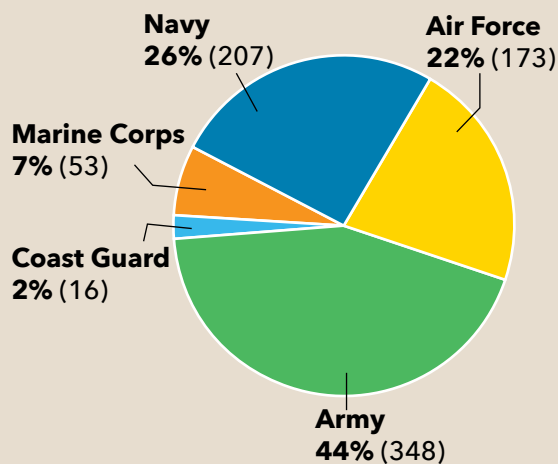
Racial Group Breakdown



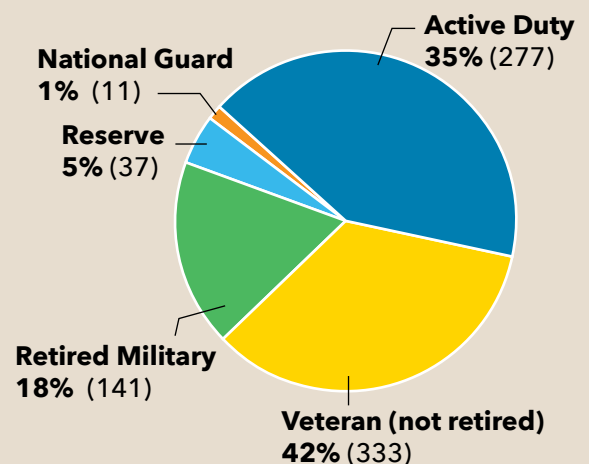
Officer/Enlisted Demographics



Service Branch



Current Service Status



⁴Department of Defense, Defense Manpower Data Center, unpublished data current as of February 28, 2018.

ACTIVE DUTY DATA AND FINDINGS

Providers: Of the respondents, 35% (262) Active Duty service women who completed this section of the survey, 88% (232) said they receive their reproductive care at a MTF while 10% (27) see a civilian provider off base and 1% said they did not receive any reproductive care. In response to the question “Do you receive information or education from your health care provider on your contraceptive options?” 66% (174) said yes, 20% (52) said no, and 14% (37) said they do not use contraceptives.

Access to contraception: In response to questions about whether they are able to receive their preferred method of birth control 97% (252) said “yes,” they are able to access their preferred method of birth control or that they chose not to use birth control. Only 3% (8) of respondents said they were not able to access their preferred method of birth control. However, of those who had been deployed, 26% (43) said “no,” they were not able to access their preferred method of birth control during deployment. The primary reasons cited for not being able to access birth control during deployment were: 1) prescription limitations that did not cover the full deployment; 2) medication storage that required refrigeration; 3) failure to stock preferred method; and 4) providers who wouldn’t prescribe birth control during deployment due to their understanding of General Orders that limit sexual contact during deployment.

Unintended pregnancies: Thirty-six Active Duty women (13%) said they had experienced an unintended pregnancy and 58% (21) of those said that it occurred while they were using birth control. Of the 36 unintended pregnancies 20 said they carried the baby to term, five miscarried, eight terminated the pregnancy and three said they preferred not to answer. Of the eight who terminated their pregnancies, four said they were denied medical advice by military health care providers and four said they did not seek advice from military health care providers. Each service woman paid between \$300-\$600 for abortion services off base and all eight said they received no follow-up care from military health care providers. When asked about their experience accessing this health care, respondents reported that it was a negative experience.

“I found out I was pregnant in the months leading up to my deployment and didn’t feel comfortable telling my doctor or chain of command for fear of retribution. I took a day of liberty after finally talking to my chief about it, he was nice but it was incredibly uncomfortable and later on he told the entire chiefs mess about it. I had to pay out of pocket.”

– Active Duty Navy Enlisted

“No support from the military and I was judged when I attempted to do a follow up appointment. I ended up seeing an off-base provider out of my pocket because on base was rude and judgmental.”

