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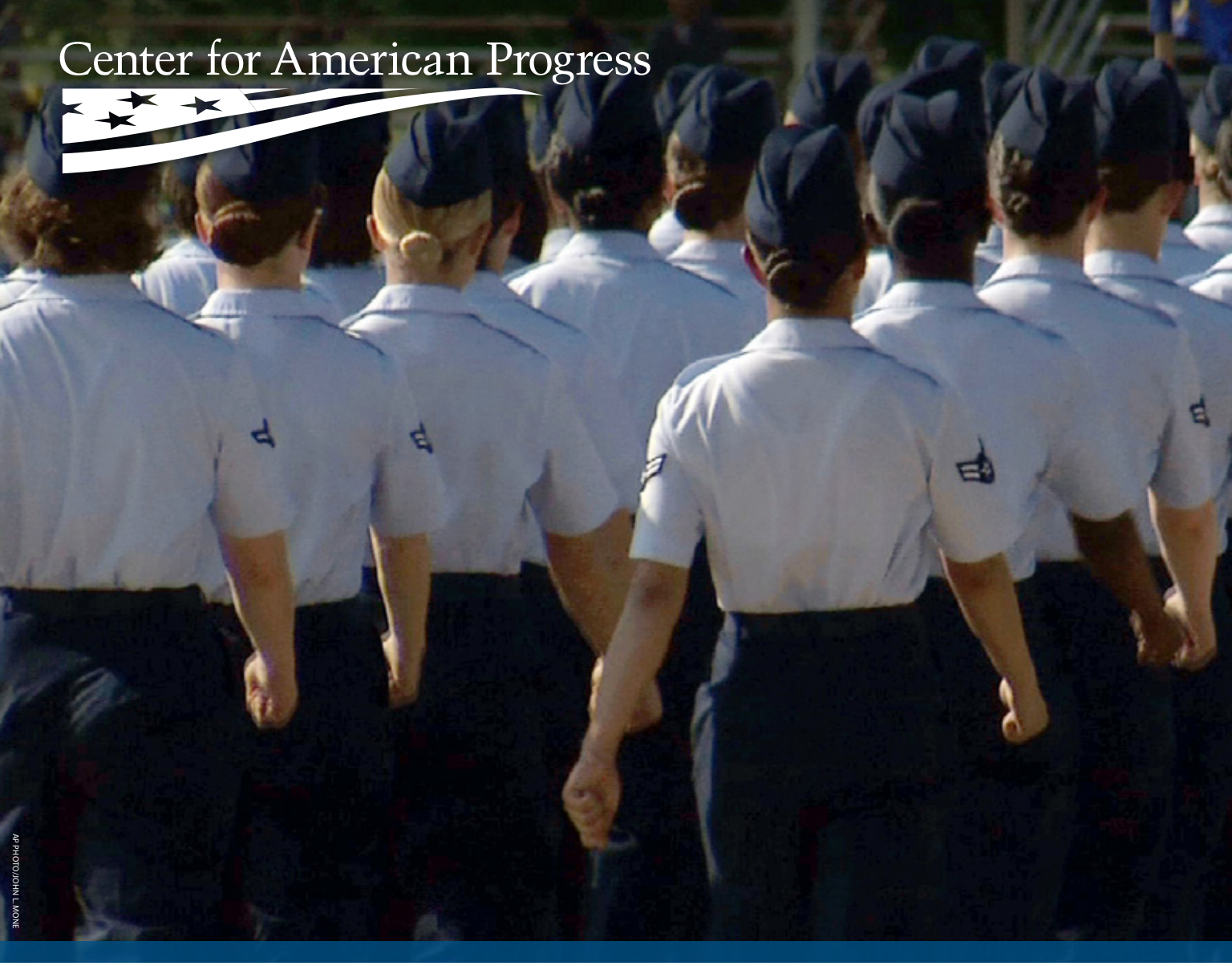

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Out of Range

Obstacles to Reproductive and Sexual Health Care in the Military

By Jessica Arons, Lindsay Rosenthal, and Donna Barry July 2014

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Introduction and summary

Women's presence and roles in the military have greatly increased over the past few decades, and the issue of sexual assault continues to be widely covered in the news. One area that receives little attention, however, is how the military falls far short of its obligations when it comes to providing servicewomen with adequate reproductive and sexual health care. The fact is, women in the armed forces fight and die to defend rights they themselves do not completely possess, and they lack access to health services that civilian women routinely use.

Not only is this an injustice to individual servicewomen, but it also impedes the military as a whole. The failure of the nation's civilian and military leaders to provide comprehensive sexual and reproductive health care undermines military readiness, unit cohesion, and equality in the ranks. For instance, when deployed soldiers cannot prevent or plan their pregnancies, they must interrupt their tours of duty, which can affect their mission. When they are not able to obtain appropriate and timely gynecological care, they may become ill and unfit to serve. Because they are required to seek permission from commanders to leave their units to access abortion care, they may postpone obtaining that care or even turn to clandestine means, both of which increase their health risks. And when they are denied benefits and opportunities afforded to their male counterparts, their status as second-class citizens in what remains a traditionally male culture is reinforced.

This report begins with a brief overview of women's participation in the armed forces, as well as the range of military health benefits available to female members of the military and female veterans. It then discusses the barriers that often inhibit women in the armed forces from getting the care they need, as well as the impact these hurdles have on the success of the U.S. military.

Finally, the report addresses recommendations for policymakers. These suggestions include, but are not limited to, steps geared toward curbing sexual assault rates, increasing access to contraceptives, and lifting bans on abortion care.

The policies and practices that the military must follow related to sexual and reproductive health care are not only unfair and unjust, but they are also costly, inefficient, and counterproductive. At a time when the United States is winding down from two wars, the size of the military is contracting, and the economy is still recovering from a significant recession, the country can ill afford to squander the talent, skills, and commitment of dedicated female soldiers by neglecting their health and well-being. Women have become an integral part of the armed forces, and they should have access to all the health care services that they need.

Women's participation in the armed forces

The United States has a long tradition of women serving in the armed forces. Women were contracted in supportive roles such as laundresses, cooks, seamstresses, and volunteer nurses as early as the Revolutionary War, but their service was not officially recognized until 1901 and 1908, when the Army and Navy Nurse Corps were respectively established.[1] During the Civil War, Dr. Mary Edwards Walker was awarded the nation's highest military award, the Congressional Medal of Honor, for her medical and battlefield service to the Union Army.[2] Although women's roles were limited, the military relied heavily on their service in both world wars: 33,000 women served during World War I, and because of shortages in male personnel, more than 400,000 served in World War II.[3]

Unfortunately, the political system also has a long tradition of stifling the careers of servicewomen by instituting discriminatory policies that prohibit them from reaching their full potential. It was not until 1948, with the Women's Armed Services Integration Act, that Congress sought to formally integrate women into the Army, Navy, Air Force, Marine Corps, and Coast Guard. But the statute limited women's service by capping the number of women allowed to serve at 2 percent of the active force and the number of servicewomen who could be promoted to serve as officers at 10 percent.[4] It also designated the highest permanent rank they could achieve as lieutenant colonel.[5] The 2 percent cap on women in the military and the restrictions on their promotion were lifted in 1967, largely because the military was struggling to recruit enough qualified personnel to serve in the Vietnam War.[6] But even after the policy was lifted, women were kept out of combat roles purely on the basis of their sex, not their physical ability.[7]

In the decades after the Vietnam War and the creation of the all-volunteer forces, the nature of warfare changed dramatically—and so did the role of women in the military. Modern wars recognize no front line of battle, a fact that made it increasingly difficult to keep women out of higher-risk assignments. As a result, while women were still banned from direct-ground-combat roles, they were slowly introduced into an increasing number of combat positions, including assignments on combat aircraft and ships—except submarines.[8]

In 1994, the Department of Defense, or DOD, issued the direct-ground-combat exclusion policy, which allowed all service members to be assigned to any position for which they were qualified but prohibited servicewomen from being assigned combat roles in units that had the primary purpose of engaging in direct-ground combat.[9] The policy, which remained in place until January 2013, essentially drew "a distinction without a difference"[10] by allowing women to be attached in supportive roles to units engaged in ground combat without being officially recognized as combat troops.[11] The result is that women who have served in the Army and Marines in conflicts over the past few decades have done so largely in the same capacities as men and have taken the same risk with their lives. For example, in Iraq and Afghanistan, women were allowed to serve as members of female engagement teams, as explosive ordnance disposal technicians, and as drivers in convoys. Yet because they were not recognized as official combat troops, they did not receive the same training and were denied formal recognition for their service and sacrifice.[12]

