P.O. Box 65089
Washington, DC 20035

LINDSAY CHURCH
Executive Director
(*they/them*)
Email: lchurch@minorityvets.org

October 11, 2022

Submitted electronically via regulations.gov

Dr. Shereef Elnahal
Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20210

Re: Interim Final Rule – Reproductive Health Services, Docket No. VA-2022-VHA-0021

Dear Ms Elnahal:

Minority Veterans of America (**MVA**) is a nationwide non-profit that works to create belonging and advance equity and justice for the minority veteran community—more than 10.2 million veterans who are or identify as women, people of color, LGBTQI+, or non-religious or religious minority, many of whom have felt marginalized, unseen, or unheard during their time in military service and afterward. We strive to be the most diverse, inclusive, and equitable veteran-serving organization in the country and believe that by creating an intersectional movement of minority veterans, we can build a collective voice capable of influencing critical change. MVA provides that voice in direct advocacy, before Congress and agencies like the Department of Veterans Affairs (**VA**), on behalf of this intersectional movement.

MVA's work also includes efforts to improve veterans' lives by providing resources and programs to help support veterans through social engagement, community connection, financial stability, and leadership development. This work puts us in contact with veterans—many from historically underserved populations—in need of accessible and affordable comprehensive reproductive healthcare services. The lived experiences of people in these populations reflect the historical exclusion from healthcare institutions, resulting in negative health outcomes.

MVA appreciates the opportunity to provide this comment[1] on VA's Interim Final Rule on Reproductive Health Services (**IFR**), which would modify VA's medical benefits package by removing the existing exclusion on abortion counseling and establishing exceptions to the exclusion on abortion care for veterans and Civilian Health and Medical Program of the VA (**CHAMPVA**)

[1] This comment letter was prepared with the assistance of Robin Thurston and Maher Mahmood, Democracy Forward Foundation.

P.O. Box 65089
Washington, DC 20035

beneficiaries.[2] MVA strongly supports the IFR.[3] Access to comprehensive reproductive healthcare, including abortion and pregnancy-options counseling, is necessary and critical to supporting veteran health and well-being, especially in the circumstances permitted by the IFR. VA's action comes at a pressing time for veterans and beneficiaries as they navigate bans and restrictions on this healthcare that are increasing across the nation.

In anticipation of the IFR, MVA asked veterans to share their personal experiences with restrictions on abortion access and counseling.[4] We received responses from people across the county. Excerpts from the veterans' responses are included throughout this comment. In brief, the inability to access abortion services and counseling has harmed the physical, mental, and emotional well-being of veterans.

Veterans and CHAMPVA beneficiaries have a pressing need for abortion access and counseling.

Congress directed the VA to "furnish hospital care and medical services" as needed to certain veterans.[5] This includes ensuring that veterans have access to abortion care and counseling. Lack of access is harmful to a veteran's physical[6] and mental health,[7] and general well-being.[8] For minority communities, the risk of these harmful consequences is heightened. The IFR allows the VA to provide crucial care and support to the health needs of veterans and their families. Implemented fully, it has the potential to help many veterans and their families across the country.

In *Dobbs v. Jackson Women's Health Organization,*[9] the United States Supreme Court overturned almost 50 years of precedent by taking away the constitutional right to abortion.[10] Since this decision, almost 26 states have enacted near-total abortion bans or restrictions on health care workers providing

---

[2] Reproductive Health Services, 87 Fed. Reg. 55,287 (September 9, 2022) (to be codified at 38 C.F.R. pt. 17), *available at* https://www.federalregister.gov/documents/2022/09/09/2022-19239/reproductive-health-services.

[3] Further information is provided in the attached statements, referenced as Exhibit 1 and Exhibit 2.

[4] We have collected and reviewed copies of the individual comments submitted by our members in response to our request for stories. We have quoted or summarized comments that we believe showcase the pressing need for this IFR. If you have questions about these comments, or require additional details, please contact us.

[5] 38 U.S.C. § 1710(a)(1)-(2).

[6] Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 Annals Internal Med. 238 (2019), https://doi.org/10.7326/M18-1666; Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women's Health Issues 55 (2015), https://doi.org/10.1016/j.whi.2015.10.001.

[7] M. Antonia Biggs et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169 (2017), https://doi.org/10.1001/jamapsychiatry.2016.3478.