– Active Duty Air Force Enlisted

ACTIVE DUTY DATA AND FINDINGS CONTINUED

Infertility support: Of the respondents, 37% percent (100) said they had trouble getting pregnant when actively trying to do so. When asked where they sought infertility advice and care 60% (59) said they went to military health care providers, 29% (28) went to a civilian provider while 20% (20) said they did not seek services for their infertility. Many respondents first sought care with the military then turned to civilian providers for support.

Respondents said that care was limited in several ways; capacity of the MTF, treatment options, and medical insurance coverage. Only five MTFs offer the full range of infertility options, including IVF, and there are waiting lists at these facilities. In all cases, if the recommended treatment is IVF it is not fully covered by the military's medical insurance (Tricare) and service women pay \$15,000 or more for one round of IVF treatment. Some MTFs offer limited diagnosis and treatment options while others offer none and refer service women to civilian providers.

"Frustrated that infertility treatment is treated as an elective rather than a disease. After waiting months on IVF waitlist and frustrated by lack of communication/ prioritization of AD members, sought second opinion through civilian provider. Both options are cost prohibitive to most."
– Active Duty Air Force Officer

"I need IVF treatment but the military would not provide it and would not refer me to an outside clinic. I had to find my own clinic and pay out of pocket thousands of dollars."
– Active Duty Army Officer

"The folks working in the clinic at Womack Army Community Hospital are awesome...but they're so over-regulated and overwhelmed that they must attempt to force everyone into cycles, they can't accommodate your schedule, and they don't do cutting edge procedures. The clinic I went to in Raleigh was the opposite. We paid over 30K, but we got pregnant with twins on our first try."
– Active Duty Army Officer



Maj. Lena Fabian (left), staff midwife, William Beaumont Army Medical Center, places a wireless monitoring system on Capt. Merry Fontenot. (Photo by Marcy Sanchez)

RESERVE AND NATIONAL GUARD DATA AND FINDINGS

Providers: Reserve and National Guard members comprised 6% (48) of total survey respondents. More than half (25), reported that they receive reproductive health care services primarily from a civilian provider, while 21% (10) receive care from a MTF and 21% (10) from the VHA. In response to the question, “Do you receive information or education from your health care provider on your contraceptive options?” 68% (32) said yes, 19% (9) said no, and 12% (6) said they do not use contraceptives.

Access to contraception: In response to questions about whether they are able to access their preferred method of birth control 86% (30) of those who use birth control said “yes.” The five women who are not able to access their preferred method of contraception said they could not access them due to cost, prescription time limits, and difficulty accessing specific brands. For example, one reported that the MTF does not regularly stock her medication and the requisite prior authorization takes an extensive amount of time. Of the 30 respondents who had sought access to their preferred method during deployment 70% (21) were able to do so while 30% (9) were unable to do so. An additional nine respondents did not use contraception during deployment. Reasons for being unable to access preferred methods during deployment are similar to those reported by Active Duty service women and include prescription refill limits and a lack of refrigeration access. There were no significant differences in access across services.

“I was only allotted to receive so many refills in advance before deploying. I had to have a family member schedule prescription refills and then pick up and ship them to me. Which often could take well over a month to receive. The catch was that a refill also could not be ordered too early in advance. At the time I was only using the contraception for regulating and minimizing symptoms and generally just to skip out on my cycle all together. You can imagine being one of the only females on a small base with no access to purchasing feminine products, with the exception of jumping in a convoy once a month to another base to buy necessities. Thankfully, my mother was able to ship me plenty of supplies...”

– Army Reserve Officer

Unintended pregnancies: Of Reserve or Guard service women, 15% (7) experienced an unintended pregnancy during military service. Two of those were using contraception at the time and five were not. Three of the women carried the pregnancy to term, two terminated, one miscarried, and one preferred not to answer. Neither of the two women who terminated received care from a military provider, although one attempted to do so but was denied treatment. The women paid \$300 and \$600 at civilian clinics and neither received follow-up care from a military health care provider. Of her experience asking an obstetrician at West Point for help, one respondent reports that she was told this “wasn’t a problem they could solve” and that she could either terminate or leave the Academy. She was further instructed not to tell anyone.

“I was scared. I had no one to turn to or talk to. There was no support before or after.”