More than 11 percent of combat veterans in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn were women.[13] More than 150 women have died in service to their country in the Afghanistan and Iraq wars alone,[14] and thousands more have suffered physical and mental wounds. But because of the ground-combat-exclusion policy, servicewomen were restricted from accessing combat-related services such as comprehensive health care overseas and the enhanced benefit package granted to combat veterans when they return home. Moreover, denying formal recognition for ground-combat experience has prohibited women from climbing the ranks and advancing in their military careers in the Army and Marine Corps. Combat experience is seen as a prerequisite to professional advancement in the military, and the combat-exclusion policy has been a key factor in perpetuating the so-called brass ceiling. To date, there have only been three female four-star generals.[15] A woman has never served as a member of the Joint Chiefs of Staff of the armed forces.[16]

In 2010, the chairman of the Joint Chiefs of Staff announced that the Pentagon was dropping the ban on women serving on submarines. In January 2013, then-Defense Secretary Leon Panetta made the historic decision to lift the ground-combat-exclusion policy, stating, "Over more than a decade of war, [women] have demonstrated courage and skill and patriotism. … [Men and women] are fighting and they're dying together. And the time has come for our policies to recognize that reality."[17] Approximately 237,000 positions previously closed to servicewomen will be open to them by 2016.[18] Without opening up these—and more—opportunities for women in the armed forces, the United States would not be able to maintain a high-quality force on a volunteer basis. In 2013, the

service branches released their implementation plans to integrate women into combat positions across the branches, and this policy should pave the way for women to gain the recognition, benefits, and career advancement they deserve for their commitment to protecting the country.[19]

DOD's decision to reverse the ground-combat-exclusion policy is seen largely as a recognition of the valor that women have demonstrated in recent conflicts: More than 255,000 women have been deployed to Iraq and Afghanistan since 2001, in roles ranging from captain to sergeant to colonel, and many have been decorated for their service.[20] As of May 2012, women veterans of Iraq and Afghanistan had received more than 400 valor awards, including two silver stars, which is the nation's third-highest award for valor.[21]

The policy reversal is also an acknowledgment that women represent an increasingly large and critical segment of the U.S. armed forces. As physicians serving in the Navy wrote, "With the Global War on Terrorism, operational forces continue to be stretched thin. The role and contribution of servicewomen remain paramount to the success of the endeavor."[22] According to DOD, in 1990 and 1991:

> *More than 26,000 women served in Operations Desert Shield and Desert Storm, according to the U.S. Army Center for Military History. Women accounted for 17 percent of Army reservists in Saudi Arabia at the height of the conflict. All told, women represented more than 8.6 percent of the Army's deployed force, and Desert Storm would be the largest deployment of military women in U.S. history.*[23]

Women currently make up 16 percent of the armed forces, and that percentage is only expected to grow.[24]

Today's servicewomen are also increasingly diverse. As journalist Michelle Chen noted in 2008, "Proportionally, people of color comprise a greater share of female veterans than of male veterans."[25] Of the approximately 200,000 active-duty military women that year, roughly half were women of color.[26] Of the more than 1.7 million women veterans nationwide, approximately 72 percent were white, 19 percent were black, 7 percent were Latina, and about 2 percent were Asian American, Pacific Islander, American Indian, or biracial or multiracial.[27]

Perhaps more importantly, 97 percent of women serving in the armed forces today are of reproductive age.[28] This report turns next to an overview of health care benefits for these women and then examines the obstacles many face in accessing the care they deserve.

Military health care benefits

All service members are entitled to health care provided by the military. Active-duty service members, National Guard and Reserve members, retirees, and their families are all eligible to receive health care through a military insurance program called Tricare.[29] Depending on the beneficiary's level of coverage, Tricare may also provide varying degrees of dental, vision, and prescription coverage. Tricare covers inpatient and outpatient care that is "medically necessary and considered proven"[30] to 9.6 million beneficiaries around the world.[31] These beneficiaries include more than 200,000 active-duty servicewomen, as well as female military spouses and all female dependents living on military bases.[32] Approximately 4 million women and girls are enrolled in Tricare or some other form of military health care, and of those, roughly 1.1 million are of reproductive age.[33]

Tricare for active-duty members is divided into Tricare Prime, the health maintenance organization, or HMO, version of the plan, into which active-duty service members and their families are automatically enrolled; Tricare Standard; and Tricare Extra. The latter two are plans similar to preferred provider organizations, or PPOs, with annual fees and broader coverage.[34] If a service member remains in active duty for at least 20 years, he or she can retain Tricare coverage after retiring. Tricare for Life is a Medicare supplement that covers veterans ages 65 and older who served in active duty or in the Reserves for at least 20 years, as well as their Medicare-eligible dependents.[35]

As the number of women in the military has increased, the military health system has made efforts to adapt to its patients' changing demographics. Tricare covers a range of basic health care for women, including annual mammograms for women over age 40; diagnostic services and therapies for infertility; and prenatal, maternity, and postpartum care.[36] However, there are still inconsistencies in coverage between men and women. For example, while Tricare offers comprehensive coverage for erectile dysfunction, it does not provide coverage for the evaluation and management of female sexual dysfunction.[37]

Tricare covers a range of contraceptives, including diaphragms; intrauterine devices, or IUDs; multiple types of oral contraceptives; and surgical sterilization.[38] The Tricare site also lists the PREVEN Emergency Contraceptive Kit as a covered contraceptive benefit,[39] even though it was discontinued on the market in 2004.[40] For more information on emergency contraception, see the section that starts on page 15. However, Tricare benefits are not on par with contraceptive-coverage benefits in private insurance plans under the Affordable Care Act, as service-women must provide co-payments for prescriptions.

Unfortunately, as with other federal government health insurance programs, Tricare restricts the coverage of abortion. As discussed in more detail below, federal law prohibits Tricare from covering abortion except when the woman's life is at risk or the pregnancy results from rape or incest.[41] Abortions cannot be performed in military facilities except under those same limited circumstances, even if a woman is willing and able to pay for her abortion out of pocket.

Veterans' health

The Department of Veterans Affairs building in Washington, D.C., prominently displays a quotation from former President Abraham Lincoln that encompasses the department's purpose: "To care for him who shall have borne the battle and for his widow, and his orphan."[42] Indeed, the very mission of the Department of Veterans Affairs, or VA, is to serve and honor America's veterans.[43]

Just as the number of women in the armed forces has increased, so too has the number of women veterans. But while policy efforts have begun to focus on the unique needs of female veterans, in many ways the inequities faced by women during their service continue when it is completed. Many veterans obtain health care through the VA's health system, but female veterans face some limits: While the VA covers birth control and sterilization, gynecological and maternity care, and other gender-specific services,[44] for instance, it does not provide coverage for abortions or abortion counseling under any circumstances.[45]

A veteran's spouse, widow or widower, or child who is not eligible for Tricare may receive health care coverage through the military health program called the Civilian Health and Medical Program of the Department of Veterans Affairs, or CHAMPVA. CHAMPVA only covers health care services and supplies that are "medically and psychologically necessary."[46] This coverage includes childbirth, family planning, and maternity care,[47] and IUDs, diaphragms, birth control pills, and sterilization are permissible methods of family planning under CHAMPVA.[48] Most prenatal, delivery, and postnatal care, including pregnancy-related health complications, is also covered under CHAMPVA. However, CHAMPVA excludes coverage for abortions and abortion counseling, except when a physician certifies that the life of the woman would be endangered if the fetus were carried to term.[49] Unlike Tricare, CHAMPVA does not yet include an exception for abortion coverage in cases of rape or incest.[50]

The influx of women into military service over the past several decades has placed new demands on VA medical staff accustomed to serving the medical needs of a predominantly male population of veterans. Many medical practitioners have expressed frustration at the lack of training they receive regarding women's health.[51] The VA is making attempts to remedy the situation by bringing in hundreds of medical professionals to meet the demand for female health care and by investing more than $1.3 billion since 2008 to address the problem.[52]

However, a recent Associated Press report shows that the VA continues to fail its female veterans.[53] The report reveals that almost 25 percent of all VA hospitals do not employ a full-time gynecologist. In addition, around 15 percent of community-based clinics do not have a women's health provider at all. More than half of all female veterans referred to nearby medical facilities do not receive timely results from their mammograms. Female veterans are placed on the VA's Electronic Wait List for patients who cannot get an appointment within 90 days more frequently than are their male counterparts. Finally, according to a 2013 VA presentation, female veterans of childbearing age are more likely to be prescribed medications that can cause birth defects than women using a private HMO.[54]

That being said, perhaps the most appalling story to come from veterans is the rates of sexual assault within VA hospitals themselves: The VA police received nearly 300 reports of sexual assault incidents from January 2007 to July 2010, predominantly against women.[55]

The United States must honor its commitment to address all of the health needs of those who serve the country, including providing the full range of reproductive and sexual health services in an environment of safety, privacy, and respect.

