Defense Advisory Committee on Women in the Services (DACOWITS)
September 2024 – Requests for Information

RECRUITMENT BARRIERS

In accordance with DACOWITS' Terms of Reference, the Recruitment and Retention (R&R) Subcommittee will assess potential recruitment barriers which inhibit the accession of women into the Military Services. In addition, the R&R Subcommittee will examine existing policies and procedures to determine whether current practices inhibit the recruitment of women, specifically assessing medical accession standards and the application of these standards.

1

The Committee continues to be interested in the recruitment of servicewomen, including barriers and facilitators that impact the pool of women qualified to join the Armed Forces as compared to men. The Committee seeks to understand potential recruitment barriers that continue to inhibit the accession of women into the Armed Forces. More specifically, DACOWITS is interested in the availability of Military Entrance Processing Stations (MEPS) appointments, any preliminary data pertaining to female recruits admitted through the Military Accession Record Pilot (MARP) program, the medical waiver process, and both the challenges and facilitators reported by recruiting commands. Additionally, by March 2022 all MEPS fully deployed a new congressionally mandated electronic health information system called Military Health System (MHS) Genesis. This marked a major change to medical record processing for accessions. The Committee understands that the Defense Department is now using medical data collected from MHS Genesis via the MARP program to review the recentness of 49 medical conditions for which the lifetime disqualification in *Medical Standards for Military Service: Appointment, Enlistment, or Induction* (DoDI 6130.03) was changed to 0.5, 3, 5, or 7 years. The Committee is also aware that in March 2024, a DoD report titled, "*Military Medical Standards for Accession*," was delivered to the Committee on Armed Services of the Senate and House of Representatives and that this report noted a need for increased MEPS personnel, including medical providers, technicians, and onboarding specialists. The Committee received briefings from Military Services' Medical Waiver Review Authorities (SMWRAs) in June 2024 (via RFI 1.1).

The Committee requests a **written response** from the **Military Services' SMWRAs** on the following:

a. For applicants awaiting waiver(s), what is the loss rate during this wait period, and what is the threshold/timeframe where losses are the most prevalent (30 days, 60 days, 90 days, etc.)? Is this different for men and women? If so, how?
b. What is the average length of time to obtain a medical recommendation from the branch's waiver authority for the following female specific disqualifying medical conditions:
    i. Pregnancy;
    ii. Abnormal uterine or vaginal bleeding;
    iii. Abnormal Pap smear/test;
    iv. Endometriosis; and
    v. Polycystic ovarian syndrome?
c. If a specialty consult is required, what is the average wait time to see a specialist for each of these female specific disqualifying conditions noted above? Additionally, provide the percentage of applicants waiting: 1) less than 30 days; 2) 31- 60 days; 3) 61-90 days; and 4) greater than 90 days, for each of the female specific disqualifying medical conditions noted above.
d. For those applicants requiring specialty consults, what percent of applicants sought care outside of the referred MEPS provider? Can applicants who sought their own consultation be reimbursed?
e. Please provide a table for FY21, FY22, and FY23 with the following information about the top five female specific disqualifying conditions (i.e., pregnancy, abnormal uterine/vaginal bleeding, abnormal pap smear/test, endometriosis, polycystic ovarian syndrome, and total of these five conditions) your Service is currently providing waivers for, broken down by the:
    i. Number of waivers granted;
    ii. Number of waivers requested;
    iii. Waiver rate percentage (number granted/number requested); and the
    iv. Average processing time (number of days) from the time the applicant is told they need additional medical consult to final determination.

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RETENTION INITIATIVES

In accordance with DACOWITS' Terms of Reference, the R&R Subcommittee will identify opportunities and innovative initiatives to more effectively retain servicewomen, utilizing retention incentives such as bonuses, special schools, retraining, and choice duty assignments.