– Enlisted Army Reservist

RESERVE AND NATIONAL GUARD DATA AND FINDINGS

Infertility support: Of Reserve/Guard respondents, 33% (16) experienced having trouble conceiving when actively trying to do so. Of those, four sought treatment from MTFs only, four from civilian providers only, five from both types of providers, and three did not seek medical services. Women who sought reproductive health services for infertility report facing barriers to treatment at MTFs as well as difficulty getting referrals to or information about civilian treatment options. Several also report that MTFs misdiagnosed conditions, such as endometriosis or thyroid deficiency, that were only resolved once the service member sought treatment from a civilian provider. Tricare and Tricare Reserve provide limited coverage for infertility. Some service women do report positive experiences, with two specifically indicating that Walter Reed's ARC Institute provided adequate care and support.

"I was able to see a civilian provider but had to fight for a referral. And even then, I was expected to come up with out of pocket costs."

– Reserve Army Officer

"Overall positive experiences from military infertility providers, but we were lucky because we were in San Diego (Balboa) and Honolulu (Tripler). However, long wait lists, not enough providers and services, etc."

– Reserve Air Force Officer



Staff Sgt. Alana Pool, 45th Medical Group medical laboratory technician, performs a microscopic examination. (Photo by Phil Sunkel)

VETERAN DATA AND FINDINGS

Providers: Women veterans comprised 42% (321) of survey respondents. They use three primary types of health care providers for their reproductive care: VHA 45% (144), MTF 12% (39) and civilian providers 38% (122). A small percentage (3%) have no health care coverage or no longer seek this type of care due to menopause. About 1% use a combination of VHA, MTF and civilian providers for their care. In response to the question, “Do you receive information or education from your health care provider on your contraceptive options?” 46% (147) said yes, 19% (60) said no, 35% (113) said they do not use contraceptives.

Access to contraception: In response to questions about whether they are able to receive their preferred method of birth control, 52% (166) of respondents said they do not use birth control. Of the women who use birth control, 89% (135) said “yes,” they are able to access their preferred method of birth control while 11% (17) said they were not able to access their preferred method of birth control. However, when asked if they were able to access their preferred method of birth control when they were deployed, 41% of those who had deployed and requested birth control said “no,” they were not able to access their preferred method of birth control. The reasons for not being able to access birth control during deployment were: 1) prescription limitations that did not cover the full deployment; 2) medication storage that required refrigeration; 3) failure to stock preferred method; and 4) providers who wouldn’t prescribe birth control during deployment due to their understanding of General Orders that limit sexual contact during deployment.

Unintended pregnancies: Of the veteran respondents, 31% (102) said they had experienced an unintended pregnancy during military service and 11% (35) said they had an unintended pregnancy after service. 46% (63) carried the pregnancy to term, 37% (50) terminated the pregnancy, 14% (19) miscarried, and five did not provide an answer. Women who terminated their pregnancies were asked if they received care from veteran or military health care providers. Six women said that they had been advised by health care providers, while 18 said they were denied advice and 24 said they did not seek advice from the military or VA providers. The women paid between \$0 and \$600 at military and civilian clinics to terminate their pregnancies. Seven women said the pregnancy was the result of a rape. Some of these women received their abortions through military facilities while others sought care outside of the military.

“Went in for UTI, was brought in and told I had a positive pregnancy test. They had already written me a script for prenatal vitamins as if I had no other choice than to carry forward with the pregnancy. I asked about the abortion pill and they said “no, military medicine does not allow it.” I asked where I could go as an alternative and they had no info. It was horrendous care and I’m a nurse!”

– Navy Officer Veteran

VETERAN DATA AND FINDINGS

"I was shamed and discouraged by my chain of command from terminating the pregnancy, despite the (also enlisted, also in the same squadron) father's statement that he would not be involved with raising the child... I had excessive bleeding after the procedure and was told by the doctors at the base hospital that they couldn't do anything for me because it was the result of a D&C. Many years later I found out I have a bleeding disorder — turns out I'm extremely lucky to have not bled to death."