[8] Ctr. for Reprod. Rights & Colum. Mailman Sch. of Pub. Health, *Abortion Is Essential Healthcare: Access Is Imperative During COVID-19* (2020), https://reproductiverights.org/sites/default/files/documents/USP-COVID-FS-Interactive-Update.pdf.

[9] 142 S. Ct. 2228 (2022).

[10] *Id.* at 2242.

abortion.[11] As a result, around 36 million women of reproductive age—of which 14.8 million, or 41%, are women of color—are without adequate reproductive health services.[12]

Many of these women are veterans. According to the VA, nearly 10% of our nation's veterans identify as women, representing the fastest growing demographic of veterans eligible for health care.[13] This share is expected to increase to 18% of the veteran population by 2040, or about two million people.[14] One of our members, a Black woman, shared the experience of being a mother while serving her country, stationed in Korea following the terrorist attacks of September 11, 2001:

> I got pregnant with my first child and headed to Fort Bragg, NC. After having my baby, I knew I was going to have to deploy. I guess you don't know strength until you decide to volunteer to deploy 3 months postpartum. My mental toughness was beyond my understanding and damn near killed me but I did it. ... As a woman veteran, I've seen strength come in the form of heart posture rather than physicality. I've seen women fight back tears, convulsions and face grimaces when saying their last goodbyes to their children on their way to a one year deployment. ... There's a different demand on women soldiers and my hat goes off to them. It's almost like we can't be women in the Army and that's been my long self journey as a veteran.

In 2020, around 550,000 women veterans used VA healthcare and over 400,000 dependents and survivors accessed care through the CHAMPVA program.[15] Approximately 155,000 veterans of childbearing age use VA healthcare and reside in states with extremely broad or total abortion bans.[16] Their need for reproductive health services will increase with the rise in state restrictions and associated clinic closures. Of the states with near-total or total bans, only one still has clinics that offer abortion

---

[11] N.Y. Times, *Tracking the States Where Abortion Is Now Banned*, https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (last updated Oct. 7, 2022).
[12] Katherine Gallagher Robbins & Shaina Goodman, Nat'l P'ship for Women & Fams., *State Abortion Bans Could Harm Nearly 15 Million Women of Color* 1-2 (2022), https://www.nationalpartnership.org/our-work/resources/economic-justice/state-abortion-bans-harm-woc.pdf.
[13] Nat'l Ctr. for Veterans Analysis & Stats., VA, *Women Veterans Report: The Past, Present and Future of Women Veterans* 1 (2017), https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf.
[14] VA, *Women Veterans in Focus* (2020), https://www.womenshealth.va.gov/WOMENSHEALTH/docs/VHA-WomensHealth-Focus-Infographic-v20-sm-508b.pdf.
[15] Letter from U.S. Senators to Denis McDonough, Sec'y of Veterans' Affs. 2 (July 28, 2022), *available at* https://www.bennet.senate.gov/public/_cache/files/d/f/dfa2a683-1876-4a2a-b48d-104838b37516/D3722BA2E640D13E535CDA3854884906.07.28.2022-letter-to-va-re-abortion-final.pdf; Sidath Viranga Panangala, Cong. Rsch. Serv., RS22483, Health Care for Dependents and Survivors of Veterans 14 (2021), https://crsreports.congress.gov/product/pdf/RS/RS22483.
[16] Courtney Rozen, *Biden's Abortion Offer for Vets Spotlights Limits of His Power*, Bloomberg L. (Oct. 3, 2022), https://news.bloomberglaw.com/health-law-and-business/bidens-abortion-offer-for-vets-spotlights-limits-of-his-power.

care.[17] In states with extreme restrictions, it is also difficult for pregnant people to prove they meet the limited exceptions, making those exceptions functionality unavailable.[18]

Even before the decision in *Dobbs*, veterans struggled to access reproductive healthcare as the VA did not provide abortion care or counseling under any circumstances. One of our organizational leaders, a queer veteran of the United States Navy, shared the struggle that they and them family faced:

