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Abortion Restrictions in the U.S. Military: Voices from Women Deployed Overseas

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A B S T R A C T

Purpose: U.S. military women and dependents have few options for abortion when facing an unintended pregnancy overseas. Federal law prohibits the use of Department of Defense facilities and funds for abortion except when the woman's life is at risk, and privately funded abortions are permitted at military facilities only if a pregnancy is the result of rape or incest. The purpose of this study was to explore military women's experiences seeking abortion care during overseas deployment.
Methods: We reviewed routine consultation data and user queries from an online service providing information about medication abortion. Information received between September 2005 and December 2009 from U.S. military women and dependents overseas was included. All women gave consent for anonymous use of their data, which were analyzed qualitatively for themes related to experiences seeking abortion.
Findings: Data were analyzed for 130 women, including 128 women in the U.S. military and 2 military dependents. Women reported facing numerous challenges accessing abortion overseas, including legal and logistical barriers to care in-country, and real or perceived difficulties accessing abortion elsewhere owing to confidentiality concerns, fear of military reprimand for the pregnancy, and the narrow timeframe for early abortion. With no perceived alternatives, some women considered unsafe methods to terminate the pregnancy themselves.
Conclusion: U.S. servicewomen overseas lack access to safe abortion services, which may place their health and careers in jeopardy. These women should have the same rights to abortion care as women living in the United States.

Introduction and Background

Women make up 14% of the U.S. military's active duty (AD) forces, and 97% are of reproductive age (Defense Manpower Data Center, 2010; Office of the Undersecretary of Defense, 2008). The most comprehensive data on unintended pregnancy in the military, conducted among a representative sample of AD women age 18 to 44 years participating in the *2005 Department of Defense Survey of Health Related Behaviors among AD Military Personnel*, found an unintended pregnancy rate of 97 per 1,000 women in the prior 12 months (117 per 1,000 women when adjusted for underreporting of abortion; Lindberg, 2011). Although this is higher than the unintended pregnancy rate among the general U.S. population, which was 51 per 1,000 women age 15 to 44 in 2001 (Finer & Henshaw, 2006), there are more younger women in the military than in the general population (Defense Manpower Data Center, 2010; U.S. Census Bureau, 2011), making comparisons difficult. If the military unintended pregnancy rate range is extrapolated to the 198,000 AD female military population of reproductive age (Defense Manpower Data Center, 2010), there are between 19,200 and 23,100 unintended pregnancies in the military each year.

Despite the high number of unintended pregnancies, federal policy under U.S. Code 1093 states that no Department of Defense (DoD) facility or funds may be used for abortion except when the life of a woman is at risk; if a pregnancy is the result of

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rape or incest, women are allowed to have an abortion at a military facility, but it must be paid for out-of-pocket by the woman (Legal Information Institute, 2010). In all circumstances, military doctors are allowed to refuse to provide abortion services on moral or religious grounds (Burrelli, 2002); however, health care providers with religious or moral objections in reproductive medicine have an obligation to either refer elsewhere for care or provide emergency care if no alternatives are available (American College of Obstetricians and Gynecologists Committee on Ethics, 2007).

The implications of these abortion restrictions are most salient for women deployed overseas, for whom there may be few or no safe abortion alternatives. Even if a woman is able to pay for services herself, abortion is legally restricted in many countries where troops are deployed (United Nations, 2007). Furthermore, although federal policy allows for abortion in cases of rape, incest, and life endangerment at military facilities, limited data suggest that they are seldom performed for any indication. According to DoD data, only two abortions were performed in U.S. military facilities worldwide in 1999, and in 2000 there was only one therapeutic abortion reported (Burrelli, 2002). However, studies have found between 9.5% and 33% of women experience an attempted or completed rape while serving in the military (Turchik & Wilson, 2010), and it is expected that at least some women who become pregnant after sexual assault would choose to abort. Pregnancy that endangers a woman's life is likely rare among servicewomen, given the required health screening during recruitment, but it clearly does occur (Haas, Rivera-Alsina, & McNamara, 2005). The few abortions performed for these indications suggest that women are obtaining them from alternative sources.