– Enlisted Air Force Veteran

"It was very difficult to come up with the \$600 when I was an E-1 living in the barracks. It was an entire month pay at the time. I didn't tell anyone but my roommate, my fiancé, my mom, and my first sergeant. I didn't really have any true support. After, I was allowed 24 hours of quarters to rest, but had to be in class the next day. I was bleeding very heavily, hemorrhaging really. I almost passed out in my language class. My MLI (military language instructor) was a Marine gunny, he called an ambulance and rode with me to the hospital. They found a small tear near my cervix and were able to cauterize it. Gunny never left my side. I told him everything that happened and he never judged me or treated me with anything but respect. After getting out of the hospital, and back to class, gunny took me out and did one-on-one tutoring to catch me up on what I had missed. The military providers at the clinic there at DLI were quite judgmental. They refused to give me a temporary profile for PT, or give me anything for the extreme pain I was in. The attitude was basically, you made this choice, you deal with it. I asked for an IUD but was told they only offered pills. I was only 18 and didn't even think to go to an off-base provider like PP to help me. Overall, it was a nightmare, but gunny was the only person who supported and helped me, and never made me feel like I was a terrible person for choosing my career over premature motherhood."

– Enlisted Air Force Veteran



Phoenix Recruiting Battalion mass oath of enlistment during half-time of the Phoenix Mercury and Las Vegas Aces Women's National Basketball Association match. (Photo by Alun Thomas)

VETERAN DATA AND FINDINGS

Infertility support: Of women veterans, 33% (108) report having trouble conceiving when actively trying to do so, either while in the military or after serving. Of those, 29% (31) sought treatment from military health care providers, 23% (25) from VHA providers and 44% (48) from civilian providers while 32% did not seek medical services. Some women received care from military or VHA and civilian providers. Women who sought reproductive health care services for infertility report facing barriers to treatment at VHA facilities. Some women report receiving some testing and services while other say they are completely denied care unless they can demonstrate that their infertility is service connected. However, many women don't know the source of their infertility which may in fact be service connected but not diagnosed as such while they were on active duty.

"I applied to the VA for services and was initially denied because I am not legally wed to a male. I appealed and received approval for IUI but not IVF. My infertility is service connected and will likely require IVF but the VA and Congress do not care because I don't have a male spouse."

– Army Officer Veteran



Army Veteran Senator Tammy Duckworth holds her daughter, conceived through IVF.
(Photo credit: Senator Duckworth's Twitter page)

RETIREE DATA AND FINDINGS

Providers: Retirees represent 18% (141) of total survey respondents. Of the 133 who answered the question, “Do you receive information or education from your primary reproductive health care provider on your contraception options?” Sixty percent (80) answered that they do not use contraception. Twenty-nine percent (39) do receive information from their primary provider about contraception while 11% (14) do not.

Access to contraception: Twenty-nine percent of retirees (38) are currently able to access their preferred methods of contraception while 5% (6) are not able to do so. The remaining 66% (87) report that they do not use contraception. The reasons for difficulty with current access mainly involve the preferred method, such as diaphragms being discontinued by providers. During past deployments, 68% (39) never had problems with access to contraception while 34% (20) did. The rest either did not need contraception during deployment or had never deployed. Experiences during deployment were mixed; some retirees were able to bring enough birth control pills for the duration of the deployment, while others were limited by prescription time constraints, even when birth control pills were necessary to manage medical conditions such as endometriosis. Retirees also echo the other categories of respondents and report that military providers’ unwillingness to discuss contraception and the need for refrigeration for the Nuva Ring were prohibitive.

Unintended pregnancies: Thirty-five percent (50) retirees reported experiencing an unintended pregnancy with 43 (32%) experiencing one during military service and 5% (7) after military service. Of the 50 retirees who experienced an unintended pregnancy, 20 were using contraception at the time. When asked about the outcome, 42% (21) said that they terminated, 38% (19) carried to term, 18% (9) miscarried, and 2% (1) did not answer. Just 21 of these service women answered the question, “Did military or VA health care providers advise you on abortion services?” Of those who answered, three reported receiving advice or care from military health care providers in connection with an unintended pregnancy, while one received assistance from VHA providers, and seven attempted to receive care from military or VHA providers and were denied. The remaining ten who answered this question did not attempt to receive care from military or VHA providers.

Those who reported terminating a pregnancy did so between 1976 and 1999 and paid varying amounts, ranging from \$200 to \$900. Two received cost-free abortions in Germany. Two retirees report that their abortions in the 1970s were covered by military health care at that time, although most retirees who shared their experiences had to pay for this procedure themselves. One reported receiving follow-up care from a military provider, while six did not, and 14 did not inform military or VA providers about the abortion.

