

Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study

CONTEXT: U.S. servicewomen have a higher rate of unintended pregnancy than civilian women, yet the military does not provide or cover abortion, except in limited circumstances. Servicewomen's experiences with abortion care have received little research attention.

METHODS: Twenty-one in-depth interviews with servicewomen who had had an abortion during active-duty service in the prior two years were conducted between January 2015 and July 2016. Women reported on their experiences accessing abortion, as well as their knowledge and opinions of the military's abortion policy. Data were analyzed thematically using inductive and deductive codes.

RESULTS: In regard to their pregnancy and abortion experiences, servicewomen cited concerns about confidentiality, stigma and negative effects on their career, which prevented half of participants from seeking care from the military. Of those who visited a military treatment facility during pregnancy, some reported feeling upset or abandoned by the lack of options counseling and referral. Women reported that the military's abortion policy had negative health and emotional consequences for servicewomen, and negative financial and logistical consequences for both servicewomen and the military. Most did not have accurate knowledge of the abortion policy. Upon learning the law, the majority believed that the military should provide and cover abortion; yet, servicewomen also expressed apprehension about the military's involvement in abortion care, because of concerns about privacy and negative effects on women's careers.

CONCLUSIONS: Policy recommendations to better meet the needs of servicewomen include wider dissemination of the military's abortion policy, establishing abortion referral and support guidelines, and improving confidentiality in military health services.

Perspectives on Sexual and Reproductive Health, 2017, 49(4):245–252, doi:10.1363/psrh.12044

By Kate Grindlay,
Jane W. Seymour,
Laura Fix, Sarah
Reiger, Brianna
Keefe-Oates and
Daniel Grossman

Kate Grindlay is an associate, and Jane W. Seymour, Laura Fix, Sarah Reiger and Brianna Keefe-Oates are project managers—all with Ibis Reproductive Health, Cambridge, MA. Daniel Grossman is director of Advancing New Standards in Reproductive Health, Bixby Center for Global Reproductive Health, University of California, San Francisco, Oakland, CA.

Women play a growing role in the U.S. military and, as of 2014, made up 15% of active-duty military forces and 19% of reserve forces.¹ As a result, women's health and well-being are increasingly important to military operations. Unintended pregnancy can negatively affect not only individual servicewomen and their careers,² but also military operations as a whole. Because women cannot remain in certain military positions after becoming pregnant, they are removed from deployment, and lose work time during and after pregnancy;³ such actions have financial and workforce planning implications for the military.

U.S. servicewomen have a higher rate of unintended pregnancy than civilian women. In 2011, the rate for the active-duty military was 72 per 1,000 women aged 18–44;⁴ the rate for the general population was 45 per 1,000 women aged 15–44.⁵ Yet, servicewomen who experience an unintended pregnancy have limited access to abortion. Federal law permits military medical facilities to provide abortion only in cases of life endangerment, rape and incest.⁶ And until recently, TRICARE—the military health insurance program for servicemembers and their families—covered abortion only when the woman's life was in danger.

However, the 2013 passage of the Shaheen Amendment expanded TRICARE to cover abortions in cases of rape and incest as well.⁷ Prior to passage of the amendment, the number of abortions performed in military facilities was small (an estimated average of 3.8 per year from 1996 to 2009⁸); whether or how abortion provision in military facilities has changed since is unclear.

Women in the military can face difficulty scheduling reproductive health care around their work responsibilities,⁹ which may affect their ability to access appointments for abortion. These barriers are amplified when women are deployed, given that abortion is highly legally restricted in many deployment countries. Under such conditions, some servicewomen turn to unsafe methods to end unintended pregnancies.²

Although 42% of unintended pregnancies among U.S. women end in abortion,⁵ and women in the military have a particularly high rate of unintended pregnancy, only one prior study that we know of has explored servicewomen's experiences with abortion care.² We sought to better understand servicewomen's abortion experiences, and their knowledge and beliefs about the military's abortion policy.

METHODS

From January 2015 to July 2016, we conducted a qualitative study of U.S. servicewomen's experiences with abortion care. To recruit participants, we distributed study information sheets and flyers at abortion clinics near military bases in the United States; in addition, we posted study information to pages dedicated to military members on Facebook, Twitter and Reddit, and to Craigslist in U.S. cities with large military bases. Women were eligible to participate if they were 18 or older, were fluent in English, had an abortion in the prior two years and had been on active duty at the time. Study staff obtained women's verbal informed consent prior to interview, and participants who completed the interview received a \$50 gift card. We received ethical approval from the Allendale Investigational Review Board.