There are several possible explanations as to why the number of abortions performed is so low for allowable indications. First, women may simply not want military involvement for a variety of reasons, and therefore would seek abortion care outside of the military system. Another factor may be the fact that the DoD usually follows host-country laws (Burrelli, 2002). As a result, even if a woman qualifies for an abortion in a military facility, she may not be able to access services in the country of deployment if it is prohibited under local law. In Afghanistan and Iraq, for example, where the majority of troops are deployed (DoD, 2010), a woman qualifying for an abortion at a military facility for rape or incest may not be able to access care in-country because abortion is banned in these countries except to save the life of a pregnant woman (United Nations, 2007). There are also few abortion providers in the military (Burrelli, 2002) owing to both limited abortion training in military residency programs (Almeling, Tews, & Dudley, 2000; Steinauer, DePineres, Robert, Westfall, & Darney, 1997) and to a lack of provider willingness. A 1994 DoD survey of 44 military obstetrician/gynecologists found that all refused to perform abortions (Burrelli, 2002).

A systematic review we recently performed did not identify any studies of servicewomen's experiences with abortion or unintended pregnancy during deployment (Holt, Grindlay, Taskier, & Grossman, 2011). Given this dearth of information and the restricted abortion access for deployed women in the U.S. military, we sought to explore women's experiences seeking abortion care during overseas deployment.

Methods

We conducted a retrospective, qualitative study analyzing data from women seeking information on medication abortion from an online service. These data came from two distinct sources: 1) de-identified e-mail queries from women looking for information on how to access medication abortion services, and 2) responses to standardized questions that were part of the online consultation to determine eligibility for early abortion. We reviewed all e-mail communication and consultation data received by the online service between September 2005 and December 2009 from women overseas who reported being on AD in the U.S. military or dependents of U.S. military personnel. All women gave consent for anonymous use of their data, and we received ethical approval for the study from Allendale Investigational Review Board.

Consultation data provided standardized information on women's age, number of children, and deployment location. It also provided information on the circumstances surrounding the unintended pregnancy (contraceptive failure, contraception non-use, rape) and reasons for seeking abortion (bad time in life for a child, no money to raise a child, wants to finish school, too young/old, family is complete, illness); if these questions were not answered as part of the consultation, where possible, user comments were used to determine coding. Additional reasons for seeking abortion that were specific to the military environment were coded inductively from user comments according to grounded theory methods (Charmaz, 2006). Textual responses were also coded inductively for themes related to women's experiences attempting to access abortion during overseas deployment. Coding was performed primarily by one investigator and reviewed by a second investigator to confirm coding. The country of deployment is noted with each quote reported here. The quantitative data reported here serve to provide background information on the study population; they cannot be generalized to the overall population of servicewomen seeking abortion as they come from a self-selected population and not a representative sample.

Results

Data were analyzed for 130 women, including 128 women in the U.S. military and 2 military dependents (one military spouse and one daughter). Background characteristics of participants are shown in Table 1. Eighty-eight women provided information on age and number of children. The median age was 26 years and median number of children was one; just under half of women (44%) had no children, half (49%) had one or two children, and 7% had three or four children. Among all 130 women, the majority (68%) were located in countries where abortion is banned except to save the life of the woman: Iraq (55%), Afghanistan (12%), and the United Arab Emirates (1%). One quarter of women were located in countries where abortion is permitted for specific indications only (Kuwait [14%], South Korea [8%], Bahamas [1%], and Samoa [1%]), and 7% of women were in countries where abortion is permitted for any indication (Bahrain [5%], Guam [1%], and Kosovo 1%]; United Nations, 2007). Two women reported being at sea and one woman did not report her location.

Circumstances of Pregnancy

As part of their routine consultation, women were asked about the circumstances of the pregnancy. Roughly half of women in this sample reported their pregnancy was attributed to contraceptive failure, one third to contraceptive non-use, 4% to rape, and 18% did not respond (Table 2). A few women wrote about difficulties accessing reproductive health services during their deployment, including not being able to obtain emergency