“I was a diesel mechanic so it was only guys in my shop, so telling my supervisor was embarrassing. It was embarrassing to get permission to take leave to get an abortion, too....I asked [my boyfriend] to help me with the money to get one and he would not until I involved his First Sergeant.”

– Retired Army NCO

RETIREE DATA AND FINDINGS

"I was on isolated duty and had to go off-island for medical care.... I caught a military hop from my duty station (in a foreign country) to an American Territory, I had to pay for my own housing while there. There was an abortion clinic with no overnight care. I was the only English-speaking woman (patient) there. Immediately after the procedure I was released and flew back to my duty station the following day. I did not get any extra medical or other leave, there was no counseling available, and no follow-up care."

– Retired Naval Officer

"I was diagnosed as pregnant by a military health care provider who simultaneously told me that I had a large ovarian tumor that needed to be surgically removed. He said that they would do the surgery while I was pregnant but that they couldn't predict the outcome for the fetus. I had to find a reputable German clinic to get an abortion and then return to the military hospital for surgery. I was young and I didn't speak German."

– Retired Army Officer

Infertility support: Of the 134 retirees who answered questions regarding infertility, 31% (41) had experienced difficulty conceiving and 69% (93) had not. Of those who did struggle to get pregnant, 59% (24) sought assistance from a military provider, 15% (6) from civilian providers, one (2%) from the VA, 2% (1) from both military and civilian providers, and 17% (7) did not seek services.

Some retirees described positive experiences receiving infertility support from military health care providers and having testing, procedures, and referrals covered or partially covered by Tricare. Two specifically reported that Walter Reed Medical Center provided good quality care. One woman said that she was "shocked that even between 1987-1990 every possible test and treatment was provided [at Walter Reed]."

While six service women described positive experiences, twice that number had negative experiences seeking infertility treatment. Limited facilities and long wait times are a recurring theme in barriers to infertility treatment. The wait time between appointments is particularly prohibitive as infertility treatments need to follow a set schedule in order to progress towards a successful outcome. Further, patients experienced a lack of consistency in providers and were uncomfortable having to discuss their situations with a new doctor at each appointment. Some service women also felt brushed off or spoken down to by military medical providers, and others had to contend with an unsupportive chain of command.

"It was very limited, expensive, and prohibitive to getting reasonable care."

– Retired Army Officer

Of particular note is an Army aviation retiree whose exposure to Methyl Ethyl Ketone (MEK) caused her to be infertile at the age of 21. MEK is a liquid solvent used for cleaning or stripping of plane parts. The Centers for Disease Control lists harm to the reproductive system as a possible long-term effect of MEK exposure. This retiree reports that her exposure caused the total loss of her ovaries at age 21 and, though her uterus remained intact, the military refused to provide IVF or other infertility care.

"Due to exposure to MEK my reproductive possibility was removed...literally."

– Retired Army Officer, formerly enlisted

ADDITIONAL FINDINGS

Officer vs Enlisted Findings

When the data is disaggregated by rank a clear difference emerged in the experiences of women officers and enlisted women. Enlisted women are twice as likely to report not receiving information about reproductive options and not having access to their preferred method of birth control. Given this information, it is not surprising that they are also twice as likely to report an unintended pregnancy than women officers. If this survey population had been more fully representative of the population of military women where enlisted women comprise 80% of the demographic group it is possible that other findings might have emerged; with the percent of unintended pregnancies and abortions being much higher.



Boatswain's Mate 2nd Class Mercedes Logan holds her son during a homecoming celebration for the Arleigh Burke-class guided missile destroyer USS Howard (DDG 83) at Naval Base San Diego. (Photo by Petty Officer 3rd Class Reymundo Villegas)

Mental Wellness Impacts

Mental wellness needs related to assaults and access to abortion surfaced in many of the comments. In total, ten women said that their unintended pregnancy was the result of a rape. One woman said that she was raped at the MEPS station hotel when she was just 17. She said she didn't know who to report it to and blamed herself. Eventually, she went on to retire from the Army but says that today she receives treatment for post-traumatic stress for the rape that occurred over 30 years ago.