In-depth interviews were conducted by phone and lasted 30–60 minutes. We used a semistructured interview guide to ask participants about their military background and demographic characteristics; experiences accessing contraceptive, pregnancy-related and abortion care during their service; and knowledge and perceptions of military abortion policies. We conducted interviews until thematic saturation was reached.

To assess knowledge of military abortion policies, we asked participants “Have you heard of the Department of Defense’s policy on abortion?” We asked those who had heard of the policy “What is your understanding of the policy?” and “How did you hear about the policy?” We described the policy to those who had not heard of it as follows: “Under DOD policy, abortions can only be provided at military facilities and covered by TRICARE in circumstances of life endangerment of the woman, rape and incest. Until January 2013, TRICARE did not cover abortion for rape or incest, but it does now. In all other cases, women must seek services on their own and pay for them out of pocket.” To assess perceptions of the military’s abortion policy, we asked all participants “What is your opinion of the Department of Defense’s policy on abortion?” and “In what ways do you think these laws impact servicewomen, and in what ways do you think these laws impact the military?”

We interviewed 21 women; an additional 19 were ineligible or declined, and 11 could not be reached for interview. Interviews were digitally recorded and transcribed verbatim. We analyzed data thematically, with inductive and deductive codes, using Atlas.ti version 6.2.28. We developed a codebook based on the interview guide and early interview transcript data. Codes were refined and expanded iteratively as additional themes emerged. To ensure intercoder reliability, two investigators independently coded each interview. A third investigator completed a final review to compare the coded interviews, and the study team reconciled any discrepancies.

RESULTS

Participant Characteristics

On average, participants were 26 years old; women ranged from age 19 to 34. Participants were officers or enlisted personnel in the army, navy, air force or marine corps,

TABLE 1. Percentage distribution of participants in a 2015–2016 study of U.S. servicewomen who had had an abortion during active duty in the previous two years, by selected characteristics

| Characteristic | % (N=21) |
|--|-------------|
| Current age | |
| 18–25 | 47.6 |
| 26–30 | 33.3 |
| >30 | 19.0 |
| Military branch | |
| Army | 57.1 |
| Navy | 23.8 |
| Air force | 14.3 |
| Marine corps | 4.8 |
| Pay grade | |
| Enlisted | 81.0 |
| Officer | 19.0 |
| Job category | |
| Transportation/aviation | 33.3 |
| Administrative support | 19.0 |
| Intelligence/combat support | 14.3 |
| Medical/emergency | 14.3 |
| Computers/technology | 14.3 |
| Media | 4.8 |
| Years of military service | |
| ≤3 | 61.9 |
| 4–7 | 14.3 |
| >7 | 23.8 |
| Ever deployed | |
| Yes | 42.9 |
| No | 57.1 |
| Race/ethnicity | |
| White | 28.6 |
| Black | 28.6 |
| Hispanic | 28.6 |
| Multiracial | 14.3 |
| Highest level of education | |
| ≤some college | 61.9 |
| Bachelor’s degree | 23.8 |
| Advanced degree | 14.3 |
| Religious affiliation | |
| Christian | 52.4 |
| None/atheist | 47.6 |
| Current relationship status | |
| Single/separated/divorced | 23.8 |
| Steady relationship/engaged | 47.6 |
| Married | 28.6 |
| Parity | |
| 0 | 71.4 |
| ≥1 | 28.6 |
| Lifetime no. of abortions | |
| 1 | 76.2 |
| >1 | 23.8 |
| Used contraceptive in 3–6 mos. before pregnancy | |
| Yes | 61.9 |
| No | 38.1 |
| Recruitment source | |
| Clinic | 81.0 |
| Facebook | 14.3 |
| Craigslist | 4.8 |
| Total | 100.0 |

Note: Percentages may not add to 100.0 because of rounding.

who worked in transportation and aviation, administrative support, intelligence and combat support, medical and emergency services, computers and technology, and media (Table 1). On average, women had served for 4.6 years; women's length of service ranged from one to 13 years (not shown). Four in 10 had ever been deployed. Twenty-nine percent each identified as black, white, and Hispanic, and 14% as multiracial. Most participants did not have a college degree. Roughly half were Christian and were in a steady relationship or engaged. Most were nulliparous, and one-quarter had had more than one abortion; the majority had been using contraceptives in the 3–6 months prior to becoming pregnant. Most participants were recruited from clinics.