Table 1
Background Characteristics

Characteristic	*n* (%)
Age, yrs	88
18–25	37 (42)
26–35	42 (48)
36–44	9 (10)
Mean	27 years
Median	26 years
Number of children	88
0	39 (44)
1–2	43 (49)
3–4	6 (7)
Median	1
Location (with country abortion policies)	130
Iraq[*]	72 (55)
Kuwait[*,†,‡,§]	18 (14)
Afghanistan[*]	15 (12)
South Korea[*,†,‡,§,¶]	11 (8)
Bahrain[*,†,‡,§,¶,‖,#]	6 (5)
Bahamas[*,†,‡]	1 (1)
Guam[*,†,‡,§,¶,‖,#]	1 (1)
Kosovo[*,†,‡,§,¶,‖,#]	1 (1)
Samoa[*,†,‡]	1 (1)
United Arab Emirates[*]	1 (1)
At sea or unknown	3 (2)

Abortion Policies (United Nations, 2007):
[*] To save the woman's life.
[†] To preserve physical health.
[‡] To preserve mental health.
[§] Fetal impairment.
[¶] Rape or incest.
[‖] Economic or social reasons.
[#] On request.

contraception or gynecologic care, which may have contributed to challenges preventing pregnancy for some women.

Reasons for Seeking Abortion

Women reported numerous reasons for wanting an abortion during their overseas deployment (Table 3). Many of these reasons were similar to those that have been reported for women in the general U.S. population (Kirkman, Rowe, Hardiman, Mallett, & Rosenthal, 2009), including it is a bad time in life for a child (78%), they are not financially stable (32%), they want to finish school (13%), they are too young or old (13%), and/or their family is complete (9%); no women reported illness as a motivator, which is most likely because servicewomen are screened for adverse health conditions before deployment. These reasons were included as predetermined response options on the standardized consultation, and women often indicated multiple factors that contributed to their decision to seek an abortion.

Textual responses provided two additional military-specific factors that contributed to some women's decisions to have an abortion. First, many women were seeking abortion so as to continue their military tour. Contrary to beliefs by some that women may become pregnant to avoid military service or an overseas deployment (Ritchie, 2001), we found women did not want to leave their military tour for either an abortion or to have a baby. As one woman in Iraq wrote, "Is there any way you could help me with this so I don't have to leave my duty? I would really appreciate this and it means a great deal to me to be here right now" (Iraq 1). Another woman in Iraq wrote about how hard she had worked for her promotion and that she wants an abortion because she "deserve[s] to finish [her] mission" (Iraq 2).

For other women, the decision to have an abortion was related to fears of military reprimand for being pregnant. Women reported being apprehensive about getting "kicked out" of the military, going to military prison, or losing rank for their pregnancies, and they did not want the military to know about the pregnancy. This was captured by a servicewoman who, in explaining her desire for an abortion, wrote, "I DO NOT want to get into any trouble because of my mistake. . . . I feel like this is my only option without jeopardizing my career" (Unknown location 1).

Table 2
Circumstances of Pregnancy

Circumstance	*n* (%)
Contraception failure	57 (44)
Did not use contraception	44 (34)
Rape	5 (4)
No response	24 (18)

Table 3
Reasons for Seeking Abortion

Reason	*n* (%)
Cannot have child at this time in life	101 (78)
No money to raise a child	42 (32)
Wants to finish school	17 (13)
Too young/too old	17 (13)
Family is complete	12 (9)
Illness	0
No response	17 (13)

Note. Multiple responses allowed.

Barriers to Care

Because of the federal prohibition against using DoD facilities or funds for abortion (with the aforementioned limited exceptions), U.S. servicewomen overseas wanting to terminate a pregnancy must pay for all medical costs out of pocket and seek services on their own, either in the country of deployment or outside of the country using their annual leave. Women reported many challenges accessing abortion services in both cases, however, with barriers falling under two domains: 1) legal restrictions and logistical barriers to care in-country, and 2) institutional and social barriers to care in another country.

Legal restrictions and logistical barriers to care in-country

Accessing care in-country would cost less money and take less time, because women would not have to be evacuated (which can cost as much as $10,000 per pregnant woman; Ritchie, 2001), and would enable women to continue their military deployment. However, the majority of women in the sample were deployed in countries with legal restrictions against abortion (92%), with few or no safe abortion options. Numerous women reported feeling "desperate" for not having abortion care through the military or any safe abortion options where they were stationed. Women furthermore reported mobility limitations that prevented them from travelling in-country to access care off-base in the cases where it may be available. The inability to travel locally for care was in some cases due to being at sea for extended periods of time, and in others the result of combat operations or other unsafe conditions related to the deployment that required servicewomen to remain on-base. As a woman stationed in the United Arab Emirates wrote, "I am near Abu

Dhabi, but I am on a secure installation and it's very, VERY rare that we get to go outside of the wire" (UAE 1).

