Family Planning, #7

RFI Question: *In October 2022, Secretary Austin published a memorandum titled, "Ensuring Access to Reproductive Health Care," which directed that policy be developed to allow for administrative absences for non-covered reproductive health care, to establish travel and transportation allowances to facilitate official travel to access non-covered reproductive health care, and to extend command notifications of pregnancy to 20 weeks unless specific circumstances require earlier reporting. The Committee would like to understand how these policies are being implemented.*

RFI Response:

7a. Servicewomen's experiences with infertility and fertility treatment.

i. Provide the annual number and percentage of servicewomen experiencing infertility for FY18-23 by Service, age, pay grade, and race/ethnicity.

These statistics are not tracked by the Service. Data is available from the Rand Corporation in the 2020 Women's Reproductive Health Survey (WRHS). Among respondents, 14.3% of surveyed Sailors and 9.6% of surveyed Marines self-reported being unable to conceive after 12 months of trying. 12.1% of surveyed Sailors and 10% of surveyed Marines were told by a doctor they had fertility problems not related to their age. These findings are similar to national rates reported by the Centers for Disease Control and Prevention (CDC) which demonstrate 13.4% of all women ages 15-49 experience difficulty getting or staying pregnant.[1] The breakdown by age, pay grade, and race/ethnicity specific to Sailors and Marines who self-reported this information is not available. The Survey report includes data on DoD wide demographics.

Department of Defense (DoD)-Wide Respondents (from Army, Air Force, Navy, Marine Corps, and Coast Guard); By Pay Grade:

Respondents of the 2020 WRHS who self-reported being unable to conceive after 12 months of trying.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
9.1%	19.4%	26.5%	10.6%	25.2%

Respondents of the 2020 WRHS who self-reported they were told by a doctor they had fertility problems not related to their age.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
8.6%	15.3%	18.5%	10.8%	17.2%

[1] *Source: Key Statistics from the National Survey of Family Growth (data are for 2015-2019).*

DoD-Wide Respondents; By Age:

Respondents of the 2020 WRHS who self-reported being unable to conceive after 12 months of trying.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
6.4%	16%	26.5%	22.8%

Respondents of the 2020 WRHS who self-reported they were told by a doctor they had fertility problems not related to their age.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
7.6%	12.9%	18.7%	16.4%

DoD-Wide Respondents; By Race/Ethnicity:

Respondents of the 2020 WRHS who self-reported being unable to conceive after 12 months of trying.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
14.1%	17.1%	14.8%	15.3%	16.7%

Respondents of the 2020 WRHS who self-reported they were told by a doctor they had fertility problems not related to their age.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
13%	13.3%	10.9%	8.9%	13.8%

ii. Provide the annual number and percentage of servicewomen requesting fertility treatment in FY18-23 by Service, age, pay grade, and race/ethnicity.

These statistics are not tracked by the Service. Data is available from the Rand Corporation in the 2020 Women's Reproductive Health Survey (WRHS). Among respondents, 13.2% of surveyed Sailors and 7.7% of surveyed Marines saw a provider from within the military health system (MHS) to talk about ways to help them become pregnant. 5.3% of surveyed Sailors and 4.4% of surveyed Marines saw a provider from outside the MHS to talk about ways to become pregnant. 11.5% of surveyed Sailors and 9.4% of surveyed Marines reported an unmet need for fertility services since joining the military. The breakdown by age, pay grade, and race/ethnicity specific to Sailors and Marines who self-reported this information is not available. The Survey report includes data on DoD wide demographics.