Abortion Decision Making

All women reported that the pregnancy that they terminated had been unintended, except for one, who had had an intended pregnancy that she terminated for mental health reasons; no pregnancy had resulted from rape, incest or life endangerment. Participants weighed a multitude of factors in deciding to have an abortion, but most (16) reported aspects of their military career—career goals, upcoming deployment, not wanting to leave units understaffed and station assignments far from social support—as significant reasons. Other military-related factors included the difficulty of living in the barracks during pregnancy, and long and inflexible work schedules that would have made raising a baby challenging. For example, one enlisted army servicewoman said:

“I wanted to remain competitive in the military....Pregnancy will hold you back like at least a year and a half, two years....I think if I wasn't in the military, I wouldn't worry about it as much, but just having a physically demanding job, it's hard to grow your family.”

Another enlisted army member remarked:

“I couldn't do my job if I was pregnant. I can't jump out of a plane....pregnant and stuff, and that's my job.”

A third enlisted army servicewoman said:

“I didn't need the stigma of looking like a complete drop-out....'cause again, the military, super 'hooahs,' totally guy-oriented. And I really didn't need to deal with going on light duty and trying to figure out a new schedule.”

Participants also noted that pregnancy compounded the challenges women faced in the military. For example, an enlisted army servicewoman said, “It's already harder to be a female in the military, whether you get pregnant or not.” Nine respondents mentioned that they might have made a different decision if they were stationed elsewhere or not in the military. An enlisted navy servicewoman stated, “If we had been home...we would've kept it.”

Experiences Seeking Abortion

In regard to their pregnancy and abortion experiences, servicewomen cited overlapping concerns about confidentiality, and abortion stigma and its career impact. As a result, only 11 visited or called a military treatment facility during

their pregnancy, most often to get or confirm a pregnancy test.

•**Confidentiality.** Those who did not go to a military facility reported having concerns that their pregnancy would go in their military record, their commander would be alerted or others would gossip. Seven women disclosed their abortions to their chain of command because they needed to request time off for the abortion, they had to explain side effects or they knew that the pregnancy would be documented in their record; three respondents mentioned feeling comfortable disclosing to a female officer. Commanders were typically supportive after finding out; one service-woman's supervisor accompanied her to the abortion clinic.

Three women reported that their commanding officers found out without their disclosing the information. One air force officer said that after she had a pregnancy test at a military treatment facility, her pregnancy was recorded in her file and, per protocol, automatically reported to her chain of command. She explained, “When you...get the paperwork back, there is a code that's a pregnancy code.” Her commander approached her with congratulations after finding out she was pregnant.

The women who did not disclose their pregnancy to their chain of command scheduled appointments during non-work hours; some of those of higher rank were able to leave work without requesting time off. To maintain confidentiality, three participants waited to have their abortion until they were home for preexisting travel plans. One woman, stationed in Guam, found out she was pregnant when she missed her period, and postponed her abortion until the end of the following month, when she was scheduled to return to the continental United States for planned leave. The other two did not state how long they waited for their travel.

Privacy concerns also affected some women's choice of abortion method, as well as decisions concerning payment. An air force officer chose not to have a medication abortion because she was required to report all prescription medications. To protect her privacy, she instead had a surgical abortion without anesthesia. She remarked, “It was an invasive procedure, but it was more invasive to my privacy, and I preferred that they didn't know.” An enlisted army servicewoman wanted a medication abortion; however, for privacy reasons, she chose to have her abortion during planned leave out of state, and ended up having to have a surgical procedure, because it did not require in-person follow-up.

Four women reported intentionally not trying to use insurance because of privacy concerns. One army officer said, “I didn't consider using any insurance....I guess I'm a very private person, and I don't want people to know this.”

•**Stigma and career impact.** Participants commonly cited concerns about stigma and the impact on their career should anyone in the military find out about their pregnancy or abortion. An enlisted navy servicewoman reported:

“I did not tell my chain of command at all. Part of that was because I'm only one of the very few females that

works within my department....There's a lot of like negative stigma that kind of goes along with that....I was recently promoted,...and this was right before my promotion."