In addition to the obvious mental wellness needs associated with those who were raped or sexually assaulted, women who chose to terminate their pregnancies said that they often experienced feelings of guilt and were shamed by military leaders and health care providers. One woman said that the stigma associated with abortion was far worse than the abortion itself. Many women wrote about keeping their assaults and abortions secret for many years. Some women want to speak out about the silence around abortions and the need for military providers to provide at least referral services even if they can't provide the care itself.

POLICY RECOMMENDATIONS

1. Conduct additional research. This study identifies gaps in knowledge and understanding relative to military women's reproductive care. The following questions must be answered:

Why do enlisted women experience higher rates of unintended pregnancies than women officers?

What percentage of military women receive abortions and what impact does this have on military readiness?

Why do military women experience higher rates of infertility than their civilian counterparts?

Which military Services provide the best and worst reproductive health care and what causes the difference in care?

2. Military women, regardless of their status or duty station should receive information about affordable abortion services and they should receive post-abortion care. Abortion is part of women's reproductive health care. No woman should be denied information or access to medical care nor should she be required to disclose her medical condition to her superior in order to access care.

3. Provide military women the full range of infertility treatment at no cost. The high rates of infertility in military women is likely linked to military service. Denying military women access to the full range of infertility treatment denies them access to service connected medically necessary care.



Vietnam Women Veterans salute during a retreat ceremony at the U.S. Army Combined Arms Support Command 1st Logistical Command Memorial at Fort Lee, Virginia. (Photo by Dani Johnson)

SUMMARY AND CONCLUSION

The good news is that 95% of active duty women report having access to their preferred method of birth control. However, women officers have greater access than enlisted women. When women leave active duty access to their preferred methods of birth control declines significantly. Furthermore, for service women from all eras who have deployed to remote locations or on board ships access is significantly degraded. However, access appears to be steadily improving over time with 74% of currently serving women saying that they have access to their preferred method of birth control during deployments.

	ACTIVE DUTY	RESERVE & GUARD	VETERAN	MILITARY RETIRED
I receive contraception education from my provider.	77% (174)	78% (32)	70% (147)	74% (39)
I have access to my preferred BC.	95% (164)	86% (30)	89% (135)	86% (38)
I had access to my preferred BC while deployed.	74% (123)	70% (21)	59% (84)	66% (39)
I had an unintended pregnancy during military service.	13% (36)	15% (7)	31% (102)	32% (43)
I had an unintended pregnancy after military service.	N/A	N/A	11% (35)	5% (7)
I was using contraception when I had my unintended pregnancy.	58% (21)	29% (2)	46% (62)	41% (20)
I terminated my unintended pregnancy.	22% (8)	29% (2)	37% (50)	42% (21)
I had trouble getting pregnant when actively trying to get pregnant.	37% (100)	33% (16)	33% (108)	31% (41)
I sought assistance from a military, VHA or civilian provider to get pregnant.	80% (80)	81% (13)	70% (76)	83% (34)
N=total respondents by status	35% (277)	5% (48)	42% (333)	18% (141)
<i>Note 1: BC=birth control</i> <i>Note 2: Data is based on whether a woman was seeking a particular type of care. For example, many women reported that they are not using birth control so they were not counted in the data about contraception education or access to preferred methods of birth control.</i>				

While some of the reduced access during deployments may be unavoidable most of it is easily remedied. The primary reason, and most easily remedied reason, is that the service woman was not prescribed enough birth control to cover the entire deployment and when refills are required they are not available at the deployed location. Some providers will prescribe enough to cover an entire deployment while others will not. A second, easily remedied reason is that some providers continue to deny prescriptions to service women during deployment citing General Orders that prohibit sexual activity during deployment. However, many women are not using birth control to prevent pregnancy during deployments. Most are using it to control or suppress their menstrual cycles or for other health related reasons. Providers should not be allowed to deny service women birth control because of General Orders that govern sexual activity. Finally, the data show a positive trend in access during deployment over time. Older women, both veterans and retirees reported the lowest level of access while currently serving women report the highest level of access.