> On May 6, 2022, we learned that [my wife] was pregnant and celebrated what was both one of the happiest and scariest moments of our lives. We live in Virginia where abortion is currently legal until the end of the second trimester, and in the third when necessary to save the life of the pregnant person. But in the backdrop loomed an effort by our state legislature to ban care at just 15 weeks.
>
> The Supreme Court's decision in *Dobbs* would ultimately be delivered on June 24. Exactly two weeks later, on July 8, 2022, my wife and I discovered through a routine ultrasound that our child's abdomen was distended to the point of concern. On August 2, 2022, my wife and I returned to the perinatal specialist only to find that the baby's condition had worsened. In that moment, my wife and I made the most painful decision either of us has ever had to make. We made what we believe was the most compassionate choice for the child we loved so much, which was to end the pregnancy.
>
> We were able to access care, not through programs like CHAMPVA which is designed to support caregivers of 100% total and permanent disabled veterans like myself, or TRICARE which she also qualifies for, but through a community-based clinic in Richmond, Virginia that has been providing care to patients in need of abortion and reproductive health services since 1973. She was able to access this care because we are fortunate enough to be able to afford private insurance and have access to non-VA providers, while living in a state that did not restrict her access to these services.

---

[17] Marielle Kirstein et al., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care*, Guttmacher Inst. (Oct. 6, 2022), https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care?utm_source=Guttmacher+Email+Alerts&utm_campaign=9a6f976b21-state+news+-+100+days+and+map&utm_medium=email&utm_term=0_9ac83dc920-9a6f976b21-260745661.

[18] According to media reports, to qualify for an exception to save the life of the mother, hospitals and medical providers have required the pregnant person to wait until serious complications develop and threaten severe illness or death, even when the fetus is non-viable. *See* Aria Bendix, *How Life-Threatening Must a Pregnancy be to End It Legally?*, NBC News (June 30, 2022), https://www.nbcnews.com/health/health-news/abortion-ban-exceptions-life-threatening-pregnancy-rcna36026/; Olivia Goldhill, *Vague 'Medical Emergency' Exceptions in Abortion Laws Leave Pregnant People in Danger, Doctors Say*, Stat News (May 20, 2022), https://www.statnews.com/2022/05/20/medical-emergency-exceptions-abortion-laws-pregnant-people/.

> During my wife's pregnancy, there were times when it felt like we were racing a clock to understand what was happening with our child. We knew every day that, even under the best circumstances, we had until early September to make a decision or we may be forced to leave the state to access care. I remember thinking that if we had to leave the state to get access to the essential care that my wife needed, I would never forgive this country. The moral injury of having served a country to protect our Constitution that no longer protected me and the ones I love was, and still is, absolutely devastating.

Moreover, VA's prior limitations on providing abortion care have historically made it expensive for veterans and beneficiaries to access care. The lack of coverage along with state restrictions made accessing care extremely difficult and expensive. As state restrictions and bans spread, pregnant people are forced to travel longer distances and incur larger expenses, including lodging, gas, airfare, childcare, and the cost of an abortion—on top of lost wages.[19] Additional expenses and time can add up when multiple trips are needed. The financial barrier is especially acute for the disproportionately high percentage of female veterans who are homeless.[20]These barriers and costs inhibit access to time-sensitive abortion care and can be financially destabilizing.[21] Veterans and their beneficiaries need a system that will allow them to navigate reproductive healthcare with consistency, timeliness, and efficiency; the IFR begins to meet that need.

Abortion access and counseling for veterans and CHAMPVA beneficiaries who can become pregnant meets a pressing healthcare need.

The IFR now permits abortion counseling and abortion care when the life or health of the pregnant veteran or beneficiary would be endangered, or when the pregnancy is the result of rape or incest, at least partially meeting the needs discussed above.[22]

Abortion care is needed when the life or health of the pregnant veteran would be endangered if the pregnancy is carried to term.

---

[19] *Service Members' Reproductive Health and Readiness: Hearing Before the Subcomm. on Mil. Personnel of the H. Comm. on Armed Servs.*, 117th Cong. 1 (2022) (statement of Rep. Jackie Speier, Chair, Subcomm. on Mil. Personnel), https://armedservices.house.gov/_cache/files/6/5/65c4d388-de1c-4dde-8f59-4594f2524653/9B644259133D55B3F1DEFB8F9335E4EC.20220729-mlp-speier-opening-statement.pdf.

[20] Eleanor Bimla Schwarz et al., *Induced Abortion among Women Veterans: Data from the ECUUN Study*, 97 Contraception 41 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5732058/pdf/nihms915509.pdf.