An enlisted air force servicewoman explained why she "didn't even consider" going to a military treatment facility by saying, "It has been my experience with friends that they've had negative repercussions...for seeking help [for an abortion] through the military." She further recounted, "I have seen people not necessarily get kicked out, but I have seen their careers affected by [abortion]." In a similar vein, an enlisted army servicewoman reported, "I didn't want the army to know until after [the abortion] was over and done with, because I didn't know what they would've done."

Women also discussed the indirect effects that trying to maintain their privacy had on their career. An enlisted army servicewoman requested time off for an "appointment." She ended up being out for the entire day for her abortion procedure and missed a call from her commander requesting that she come back in to work. As a result, she was issued a "negative counseling," a disciplinary form, for not being at her place of duty.

Although many women who told their chain of command about their abortion had positive experiences, servicewomen sometimes had conflicting experiences within their chain of command. The participant whose supervisor accompanied her to the clinic reported that another commander (whom she did not tell directly) told her she might have to change work assignments because he believed that her abortion might "permanently damage" her body and that she might be emotionally unstable afterward.

Logistics of Care

Seventeen servicewomen had surgical abortions, and four had medication abortions. Job requirements, work schedules and the possibility of deployment influenced some women's choice of method. Five had a surgical abortion because of the quicker recovery or minimal follow-up; this was especially important for those who were or might be traveling. One air force officer explained:

"If you do the medical abortion, you have to go in for a checkup three weeks after you take the pills, and I wasn't sure if I was going to be here or not....I may have been deployed. So I opted for the surgical."

All participants had their abortion in the United States, except one, who had hers off base while stationed in Germany. Seventeen servicewomen found abortion clinics via the Internet, one received assistance from a family member, and three were given a list of local providers by a military treatment facility. An enlisted navy servicewoman reported that a military provider said that she could not officially provide referrals, but informally shared names of clinics that friends had used. Two participants went to clinics they had previously been to for abortion care. Most traveled about an hour each way to the clinic (travel time ranged from five minutes to two hours); three in Louisiana and Texas had to visit the clinic on two days because of state abortion restrictions.

Three participants in Washington had state Medicaid insurance in addition to TRICARE and had their abortions covered by Medicaid; of those, two enrolled during their abortion visit. All others paid out of pocket for their procedure; costs averaged \$493 and ranged from \$320 to \$800. Seven women split the cost with the man involved in the pregnancy, one split the cost with a family member, and seven used military discounts offered by clinics.

The Policy's Impact on Women

Nearly all participants—regardless of their stance on the policy itself—reported that the policy had negative effects on servicewomen, including health consequences, financial and logistical burdens, emotional effects and career impacts. Only two felt that the policy positively affected servicewomen—believing that it kept the military out of their personal affairs.

•**Health consequences.** Five women noted health consequences of the abortion policy. In one case, not knowing the policy delayed access to services. An air force officer had assumed the military provided abortion and gone to a military treatment facility for her pregnancy test; the results took one week to come back. She stated:

"I was kind of freaking out because obviously I was thinking about having an abortion, and I knew every week longer that I waited, that it would make the decision a lot more difficult. I finally got in with a [military] provider... and they informed me then that they wouldn't [perform abortion]. So it kind of angered me a little bit, because I could've probably gone to Planned Parenthood and gotten the results a lot faster."

An army officer, who did not want to disclose her abortion, explained that she was unable to recover as medically recommended:

"I was still bleeding, and I wasn't able to, like, use the restroom whenever I wanted, and I had to wear like tampons and stuff, which I know you're not supposed to do after....I wasn't able to follow the postop instructions as much as I wanted to. And if I would've had the option, I definitely would've called in [to take time off]."

An air force officer said:

"[The military treatment facility] made it adamantly clear...if anything happened to you, I wouldn't be covered, like, God forbid, something went wrong with the procedure."

An enlisted air force servicewoman stated that the policy could make some servicewomen, especially when deployed, receive substandard health care if they got care locally:

"We can be stationed all over the world, and...for other places that aren't up to par with their health care standards,...you're putting women in a really dangerous situation where they're probably not getting the safest health care, they probably don't have access to the most modern technology, and it's just putting them in a really bad situation overall."