DoD-Wide; By Pay Grade:

Respondents of the 2020 WRHS who self-reported they saw a provider from within the MHS to talk about ways to help them become pregnant.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
6.6%	15.2%	22%	12.9%	25.6%

Respondents of the 2020 WRHS who self-reported they saw a provider from outside the MHS to talk about ways to become pregnant.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
2.8%	9.8%	14.4%	7%	15.1%

Respondents of the 2020 WRHS who self-reported an unmet need for fertility services since joining the military.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
8.8%	14.6%	17.4%	8.8%	17%

DoD-Wide Respondents; By Age:

Respondents of the 2020 WRHS who self-reported they saw a provider from within the MHS to talk about ways to help them become pregnant.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
5.3%	13.2%	23.2%	17.3%

Respondents of the 2020 WRHS who self-reported they saw a provider from outside the MHS to talk about ways to become pregnant.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
2.1%	7.4%	15%	12.9%

Respondents of the 2020 WRHS who self-reported an unmet need for fertility services since joining the military.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
6.9%	13%	17.5%	14.3%

DoD-Wide Respondents; By Race/Ethnicity:

Respondents of the 2020 WRHS who self-reported they saw a provider from within the MHS to talk about ways to help them become pregnant.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
12.1%	14.1%	12.1%	12.9%	14.4%

Respondents of the 2020 WRHS who self-reported they saw a provider from outside the MHS to talk about ways to become pregnant.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
7.4%	8.8%	6.2%	6.3%	6.3%

Respondents of the 2020 WRHS who self-reported an unmet need for fertility services since joining the military.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
10.8%	14.2%	12.4%	10.3%	11.8%

iii. What standard is used to define and or ascertain whether fertility issues are 'injury/illness" related' or 'service-linked' and therefore eligible for Service-provided fertility services/care?

Under the Supplemental Health Care Program, Service members who had a serious illness or injury while on active duty (Category II or III) and lost natural reproductive ability due to that

illness or injury may be eligible for coverage of certain infertility treatments. Additionally, cryopreservation and fertility treatments may be partially covered for service members with Category II or III illness as a result of cancer if they are undergoing radiation and/or Chemotherapy.

A serious or severe illness or injury is defined as being Category II or III in accordance with Department of Defense Instruction 1300.24, Recovery Coordination Program (RCP). A service member is placed in Category II if they have a serious injury or illness, is unlikely to return to duty within a time specified by his or her Military Department and may be medically separated from the military. A service member is placed in Category III if they have a severe or catastrophic injury or illness, are highly unlikely to return to duty and will most likely be medically separated from the military. In the case of fertility services, a Service member must have a serious or severe illness or injury that has directly impacted their ability to procreate to qualify for fertility services that are normally not covered by the TRICARE.

iv. How many servicewomen in FY18-23 were eligible for Service-covered fertility services care, by age, pay/grade and race/ethnicity?

DHA tracks Servicemembers' use of fertility treatment utilizing TRICARE Supplemental Health Care Program. Available data from the Rand Corporation Women's Reproductive Health Survey demonstrates that 83.2% of Navy respondents report TRICARE as the Payor for fertility services. However, fertility services in this data includes advice and counseling and does not differentiate coverage for medications or procedures.

DoD-Wide; By Pay Grade:

Among respondents of the 2020 WRHS who reported they received fertility treatment since joining the military, reported payor for fertility treatment was TRICARE.				
E1-E4	E5-E6	E7-W5	O1-O3	O4-O6
84.1%	83.5%	81.6%	83%	79.8%

DoD-Wide Respondents; By Age:

Among respondents of the 2020 WRHS who reported they received fertility treatment since joining the military, reported payor for fertility treatment was TRICARE.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
86.4%	84.2%	81.3%	73.3%

DoD-Wide Respondents; By Race/Ethnicity:

Among respondents of the 2020 WRHS who reported they received fertility treatment since joining the military, reported payor for fertility treatment was TRICARE.				
Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian	Other
83.3%	81.5%	82.4%	83.1%	84.7%

v. Regarding military treatment facilities (MTFs) that provide fertility services, how long are average wait times for servicewomen between requesting an appointment and seeing a provider for fertility services?