Barriers to accessing health care

Servicewomen and servicemen require appropriate health care in order to live healthy and productive lives and serve the country effectively. Yet female troops encounter significant obstacles to comprehensive health care, especially when serving overseas. These range from inconsistent gynecological care to inadequate access to family-planning methods to serious invasions of privacy. The military has a history of regulating sexual activity, from prohibiting specific sexual relationships to enforcing a now-invalidated criminal penalty for becoming pregnant during active duty.[56]

Lack of access to reproductive health care for female service members is due in part to the fact that the military presumes that its members are not engaging in sexual activity. However, given the rates of both sexual violence and consensual sexual activity, this is clearly an outdated presumption—one that must change if service members are to get the care they need.

Sexual health

Before troops are deployed to a combat zone or on an operational mission, the military attempts to ensure that their medical, financial, and personal affairs are in order. The predeployment health assessment verifies that service members will not need routine health maintenance when they are overseas because such care may not be readily available.[57] However, a 2005–2006 study published in 2009 on female soldiers' predeployment health care screenings found that while more than half of deployed soldiers received an annual gynecological exam within three months of deployment, many women did not receive timely screenings.[58] Ten percent did not receive an annual gynecological exam—with a cervical cancer screening, among other tests—in the 12 months prior to their deployment, and more than 16 percent were not screened within six months of their deployment.[59]

Reproductive and sexual health issues that are not addressed before deployment will eventually require attention. The same study referenced above found that 16 percent of patients required additional cytologic screening tests—Pap smears and colposcopies, for example—after deployment.[60] However, accessing medical care—especially reproductive or sexual health care—is especially difficult when in the field. More than one in three women deployed in Operation Iraqi Freedom had at least one gynecological problem such as vaginal discharge, which can indicate a sexually transmitted infection, during her deployment, and 15 percent of those women were unable to obtain the medical care they needed.[61] Similarly, in a survey of 251 servicewomen in Iraq, 23 of the 52 who reported gynecological problems said they did not have access to appropriate care.[62]

Even when servicewomen are ultimately able to obtain reproductive or sexual health care, too often it is not easily available. Military treatment centers frequently lack the capacity to provide comprehensive health services for women, forcing many women to leave the base—only after obtaining permission from their commanding officers—to find the care they need. In fact, nearly 40 percent of women who needed gynecological care while deployed in Iraq had to use either a ground convoy or an aircraft—11 percent and 28 percent, respectively—in order to obtain it.[63] Given that a large number of casualties occur during ground convoys, requiring women to go off base to receive necessary care puts them at additional risk.

Regardless of deployment status, servicewomen's sexual health appears to be markedly worse than that of civilian women when it comes to sexually transmitted infections, or STIs, though comparisons with civilian populations with similar ethnic and age breakdowns have not been completed on a large scale. According to a 2012 literature review, the STI rates of military women are seven times higher than those of their civilian counterparts.[64] The researchers attributed the increased rates to inconsistent condom use, multiple sexual partners, and binge drinking. In another study, only one-third of active-duty unmarried women used a condom during their most recent sexual encounter, and almost two-thirds had more than one sexual partner in the prior year.[65] In particular, servicewomen were reluctant to ask for or use condoms because they feared being labeled as promiscuous or because they worried that if the condoms were found, they could be used as evidence that the women violated restrictions on sexual activity during deployment.[66] Given the young age of female military recruits and service members and the increasing numbers of Latina and African American women who constitute these groups—and who, due to a variety of socioeconomic reasons, generally have the highest rates of STIs among females in the general U.S. population—larger-scale comparison studies need to be undertaken to better understand the high rates of STIs in military populations.

Women who engage in sexual activity with members of the same sex face unique barriers to accessing adequate sexual and reproductive health care within the armed forces. Studies analyzing the effects of the now-repealed "Don't Ask, Don't Tell" law found that under that policy, lesbian, gay, bisexual, and transgender, or LGBT, service members were unlikely to receive common screenings that are especially important for LGBT sexual health because they feared being discharged from the military if they disclosed their need for certain care to a military health care provider.[67] According to an *OutServe Magazine* interview with medical experts in LGBT health, many health care providers, including those in the military, may not be trained to adequately screen for sexual history—for instance, whether a service member has engaged in sexual activity with a partner of the same sex.[68] Accurate screening for sexual history is necessary to determine appropriate types of preventive and follow-up care in order to optimize both sexual and overall health.[69] For example, women who exclusively or primarily have sex with women are less likely than other women to get regular screenings for breast cancer—often due to previous poor experiences with the health care system, as well as fear of discrimination—and are at heightened risk for certain STIs.[70]

While the repeal of "Don't Ask, Don't Tell" may help address some of these concerns for lesbian, gay, and bisexual service members, transgender individuals are still prohibited from serving in the military under current Department of Defense policy.[71] Until this changes, they will continue to face discrimination and will be reluctant to use military health care facilities. A 2009 survey showed that 24 percent of transgender veterans say they were refused treatment at a military health care facility because they are transgender, and—due to a fear of discrimination or maltreatment—43 percent postponed or refrained from seeking medical care when they were sick.[72]

Sexual assault

Given its dismaying prevalence in the military, sexual assault must be addressed when discussing servicewomen's sexual and reproductive health. Sexual violence against servicemen and servicewomen has reached epidemic proportions, again underscoring the need for access to sexual health services overseas. According to DOD official reports, there were 3,374 reported sexual assaults that involved 2,949 active-duty service-member victims in the military in fiscal year 2012.[73] In 2008, "[w]omen serving in the US military [were] more likely to be raped by a fellow soldier than killed by enemy fire in Iraq."[74]

Even worse, experts believe that the number of reported sexual assaults is a significant underrepresentation of actual assault activity, as DOD estimates that only 11 percent of assaults are reported each year.[75] Using that estimate, then, there were actually about 26,000 sexual assaults in the military in 2012, compared with an estimated 19,300 in 2010—an increase of 34 percent in just two years. Indeed, a survey of female veterans who served in the Vietnam War, post-Vietnam, and from 1990 to 2003 revealed that 79 percent experienced incidents of sexual harassment during their service, while 30 percent experienced a rape or attempted rape.[76]

Although the majority of sexual assault victims in the military are men because there are more men serving in the armed forces, the prevalence of sexual assault perpetrated against female service members is more than five times higher than for male service members.[77] Indeed, there was a 1.7 percent increase in the number of reports of unwanted sexual contact committed against female service members in 2012, while the number for male service members remained statistically unchanged.[78]

Military sexual assault has consequences ranging from unintended pregnancy; to post-traumatic stress disorder, or PTSD; to homelessness, depression, and substance abuse among women veterans.[79] Sadly, although sexual assault is a leading cause of PTSD among female veterans, clinicians at the Department of Veterans Affairs are more than seven times less likely to diagnosis a female veteran with PTSD than a male veteran who presents PTSD symptoms as a result of combat trauma.[80] Possible reasons for this discrepancy include a widespread bias against noncombat PTSD diagnoses among VA clinicians and chronic underreporting of sexual assault by victimized servicewomen and female veterans.[81] Even if a servicewoman or female veteran does report a sexual assault, in order to receive disability benefits related to the trauma, she has to be diagnosed with a health problem such as PTSD, submit proof that she was harassed or assaulted, and have a VA examiner confirm a connection between the trauma and the health condition.[82] The Ruth Moore Act[83] would help resolve some of the barriers to care for female veterans by removing an unfair burden of proof that hinders veterans from receiving benefits for care related to military sexual assault.[84]

The lack of adequate gynecological care at military facilities only compounds the trauma and poor health outcomes that can result from sexual assault. For instance, a woman who is reluctant to report a rape and who must obtain permission to seek care off base may decide to forgo care altogether, potentially leading to a host of untreated physical and emotional problems.