•**Financial burden.** Five servicewomen noted the financial burden of paying for an abortion out of pocket; for some, the abortion cost them an entire paycheck. One enlisted army servicewoman recounted how she had to piece together the payment, which delayed her care:

“The ultrasound my sister helped me pay for because it was like last minute, and I didn’t have enough money. But I had half of it, and she paid for the rest. And then I had the abortion like a week or two after, and I paid for that with an entire check....It was hard because it was all last-minute, and I had to think about it and plan how I’m going to spend my money.”

Some participants noted that financial barriers could be especially hard for younger or junior enlisted women. For example, an air force officer commented, “It’s kind of disheartening to think about the younger airmen or enlisted personnel that maybe don’t get paid as much, to know that that chunk of money is kind of a huge portion of their paycheck....[and] that they don’t cover that under our medical plan.”

•**Logistical burden.** Six respondents mentioned the logistical burden of traveling off base to obtain abortion care. An air force officer stated, “The military makes it easy for you to have kids, but not easy for you to not have kids.” She went on to explain, “Some weeks, it would’ve been impossible for me to get free time [to have an abortion].” Another air force officer commented, “You have enough to go through. And then also you have to think about the cost of it and...the extra steps, instead of it just being taken care of like [other health services] normally would.”

Two servicewomen noted that their abortion appointments were delayed because of inflexible work schedules or logistical difficulties, compounded by seeking care off base. One army officer explained, “In the evenings, I didn’t have any freedom. I was on training in Georgia, and so I didn’t have a car. And so that’s why I had to wait all the way until the weekend to go get a pregnancy test, and then I had to wait until the following weekend [for the abortion].”

•**Emotional impact.** Eleven servicewomen noted that the policy made them feel stressed, unsupported, judged, burdened or embarrassed. An enlisted navy servicewoman said that the policy “kind of makes me feel like a bad person.... Since they don’t offer it, it makes you feel like they’re not supportive of it, which makes it feel like if you were to go to medical, they would look down on you for it.” In contrast, two women reported having a positive emotional reaction upon learning that abortion is covered and provided by the military in cases of rape. An army officer stated, “[That] gives us reassurance that there’s someone that cares.”

Some who visited a military provider were disappointed or upset when they found out the military would not provide abortion care or counseling. An enlisted navy servicewoman said:

“I was pretty, pretty upset....I was looking for help because [the pregnancy] was an accident, and I didn’t want to bring a baby in the world if I can’t bring him up, give him a good life.”

Another enlisted navy servicewoman stated:

“Once I told them I wasn’t going to keep it, it was like, ‘Okay, you’re on your own.’ They couldn’t provide me any other help, even if that was something as simple as a reference.”

In many of these cases, women reported that military providers operated under the assumption that they planned to have the baby, and did not include any options counseling. An enlisted army servicewoman, who went to a military treatment facility thinking it would provide or counsel on abortion recalled, “It was awkward, ‘cause [my clinician] kept asking me....all these questions for people that want to keep the baby. But I didn’t want to keep the baby.” Others reported there was “virtually no information” about abortion options.

Some participants discussed feeling alone during the abortion process and thought formal military support such as an advocate or counselor would have been helpful. One enlisted navy servicewoman stated, “If they can’t help financially, maybe they could help emotionally.” Similarly, an enlisted respondent in the army, who had called a military provider after a positive pregnancy test, commented:

“What kind of shocked me was the fact that they didn’t even ask me to come in...to even just do a small ultrasound just to make sure that everything was okay and to talk to me face-to-face about my options. And they were pretty much saying, ‘Well, we don’t do that,’ unless I was raped or a victim of a sexual crime....I felt like the army [was] just kind of, like, ‘Okay, well deal with it on your own, and then you have to pay for it, too, on your own.’ And I just kind of felt, I don’t know, like thrown away...What also made me upset [was] that they didn’t even offer like, ‘Hey, there might be a family advocate that you would like to talk to about it first.’ Like nothing.”

•**Career impact.** Seven participants noted that the policy could harm female personnel’s career progression, and nine felt that it could stigmatize and burden servicewomen. Some felt unwanted pregnancies make servicewomen seem “useless” or “look bad” to their command, whereas others discussed the stereotypes, double standards and added difficulty that servicewomen face. One enlisted army servicewomen explained that the policy affects women greatly “because we’re expected to basically be able to do what males are able to do, but males don’t have the same circumstances that we do—mainly, that they cannot physically get pregnant, so they don’t have to deal with this.”