[21] *Service Members' Reproductive Health and Readiness: Hearing Before the Subcomm. on Mil. Personnel of the H. Comm. on Armed Servs.*, 117th Cong. (2022) (statement of Dr. Ghazaleh Moayedi, Bd. of Dirs., Physicians for Reprod. Health & Tex. Equal Access Fund), https://armedservices.house.gov/_cache/files/1/b/1b5117ac-ef47-44f5-a824-9003f5730415/ED33ECBFAED908FEEB4167EE7B832944.20220729-mlp-witness-statement-moayedi-.pdf.

[22] 87 Fed. Reg. at 55,294.

Abortion is often a medical necessity. As the VA recognizes, removing existing prohibitions is necessary to protect veterans' life and health.[23] In the United States, around 700 people die every year because of pregnancy-related complications, the highest maternal mortality rate of any developed country.[24] Another 50,000 people each year have unexpected outcomes of labor and delivery with serious short- or long-term health consequences.[25] The landmark Turnaway Study[26] reported that women who were denied abortions and gave birth had "more life-threatening complications like eclampsia and postpartum hemorrhage" as compared to those who received wanted abortions.[27] Other physical effects included "chronic headaches or migraines, joint pain, and gestational hypertension".[28] This maternal health crisis is especially acute for non-white people. For example, Black people have a maternal mortality rate three times higher than White people,[29] and for Native people the death rate is twice as high.[30]

These risks are pronounced for veterans. Veterans who use VA for maternity care are at increased risk for maternal morbidity and mortality as they are older than the average non-veteran giving birth.[31] They also have higher rates of chronic medical and mental health conditions, such as chronic post-traumatic stress disorder, severe hypertension, and chronic renal disease.[32] Veterans and CHAMPVA beneficiaries who become pregnant face these risks to their health and lives.

---

[23] 87 Fed. Reg. at 55,288.
[24] Aria Bendix & Dana Varinsky, *The Biggest Health Risks Women Would Face if Roe v. Wade is Overturned*, NBC News (May 4, 2022), https://www.nbcnews.com/health/health-news/health-risks-overturning-roe-v-wade-abortion-rcna27109.
[25] Ctr. for Disease Control & Prevention (CDC), *Working Together to Reduce Black Maternal Mortality* (Apr. 6, 2022), https://www.cdc.gov/healthequity/features/maternal-mortality/index.html.
[26] Advancing New Standards in Reprod. Health & Univ. of Cal. S.F., *The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study* (2020), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.
[27] *Id*. at 2.
[28] *Id.*
[29] CDC, *Working Together to Reduce Black Maternal Mortality*, *supra* n. 24.
[30] Elizabeth Chuck & Haimy Assefa, *She Hoped to Shine a Light on Maternal Mortality among Native Americans. Instead, She Became a Statistic of It*, NBC News (Feb. 8, 2020), https://www.nbcnews.com/news/us-news/she-hoped-shine-light-maternal-mortality-among-native-americans-instead-n1131951.
[31] Examining Women Veterans' Access to the Full Spectrum of Medical Care, Including Reproductive Healthcare, through the Department of Veterans Affairs Veterans Health Administration: Hearing Before the Comm. on Veterans' Affs., 117th Cong. 2 (2022) (statement of Shereef Elnahal, Under Sec'y for Health, Veterans Health Admin.), https://docs.house.gov/meetings/VR/VR00/20220915/115111/HHRG-117-VR00-Wstate-ElnahalS-20220915-U1.pdf.
[32] Jonathan G. Shaw et al., *Post-traumatic Stress Disorder and Antepartum Complications: a Novel Risk Factor for Gestational Diabetes and Preeclampsia*, 31 Pediatric & Perinatal Epidemiology 185 (2017), https://doi.org/10.1111/ppe.12349; David C. Jones et al., *Outcome of Pregnancy in Women with Moderate or Severe Renal Insufficiency*, 35 New Eng. J. Med. 226 (1996), https://doi.org/10.1056/NEJM199607253350402.

In addition, though the VA offers a full range of effective contraceptive care, veterans still experience a higher rate of unintended pregnancies, compared to the general U.S. population.[33] Abortion services are still needed despite the availability of contraceptives due to their risk of failure. Of veterans who become pregnant, one study found that more than half of women seeking abortion services had been using contraceptives when they became pregnant.[34]

Abortion care and abortion counseling are necessary to protect the mental health of the pregnant person in cases of rape and incest and other circumstances.

