



Commentary

A Policy of Discrimination: Reproductive Health Care in the Military

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Introduction and Background

They have preserved our way of life with unwavering patriotism and quiet courage, and ours is a debt of honor to care for them and their families. (*The White House Office of the Press Secretary, 2010*)

In 2002, the wife of a young U.S. Navy sailor was given the news that her fetus had no brain, a birth defect known as anencephaly (*Wilson, 2010*). This condition is not compatible with life, and, at 16 weeks of gestation, the couple decided not to continue the pregnancy. In fiscal 1977, over 25,000 abortions were performed in military facilities (*Boonstra, 2010; Burrelli, 2008*). However, in 2002 federal law prohibited termination of the pregnancy at the military health care facility where they were stationed. In addition, federal funds could not be used for the abortion (*10 USC 1093, 1996*).

This young family faced a \$3,000 medical bill for the abortion procedure at a local civilian clinic, or the pain of going through 5 months of carrying a fetus that would die. Service members make less than civilians in similar occupations and depend on the military for their health coverage (*Wilson, 2010*). The additional \$3,000 was beyond the financial capability of the couple. With the help of family and friends, they were able to overcome the financial burden and obtain the abortion. Had the family been stationed overseas, finding a civilian abortion provider may not have been possible.

While stationed overseas in the Philippines from 1989 to 1991, one of the authors (J.T.J.) witnessed firsthand the burden of restrictive abortion policy. Active duty women electing to terminate an unwanted pregnancy were forced to make a difficult choice: Take emergency leave and travel to Hawaii for a legal abortion (at their own expense) or obtain an illegal abortion under unsafe conditions locally. Not surprisingly, the burden of

unsafe care fell disproportionately on our youngest, most vulnerable junior enlisted personnel.

The Military Health System (MHS), the medical network within the Department of Defense (DOD), is charged with worldwide provision of health care to all U.S. military personnel. Currently, the MHS delivers health care to approximately 9.6 million service members, veterans, and family members. With a \$50 billion budget, 59 hospitals and 364 health clinics, the MHS goal "on and off the battlefield, in times of peace and war . . . is to ensure that the highest standard of care is delivered" (*DOD, 2010d*).

After the creation of an all volunteer force in 1973, women joined the military with increasing numbers and today make up 15% of active duty personnel (*DOD, 2010c*). Additionally, women compose almost 17% of the military reserves and National Guard (*Women in Military Service for America, 2009*). Female dependents served by the MHS number 4.6 million as of December 2009 (*TRICARE Management Activity [TMA], 2010*). In response to the growing number of women serving in the military, the MHS adapted to the need for more female-specific health care by increasing resources for all aspects of women's health including breast care, pregnancy, and women's health care in forward-deployed medical facilities.

Correspondingly, the Department of Veterans Affairs (VA) began providing medical care for female veterans in 1988 (*VA, 2010*). At present, women are the most rapidly growing segment of the care-eligible veteran population (*Goldzweig, 2006*). The goal of the VA's Women Veteran Health Program is "to be a national leader in the provision of health care for women, thereby raising the standard of care for all women" (*VA, 2010*). The MHS and VA have adapted to the growing numbers of female patients in many effective and admirable ways (*DOD, 2010d; VA, 2010*).

Health Care Gap

Despite these extensive efforts, there remain several significant health care disparities between active duty, reserve, and female dependents served by the MHS and civilian women in the United States. The pregnancy rate of forward-deployed female

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Table 1
10 USC Sec.1093. Performance of Abortions: Restrictions

(a) Restriction on use of funds	Funds available to the Department of Defense may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.
(b) Restriction on use of facilities	No medical treatment facility or other facility of the Department of Defense may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest.

soldiers is 13% per year (TMA, 2009). Most of these pregnancies are unplanned and occur among younger, enlisted service members 18 to 25 years old (Custer, 2008). General Order Number 1 "prohibits sexual relationships in the field," yet unintended pregnancies remain the leading cause of U.S. servicewomen's evacuation from combat zones (Christopher, 2007).

Unintended pregnancies occur despite freely available contraceptives provided by the MHS. Research has shown that contraceptive failure is a result of ineffective training and lack of knowledge about contraceptives and their use, as well as cultural norms in the military that equate contraceptive use with promiscuity (Chung-Park, 2007, 2008). Additionally there are few data regarding the use of the most effective, long-acting, reversible contraceptive (LARC) methods, such as intrauterine devices, injections, and implants in this population. Side effects of hormonal methods that are related to contraceptive compliance issues are also under-investigated among military women.