2

The Committee continues to be interested in the retention of servicewomen and whether geographic stability and co-location policies for dual military couples and non-married Service members with shared parental custody of a child could encourage men and women to stay in the military. In March 2024 (via RFI 1), the Committee received briefings from the Military Services on the status of their geographic stability and co-location policies, and the Committee was provided written responses in June 2024 from the Military Services on their co-location efforts from FY22 to date.

In April 2024, the Marine Corps instituted a new position, called the Dual-Military Monitor (DMM), designed to help provide better co-location for dual-military couples. As of June 6, 2024, 11,863 Marines (officer and enlisted to include Marines in the Active-Reserve component) are married to another military member and approximately 1,500 dual-military Marines make PCS moves every year. Nearly 60 percent of female Marine marriages are dual-military, as compared to the DoD average of 45 percent. The Marines realize the importance of improving co-location policies and procedures which are critical for the personal and professional longevity of these couples. This new DMM position serves as a centralized point of contact with the sole responsibility to supervise dual-military PCS moves. This resource streamlines what was previously a decentralized process across 75 different assignment personnel by providing a stopgap with checks and balances.

The Committee requests a **briefing** from the **Marine Corps** on the DMM role and the procedures used to support dual-military couples. Please include how the DMM interacts with Servicemembers, their Monitors and /or other service Assignment Officers, any lessons learned to date, and any anticipated modifications going forward.

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IMPLEMENTATION OF WOMEN, PEACE, AND SECURITY REQUIREMENTS

In accordance with DACOWITS' Terms of Reference, the Employment and Integration (E&I) Subcommittee will examine the Military Services' efforts to fulfill requirements of the U.S. Strategy on Women, Peace, and Security (WPS), specifically related to the WPS Strategic Framework and Implementation Plan. In addition, the E&I Subcommittee will examine WPS long-term defense objectives to assess women's meaningful participation within the Joint Force, as well as women's representation across all ranks and all occupations.

3

The Committee continues to research the WPS study topic, examining specifically Defense Objective 1 to better understand how the Defense Department "*exemplifies a diverse organization that allows for women's meaningful participation across the development, management, and employment of the Joint Force*."

The Committee requests a **written response** from the **OSD, Joint Staff (JS), and the Military Services** on the following:

a. The published process for assignments to joint duty assignment list (JDAL) positions. Specifically, provide overall guidance and direction given to the Military Services regarding criteria for nomination, the evaluation/selection review process, and approval process for assignment to JDAL billets. In addition:
   i. **OSD/JS:** Provide any existing guidance on how OSD/JS directs/encourages/requires any review of gender equity in the JDAL assignment process.
   ii. **Military Services:** Each Service should offer in greater detail (within the written response) how officers are selected for JDAL billets including the Services' selection process from nomination to final approval for JDAL billet assignment.
   iii. **Military Services:** Is gender considered in the review process for joint duty assignments? If so, how, and is gender data collected?

b. Discuss the published process for enlisted management with respect to joint duty assignments. Specifically overall guidance and direction given to the Military Services regarding criteria for nomination, the evaluation/selection review process, and approval process for assignment to joint billets.
   i. **OSD/JS:** Provide any existing guidance on how OSD/JS directs/encourages/requires any review of gender equity in the assignment process.
   ii. **Military Services:** Each Service should offer in greater detail (within the written response) how enlisted Service members are selected for joint billets, including the selection process from nomination to final approval.
   iii. **Military Services:** Discuss any review process or direction criteria which takes gender into consideration for joint assignments.

c. **Military Services:** Is there a process to ensure equitable representation of female officers in JDAL billets (that is comparable to rank/specialty percentages of women within the Service)? If so, please describe this process in detail.

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INTIMATE PARTNER VIOLENCE AND DOMESTIC ABUSE

In accordance with DACOWITS' Terms of Reference, the Well-Being and Treatment (WB&T) Subcommittee will assess updates to the DoD Instruction 6400.06, "*Domestic Abuse Involving DoD Military and Certain Affiliated Personnel*," dated May 16, 2023, and determine whether the DACOWITS' 2019 recommendations related to domestic abuse were implemented. In addition, the WB&T Subcommittee will examine the status, increase, or decrease in domestic abuse incidents; the effectiveness of current DoD and Military Services' policies; and evaluate whether there are additional policy inconsistencies that need to be remedied (e.g., definition of intimate partner).