Veterans, like all people, deserve the autonomy to make decisions that impact their own body, health, and well-being. VA's decision to provide abortion counseling helps meet this need. Counseling will ensure pregnant veterans and beneficiaries can seek advice, receive information, and inquire about various options to make fully informed health care decisions. The IFR correctly notes that abortion counseling is part of pregnancy options counseling and a critical component of providing a high quality, comprehensive, patient-centered reproductive health care.[35] While abortion is a high profile policy issue, many people have limited knowledge of its medical details, such as the option for medication abortions, making counseling necessary.[36] A veteran's ability to exercise control over this important decision is critical to living a fulfilling life free from undue government interference. We applaud VA's decision to support veterans in making their own decisions regarding what's best for their life, health, family, and future.

Control and autonomy are even more critical when the pregnancy is the result of rape or incest. The IFR correctly recognizes that abortion access is necessary to protect the mental health of veterans and CHAMPVA beneficiaries who became pregnant under these circumstances.[37] Such pregnancies are too frequent—the CDC has determined that almost 3 million women in the United States experienced rape-related pregnancies in their lifetime.[38] Carrying such a pregnancy to term can compound trauma with the constant physical reminder of the original violation and cause mental health consequences, including anxiety, depression, and post-traumatic stress disorder (**PTSD**).[39] Our members who have become pregnant as a result of being raped, with long-term negative impacts on their emotional and mental wellbeing, can attest to the need for abortion in these circumstances.

---

[33] Schwarz et al., *Induced Abortion among Women Veterans*, supra n. 19, at 44 tbl. 2.
[34] *Id.*, at 42.
[35] 87 Fed. Reg. at 55,292.
[36] Ashley Kirzinger et al., *Abortion Knowledge and Attitudes: KFF Polling and Policy Insights*, Kaiser Fam. Found. (Jan. 22, 2020), https://www.kff.org/womens-health-policy/poll-finding/abortion-knowledge-and-attitudes-kff-polling-and-policy-insights/.
[37] 87 Fed. Reg. at 55,292.
[38] Ctr. for Disease Control & Prevention, *Pregnancy Resulting from Rape*, https://www.cdc.gov/violenceprevention/sexualviolence/understanding-RRP-inUS.html (last reviewed June 1, 2020).
[39] 87 Fed. Reg. at 55,292.

These risks are especially significant for veterans. Veterans already have high rates of mental health conditions making them a vulnerable population.[40] Their mental health challenges and related issues include PTSD, depression, suicidality, traumatic brain injury, substance abuse, and interpersonal violence.[41] The mental health risks of being unable to access a desired abortion[42] are especially high for veterans given their disproportionately acute mental health needs.

Further, the frequency of sexual violence in the military is at crisis levels, compounding the potential mental health consequences of carrying a pregnancy resulting from rape or incest. The continued impacts of sexual harassment and assault on veterans are so significant that the VA has identified "military sexual trauma" as a unique healthcare need.[43] Indeed, about one in three women veterans tell their VA healthcare provider they experienced sexual harassment or assault while in the military.[44] One of our members shared her experience of horrific abuse:

> I was raped every day for 2 weeks in which I was impregnated and terminated the pregnancy. My own commander told my husband that I was a lost cause and that he should leave me be. He also told him that I was pregnant but left out the part of how I was pregnant. My commander walked around with my medical records and would laugh at all the diagnosis and personal information that the army caused. He even went as far as reading my medical records in front of my unit. ... Finally my grandmother flew up to bring me home because the woman that went in to serve her country was put out with nothing. Not my dignity, not anything. I am not the same at all. I cry everyday and contemplate suicide. ... But this minority Veteran isn't giving up. I will get my life back.

The combination of disproportionate mental health vulnerability and prior experiences of sexual violence makes the option of abortion especially necessary to protect the mental health of veterans who are pregnant because of rape or incest.

The IFR's express acknowledgement of the mental health vulnerability that pregnant veterans experience is consistent with our members' experience. One veteran provided the following description of how precarious her mental health and personal stability is following her service:

---

[40] Schwarz et al., *supra* n. 19, at 41.
[41] Catarina Inoue et al., *Veterans and Military Mental Health Issues* (2022) (ebook), https://www.ncbi.nlm.nih.gov/books/NBK572092/?report=printable
[42] Biggs et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion*, supra n. 6, at 174.
[43] VA, *Military Sexual Trauma*, https://www.womenshealth.va.gov/topics/military-sexual-trauma.asp (last visited Oct. 11, 2022).
[44] *Id.*

> I was 17 and stationed in Germany. Where I started drinking and get high with two [of my Sergeants]. They both would take advantage of me while intoxicated. I thought they were just looking out for me and I owed them. I was always assigned to one of them when duties came along. I then got pregnant by one and his wife took me for a horrific abortion. Now I am struggling for sobriety while homeless, widowed, and losing custody of my three kids. I have lost everything, even hope at times.