Institutional and social barriers to care in another country

In addition to the legal restrictions and logistical difficulties women faced in trying to access an abortion in-country during deployment, many women reported real or perceived institutional and social barriers that discouraged them from seeking annual leave to have the abortion elsewhere. The fear of facing punishment if military authorities knew about their pregnancy, even in cases of rape, both contributed to some women's desire to have an abortion, as previously described, as well as their difficulties in accessing one. In most cases, to take leave in the middle of a deployment, women would need to explain the reason why to their chain of command—and because of concerns of being punished, many women were reticent to tell military authorities about their pregnancy or have military involvement. This is illustrated by the following woman who wrote:

> Well I'm coming close to 9 weeks pregnant. . . . I'm in Iraq because I'm in the Army and being out here we are not allowed to have sexual intercourse and I did anyway. . . . Now I'm in this position and I can't tell anyone because they will try everything in their power to either get me in the worst trouble . . . or just discharge me out of the Army and I don't want that to happen to me. . . . It's happened to four females out here already and I'm scared" (Iraq 3).

For some women, the fear of military reprimand was linked to concerns of losing their source of income, which was an important means of support for their families. A woman in Iraq spoke about how she could not receive an abortion in the country where she was deployed, and also did not want to seek permission to leave the base because she feared she would lose her salary: "I am in the U.S. Army and I cannot receive an abortion while deployed to Iraq. If the Army finds out that I am pregnant they will kick me out of the Army. The salary I earn supports my mother and two sisters at home. I cannot afford [for] this to happen. Please, please help me" (Iraq 4).

Although women on U.S. military bases should be able to receive abortion services for pregnancy resulting from rape, five women in our sample reported being sexually assaulted and were seeking to terminate their pregnancy outside of the military system. All five women did not provide information about why they were seeking abortion outside a military facility; however, two women specifically reported not wanting military involvement. One woman feared she would not be believed about the rape and could risk her career if the military found out: "I am a single female serving my country in the country of Iraq. I didn't report my situation to anyone here because we already had a female cry wolf on a rape situation here early on in this deployment and I did not want to be looked at like a liar immediately. No I do not know my attacker. No I did not file a report. No I am not going to. I could lose my career" (Iraq 2). Another woman who was raped thought her reasoning was self-evident: "I am in the military and got raped and became pregnant. For obvious reasons I would like to just move on without military intervention" (South Korea 1).

Among the numerous difficulties servicewomen reported with regard to accessing abortion services overseas, concerns about maintaining confidentiality and/or being judged by others were among the most frequently mentioned. Some women were apprehensive about others finding out about their abortions owing to perceived breaches of confidentiality, and for this reason wanted to have the abortion without military involvement. This is exemplified by one woman who wrote that she would normally seek an Army physician for medical issues, but that "the Army makes it impossible to keep my pregnancy confidential and not everyone is open-minded about abortions" (Iraq 5). In another circumstance, an 18-year-old dependent of a servicewoman based in South Korea did not want to visit a military doctor because she was worried that her mother would find out about her pregnancy.

For some women who either wanted or had to take annual leave to have an abortion there was an additional barrier: time. Abortion early in pregnancy is safer (Bartlett et al., 2004), and medication abortion is generally used only through 9 weeks of pregnancy (Wiegerinck et al., 2008). Compounding this already limited timeframe is the time it then takes to process their evacuation to the United States or other country with abortion access, schedule an appointment once they arrive, and wait for their visit. As one woman wrote, "it would take too much time for me to be sent back to the States and processed for me to meet the 9-week requirement for [a medication abortion]" (Iraq 5).