4

The Services' fatality reports from FYs 2012-2022, as reported to the Committee in June 2024 via RFI 6, reflect that there were 516 Intimate Partner Violence (IPV) related suicides and homicides, and that the vast majority (50 to 89 percent) of those involved weapons (most often guns) and typically these weapons were readily available in the home. The Committee is interested in learning more about whether these offenders and victims had been known to installation Family Advocacy Program (FAP) personnel prior to the fatality incidents and how gun possession is addressed by command and/or other installation officials when known/suspected offenders possess firearms.

The Committee requests a **written response** from **Office of Military Community and Family Policy (MC&FP) via the Military Community Advocacy (MCA) Directorate and the Military Services (Army, Navy, Marine Corps, Department of the Air Force (Air & Space), Coast Guard, and National Guard)** on the following:

a. In FY21-22, how many of the offenders who committed domestic-violence associated suicides/homicides and how many of the IPV homicide victims were known to FAP prior to the fatal incidents? Provide the numbers by FY and by offender/victim/Service status.
b. How many of IPV offenders or victims were known to possess firearms before the fatality incident?
c. If known, in how many instances of IPV fatality incidents had firearms been removed from an offender's home, had the offender voluntarily turned them in for storage outside the home, or had removal attempts been made prior to the fatality incident?
d. What are the strategies/procedures used to determine whether an alleged offender owns or possesses a firearm (personally owned or military-issued)?
e. Are known offenders required or encouraged to store firearms outside the home? Provide information about the policies/procedures/protocols relevant to removing firearms from residences of those known to the installation FAP.
f. How often is an offender removed from his/her home environment in IPV/DA situations? In addition, what are the criteria, circumstances, and relevant regulatory/policy provisions which are used to make such a decision? Identify the procedural differences for on- and off-base housing.
g. **Military Services:** What are your Services' strategies to identify suicidal ideation, monitor those at risk, and prevent domestic abuse related suicides?
h. **MCA:** Does MCA work with the Defense Suicide Prevention Office, and if so, what collaborations have resulted in new programs/policies? Are there any upcoming collaborative efforts underway?

5

The Committee is interested in learning whether the Army National Guard and Air Force National Guard have any IPV/DA policies and programs, and if so, what is the extent or ability of the Guard is to offer family advocacy services to Service members and their spouses/intimate partners who are affected by or report IPV/DA. The Committee requests a **written response** from the **National Guard Bureau** on the following questions:

a. What IPV/DA abuse programs are offered to Service members in the Guard? Are Service FAP regulations in effect? If so, when?
b. If there are no policies addressing IPV/DA, please advise whether the NGB intends to implement a policy, the projected implementation date, and how this policy may vary from current Service regulations.
c. Are there any resources or other support available to Service members in the Guard who may report abuse? If so, please explain what the Guard capacity and range of resources are, as well as how continuity of care addressed?
d. What challenges has the Guard experienced in addressing IPV/DA within their components or in formulating policies? Please describe.

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FAMILY PLANNING

In accordance with DACOWITS' Terms of Reference, the Well-Being and Treatment (WB&T) Subcommittee will examine existing Defense Department and Military Services' institutional policies and procedures to identify gaps that potentially inhibit family planning, to include eligibility for fertility services. In addition, the WB&T Subcommittee will assess the demand for expanded fertility access within a constrained supply of resources and identify obstacles and challenges to obtain access to care.