The Policy’s Impact on the Military

Eleven participants thought that by making abortion access difficult, the military’s policy could lead more servicewomen to carry unwanted pregnancies. Three thought that such pregnancies would affect the military’s finances, and seven that they would affect troop readiness and personnel.

One enlisted air force servicewoman stated, “From a financial perspective, you have people having kids who don’t necessarily want to have kids, and that’s more money that the military’s dishing out for health care or benefits

in general.” An army officer commented, “If you have a female soldier who wants an abortion, I don’t see why you would...pigeonhole her into having a child when it doesn’t make sense for you as the employer.” Others thought that resulting unwanted births could lead to fewer servicemembers’ being mentally or physically prepared for their jobs or deployment, which might affect overall troop readiness. For example, an enlisted army servicewoman, noting that women she knew had sought abortion care because they wanted to deploy with their units, commented that the military “definitely...would have a more successful readiness rate” if it covered abortions. An army officer stated:

“You are losing a lot of female servicemembers, because of the fact that some...might not be financially secure enough to pay for the abortion out of pocket. So they decide to continue with the pregnancy....I feel like it affects [the military’s] strength in numbers.”

In contrast, one air force officer felt the military’s abortion policy had a positive effect, and believed that it kept the military “out of controversy.” An enlisted army servicewoman was concerned that abortion coverage or provision in cases of rape may encourage false rape allegations; however, she supported the policy.

Knowledge and Opinions of the Policy

Only 11 participants had any knowledge of the military abortion policy. Of these, two were aware only of the exception in cases of rape, and nine were aware only of the exceptions in cases of incest and life endangerment. Most had learned about the policy after becoming pregnant and seeking care at a military treatment facility.

All participants were doubtful that other servicewomen knew about the policy, because of the lack of education by the military. An enlisted army servicewoman commented, “I can ask all my friends, and I bet they would tell me no, they’d never heard. We don’t hear anything much about women’s issues.” Several participants speculated that the lack of education was related to gender dynamics. For example, an enlisted army servicewoman asserted, “The military in general is obviously a male-based job, and I don’t think any of the males care.” Two participants—a medical provider and one who had served for 12 years—expressed surprise that they had never been briefed on the policy, given that they worked in the medical field and had served for a long time, respectively. Ten mentioned that the military should be more proactive in educating personnel about the policy.

After being briefed about the policy, 15 participants believed that abortion care should be covered or provided at military treatment facilities in all cases. They commented that the military should not be able to “pick and choose” which health needs are covered, and that it was a matter of fairness. One enlisted army servicewoman said, “They should allow abortions because we’re serving our country.” Another commented, “We pay for TRICARE. It’s not like it’s free. We pay for it, so the medical insurance that we pay

for, we should be able to use it when we need to use it.” And another, who felt abortion should be treated like any other medical procedure, explained, “We don’t always plan to break our leg, but the government still pays to manage and take care of us when that happens.” Several of these participants believed abortion care should be covered by TRICARE, but personally preferred a nonmilitary provider to keep it off their medical record or for fear that someone might see them going to the military clinic.

On the other hand, six participants thought TRICARE should not cover abortion for general indications or had mixed feelings. A few of these women stated that their pregnancy was their “fault” or “mistake.” As an air force officer expressed, “It is expensive, but I made my bed, and now I’m going to lay in it....I don’t think the taxpayers should pay for my mistake.” Most cited concerns about confidentiality and their careers’ being negatively affected if the military were involved. The air force officer explained that while she wanted to be under the care of her own doctor, she was more concerned about the possible impact on her career:

“I don’t know if the military would use, I don’t want to say, use that against you, but you know, when you’re coming up for promotions.”

Other participants expressed concerns about the paper trail that an abortion would leave. One enlisted navy servicewoman stated, “I feel like it’s a good thing that the navy is not involved with the whole abortion process or paying for it....Once they start snooping, then they’re going to have an opinion [about] what you can and what you can’t do [in your career].” She added, however, that an exception could be made during deployment, given that flying from an overseas setting could be especially burdensome.