Contraception

Contraceptive access on military bases is regulated by military pharmacy formularies. Military treatment facilities, or MTFs, are only required to stock the medications that are listed on the Basic Core Formulary, or BCF—a list that is decided by a DOD committee chaired by the director of Tricare Management Activity.[85] While a variety of oral contraceptive pills are listed on the BCF,[86] several other commonly used contraceptives are not, even though they are covered by Tricare.[87] These include methods with less frequent administration and more consistent use, such as the vaginal contraceptive ring, Depo-Provera, and intrauterine devices.[88] Furthermore, military pharmacies are not required to carry barrier methods such as condoms in the BCF, nor are such methods covered by Tricare.[89]

Contrary to what some may believe—that servicewomen are irresponsible with their birth control or invite pregnancy to avoid deployment assignments—it appears that accessing appropriate contraception is the real obstacle.[90] A systematic review of the literature on contraceptive use among servicewomen did not substantiate the claim that women become pregnant to avoid aspects of military service.[91] Rather, they face a number of challenges to obtaining and using contraception that their civilian counterparts do not.[92]

In fact, the evidence suggests that servicewomen use contraception at higher rates than the general population when they are stationed in the United States, though it is impossible to draw any firm conclusions given that there are not adequate representative data samples across all the military branches. While direct comparisons between civilian and military rates are challenging for a number of reasons,[93] it is estimated that approximately 62 percent of women of reproductive age in the general U.S. population use contraceptives.[94] In contrast, a review of several studies that examined contraceptive use among servicewomen found that overall utilization among women on U.S. bases ranges from 50 percent to 88 percent.[95] Utilization rates decrease during deployment to between 39 percent and 77 percent[96] because of the unique barriers to contraceptive access that arise in that context.[97]

A survey of servicewomen's experiences accessing contraception during deployment found that one-third of servicewomen could not obtain the method of birth control they wanted before deployment for a variety of reasons, including short notice of their deployment.[98] Fifty-nine percent of respondents reported that they

did not speak to a provider about contraceptive options prior to deployment, and 41 percent found that their prescriptions were difficult to refill once they were deployed.[99] In some instances, servicewomen also reported that their health care providers discouraged the use of long-acting methods such as IUDs and sterilization for outdated reasons that included nulliparity, or no prior births, as a contraindication for IUD insertion.[100] Still others reported that they were instructed to get their reproductive health care predeployment from their civilian doctor and then found that either their chosen method of contraception could not be obtained from military providers once deployed, that there were no supplies or no providers available where they were stationed, or that they were pressured by their superior officers to not take time off from their duties to access medical care.[101]

Overseas, the side effects and limited access to ongoing contraceptive care pose challenges to continued contraceptive use. For example, in one study, 50 percent of deployed women said they did not feel comfortable accessing gynecological services from their unit's provider.[102] Correct adherence to birth control methods can also be difficult overseas, and the very conditions of deployment can obstruct proper use of some contraceptive methods. Deployed servicewomen often cross multiple time zones in a short period of time, leading to confusion about when to take oral contraceptives.[103] A study of servicewomen in Iraq revealed that more than half of contraceptive-patch users reported detachment of the patch in hot desert conditions.[104]

Finally, there is a serious education and information gap within the armed forces when it comes to the purpose and appropriate use of contraception. Servicewomen may use contraception for a variety of reasons, including menstrual suppression.[105] But the misconception among some military leaders that birth control is used exclusively for pregnancy prevention, particularly against a backdrop of regulated sexual activity, causes a stigmatization of contraceptive use and services within the military health system, creating a significant barrier to needed health services for women in the military.[106]

Emergency contraception

Given the astounding rates of sexual assault in the military and the difficulties in accessing contraception, it is critical that servicewomen have access to emergency contraception, or EC, to prevent unintended pregnancy after intercourse—both for the women in need and for their military units. Despite this, it has been a long and bumpy road for military women to gain seamless access to EC.

Although the U.S. Food and Drug Administration, or FDA, approved Plan B as a prescription medication in May 1999,[107] it did not appear on DOD's BCF until April 2002.[108] It was then immediately removed from the list by the Bush administration's assistant secretary of defense for health affairs one month later.[109] Nevertheless, the Congressional Research Service reports that in 2005 some MTFs were offering Plan B to sexual assault survivors and other service members who had engaged in unprotected sex, and military physicians also were prescribing the medication for service members to fill at civilian pharmacies.[110]

On August 24, 2006, the FDA approved the sale of Plan B over the counter, or OTC, for people ages 18 and older. In March 2009, a federal judge ruled that the FDA must make Plan B and its generic version, Next Choice, available OTC to people ages 17 and older. Those ages 16 and younger still needed a prescription.[111] However, DOD did not recommend adding Next Choice to the BCF until November 2009, after President Barack Obama had taken office. Only at that point did the agency officially approve the practice of voluntarily stocking EC at MTFs.[112] This recommendation to add Next Choice to the BCF and require that it be stocked at MTFs was finally approved in February 2010.[113]

Because the manufacturer stopped making Next Choice in early 2013 in favor of its one-pill regimen, Next Choice One Dose, the DOD Pharmacy and Therapeutics Committee recommended in May 2013 that Plan B One-Step, the one-pill version of Plan B, be added to the BCF. However, each branch of the armed forces could determine any age limits with which the MTFs would have to comply.[114]

In the meantime, litigation over civilian access to EC was brewing and ultimately resulted in Plan B One-Step being approved by the FDA in June 2013 for full OTC access with no age restrictions.[115] In February 2014, the FDA ruled that the generic brands, including Next Choice One Dose, could also be sold OTC with no point-of-sale restrictions, such as showing proof of age.[116] In light of the developments in the civilian arena, the DOD Pharmacy and Therapeutics Committee modified its May 2013 decision: Because Plan B One-Step is now an OTC drug, the committee determined that no EC pill would be included in the BCF. However, the committee ordered all MTFs to carry Plan B One-Step with no apparent age limits and to provide it free of charge.[117] Additional brands of EC pills are listed in the Tricare formulary and available with a prescription at no cost in the MTFs or with $5 to $17 co-payments at participating retail pharmacies.

This decision to provide Plan B One-Step to all ages free of charge is an incredible victory and means that military women who access EC at MTFs now have better access to EC in many cases than most civilian women, given that private insurance companies are not required to cover OTC birth control without a prescription and that civilian pharmacies are not required to stock the drug and typically sell it for approximately $50. However, as the Affordable Care Act requires that most private insurance plans cover prescription EC without a co-pay, Tricare is still behind the times in charging co-pays for prescribed EC brands purchased off base.

Although much progress has been made, servicewomen had to deal with a significant delay after EC first came on the market, and even when Next Choice was part of the BCF, DOD guidance indicated a higher age limit than that required by the 2009 court ruling.[118] As with other policy restrictions on reproductive health care in the military, the long road to access for EC is yet another example of servicewomen not always being afforded the same rights as the civilians they fight to defend. Hopefully, this matter has finally been put to rest and access to EC in the military will not be subject to political gamesmanship in the future.

Pregnancy

In 1951, President Harry S. Truman signed Executive Order 10240, which permitted the armed forces to discharge a woman if she became pregnant, gave birth to a child, or became a parent by adoption or as a stepparent.[119] DOD interpreted this grant of permission as a mandate, and it proceeded to issue regulations requiring that all military women who become pregnant must be summarily discharged.[120]

Some reports indicate that during the Vietnam War, military officers preferred to help servicewomen obtain access to abortion in Japan—because it was not permitted in Vietnam—rather than discharging them for being pregnant.[121] Nevertheless, the discharge policy stayed on the books until 1976, when the U.S. Court of Appeals for the Second Circuit decided that a Marine Corps policy following the Truman executive order violated the Fifth Amendment's due-process clause because it was based on the impermissible assumption that pregnant women were permanently unfit for military duty.[122] As a result, Congress overturned the executive order by enacting the Defense Officer Personnel Management Act, or DOPMA, on December 12, 1980.[123] DOPMA repealed laws that required distinct appointment, promotion, and separation procedures for servicewomen in the Army, Navy, and Marine Corps. Now, each individual service branch decides how to handle pregnancy in its ranks.