Another problem with contraception in the MHS is access. Although free of charge, access to birth control is not without price. One active duty soldier reported "and you can buy condoms at the PX if you have the nerve to do it in front of 50 onlookers" (Heraldnet, 2004). In her forward-deployed unit, women had been warned of "harsh punishment" for becoming pregnant (Joyce, 2009). She noted, "The Army had even stopped handing out condoms to her unit," apparently hoping the lack of protection would curtail sexual activity (Heraldnet, 2004).

In the distant past, pregnant servicewomen were summarily discharged from military service. Today, they are transferred out of forward-deployed units without further recourse. Not only does this result in loss of combat readiness for the unit, but often jeopardizes the career of the pregnant soldier or sailor (Alliance for National Defense: A Positive Voice for Military Women, 2005; Christopher, 2007). The expenses associated with training, deployment, and discharge of pregnant active duty women represent additional costs and burdens to military preparedness.

Despite the military and personal consequences of intercourse and pregnancy, it is clear that "birth control and no-sex rules aren't working" (Heraldnet, 2004). In a more practical approach, emergency contraception (EC) has been approved for women in forward-deployed units (Kolbi-Molinas, 2010). The decision to provide female enlistees with "emergency contraception" was based on a recommendation by an independent advisory panel of military doctors and pharmacists. The new policy means EC will become a standard part of every medical facility's formulary, including those on bases in Iraq and Afghanistan. Unfortunately, access to EC will still require being seen by a military health care provider and admission by the woman that sexual relations have occurred.

Fear of discipline and career-damaging consequences makes disclosure of intercourse risky. An Army warrant officer who was

stationed in Baghdad reported that some pregnant soldiers in "her unit opted to perform abortions on themselves rather than face disciplinary measures" (Heraldnet, 2004). Although military physicians take the same Hippocratic Oath as civilian physicians, they also take an oath to serve the U.S. Constitution and their commanding officers. These conflicting mandates can lead to loss of confidentiality and privacy in the military care system. With the possibility of reprimand, reassignment, or worse, it seems EC may still remain out of reach for forward-deployed women soldiers and sailors despite the new DOD directive (Duke & Ames, 2008).

Abortion Care

Even with easier access to EC and better contraceptive use unplanned pregnancy will still occur when young, mostly single, men and women spend months together (Biggs, 2009). In the United States, the option of terminating an unplanned pregnancy is commonly available and legal. This basic reproductive health care service is not provided by the MHS. With almost half of pregnancies in the United States unplanned (Gutmacher Institute, 2010), it is unrealistic to expect there will not be unplanned pregnancy among women depending on health care from the MHS. Currently, abortion is banned in military hospitals, even with private funding. Therefore, access to safe and legal abortion services through a MHS facility is not available to the 100,000-plus women serving overseas, female veterans living overseas or female family members living on foreign bases (NARAL Pro-Choice America Foundation, 2010b).

The subject of abortion in this country is both emotional and controversial. Nevertheless, abortion is a common and legal medical procedure in the United States. Therefore, it is both reasonable and ethically consistent for the MHS to allow access to this legal procedure to its active duty personnel, dependents, and veterans. Under current law, federally funded facilities are prohibited from offering termination of pregnancy unless the woman's life is in danger or when the pregnancy is the result of rape or incest (10 USC 1093, 1996). If the pregnancy is the result of rape or incest, the woman may obtain a procedure, but must pay for the abortion with personal funds. With the rising rates of sexual assault in the armed forces (DOD, 2010b), it is unconscionable not to fund termination of pregnancy from rape for our service members and veterans.

In the MHS, if a woman's life is in danger because of her pregnancy, she is likely to be referred to civilian providers for termination because fewer than four abortions per year have been performed at DOD facilities for the past 8 years (Burrelli, 2008). For forward-deployed soldiers and their families, as well as veterans living in other countries, referral often leads to considerable delays in obtaining abortion care. Although abortion procedures have a very low complication rate, this does increase with increasing gestational age (Boonstra, 2010; Gutmacher Institute, 2010). Additionally, there is the cost of MEDEVAC, loss of combat unit assets, and the lost investment in training the soldier (Albright, 2007; Belmont, 2010).

In foreign countries where abortion is legal, women may seek abortion care outside the MHS. This is no easy task, however. In the words of one service member: "I will never forget the humiliation I felt. . . . I was turned away by my doctors. . . . Although I serve in the military, I was given no translators, no explanations, no transportation and no help for a legal medical procedure" (National Abortion Federation, 2010). In countries where abortion is illegal, with no other option available, the

military requires female service members to return home within 2 weeks of confirmed pregnancy (Clark, 2010). Veterans and female dependents must travel, often at great expense, to receive abortion care (Keenan, 2010).