For veterans who are this vulnerable and become pregnant, abortion may be necessary to protect their mental health. As one of our members explained of her decision to have an abortion: "Before my abortion, I had been raped by a classmate [at army training]. And several soldiers have attempted to sexually assault me early on in my career. By this trauma alone, I was barely holding everything together [at the time I became pregnant]."

We encourage the VA to expressly acknowledge that veterans have compelling mental health needs to end a pregnancy in circumstances besides rape or incest. These may include pregnancies with fetal abnormalities or conditions that are incompatible with life. Under these circumstances, abortion may be essential to protect the veteran's mental health. We note too that there is a profound moral injury, with associated consequences for mental wellbeing, for veterans who fought to protect the United States Constitution but are now being denied the constitutional right of autonomy over their own bodies. As Senator Tammy Duckworth eloquently explained:

> The question that I have is: When is it that American women have the right to bodily autonomy? ... Apparently, I had the right to decide to use my body to fight wars in this country. It was okay for me to decide to use my body to fly a helicopter into combat, where it was also okay for me to lose my legs, parts of my body, in defense of this great nation. ... Female veterans should not be limited by what part of the country they happen to be living in. They should have full control over their bodies—the way they did when they were carrying rucksacks and M4s.[45]

The IFR promotes equity because lack of abortion access and counseling disproportionately negatively impacts minority groups of veterans and CHAMPVA beneficiaries.

Abortion restrictions disproportionately impact minority and disadvantaged communities.[46] Specifically, these bans disproportionately harm minority communities including Black. Brown, queer folks, people with disabilities, young people, immigrants, people who are incarcerated or detained, and

[45] Mariel Padilla, *The 19th Explains: How Pregnant Veterans May Access Abortions Despite State Restrictions*, 19th (Sept. 8, 2022), https://19thnews.org/2022/09/pregnant-veterans-military-abortion-access-state-restrictions/

[46] *See* Robbins & Goodman, Nat'l P'ship for Women & Fams., *State Abortion Bans Could Harm Nearly 15 Million Women of Color*, *supra* n. 11.

members of the armed forces.[47] Among veterans, those most in need of comprehensive reproductive health care are gender, sexual, racial, and ethnic minorities. In addition, an estimated over one million veterans are lesbian, gay, or bisexual,[48] and about 134,000 veterans are transgender.[49]

As a result of structural inequities, the consequences of abortion restriction are devastating for minority communities and low-income pregnant people. These populations are "more likely to face barriers in accessing routine health care services," which includes prenatal care.[50] Because these minority communities are less likely to receive prenatal care, it increases their risk for complicated health issues during the pregnancy.[51] As a result, they experience a higher rate of maternal morbidity and are more likely to die from complications.[52] In each of these categories, minority communities are more likely to experience complications, and thus more likely to need the critical access and counseling this IFR provides.

The financial burden of accessing abortions disproportionately impacts populations that already experience disparities.[53] For example, the rate of unintended pregnancy for white women sits at 33%, while for Hispanic women it is 58% and Black women it is 79%.[54] Yet Black and Hispanic women face socioeconomic disparities, health inequities, and housing instability at a higher rate than white

---

[47] *See* Statement of Ghazaleh Moayedi, *supra* n. 20; *see also* Samantha Artiga et al., *What Are the Implications of the Overturning of Roe v. Wade for Racial Disparities?*, Kaiser Fam. Found. (July 15, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/ (discussing abortion implications to communities of color); Kiara Alfonseca, *Why Abortion Restrictions Disproportionately Impact People of Color*, ABC News (June 24, 2022), https://abcnews.go.com/Health/abortion-restrictions-disproportionately-impact-people-color/story?id=84467809; Lauren Paulk, *Abortion Access Is an LGBTQ Issue*, Nat'l Ctr. for Lesbian Rights (Oct. 1, 2013), https://www.nclrights.org/abortion-access-is-an-lgbt-issue/; Ctr. for Reprod. Rights, *The Disproportionate Harm of Abortion Bans: Spotlight on Dobbs v. Jackson Women's Health* (Nov. 29, 2021), https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-disproportionate-harm/.