6

Various reports, such as the *2023 DoD Inspector General Management Advisory: Concerns with Access to Care and Staffing Shortages in the Military Health System*, continue to raise concerns about access to care at smaller military treatment facilities (MTFs), staffing shortages in CONUS and OCONUS MTFs, and the impacts of Defense Health Agency (DHA) policies and processes on the ability of beneficiaries to access care. The Committee is interested in obtaining more information about Service efforts and challenges in providing reproductive women's health care in CONUS and OCONUS MTFs.

The Committee requests a **briefing** from **Defense Health Agency (DHA) and the Military Services (Army, Department of the Navy, and Department of the Air Force (Air & Space)),** on the following questions.

a. **Military Services:** Please provide:
   i. the number of women's health clinics and the number of walk-in contraceptive clinics in your Service.
   ii. include a list of where these facilities are located.
   iii. their operating days and hours.
b. **DHA:** What are the utilization rates at these clinics by month and year for the years FY20-23? Do they serve both servicewomen and female dependents? If so, break out usage rates by servicewomen and dependent women.
c. **DHA:** Are there any limitations as to which populations these clinics serve? For example, do these clinics serve only pregnant women, or only women with certain health issues, or only servicewomen.
d. **DHA:** Specify the range of services provided by these clinics.
   i. Identify the full range of services related to women's reproductive health care they are staffed to provide. Do they provide care for contraception, pregnancy, fertility treatment, hormonal issues such as perimenopause and menopause, and other women's reproductive health conditions?
   ii. If services are limited, can the clinic/providers in those clinics provide referrals to appropriate specialist on/off-base or must servicewomen go back through a primary care manger (PCM) to obtain specialist care?
   iii. Is counselling or other information provided regarding fertility and other reproductive and family planning matters?
e. **DHA:** Provide a breakdown of the type and number of medical provider authorizations at each clinic, including administrative staff, OB/GYNs, nurses, midwives, physician assistants, medical technicians, and any other positions.
f. **DHA:** Provide current staffing numbers at each women's health and contraceptive clinic.
g. **DHA:** Provide the number and percentage of vacant positions at these clinics.
h. **DHA:** Describe/identify the staffing model or algorithm that is used to establish the number of authorizations for the women's health and contraceptive clinics? In addition:
   i. Is the staffing model based on the number of servicewomen and dependent females at the installation or some other criterion? Explain.
   ii. How frequently is the staffing model updated?
   iii. When was the last update completed?
i. **DHA:** What women's health-specific training do theses clinic providers receive, particularly as it relates to women's reproductive health, including perimenopause, menopause, contraception, and reproductive health?

	j. **DHA:** How many OB/GYNs have training in reproductive endocrinology and how many does the Service actually require? What is the staffing percentage? k. **DHA:** Do any women's health clinics or reproductive clinics offer telehealth or any other remote services? If so, which clinics and what type of services? Only for the locally based population? What are the utilization rates for remote services in the last two years? l. **Navy:** What women's health services are performed on board ship versus on shore? Is routine care (e.g. pap smears, pelvic examinations) for deployable personnel on sea duty scheduled at shore facilities while in port or is such care provided on ship? Are telehealth services available to shipboard personnel? m. **Army, Marine Corps, and the Department of the Air Force**: i. What kinds of women's health care services/invasive examinations are provided by unit-embedded providers (e.g., Army medics), if any? ii. What is the extent and the range of services performed by embedded providers in terms of contraception, preventive care, hormonal issues, and other reproductive healthcare? iii. Are servicewomen referred to a medical facility for such care? iv. Describe the scope and limitations of care which may be provided by unit-embedded medical providers both at home station and while deployed. n. **DHA/Military Services:** Do the DHA or Military Services plan to open more women's health clinics or contraceptive clinics in the future? If so, where and what is the projected timeline? o. **DHA:** What is the average lifetime medical cost calculated by DoD/DHA/actuaries, both with and without dependents, for a serviceman? Alternatively, provide annual budget planning estimates. p. **DHA:** What is the average lifetime medical cost calculated by DoD/DHA/actuaries, both with and without dependents, for a servicewoman? Alternatively, provide annual budget planning estimates.