While the armed forces are no longer permitted to dishonorably discharge servicewomen for being pregnant, they are free to treat pregnant servicewomen in disparate ways. In the Navy, "[p]regnant servicewomen are considered non-deployable and are usually not assigned to overseas commands."[124] In the Army, pregnant servicewomen can choose to remain on active duty, request temporary leave or a transfer, or request separation from the service altogether.[125] If they request separation, it can be honorable or uncharacterized if their rank so requires, and they can re-enlist seven months after giving birth.[126] While these policies may seem like a fair accommodation of pregnant servicewomen's needs, the amount of discretion left up to each commanding officer to decide how a unit will function leads to the unfortunate marginalization of pregnant servicewomen in some of those units.

For example, a 2009 study on how pregnancy affects the Navy revealed that although pregnant sailors must be limited to working 40-hour weeks, 70 percent of respondents reported that their work hours were actually reduced to less than that.[127] Unmarried pregnant women especially experienced disparate treatment: 20 percent of single respondents did not consider their commands to be supportive, and 44 percent of single, pregnant servicewomen were transferred from operational platforms, compared with only 30 percent of their married counterparts.[128]

Another study of a large U.S. Army brigade combat team deployed in Operation Iraqi Freedom found that over 15 months, 10.8 percent of women were medically evacuated for pregnancy-related reasons.[129] While many of those evacuations may have been medically necessary, becoming pregnant should in no way justify the sidelining of a woman's military career, especially when one considers that unintended pregnancy could be mostly preventable were the military to devote the proper resources.

Female service members do not cease to be functioning, well-trained troops when they become pregnant. While their health concerns change during pregnancy, their talents and commitment to their units do not. Most pregnancies do not result in declining work performance. For those military assignments that require strenuous physical exertion, efforts should be made to reassign pregnant servicewomen to positions where they can still contribute to the force. Pregnancy is a temporary condition, and, as with a soldier whose injuries can heal, a pregnant woman will be able to serve again at full capacity—provided she receives adequate care and support during and after her pregnancy. Evacuations, transfers, and reductions in duty should occur only if medically necessary and with the consent of the pregnant woman.

Unintended pregnancy

As discussed above, servicewomen use contraception at comparable rates to their civilian counterparts. Yet numerous studies have demonstrated that the unintended-pregnancy rates for servicewomen are significantly higher than the rates for civilians.[130] Every year, approximately 10 percent of active-duty women in the military become pregnant, and more than half of those pregnancies are estimated to be unintended.[131] While approximately 49 percent of pregnancies among the general U.S. population are unintended,[132] the overall proportion of unintended pregnancy in the military was estimated to be 50 percent higher than the unintended-pregnancy rate among civilian women in 2008.[133] One of the few studies that has analyzed unintended pregnancy among a representative sample of active-duty servicewomen—and the only study that has adjusted its analysis for the age of servicewomen relative to the general population—found that rates of unintended pregnancy among servicewomen were a full 50 percent higher than those among the general U.S. population in 2008: 78 per 1,000 pregnancies in the military, compared with 52 per 1,000 pregnancies in the general population.[134] However, the rate among women in the military may be even higher due to the underreporting of abortions.[135]

Unintended-pregnancy rates in the military are highest among younger, less educated, and nonwhite service members. Married or co-habiting servicewomen also experience unintended pregnancy at higher rates than their single counterparts.[136] These data closely mirror demographic trends in the civilian population, but the rates are still higher in the military.[137] Moreover, active-duty women are younger, on average, than the general civilian population.[138] Young women ages 18 to 24 in civilian society have the highest unintended-pregnancy rates of any other age group.[139] It raises serious concerns that unintended-pregnancy rates among servicewomen were still 50 percent higher than in the civilian context even after adjusting for the higher proportion of young women enlisted in the military.

Not only are young women and junior enlisted women in the military at higher risk of unintended pregnancy than their civilian counterparts in the same age range, but they are also the group most at risk of being sexually assaulted in the military.[140] According to DOD's most recent report, 69 percent of victims of military sexual assault who filed unrestricted reports—meaning they allowed demographic information to be released—were between ages 16 and 24; another 25 percent were between ages 25 and 34.[141] This correlation, that the servicewomen most affected by military sexual assault are also the most likely to experience an unintended pregnancy, does not mean that military sexual assault is solely

to blame for high rates of unintended pregnancy. But it is a contributing factor that should be aggressively addressed, particularly when considering the evidence below that demonstrates the difficulty of isolating the other factors that contribute to unplanned pregnancy in the armed forces.[142]

Given that active-duty women are much more likely to have coverage for contraception than their civilian counterparts because they are enrolled in Tricare and have access to MTFs, and given that they use contraception at rates comparable to the civilian population, researchers have struggled to identify the causes underlying their higher rates of unplanned pregnancy.[143] To complicate matters further, the most rigorous assessment of unintended pregnancy among servicewomen to date found that while rates of contraceptive use among servicewomen decline while they are deployed, there was no significant difference between unintended-pregnancy rates among women who had been deployed in the previous 12 months and those who had not.[144] Thus, barriers to contraception alone do not necessarily explain the disproportionate share of unintended pregnancies among servicewomen.

Instead, the study identified three likely factors that contribute to unplanned-pregnancy rates, none of which are definitive given the paucity of available data:[145]

- Lack of proper contraceptive counseling and care prior to deployment and lack of adequate care and supplies while deployed, which in turn lead to lower use of contraception, use of less effective methods, and lower adherence to methods while deployed

- Confusion about military policies that restrict sexual relations among service members, which discourage women from speaking openly with their doctors or seeking medical care

- High rates of rape in the military

While more research is needed to fully understand the unique needs of servicewomen when it comes to pregnancy prevention, each of the contributing factors outlined above can and should be the focus of targeted policy interventions throughout the armed forces.

Abortion

While barriers to certain types of care are certainly disconcerting, none has been as systematically restricted in the military as abortion care.

Military restrictions on abortion date back to the late 1970s, when the first legislative restriction, known as the Dornan Amendment, was attached to the 1978 Department of Defense Appropriations Act.[146] The Dornan Amendment prohibited military funding for abortion, which was interpreted as denying insurance coverage for abortion except in the cases of life endangerment, rape, incest, or severe health consequences to the pregnant woman. The 1979 DOD appropriations bill renewed the ban but with no health exceptions.[147] The 1980 ban included rape and incest exceptions,[148] but in 1981, those exceptions were removed altogether.[149] In 1984, the insurance coverage ban was codified in the 1985 Omnibus Defense Authorization Act[150]—meaning that it became part of permanent law and could no longer be changed in the annual appropriations process—with an exception only for life endangerment.

In 1988, the Reagan administration expanded the interpretation of the ban on military funding for abortion by barring abortions from being performed in military medical facilities altogether, except in life-threatening situations, regardless of the circumstances or whether a woman was able to pay for the procedure out of pocket.[151] There was a brief respite under President Bill Clinton, who in 1993 signed an executive order that permitted abortions at military facilities for any reason so long as the pregnant woman paid with her own funds.[152] But in 1995, Congress overturned this executive order in the FY 1996 DOD appropriations bill, with exceptions for cases of life endangerment, rape, or incest.[153] It then codified that provision in the FY 1996 National Defense Authorization Act.[154]

From that point on, only life-saving abortions were covered, and only privately funded abortions for rape and incest could be provided at military facilities. While several bills and amendments were introduced over the years to overturn these bans, none were successful until December 2012, when the Shaheen Amendment to the National Defense Authorization Act, which added Tricare coverage for abortion in instances of rape and incest, was finally enacted.[155]

From 1981 through 2012, abortion services were only covered by the military's insurance plan in cases of life endangerment. Only now are policies being developed to cover abortion for cases of rape and incest as well. This progress means that the exceptions for the coverage ban and the facilities ban are finally aligned, but it is not nearly sufficient.

While the passage of the Shaheen Amendment represents some progress, the fact remains that unless there is a life-threatening medical emergency or a pregnancy results from rape or incest, Tricare will not cover abortion, counseling, referral, preparation, or follow-up appointments. These restrictions force women who have Pentagon-provided health insurance to pay for an abortion out of pocket in most cases.[156] In addition, Congress still bans the use of military facilities to perform abortions except in those same three instances of life endangerment, rape, and incest.[157] Together, these two policies mean that a woman whose pregnancy does not satisfy one of those exceptions cannot obtain an abortion at a military facility at all, even if she is able to pay for the service out of pocket.