DHA has authority, direction, and control of the MTFs and tracks TRICARE access standards for primary and specialty care. The Navy monitors Service Member's Individual Medial Readiness and ensures adequate access to the health care readiness needs of the member.

vi. *What is the capacity of those MTFs to provide non-covered fertility services (e.g., number of women/year; types of fertility services)?*

DHA has authority, direction, and control of the MTFs and will provide this data.

vii. *Provide the numbers of women who were provided non-covered fertility services by MTFs for the last five years (FY18-23).*

DHA has authority, direction, and control of the MTFs and will provide this data.

viii. *What are women charged by the MTFs for non-covered fertility services and how does that compare to the cost for equivalent services in civilian facilities?*

DHA has authority, direction, and control of the MTFs and will provide this data.

ix. *Are there programs within other Services, similar to the Coast Guard, that provide counseling and/or financial assistance for fertility treatment?*

The Service does not have a program that provides financial assistance for fertility treatment.

To provide counseling on fertility treatment Chapter 15 of the Manual of the Medical Department directs that Service women must be counseled annually on family planning, health promotion. Further, counseling will be based on a Service member's lifestyle, health history, risks, and preferences.

The Navy Bureau of Medicine and Surgery (BUMED) Office of Women's Health (OWH) and Female Force Readiness Navy Medicine Operational Clinical Community (FFR NMOCC) developed a Navigating Infertility as a Service Woman, available on the Women's Health Webpage. This resource includes information on fertility services available to service members, fertility treatment considerations, mental health impacts of fertility treatment, available support resources, and more.

x. *Has DHA identified any evidence on whether servicewomen experience a greater incidence of infertility/fertility problems (e.g., delaying pregnancies to older ages to accommodate Service/career concerns, job-related stress, or work/combat/deployment-related exposures) as compared to the population of the U.S.?*

Defer to DHA for response.

xi. *What is the average age of first pregnancy for servicewomen?*

These statistics are not specifically tracked by the Service, but a close measure from the 2020 WRHS demonstrates that Service members ages 35-44 are most likely to have had a military

pregnancy, and pregnancy was least likely to have been experienced by Service members ages 18-24.

DoD-Wide Respondents; By Age:

Respondents of the 2020 WRHS who have experienced a pregnancy since they joined the military.			
Ages 18-24	Ages 25-34	Ages 35-44	Ages 45+
24.8%	42.5%	70.1%	58.7%

7b. How do the Services determine the staffing standard for OB/GYNs or other women's specialty care professionals on installations? And what is the total authorization?

Navy medical manpower requirements are determined by identifying the type and level of medical personnel needed to perform the Navy's work within OPNAV approved required capabilities. Navy specifically defines the required capabilities using Required Operational Capabilities (ROC) and Projected Operational Environment (POE) documents (for fleet and operational units); or Mission, Functions, and Tasks (MFT) documents (for shore activities). Each manpower requirement aligns to specific duties, tasks, and functions to be performed, as well as the specific skill level required to perform the delineated functions based on workload and demand (per OPNAVINST 1000.16L CH-3). These requirements are rigorously reviewed, reevaluated, and updated based on workload and demand by the Navy Manpower Analysis Center (NAVMAC). The specifically mandated processes associated with NAVMAC requirements validation are outlined in OPNAVINST 1000.16L CH-3.

Total authorizations are noted in the tables below.

i. What number and percentage of authorized OB/GYN and other women's specialty care professionals (e.g., Certified Nurse Midwives) positions are actually filled?

	Total Personnel	Personnel In Training	Net Personnel	Discrete Authorizations	Total Authorizations*	% Manned (Discrete)	% Manned (Total)
OBGYN	116	35	81	89	96	91%	84%
Midwife	30	1	29	21	28	138%	104%
Maternal Infant Nurse	116	5	111	120	120	93%	93%

	Total Discrete Authorization Fills	% Filled	Net Personnel Assigned within Specialty	Personnel Assigned Outside Specialty
OBGYN	70	79%	68	13
Midwife	20	95%	20	9

Maternal Infant Nurse	95	79%	81	30

*Total Authorizations includes "fair share" authorization allocations, which include leadership and outside clinical specialty positions.

i. What are the accession and retention statistics for OB/GYNs and related specialty care providers?