Impact of Abortion Restrictions on Women's Health and Careers

In some cases, with no other perceived alternatives, women reported considering unsafe methods to terminate the pregnancy themselves. A 23-year-old woman stationed in Bahrain wrote about being turned away from five clinics and that she contemplated taking "drastic measures that would have harmed me in ways I wouldn't like to imagine" (Bahrain 1), and another 24-year-old woman desperately wrote, "they will not let me stay here and I cannot afford to live back home so I'm thinking of doing something real bad; please help me" (Iraq 6). Some women also reported that their careers might be harmed if they were not easily able to obtain an abortion. A few women feared losing rank due to the pregnancy; one woman wrote that the military would not allow her to stay on AD if she were a single parent, and that her career would be lost if she had to have the baby.

Discussion

This study provides a glimpse into some of the challenges faced by U.S. military women seeking abortion during an overseas deployment, while at the same time highlighting their motivations for choosing pregnancy termination. Although their reasons for seeking abortion are not unique, it is striking that some were specifically motivated by a desire to complete their tour of duty or continue their military career. The cases of women who were raped are particularly concerning, because these women should be able to access abortion care at a military facility.

Our finding that almost half of women reported their pregnancy was attributed to contraceptive failure is similar to prior research with servicewomen, which found that 35% to 53% of unintended pregnancies were attributed to contraceptive failure (Biggs, Douglas, O'Boyle, & Rieg, 2009; Clark, Holt, & Miser, 1998; Robbins, Chao, Frost, & Fonseca, 2005). In two recent studies conducted among women presenting at outpatient facilities during Operation Iraqi Freedom, investigators found hormonal methods were the most common contraceptive used by servicewomen; however, 16% to 20% of women reported forgetting to take their pills or replace patches during deployment, and half of those using the patch reported that it fell off owing to climate and other deployment conditions (Nielsen, et al., 2009; Thomson & Nielsen, 2006). These studies furthermore found that 45% to

61% of women reported using no method of contraception or abstinence only (Nielsen et al., 2009; Thomson & Nielsen, 2006). Contraceptive non-use among servicewomen has been found to be related to inconsistent availability of methods during deployment (Nielsen et al., 2009; Thomson & Nielsen, 2006), adverse side effects, and because women were not planning to have sex (Clark, et al., 1998).

Long-acting reversible contraception, such as intrauterine devices and implants, have low failure rates (Centers for Disease Control and Prevention, 2010) and are the most cost-effective reversible methods (Mavranezouli, 2009). The 2010 U.S. Medical Eligibility Criteria for Contraceptive Use advises that intrauterine devices are safe for women with and without children (Centers for Disease Control and Prevention, 2010). Long-acting reversible contraception methods are rarely used by servicewomen (Nielsen et al., 2009; Thomson & Nielsen, 2006), but may be particularly appropriate in a deployment setting, where remembering to take pills or other user-dependent methods, varying time zones, and accessing refills can pose challenges. The levonorgestrel intrauterine device may be particularly beneficial for servicewomen, because it is recommended for both pregnancy prevention and menstrual suppression. Long-acting reversible contraception methods should be more widely incorporated into the range of contraceptive options for servicewomen. Increased access to and use of these methods may help to prevent unintended pregnancies among women in the military.

Even with increased use of more effective contraceptive methods, some servicewomen will continue to have unintended pregnancies, because no method is 100% effective. These women need to have safe abortion options during their deployment overseas. As this study shows, legal restrictions and mobility limitations in the country of deployment prevent many women from accessing abortion care where they are stationed. For these women seeking abortion, the only option is to take annual leave to have the procedure in the United States or another country. This, however, can have high financial costs for the military; health costs, because the abortion may be time sensitive and evacuation may take too long, or because women may resort to unsafe methods to avoid evacuation; and operational and troop readiness costs, because women are forced to leave a deployment that is relying on their service.