DISCUSSION

In speaking about their experiences with and perceptions about pregnancy and abortion in the military, servicewomen cited frequent and interconnected concerns about confidentiality, stigma and possible negative effects on their career. These factors prevented about half of women from seeking care through military channels. Women described a range of consequences of not disclosing their abortions—from inability to follow medical guidelines after the procedure and adverse health effects of unsafe care to negative career impacts because of an unexplained work absence. On the other hand, few who had gone to a military treatment facility while pregnant had been counseled on abortion options or given a referral.

Most participants did not have accurate knowledge of the military’s abortion policy. After learning about it, however, the majority felt that the military should provide and cover abortion. Servicewomen associated the policy with negative consequences for individual women and the military. At the same time, women’s apprehension about the military’s involvement in abortion care—in terms of privacy issues and possible negative career impacts—indicates a need for greater reassurance about confidentiality and reduction of

abortion-related stigma in the military medical environment and broader military culture.

A minority of women in our study were against TRICARE's covering abortion; these women cited concerns about confidentiality and potential negative effects on their career if the military were involved, and some felt personally responsible. By contrast, among U.S. abortion patients more generally, Cockrill and Weitz found support for restrictions that women perceived as protective and opposition to ones they perceived as added burdens; however, women tended to be in favor of public financial coverage of abortion through Medicaid.¹⁰ Our finding may reflect a heightened concern about confidentiality among women in the military, as they are in a closed system, in which they live and work alongside their medical providers.

The barriers to abortion care faced by the servicewomen in this study have some parallels to those faced by civilian women in the general population. State restrictions and abortion regulations lead to increased cost and travel time to obtain care,^{11–14} which can compromise women's health, privacy and finances.¹¹ Many military bases in the continental United States are located in remote areas of states with restrictive abortion policies, where women face the combined impacts of military restrictions and local obstacles to care. Women who are deployed abroad or at sea face even greater geographic barriers.

Our findings highlight the need for several policy and practice changes to improve care for servicewomen. First, as recommended by many respondents, the military's abortion policy should be disseminated among all servicemembers. Half of our study participants had no knowledge of the policy, and only two knew about provision and coverage in cases of rape. Consistent with our findings, in a 2010 survey of U.S. servicewomen who had ever been deployed, only 8% knew the policy in cases of rape.¹⁵ Given that more than one in seven U.S. servicemembers are female¹ and that pregnancy is the primary reason for women's noncombat medical evacuation from deployment,¹⁶ it is paramount that military personnel receive full information about reproductive health services and policies.

Many participants had expected the military to provide abortion care or counseling and had been surprised or angered when they were turned away. In addition, not knowing the policy in advance caused some women to experience delays in care. The 2016 National Defense Authorization Act mandates that clinical practice guidelines be established for contraceptive care and that servicemembers have access to comprehensive contraceptive counseling during annual, predeployment and deployment health visits;¹⁷ information on abortion services and coverage could be added to such counseling.

Additionally, our results suggest a need for abortion referral and support guidelines. For some women, the lack of counseling and support made a difficult situation worse. It also represents a missed opportunity to engage women in the health care system and to facilitate their smooth recovery postabortion, especially if they have received care

at a nonmilitary facility. Furthermore, some women faced assumptions from military providers regarding their pregnancy intentions, or even received default prenatal counseling following a positive pregnancy test. Counseling on and referrals for the full range of pregnancy options are needed.

The study's findings also highlight the need for improved confidentiality in military health services. Many women avoided the military system because of concerns about privacy and the possible negative impact on their career—concerns that were at least in part validated by one respondent's experience of having her pregnancy reported to her chain of command. Operational needs to know about pregnancy must be balanced with women's need for privacy. Similar findings were previously reported in research highlighting confidentiality concerns and health-seeking stigma during deployment. Servicewomen commonly need to inform their chain of command to access health care, and in some cases, they have to disclose the reason for care.^{9,18} Also, women report that it is challenging to maintain confidentiality while accessing health services because of "gossip" and the close quarters of the military base.⁹ Addressing these issues is paramount to ensure that servicemembers feel comfortable and safe accessing all health care.

This study provides additional information that supports changing military abortion coverage and provision policies. Most participants believed the military should both cover and provide abortion care, and several felt that current restrictions were unfair in excluding a health service from coverage, especially one necessary for maintaining troop readiness. On average, women reported paying about \$500 for their abortion. For a junior enlisted servicewoman with four years' experience, this represents nearly one-quarter of her monthly salary, and for those of lower ranks, it is roughly one-third.¹⁹ Some abortions cost participants their entire paycheck.