All OBGYNs are obtained via training Navy physicians under GME training programs after commission. The Navy Medical Corps currently has 32 medical officers training in an OBGYN residency and will be starting another 13 medical officers in an OBGYN residency training program this July. Three current OBGYN physicians are currently in fellowship training into subspecialties, and two more start fellowship this July. The current 5-year loss rate for OBGYN providers is 13.49%. The current 3-year loss rate for OBGYN providers is 14.95%.

The overwhelming majority of Navy Nurse Corps accessions are unspecialized nurses, who are trained into a given specialty after commission. There is currently one Nurse Midwife in training, one beginning training in Academic Year (AY) 2024, and additional projected opportunities for training beginning in AY 2025. The five-year loss rate for Midwifery is 7.33%, and three-year loss rate is 7.69%.

The Navy Nurse Corps trains most Maternal Infant nurses into their clinical specialty after commission. In addition, a subset of these nurses will train as Advanced Practice Nurses within the specialty while on Active duty. Five members are currently assigned to advanced practice training, with three graduating in FY 2024, two more members begin training in AY 2024, and additional opportunities to begin advanced practice training are projected for AY 2025. The five-year loss rate for Maternal Infant nursing is 13.35%, and three-year loss rate is 14.71%.

ii. Describe any incentives or initiatives to encourage OB/GYNs to work overseas. What are the numbers of OB/GYNs relative to the servicewoman population in overseas locations?

The Navy values diversity in assignments. Serving in overseas locations provides a unique opportunity for professional development in both clinical and leadership acumen. The Deputy Assistant Secretary of the Navy (Manpower and Reserve Affairs) has directed presidents of promotions boards give favorable consideration to members with proven success in diverse assignments, including OCONUS locations.

The Navy determines medical manpower requirements in the same manner for both CONUS and OCONUS locations. Navy medical manpower requirements are determined by identifying the type and level of medical personnel needed to perform the Navy's work within OPNAV approved required capabilities. Navy specifically defines the required capabilities using Required Operational Capabilities (ROC) and Projected Operational Environment (POE) documents (for fleet and operational units); or Mission, Functions, and Tasks (MFT) documents (for shore activities). Each manpower requirement aligns to specific duties, tasks, and functions to be performed, as well as the specific skill level required to perform the delineated functions based on workload and demand (per OPNAVINST 1000.16L CH-3). These requirements are

rigorously reviewed, reevaluated, and updated based on workload and demand by the Navy Manpower Analysis Center (NAVMAC). The specifically mandated processes associated with NAVMAC requirements validation are outlined in OPNAVINST 1000.16L CH-3.

7c. Efforts to normalize the need for women's reproductive care and pregnancy care within the Services to assure awareness, care, and routine consideration of women's unique health care needs, so those needs are not inadvertently overlooked or not accounted for.

i. Describe pre-deployment and deployment-related policies or procedures that are specific to women's reproductive healthcare needs (e.g., contraceptive, and menstrual issues).

DHA-PI 6200.02 (released on May 13, 2019) directs that contraceptive counseling (that includes the full range of contraceptives and information on menstrual suppression) be provided to all Service members at regular intervals including during the assessment of pre-deployment readiness for deployment.

The annual Periodic Health Assessment (PHA) also provides an opportunity to address the unique health care needs of Service women based on their individual risk and self-assessment. SECNAVINST 6120.3A directs that that family planning counseling during the PHA include comprehensive information regarding contraceptive methods and indications (to include efficacy for pregnancy prevention and ability to protect against sexually transmitted infection and HIV infection); menstrual suppression; potential side effects and limitations (e.g., in a deployed environment); and emergency contraception. It also directs that female-specific health screening be conducted in accordance with the United States Preventative Services Task Force (USPSTF) "A" and "B" grade recommendations.