As this study highlights, expanded abortion access in military facilities overseas is necessary but not sufficient to ensure that women can access safe, timely care. Abortion provision must also be accompanied by confidence that a reported pregnancy will not lead to reprimand, and that women's confidentiality will be maintained. A large number of women expressed fears of military punishment if their pregnancy was discovered by military authorities, even in some cases of rape. These concerns seem to stem from policies prohibiting or discouraging sexual activity during deployment. During Operation Iraqi Freedom/Operation Enduring Freedom, sexual relationships between unmarried people (Freakley, 2006), unmarried members of the opposite sex spending the night in the same living quarters (Turner, 2005), and pregnancy itself (Cucolo, 2009) have at varying times and locations been punishable offenses under General Order Number One, a United States Central Command order that lists prohibited activities for DoD personnel. Furthermore, sexual relationships are a chargeable offence under the Uniform Code of Military Justice, a Congressional code of military criminal law, in a number of circumstances (Brown, 2008). These policies create an environment of fear for some women, and may prevent them from accessing the safe, legal care that they are entitled to. Policies should instead emphasize the prevention of unintended pregnancies rather than punishing the women (and men) who have them. Furthermore, even if it is only a perception, women's concerns of confidentiality breaches in the military health system should be taken seriously and directly addressed so that women feel assured that their privacy will be respected for any health issue they may encounter.

Additionally, a policy of expanded abortion access overseas must also be accompanied by willing and able providers. Currently, even in circumstances in which abortion is allowed at military facilities, there may be no trained clinician to perform them. If military providers are unwilling or unable to perform an abortion, the DoD should contract out for providers who are able to provide this essential health service. Finally, the current DoD policy of following host country laws may prevent abortion for nearly all indications in some countries where troops are deployed. This places women's health and careers in jeopardy, and should not be applied to the provision of health services. There are examples of using medications on a U.S. military base that are not approved for use in the host country, such as emergency contraception (Stein, 2010), which might provide precedence for providing medication abortion, for example.

This study has several limitations. First, these data come from a self-selected population seeking information on medication abortion, and our sample is not representative of all U.S. servicewomen seeking abortion. AD women located in countries where abortion services are accessible may more easily obtain care off base. Second, because this was a retrospective study based on a convenience sample, our analysis is limited to the available data that women provided in their consultation, comments, and queries. Finally, although there are no published data on the incidence of abortion among servicewomen overseas, our sample likely represents a very small proportion of all military women seeking abortion during this time period. Despite these limitations, this study provides new information about how military policy adversely affects some women stationed abroad.

The women in this study reported numerous barriers to abortion care during overseas deployment, including legal and logistical barriers to care in-country, and institutional and social barriers to accessing care elsewhere. In some cases, these factors made women consider unsafe abortion methods to terminate the pregnancy themselves. Although additional research with a representative sample is needed to further explore these issues, these challenges indicate that efforts are needed to improve access to safe, confidential abortion services for military women and dependents overseas.

References

American College of Obstetricians and Gynecologists Committee on Ethics. (2007). ACOG Committee Opinion No. 385 November 2007: The limits of conscientious refusal in reproductive medicine. *Obstetrics and Gynecology*, 110, 1203–1208.

Almeling, R., Tews, L., & Dudley, S. (2000). Abortion training in U.S. obstetrics and gynecology residency programs, 1998. *Family Planning Perspectives*, 32, 268–271.

Bartlett, L. A., Berg, C. J., Shulman, H. B., Zane, S. B., Green, C. A., Whitehead, S., et al. (2004). Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics and Gynecology*, 103, 729–737.

Biggs, R. L., Douglas, B. H., O'Boyle, A. L., & Rieg, T. S. (2009). The impact of pregnancy on the individual and military organization: A postpartum active duty survey. *Military Medicine*, 174, 61–75.