Limitations

There are several limitations to this study. We used a self-selected convenience sample, to which women opted in by contacting the researchers, and this may have introduced bias. Our results are not generalizable to the military as a whole, but rather provide insight into some servicewomen's experiences accessing abortion. We interviewed only women who had had abortions in clinics, and did not capture experiences of women who were unable to get abortion care, or who sought abortion online or through other informal and possibly unsafe means. Furthermore, women recruited from clinics near military bases (the majority of our participants) may have had easier access to services than other women. Participants were recalling experiences from up to two years prior, so some potential for error is possible. Finally, interviews discussed potentially sensitive information that some servicewomen may not have been comfortable disclosing to an interviewer.

Conclusions

This study provides new data on servicewomen's experiences seeking abortion during military service and knowledge and attitudes of the military's abortion policy. These findings highlight the challenges servicewomen may face in accessing abortion, as well as a number of policy solutions to better meet their needs. Further research on the prevalence of abortion in the military is needed. In addition, studies should explore the experiences of women who are unable to access abortion during military service.

REFERENCES

- Office of the Deputy Assistant Secretary of Defense (Military Community and Family Policy), 2014 *Demographics: Profile of the Military Community*, 2014, <http://download.militaryonesource.mil/12038/MOS/Reports/2014-Demographics-Report.pdf>.
- Grindlay K et al., Abortion restrictions in the U.S. military: voices from women deployed overseas, *Women's Health Issues*, 2011, 21(4):259–264.
- Ritchie EC, Issues for military women in deployment: an overview, *Military Medicine*, 2001, 166(12):1033–1037.
- Grindlay K and Grossman D, Unintended pregnancy among active-duty women in the United States military, 2011, *Contraception*, 2015, 92(6):589–595.
- Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852.
- Legal Information Institute, *US Code § 1093, Performance of Abortions: Restrictions*, 2013, <http://www.law.cornell.edu/uscode/10/1093.html>.
- P.L. 112–239, Jan. 2, 2013.
- Burrelli DF, *Abortion Services and Military Medical Facilities*, Washington, DC: Congressional Research Service, 2013.
- Manski R et al., Reproductive health access among deployed U.S. servicewomen: a qualitative study, *Military Medicine*, 2014, 179(6):645–652.
- Cockrill K and Weitz TA, Abortion patients' perceptions of abortion regulation, *Women's Health Issues*, 2010, 20(1):12–19.
- Fuentes L et al., Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas, *Contraception*, 2016, 93(4):292–297.
- Gerds C et al., Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas, *American Journal of Public Health*, 2016, 106(5):857–864.
- Roberts SC et al., Implications for women of Louisiana's law requiring abortion providers to have hospital admitting privileges, *Contraception*, 2015, 91(5):368–372.
- Karasek D, Roberts SC and Weitz TA, Abortion patients' experience and perceptions of waiting periods: survey evidence before Arizona's two-visit 24-hour mandatory waiting period law, *Women's Health Issues*, 2016, 26(1):60–66.
- Grindlay K et al., US military women's experiences with unintended pregnancy and abortion during overseas deployment, paper presented at the annual meeting of the National Abortion Federation, Chicago, Apr. 9–12, 2011.
- Belmont PJ, Jr., et al., Disease and nonbattle injuries sustained by a U.S. army brigade combat team during Operation Iraqi Freedom, *Military Medicine*, 2010, 175(7):469–476.
- P.L. 114–92, Nov. 25, 2015.
- Grindlay K and Grossman D, Contraception access and use among U.S. servicewomen during deployment, *Contraception*, 2013, 87(2):162–169.
- United States Army, Army pay chart and basic pay: active duty soldiers, 2017, <http://www.goarmy.com/benefits/money/basic-pay-active-duty-soldiers.html>.

Acknowledgments

The authors thank Bridgit Burns, Jocelyn Fifield, Stephnie Igharosa, Sharon Lebenkoff and Elizabeth Sanderman for their assistance with data collection and coding. They gratefully acknowledge the Society of Family Planning Research Fund for its generous support of this work.

Author contact: kgrindlay@ibisreproductivehealth.org