The Military Access to Reproductive Care and Health, or MARCH, for Military Women Act, reintroduced in March 2013, would lift the facilities ban and allow privately funded abortions to be performed on bases.[158] However, there is no pending legislation that would lift the military's abortion-funding ban entirely, allowing all abortions to be provided and paid for by the military.

Timeline of abortion restrictions in the U.S. military

Pre-1970: Access to abortion varies. During the Vietnam War, from 1961 to 1975, military facilities generally did not provide abortion services, but the military did pay for medical evacuations to nearby countries that permitted abortions locally, such as Japan.[159]

1970: DOD authorizes abortion in military facilities "when medically indicated or for reasons involving mental health and subject to the availability of space and facilities and the capabilities of the medical staff."[160]

1971: President Richard Nixon announces the Good Neighbor Policy, which directs that the provision of abortions on military bases must "correspond with the laws of the states where those bases are located." "States" included American states, as well as foreign nations.[161]

1973: The U.S. Supreme Court determines that the right to abortion is constitutionally protected in *Roe v. Wade.* DOD directs medical facilities to provide abortions only if two physicians find that the abortion is "medically indicated" or required for "reasons of mental health" and if DOD funding for abortion does not conflict with the law of the state where the abortion is to be performed.[162]

1976: The Hyde Amendment passes for the first time, banning insurance coverage of abortion in Medicaid—a civilian health program for the poor—and later becoming a model for other government restrictions on abortion coverage, including the military.[163]

1976 to 1977: Approximately 26,000 U.S. servicewomen and military dependents obtain an abortion in military facilities or under the Civilian Health and Medical Program of the Uniformed Services, the predecessor to Tricare, during this one-year period.[164]

1978: Congress approves the Dornan Amendment in the FY 1979 DOD appropriations bill, prohibiting the use of federal military funds for abortion care except in cases of life endangerment, reported rape or incest, or "severe and long-lasting physical health damage" to the woman, as determined by two physicians.[165]

1979: Approximately 1,300 abortions are performed in military hospitals abroad but are paid for with private funds. Congress renews the Dornan Amendment without a health exception for FY 1980.[166]

1980: Congress modifies the rape and incest exceptions to the Dornan Amendment.[167]

1981: Congress removes the rape and incest exceptions from the Dornan Amendment, which goes into effect in 1982.[168]

1984: President Ronald Reagan signs the 1985 DOD authorization bill into law, permanently codifying the ban on military funding for abortion, except in cases of life endangerment.[169]

1988: President Reagan directs DOD to ban privately funded abortions from being performed at military facilities overseas, with no exceptions.[170]

1993: President Bill Clinton directs DOD to reverse the military-facilities ban. But the directive preserves the Good Neighbor Policy, as well as the right of military health care workers to refuse to perform abortions.[171]

1995: Congress amends the FY 1996 DOD appropriations bill to prohibit the performance of abortions at military facilities except in cases of life endangerment, rape, or incest. Under this ban, servicewomen and military dependents must use private funds to pay for abortions obtained at military facilities for rape or incest.[172]

1996: President Clinton signs the FY 1996 DOD authorization bill into law, permanently codifying the military-facilities ban on abortion, except in cases of life endangerment, rape, or incest. It still stands today.[173]

1996 to 2011: Members of Congress who support reproductive rights try but fail to relax or repeal the bans on military funding and facilities.[174]

2012: The Shaheen Amendment modifies the DOD authorization bill to include Tricare coverage for abortion in cases of rape or incest.[175]

2013: Sen. Kirsten Gillibrand (D-NY) and Rep. Louise Slaughter (D-NY) reintroduce the MARCH for Military Women Act, which would repeal the military-facilities ban and allow abortions to be performed on base—for reasons other than life endangerment, rape, and incest—if paid for with private funds.[176]

As if the continuously changing bans are not challenging enough, additional barriers impede servicewomen's access to abortion. Even if a servicewoman seeking an abortion does qualify for one of the exceptions to the coverage and facilities bans, it is highly unlikely that she will be able to locate the care she needs at a military facility for a number of reasons:

- The military has a policy that does not require a physician to perform an abortion if he or she has a moral objection.[177]

- A socially conservative culture in the military generally, and among military physicians in particular, results in virtually no physicians volunteering to perform the procedure.[178]

- The hierarchical nature of the military and the close ties that deployed service members form—including physicians—make it difficult for subordinates to express disagreement with a policy or practice, particularly on a contentious issue.[179]

- Because a medical team must be made up of volunteers, "any member of a medical team needed to perform an abortion can essentially 'veto' it."[180]

- Recent reductions in civilian medical personnel resulting from DOD budget cuts limit the number of physicians at MTFs. As of 2010, the Obama administration's long-term defense-spending plans included cutting 5,600 civilian medical personnel from the Army over the following six years and reducing comparable cohorts in the Navy and Air Force by nearly 2,000.[181] Such cuts may necessitate rotating overseas uniformed physicians back to the United States to compensate for the loss of civilian medical staff at the facilities here, which would naturally reduce the availability of services abroad, including abortion.[182]

- Because military physicians are paid a salary regardless of the individual services they provide, they may lack the incentive to offer a full range of reproductive health care to servicewomen.[183]

Finally, some doctors may refuse to provide safe abortion care to female troops because they do not consider it a part of their military duty or mission. As one spokesperson for Americans United for Life put it, "These are clinicians and facilities that are intended to save the lives of members of the military, not perform abortions."[184] These kinds of comments ignore the fact that some servicewomen's lives are endangered by unintended pregnancy, either by the pregnancy itself or by

the consequences of a self-induced or botched clandestine abortion. One 26-year-old servicewoman profiled in 2009 told her story of a self-induced abortion that resulted in life-threatening blood loss.[185] For fear of jeopardizing her career, she did not report that she had been raped. After trying twice to terminate her pregnancy, she was publicly sanctioned under the Uniform Code of Military Justice and ultimately was discharged honorably due to acute anxiety, PTSD, and depression.

On top of the institutional barriers, yet another policy actively affects servicewomen's access to abortion care: DOD's so-called Good Neighbor Policy, directed by President Nixon in 1971,[186] whereby the U.S. military follows the prevailing laws and rules of foreign countries regarding abortion in their facilities abroad.[187] Due to the expansion of military bases overseas, the current reality is that most countries where American military personnel are stationed restrict or outlaw abortions altogether.[188]

Thus, even if a pregnant servicewoman managed to find a military physician willing to terminate her pregnancy, the laws of the country where she is located may operate to prohibit the abortion. This problem is particularly an issue of concern for the thousands of servicewomen deployed to countries in the greater Middle East, Africa, and Asia where abortion is banned in all circumstances except life endangerment.[189] It should come as no surprise, then, that some U.S. servicewomen deployed in countries where abortion is illegal seek information online about abortion-inducing medication. Such a method is quite safe, but the pills can sometimes be difficult to obtain. Servicewomen may also consider unsafe methods to terminate their pregnancies themselves.[190]

These restrictions, combined with confusion about the ever-changing policies, lead to virtually no abortions being performed on military bases. Whereas prior to 1988, about 30 abortions were performed annually at military facilities, from 1996 to 2010, only about 53 abortions were performed at military facilities in total—an average of 3.79 abortions per year.[191] Sadly, as demonstrated above, this figure is not a result of lower rates of sexual assault or rape, nor is it a result of higher contraceptive use among service members. It is the effect of the intersecting, restrictive laws and policies against the provision of comprehensive reproductive health care in the military.

Due to these policies, and with scarce access to safe and legal abortion care on overseas military bases, DOD regulations require that a pregnant servicewoman seeking an abortion be flown back to the United States within two weeks of reporting that she needs one.[192] While this policy may be an attempt to compensate for the barriers to care women face while deployed, it creates yet another potential disincentive to report an unintended pregnancy and seek an abortion.