Brown, D. (2008). Ban on sex for soldiers in Afghanistan lifted Sort of. Available: http://www.military.com/features/0,15240,167950,00.html. Accessed August 24, 2010.
Burrelli, D. F. (2002). *Abortion services and military medical facilities*. Washington, DC: Library of Congress.
Centers for Disease Control and Prevention. (2010). *US medical eligibility criteria for contraceptive use, 2010*. Atlanta, GA: MMWR. 59(RR-4).
Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
Clark, J. B., Holt, V. L., & Miser, F. (1998). Unintended pregnancy among female soldiers presenting for prenatal care at Madigan Army Medical Center. *Military Medicine*, 163, 444–448.
Cucolo, A. A. (2009). General Order Number 1 (GO #1). Available: http://documents.nytimes.com/general-order-no-1-prohibited-activities-for-soldiers#document/p1. Accessed August 24, 2010.
Defense Manpower Data Center. (2010). Department of Defense personnel statistics: Number of active duty females by age. Information obtained through the Freedom of Information Act from the Defense Manpower Data Center.
Department of Defense (DoD). (2010). Active duty military personnel strengths by regional area and by country (309A): June 30 2010. Available: http://www.globalsecurity.org/military/library/report/2010/hst1006.pdf. Accessed April 14, 2011.
Finer, L. B., & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, 38, 90–96.
Freakley, B. C. (2006). CJTF-76 General Order Number 1-Punitive Prohibitions. Available: http://www.sexcrimedefender.com/files/gen20order201.pdf. Accessed August 24, 2010.
Haas, D. M., Rivera-Alsina, M. E., & McNamara, M. F. (2005). Maternal mortality in the U.S. Department of Defense, 1993–1998. *Journal of Reproductive Medicine*, 50, 951–953.
Holt, K., Grindlay, K., Taskier, M., & Grossman, D. (2011). *Unintended pregnancy and contraceptive use among women in the U.S. military: A systematic literature review. Military Medicine*, In press.
Kirkman, M., Rowe, H., Hardiman, A., Mallett, S., & Rosenthal, D. (2009). Reasons women give for abortion: A review of the literature. *Archives of Women's Mental Health*, 12, 365–378.
Legal Information Institute. (2010). U.S. Code § 1093. Performance of abortions: Restrictions. Available: http://www.law.cornell.edu/uscode/10/1093.html. Accessed October 25, 2010.
Lindberg, L. D. (2011). Unintended pregnancy among women in the US military. Contraception, In Press (doi:10.1016/j.contraception.2011.01.017).
Mavranezouli, I. (2009). Health economics of contraception. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 23, 187–198.
Nielsen, P. E., Murphy, C. S., Schulz, J., Deering, S. H., Truong, V., McCartin, T., et al. (2009). Female soldiers' gynecologic healthcare in Operation Iraqi Freedom: A survey of camps with echelon three facilities. *Military Medicine*, 174, 1172–1176.
Office of the Undersecretary of Defense. (2008). Demographics 2008: Profile of the military community. Available: http://cs.mhf.dod.mil/content/dav/mhf/QOL-Library/Project%20Documents/MilitaryHOMEFRONT/Reports/2008%20Demographics.pdf. Accessed October 25, 2010.
Ritchie, E. C. (2001). Issues for military women in deployment: An overview. *Military Medicine*, 166, 1033–1037.
Robbins, A. S., Chao, S. Y., Frost, L. Z., & Fonseca, V. P. (2005). Unplanned pregnancy among active duty servicewomen, U.S. Air Force, 2001. *Military Medicine*, 170, 38–43.
Stein, R. (2010, February 5). *Pentagon to stock health facilities with morning-after pill*. Washington, DC: Washington Post. Available: http://www.washingtonpost.com/wp-dyn/content/article/2010/02/04/AR2010020404050.html. Accessed August 24, 2010.
Steinauer, J. E., DePineres, T., Robert, A. M., Westfall, J., & Darney, P. (1997). Training family practice residents in abortion and other reproductive health care: A nationwide survey. *Family Planning Perspectives*, 29, 222–227.
Thomson, B., & Nielsen, P. (2006). Womens health care in Operation Iraqi Freedom: A survey of camps with echelon I or II facilities. *Military Medicine*, 171, 216–219.
Turchik, J. A., & Wilson, S. M. (2010). Sexual assault in the U.S. military: A review of the literature and recommendations for the future. *Aggression and Violent Behavior*, 15, 267–277.
Turner, T. R. (2005). General Order Number 1 (GO-1). Available: http://img.slate.com/media/1/123125/123073/2133676/2150683/GO%201%201%20NOV%2005.pdf. Accessed August 24, 2010.
United Nations. (2007). *World abortion policies 2007*. New York, NY: United Nations.
U.S. Census Bureau. (2011). Annual estimates of the resident population by sex and selected age groups for the United States: April 1, 2000 to July 1, 2008 (NC-EST2008–02). Available: http://www.census.gov/popest/national/asrh/NC-EST2008-sa.html. Accessed April 13, 2011.
Wiegerinck, M. M., Jones, H. E., O'Connell, K., Lichtenberg, E. S., Paul, M., & Westhoff, C. L. (2008). Medical abortion practices: A survey of National Abortion Federation members in the United States. *Contraception*, 78, 486–491.

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