SUMMARY AND CONCLUSION



Lt.j.g. Megan Lewis, from Pleasant Grove, Utah, assigned to the Blue Crew of the Ohio-class ballistic missile submarine USS Kentucky (SSBN 737), is welcomed home to Naval Base Kitsap-Bangor by her family following the boat's routine strategic deterrent patrol. (Photo by Petty Officer 1st Class Amanda Gray)

The data on unintended pregnancies reveals a significant percentage of unintended pregnancies in military women. In the four groups of military women studied the highest rate occurred among now retired women at 32%. This is not surprising since this group of women represents women who experienced most, or all of their reproductive years, while currently serving women are much younger and may eventually also experience an unintended pregnancy. Unfortunately, the medical options available to military women who have unintended pregnancies are severely restricted. There is only one available option within the existing health care systems and that is to carry to term unless the pregnancy is the result of a rape, incest or the life of the mother is at risk.

Of the 81 women who reported that they had terminated their pregnancies, ten said that their unintended pregnancy was the result of a rape and four of those pregnancies were terminated in military facilities.

The remaining 77 military women terminated their pregnancies with little or no assistance from military or VA health care providers even after they sought assistance from them. The most commonly cited

provider of choice was Planned Parenthood where the women paid between \$300-\$900 for the procedure. Some women reported requiring physical and or mental support after their procedure but said that they were denied care.

Unintended pregnancies are shown to be the lowest in the currently serving groups of service women and highest in the veteran and retiree groups. This data could reflect the age of the respondents with the youngest women in the currently serving categories still in their reproductive years and not having yet had an unintended pregnancy or it could be indicative of better access to reliable birth control. In all categories a significant percentage of the respondents said that they were using birth control when the unintended pregnancy occurred.

The most surprising data revealed in this survey was the percentage of military women who report having trouble getting pregnant when actively trying to do so. In all four categories of military women more than 30% report having problems getting pregnant when actively trying to do so with the highest percentage (37%) coming from currently serving military women. This is dramatically higher than the national average. According to the Centers for Disease Control and Prevention (CDC) approximately 12% of US women have "impaired fecundity" which is defined as difficulty in either getting pregnant after actively trying for one year or being able to carry a pregnancy to live birth.⁵

The CDC cites advanced age as the principal reason for impaired fecundity. Unfortunately for military women who may be delaying having children due to military commitments the treatment options are limited by location, accessibility and cost. Only five military hospitals offer the full range of infertility treatments and even at those hospitals there are long wait lists and service women

⁵National Health Statistics Report. 2013. <https://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf>

SUMMARY AND CONCLUSION

have to pay some of the costs for their own treatment. Military women who are not able to get care at one of the five established treatment facilities must use their Tricare insurance with a civilian provider. However, Tricare limits coverage to a few tests and procedures and completely excludes in vitro fertilization (IVF). Military women report paying approximately \$15,000 for just one round of IVF treatment.

Women veterans are even more limited in their options. In order to get any kind of VHA infertility care a woman veteran must be able to show that her infertility is service connected. If the woman is able to establish service connected infertility she will be referred to a civilian provider for care. Women veterans who don't know the source of their infertility seem to be treated on a random basis depending on the VHA hospital and the provider that they see. Some are totally denied care while others receive limited care.

Finally, military women who are not in a heterosexual marriage seem to receive very mixed infertility care. While it is official policy to provide infertility services regardless of sexual orientation or marital status, our research found that reality does not match policy. Several women reported that they were denied infertility treatments because they were gay or not married.

In follow-up interviews women who reported infertility believe that their infertility is linked to exposure to toxins on the job, during deployments and on military installations where they live. One infertile woman officer who did three deployments to Iraq believes contaminated water, plastic water bottles, and poor air quality due to burn pits and other air pollutants may be to blame. Another woman says that as a fuel handler she was exposed to many toxins that may have caused her infertility. One woman reported that ill-fitting equipment in the form of oversized body armor that she wore for extended periods in Iraq caused abdominal hernias that have been medically linked to her inability to carry a baby to term. This data clearly cries out for more research by the military but in the interim military women whose infertility is likely linked to military service should be afforded access to all available infertility diagnosis and treatments at no cost.

Military women deserve access to the full range of reproductive health care services to ensure mission-readiness, optimize their own health and well-being and that of their families, enable career advancement, and to decide if, when, and how to start a family.



Soldiers wear the new Army uniform "Pink & Green" prototypes, including the officer's maternity uniform worn with pants. (Photo credit: US Army)

THANK YOU

SWAN thanks the **Moriah Fund** for their long-standing support to advancing women's rights and women's reproductive health.

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