In contrast, most private-sector, employer-sponsored health plans do cover abortion.[193] Thus, in this respect, many civilian women enjoy better health benefits than do women in uniform. DOD is not similar to other employers in many aspects, but the ways in which it differs from the private sector have no bearing on its ability to cover abortion care. It is true that servicewomen are subject to additional legal standards to which civilian women are not because of traditional deference to the military in the civilian court system. For instance, the ruling in *Feres v. United States*, also known as the *Feres* doctrine, limits the ability of soldiers to sue the government for personal injuries sustained while on active duty.[194]

In addition, "violations of individual rights are sometimes permitted if they are deemed necessary to support the military's mission. The military could therefore constitutionally ban abortions on military bases, if it were proven that abortions interfere with military missions."[195] How providing abortion care on bases could possibly interfere with the military's missions is beyond explanation; nevertheless, military policy and congressional law conspire to make abortion services almost entirely unavailable in military facilities. Politics alone is the reason for these unfair and counterproductive restrictions.

Due to high sexual assault rates and barriers to consistent contraceptive access, abortion remains a particularly necessary medical service for women in the military. While the actual or likely abortion rate for military women is not known, their rates of unintended pregnancy are higher than the civilian rates, and 4 in 10 unintended pregnancies in the general population end in abortion. Regardless of how the abortion rates of servicewomen compare with those of civilian women, as long as there is a need for abortion care, the country has an obligation to meet that and any other medical needs of those who have volunteered to serve.

The health risks posed by all of these barriers to abortion access are serious. Delaying abortion and seeking abortion care in countries where medical services are below U.S. standards or where abortion is illegal greatly increases risks for serious complications.[196] Such health risks also pose a military-readiness problem because they compromise the physical fitness of trained military troops. Abortion care should be viewed just as any other medical procedure at MTFs, and terminating a pregnancy should be handled with the same urgency and care as any other medical need to ensure that servicewomen can return to their units as swiftly as they desire, without risking their health and well-being or their careers and without undermining military readiness and unit cohesion.

Invasion of privacy

Because of the military's hierarchical nature and its national security mission, there can be little medical privacy for service members at times—a serious contrast with the civilian population, even though both sectors are supposedly protected by health care privacy laws such as the Health Insurance Portability and Accountability Act, or HIPAA.[197]

There are a number of ways in which the military system impedes the privacy of its soldiers. For instance, commanding officers are sometimes able to see service members' medical files when it is a matter of "assuring the proper execution of the military mission."[198] Reports of sexual assault can spread quickly among close-knit units, especially overseas. Although victims of military sexual assault have been able to file restricted reports since 2004 to obtain medical services related to their attack without relinquishing confidentiality, that process forfeits their ability to pursue criminal charges.[199] Service members who file unrestricted reports in order to pursue criminal charges give up their confidentiality because their commander will have access to the report.[200] Moreover, it appears that most service members do not trust that confidentiality will be maintained even through the restricted reporting option. Of the approximately 26,000 service members estimated to have been victims of military sexual assault in FY 2012, only 981 chose to make restricted reports of sexual assault.[201]

Privacy concerns also arise in accessing contraception. Despite military policies that state the importance of contraceptive access, servicewomen and servicemen find that few systems exist for confidentially dispensing condoms to service members, which increases the risk of both unplanned pregnancies and STIs.[202] The military-readiness challenge is apparent in these cases, as "[s]uch infections can impair the ability of military members to serve and increase the risk of long term health complications, such as pelvic inflammatory disease and infertility."[203]

Pregnancy in the military, especially if unintended, also is fraught with potential privacy violations. Becoming pregnant overseas, especially for a young new recruit, can often end a military career: "'The military doesn't forgive you,' said one unmarried former Marine who tried to self-abort when she got pregnant in Iraq in 2006. 'You're never going to get promoted again.'"[204]

The desire to keep a pregnancy hidden by having an abortion secretly is therefore strong. As one former Marine sergeant commented, "If you get sent home for something like that, everyone will know about it ... That's a really bad stigma in the military. I thought, that's not me, I've worked harder and I could outrun all the guys. So I chose to stay, and that was just as bad."[205]

Because of the legal restrictions on abortion in the military, servicewomen face significant intrusions into their privacy when they attempt to access care. For instance, to obtain abortion care under the rape exception to the insurance and facilities bans, a woman must first report the rape. Naturally, privacy concerns contribute to underreporting, as evidenced by the fact that 89 percent of military sexual assault crimes currently go unreported.[206] If a woman was not raped or does not wish to report a rape, she must seek permission to leave the base to obtain abortion care. However, servicewomen state that commanding officers may inquire into the nature of care that a service member seeks and can sometimes attempt to deny leave for an abortion, which may further deter women from seeking such leave.[207] If she declines to share her reason for taking leave due to a desire to maintain privacy, she will not be eligible for medical leave and free transportation to get her to an off-base clinic, as provided in response to other medical conditions.

Essentially, the military hierarchy, while justified as a necessary combat tool, results in the unit commander becoming the gatekeeper for a servicewoman's health care, putting a soldier who needs an abortion in an untenable position. She must seek permission to leave the base from her commanding officer, which on its own constitutes a breach of privacy and creates the opportunity for delay, and she might understandably fear a loss of confidentiality, stigma, and possible retaliation resulting from notifying the chain of command of her medical needs.

Sexism

While congressional restrictions are beyond the uniformed military's control, little will change to improve access to reproductive and sexual health care unless attitudes within the military itself change. When women are denied benefits or opportunities that are afforded to their male counterparts, their career opportunities and unit cohesion are compromised. Asserting that the military is a traditionally male environment and women should either deal with it or leave is not a tenable approach if the country wants to maintain a high-quality, all-volunteer force, given the growing number of women in the force and the increasingly crucial roles that they fill. Marginalizing sexual activity, contraception, pregnancy,

and abortion as issues that only confront women is a disingenuous portrayal of how human beings, including soldiers and military officers, express their sexuality and seek to control their fertility and reproduction.

According to the U.S. Government Accountability Office, active-duty women have expressed concern about the attitudes and the climate established by the command personnel who may not understand women's health care needs.[208] Despite orders to treat all soldiers equally, the reality is that sex discrimination, sexual harassment, and sexual assault plague a large percentage of servicewomen at some point during their careers. All levels of the military hierarchy should share responsibility for this epidemic.

A study conducted in the early 2000s involving more than 500 women veterans found that, statistically speaking, servicewomen who work in offices where sexual harassment is tolerated or encouraged are significantly more likely to be sexually assaulted.[209] Of the 500 respondents, 79 percent reported being sexually harassed during their service, and 30 percent reported an attempted or completed rape. Accounting for the unreported rape rates brings this number to 54 percent. In other words, more than half of respondents reporting sexual harassment in the military workplace were likely survivors of an attempted or completed rape. The compelling implication of these results is that tolerating or condoning sexual harassment in the workplace—an overwhelmingly common experience for many servicewomen—leads to sexual assault, which leads at times to unintended pregnancy. Servicemen and officers must face this reality and become part of the solution.

The directed redress process for such incidents is reporting through the chain of command, which can be an extremely intrusive and stigmatizing process that naturally results in underreporting, as described above and in more depth in a report from the Center for American Progress that focuses specifically on sexual assault in the military.[210] Moreover, other processes for addressing sexual assault claims are either highly dysfunctional or outright barred. In the jurisprudential realm, for instance, the *Feres* doctrine has been applied to sexual assault in at least two cases, meaning that it is a "combat-related injury" for which service members cannot sue.[211]

Sexism and sexual assault can undermine internal cohesion and military readiness. While combat effectiveness requires technical skills, unit cohesion is also an integral component.[212] Furthermore, being victimized within one's own unit has a long-lasting effect on a servicewoman's career, not to mention her mental and physical health. Analysis by the Military Leadership Diversity Commission on retention

rates across the services revealed that women have lower rates of continuation throughout all branches of service.[213] It is likely that gender-related mistreatment and violence are contributing factors to this phenomenon—which, among other effects, costs the military billions of dollars for training their replacements.

Sexism both contributes to the lack of comprehensive reproductive health care for servicewomen and leads to further disparate treatment. By viewing sexual and reproductive health as exclusively a problem for servicewomen and a problem they must sometimes solve themselves, the military simultaneously diminishes women's opportunities and sends a message that they are not equal to men. Enlisted personnel and officers at all levels have a part to play in the eradication of the inferior treatment of servicewomen and should act to tear down the barriers to full reproductive and sexual autonomy for servicewomen and servicemen alike.

The impact

Insufficient information about sexual health, inconsistent access to contraception, and a culture of sexual harassment and assault constitute a perfect storm that leads to exceptionally high rates of unintended pregnancy. Add in the restrictions on access to abortion care, as well as the requirement to seek permission for care off base, and servicewomen have strong incentives to take matters into their own hands and risk their safety to end an unplanned pregnancy. Not only can these problems have a devastating effect on the lives of individuals, but they also take a toll on the military's effectiveness and its bottom line.