Chapter 15 of the Manual of the Medical Department (MANMED) directs that Service women must be counseled annually on unintended pregnancy prevention, family planning, emergency contraception, and health promotion. MANMED Chapter 15 also outlines the recommendation for Service Women to have annual well woman exams. The annual well woman exam provides an opportunity to conduct reproductive health education, but also allow the Service member to address their unique health care needs.

ii. Describe policies, procedures, or training initiatives in place to ensure non-specialty medical providers, including primary care physicians and nurses, are able to provide informed and appropriate care and counseling for servicewomen's reproductive care, particularly in remote or deployed locations.

The BUMED OWH has led efforts to identify and implement essential women's health proficiencies required for operational providers to equip a medically ready force to provide quality women's healthcare. These proficiencies have been endorsed by the Navy Surgeon Genal, the Fleet Health Integration Panel, and the Marine Corps Health Services Operational Advisory Group. The BUMED OWH coordinates with the various operational provider training schoolhouses to incorporate the proficiency requirements into curriculum.

The BUMED OWH and the FFR NMOCC regularly produce educational resources to guide non-specialty medical providers in reproductive care. Examples of resources that guide providers in appropriate care and counseling for servicewomen's reproductive care include:

- Women's Health Provider Treatment Algorithms: These tools guide providers to determine whether to treat or escalate female patients to a higher level of care, thus increasing the quality and standardization of women's healthcare in operational settings.
- Emergency Contraception Tool-kit: Provides a flow chart to aide providers in best practices for prescribing the most effective emergency contraception.
- Nurse Run Protocol for Self-Collected Vaginal Discharge Swabs- Provides a tool-kit for providers and operational clinics to establish a process for patients to self-collect swabs for vaginal discharge complaints. This allows for expedited access to address vaginal health concerns and increases privacy for women.
- Provider Guide to Intimate Partner Violence (IPV): Provider guide to identifying risks and signs of intimate partner violence and how to support service members who may be suffering from IPV.
- Neuromusculoskeletal Considerations During Pregnancy and Postpartum: Provider guide on relevant neuromusculoskeletal health considerations to counsel patients during their pregnancy and postpartum period.
- Extended Duration Long-Acting Reversible Contraceptive (LARC) Resource for Providers: Provider guide on counseling patients on the option to utilize a LARC for an extend duration based on evidence of safety and efficacy.
- Encouraging Continued LARC Resource for Providers: Provider guide on mitigating bothersome symptoms of some LARC options to encourage continued use of the device if desired by the patient.

The BUMED OWH also hosted a Virtual Women's Health Seminar to provide a training opportunity for providers interested in sharpening their skills in basic, primary care level women's health concerns and medical readiness. 115 clinicians participated in the live webinar event. An ongoing virtual self-study option is available for clinicians unable to attend the live event.

7d. Does the Periodic Health Assessment (PHA) include questions related to reproductive health topics, such as contraception, sexual activity, fertility, or family planning? If so, describe. Please provide a copy of the PHA questionnaires.

Counseling on the desire for pregnancy, as well as contraception education and counseling are provided for all Sailors and Marines during annual PHAs. An inquiry about current contraceptive use and interest in contraceptive counseling is included as part of the annual PHA. The annual PHA also allows Service members the opportunity to discuss any family planning concerns they may have. SECNAVINST 6120.3A directs that that family planning counseling during the PHA include comprehensive information regarding contraceptive methods and indications (to include efficacy for pregnancy prevention and ability to protect against sexually transmitted infection and HIV infection); menstrual suppression; potential side effects and limitations (e.g., in a deployed environment); and emergency contraception. It also directs that female-specific health screening be conducted in accordance with the United States Preventative Services Task Force (USPSTF) "A" and "B" grade recommendations.

Hours Expended Answering this RFI: 4
Office responsible: BUMED N10C2, Office of Women's Health