History of Abortion in the MHS

In the 1960s, abortions were “quietly” provided at military facilities, even in states where abortion was illegal (Ponder, 2010). In 1970, orders were issued allowing military hospitals to perform abortions when “medically necessary or when the mental health of the mother is threatened.” However, in 1971 President Nixon ordered military facilities to abide by state abortion laws effectively stopping abortion care in states where the procedure was illegal (Boonstra, 2010; Crawford, 2004). In 1975, the DOD directed military facilities to provide abortions in accordance with the 1973 *Roe v. Wade* Supreme Court decision (National Committee for a Human Life Amendment, 2010). Over 20,000 abortions were performed annually in military facilities during the mid 1970s (Burrelli, 2008).

In 1976, the Hyde Amendment passed by the House of Representatives as part of the Department of Labor and Health, Education, and Welfare Appropriation Act, prohibited use of federal funds for abortion except when the mother's life is endangered by her pregnancy (Alliance for National Defense: A Positive Voice for Military Women, 2008; Henshaw, Joyce, Dennis, Finer, & Blanchard, 2009). Starting in 1979, a similar amendment was attached annually to the DOD appropriations bill, and eventually codified in Title 10 of the U.S. Code as part of the Omnibus Defense Authorization Act of 1985 (Crawford, 2004). See Table 1 for Title 10 of the U.S. Code, part a and part b. Even after this loss of funding, service members overseas could still obtain abortions in military facilities by paying out-of-pocket. This practice continued until June 1988, when a memorandum issued by Dr. William Mayer, then-Assistant Secretary of Defense (Health Affairs), prohibited the use of overseas military medical facilities for abortions. In 1993, newly elected President Clinton immediately reversed this ban on abortion in military facilities allowing “abortion services to be provided, if paid for entirely with non-DOD funds” (Burrelli, 2008; Joyce, 2009). In 1995, Congress passed an amendment restricting use of federal facilities for abortion, resulting in what is now 10 USC Sec 1093(b), prohibiting the use of a “medical treatment facility or other facility of the Department of Defense” to perform an abortion except for maternal life-endangerment or in the case of rape or incest (NARAL Pro-Choice America Foundation, 2010a). Attempts to reverse this policy have been rejected by congress.

Conclusion

The Military Health Service (MHS) was created to fulfill President Abraham Lincoln's promise to veterans: “To care for him who shall have borne the battle and for his widow and his orphan” (Barbara, 2008). For at least 200 years, women have been part of the defense force of our nation, and are now serving in higher numbers than ever before. From 1980 to July 25, 2009, the DOD reports 2,495 women killed while on active duty (DOD, 2010a). There are now 1.8 million female U.S. veterans (VA, 2007).

Unplanned pregnancy continues to be a problem in both the U.S. civilian population and among users of the MHS. If a female service member decides the time is not appropriate for child-bearing, she will have a hard time exercising her right to

a procedure that is both legal and safe in the nation she defends. The prohibition of abortion care at military treatment facilities using private funds is unfair and discriminatory. Women soldiers and sailors unduly bear the consequences of sexual activity and they should not have to sacrifice their careers if pregnancy occurs. Nor should they be denied comprehensive reproductive care because they have had the courage to join the military and protect the freedoms afforded others by their service.

Recommendations

1. All military personnel receive targeted and appropriate sex education including recommendations for the use of highly effective LARC methods that do not require user intervention (IUDs, implants, and injections).
2. An anonymous, routine system for contraception distribution among forward-deployed personnel must be developed and implemented. At the very least, condoms and EC must be available to all service members without the need to admit to prohibited activity.
3. Women service members need to be deployed with a suitable contraception method already in place, such as LARC, multiple packs of oral contraceptives, or multiple doses of EC with scheduled, routine follow-up in theater. The military requires all soldiers and sailors to be vaccinated against yellow fever and anthrax. Protection against unintended pregnancy should be equally routine.
4. Military health care providers must be allowed to provide completely confidential reproductive health care. This reassurance is necessary to convince young soldiers that accessing military care will not result in negative repercussions to their careers.
5. The private funding ban on abortions at MHS facilities must be lifted. Additionally, the conversation should be broadened to reverse or limit the scope of the Hyde amendment, because it is unacceptable that military active duty women or dependents should self-finance abortions required because of sexual assault or for genetic or fetal abnormalities.
6. Manual vacuum aspiration, a simple 10-minute clinic procedure, and medical abortion using mifepristone and misoprostol should be provided at every military health facility. Both procedures are within the scope of practice of primary care physicians and offer safe and effective means of managing early first trimester abortion, both elective and spontaneous. Having trained personnel and equipment available to provide this basic reproductive health service at overseas military health facilities would increase mission readiness and prevent the need for MEDIVAC.

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