Pregnancy, whether planned or unplanned, costs the military in more ways than one. Naturally, there will always be fiscal costs associated with pregnancy:

> *The military can pay a high financial cost for all pregnant active duty members in salaries and time lost to duty for prenatal care, labor and delivery, and postpartum recovery periods. ... Losses as the result of pregnancy within the operational forces have an across-the-board impact and can lead to readiness and personnel challenges.*[214]

But pregnancy among servicewomen also carries additional costs—both for the woman and the armed forces—that are less likely to be encountered during pregnancies in a civilian context. For example, pregnant servicewomen have a higher risk for complications and adverse pregnancy outcomes, as they are five times more likely than civilians to undergo preterm labor.[215] Explanations put forth for such disparities include a taxing physical workload with minimal rest periods, psychosocial stress in the workplace, prolonged standing, and extreme temperatures.[216] As a result, pregnant servicewomen have high rates of hospitalization, which costs the military both time and money. In a Navy study, 20 percent of the pregnant respondents were hospitalized during their pregnancy, with preterm labor accounting for 50 percent of admissions.[217] Another common consequence of military pregnancy is reduced work hours and reassignment. [218] As noted above, 70 percent of respondents to this same study had their work hours reduced to fewer than 40 hours per week during their pregnancy,[219] which can both harm individual careers and impede productivity.

When a pregnancy is unintended, these problems are only compounded. As former U.S. Air Force Colonel Martha McSally put it, "a poorly-timed pregnancy in today's high tempo military … can have a significant effect on military effectiveness."[220] Because women are an integral part of U.S. military forces, unplanned absences due to pregnancy can present problems for individual units and for the overall force.

The military particularly feels the cost of lost service due to unintended pregnancy among its young, new recruits. According to the Navy study, 82 percent of single women's pregnancies were unplanned.[221] The study revealed that female sailors were most at risk of unintended pregnancy during their initial enlistment and when assigned to deployable units. Those who experienced an unplanned pregnancy were more likely to be transferred earlier from their commands, more in need of financial assistance, less likely to have the fathers of the babies involved, and more likely to require treatment for acute pregnancy complications.[222] These unintended pregnancies can also jeopardize training and careers, as "[t]he initial 3-4 years in a sailor's career are geared toward the acquisition of crucial training and skills followed by extensive and sustained deployments. Such rigors do not allow the easy integration of pregnancy, planned or otherwise, into the career path of junior sailors."[223]

Unplanned pregnancies are also more likely to create problems that affect the unit, such as tension, harsh judgment of servicewomen, and perceived or actual disruption to the unit's mission, generally undermining unit cohesion and readiness. Opinions often vary based on the rank of the woman who is pregnant. As one researcher noted:

> *There was a general perception that women officers and senior enlisted personnel try to time their pregnancies to have the least effect upon the unit … . These opinions stood in marked contrast to those concerning junior female personnel, especially single mothers. Single, pregnant, junior enlisted personnel were considered the most problematic because the pregnancies were less likely to be planned and more likely to create other problems, such as financial and child-care problems, that impacted the unit.*[224]

While it is valuable to survey current attitudes within the unit toward unintended pregnancy, it is also important to note that viewing single, pregnant, junior enlisted personnel as "problematic" negates the fact that two people are required to create a pregnancy and that these are the same troops who are at the highest risk of being sexually assaulted. Assigning them the blame without acknowledging structural inequalities perpetuates the prejudiced treatment of servicewomen and permits sexual assault rates to rise without addressing the root causes of unintended pregnancy.

In 2009, the frustration with unintended-pregnancy rates caused the commander of U.S. forces in northern Iraq to threaten to court-martial pregnant servicewomen and the men who impregnated them, despite the fact that the men involved often go unnamed.[225] Although he quickly walked back from this threat, the incident illustrated both how unprepared the military is to handle high unintended-pregnancy rates and how pregnant servicewomen are targeted within the ranks as the primary cause of the problem.

Recognizing the effects that unplanned pregnancy has on servicewomen and their units alike, the Department of Defense adopted the national Healthy People 2010 objective of increasing the intended-pregnancy rate to 70 percent.[226] But clearly, it is far from achieving that goal.

Seen in this larger context, the military's restrictions on access to abortion care become even more egregious. Losing a service member's presence in a deployed unit because she has to be flown to another country for what is supposed to be a constitutionally protected medical procedure compromises unit cohesion and leaves commanding officers with one less service member completing her duties. In addition, the cost of a flight typically from destinations in the Middle East is an unnecessary expenditure when the procedure could safely be conducted on base at a military treatment facility if all military abortion bans were removed.

Finally, for those who become pregnant as a result of sexual assault, the process of reporting the assault, obtaining the leave, flying to a country where care is more readily available, and the overall lack of medical privacy represents an abject and wholly unjustified failure on the part of the military to adequately address the physical and mental health needs of a servicewoman who has been victimized by a colleague while serving her country. Regardless of the circumstances of the pregnancy, the policies regarding abortion in the military result in publicizing an extremely intimate medical decision and perpetuating blistering stigma toward a pregnant servicewoman—first for getting pregnant, second for having an abortion, and third for leaving her unit behind to obtain care.[227]

When a pregnancy is wanted, the military should find ways to accommodate the pregnancy and ensure that the woman's career is not harmed by her decision to carry her pregnancy to term. But when a servicewoman wishes to end her pregnancy, it is foolish to put up obstacles to abortion care that will result in financial and productivity costs to the military and personal and emotional costs to the woman.

Policy recommendations

Taking meaningful steps to curb sexual assault rates and increase access to contraception are effective and doable actions that Congress and the armed forces can take now to protect the health of servicewomen and bolster military readiness. Moreover, an obvious solution to the financial and readiness costs of unintended pregnancy is to lift the coverage and facilities bans on abortions at military treatment facilities for servicewomen who wish to end their pregnancies. This will ensure privacy and access to safe abortion care on bases, so as to mitigate reassignment and/or evacuation costs while improving health outcomes.[228]

Specifically, the Pentagon and Congress should:

- Ensure that women receive appropriate and timely gynecological screenings and follow-up care before deployment
- Provide both female and male soldiers with complete information and counseling about a full range of contraceptive options, including the most effective methods during deployment, and make predeployment contraceptive counseling routine
- Collect consistent and comprehensive data on contraceptive access and use among all of the service branches
- Collect consistent and comprehensive data on the incidence and treatment of sexually transmitted infections, and improve access to treatment
- Ensure all forms of emergency contraception are stocked in all medical treatment facilities
- Pass the recently introduced Access to Contraception for Women Servicemembers and Dependents Act of 2014 to ensure that cost sharing is not required for any method of contraception, whether that contraception is provided through a facility of the uniformed services, the Tricare retail pharmacy program, or the national mail-order pharmacy program

- Take dispositional authority for sexual assault cases out of the chain of command and take needed steps to increase both individual and institutional accountability for sexual assault in the military, as described in CAP's report on military sexual assault

- Provide fair and reasonable accommodations for servicewomen who choose to carry their pregnancies to term

- Ensure that the Shaheen Amendment is fully implemented

- Pass the Ruth Moore Act to ensure that veterans who have been sexually assaulted in the military have coverage for needed medical care

- Lift all coverage and facilities bans on military abortion care, vacate President Nixon's Good Neighbor Policy, and ensure that sufficient numbers of military medical personnel are trained and willing to provide abortion care

Political obstacles may impede the implementation of some of these suggestions, but the country must address each of these points in order to fully provide for its female service members. If these items are addressed, women in the military will be able to focus even more closely on the task at hand—protecting our country.

Conclusion

Honoring the women who serve both at home and abroad is a core American value. It is unfair and ineffective to deny servicewomen access to comprehensive reproductive and sexual health care services. Equally important, this denial undermines military readiness and jeopardizes a servicewoman's ability to respond effectively when her unit needs her.

All U.S. soldiers—women and men—deserve to have all of their health care needs met while serving. Roadblocks to obtaining that care—whether set up through ignorance, lack of interest, or politics—have no place in the military's health care system. Women now comprise 16 percent of the U.S. armed services. They play a vital role in defending the nation's freedoms. The least the United States can do to repay their service is honor their rights and protect their health.

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