[48] Gary J. Gates, *Gay Veterans Top One Million*, Urban Inst. (2003), *available at* https://www.urban.org/research/publication/gay-veterans-top-one-million.

[49] Gary J. Gates, *Transgender Military Service in the United States*, Williams Inst.(2014), https://escholarship.org/uc/item/1t24j53h.

[50] Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department*, 2 J. Am. Coll. of Emergency Physicians Open, at 2, https://doi.org/10.1002/emp2.12549.

[51] *Id.*; Juanita Chinn, et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212, 215 (2021) (explaining that "Non-Hispanic Black women are at a disadvantage regarding the protective factor of the early initiation of prenatal care").

[52] Ctr. for Disease Control & Prevention, *Working Together to Reduce Black Maternal Mortality*, *supra* n. 24.

[53] *Open Session Legislative Hearing on H.R. 6052, H.R. 5776, H.R. 6638, and Several Discussion Drafts Before the Subcomm. on Oversight & Investigation of the H. Comm. on Veterans' Affs.*, 117th Cong. (2022) (statement of Minority Veterans of Am.), *available at* https://docs.house.gov/meetings/VR/VR08/20220330/114548/HHRG-117-VR08-Wstate-ChurchL-20220330-U1.pdf.

[54] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011* 374 New Eng.. J. Med. 843, 846-47 tbl. 1(2016), https://doi.org/10.1056/NEJMsa1506575.

women, as do unmarried women.[55] Similarly, LGBTQ+ veterans face economic, housing, and health insecurities, yet same-sex couples who want to build a family are excluded from accessing VA programs and services that will help them afford that.[56]

While MVA applauds the IFR, additional barriers to full access remain, particularity for minority veterans.

The IFR is a significant step in improving access to the full spectrum of medical care for veterans and CHAMPVA beneficiaries who may become pregnant. Despite this important step, additional barriers to full access remain, particularly for minority veterans. Those barriers might result in the policy not having its intended impact.

Some barriers are in the IFR itself: *"if determined needed by a health care professional, when the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term or the pregnancy is the result of an act of rape or incest…"*[57] As written, the IFR creates an "exception-based" policy, which can be inadequate and harmful because it is conditioned on a medical provider's decision. There may be some veterans who will qualify under the IFR but will not receive the necessary care. For example, medical providers may be concerned about criminal liability or may delay or deny care until the danger to the "life or health" is serious or critical. We encourage the VA to provide clear guidance so that no veteran or CHAMPVA beneficiary is denied abortion care because their condition is not deemed sufficient to put their life or health in danger, because they are not believed when stating that the pregnancy is the result of rape or incest, or because the provider is personally opposed to abortion. In short, for this IFR to work for the veterans and beneficiaries it is intended to help, medical providers should not be allowed act as gatekeepers, particularly not as a result of their religious beliefs or their personal skepticism of the patient's circumstances.

The IFR also fails to address economic barriers to access. The VA's health facilities are geographically dispersed, many of them will not have the necessary providers qualified to do abortion procedures. Will the VA provide funding, medication abortion, or travel allowances in order to address the economic barriers to healthcare access?

The VA also must provide a more welcoming environment for veterans seeking reproductive healthcare. One in four women veterans reported experiencing sexual assault while seeking care at VA

[55] Off. of Health Equity, VA, *Racial and Ethnic Minority Veterans*, https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp (last updated July 9, 2020).
[56] Lindsay Mahowald, *LGBTQ+ Military Members and Veterans Face Economic, Housing, and Health Insecurities*, Ctr. for Am. Progress (Apr. 28, 2022), https://www.americanprogress.org/article/lgbtq-military-members-and-veterans-face-economic-housing-and-health-insecurities/.
[57] 87 Fed. Reg. at 55,288.

P.O. Box 65089
Washington, DC 20035

facilities.[58] A report by the Office of the Inspector General indicated that the Department "has not followed through on promises to take steps to ensure women veterans feel safe and welcomed."[59] The VA needs to ensure veterans feel safe in accessing the care the IFR would provide.

Conclusion

The VA had said it "is taking these steps [in the IFR] with its primary mission in mind: to preserve the lives and health of pregnant Veterans and CHAMPVA beneficiaries" (Elnahal, S., 2022.) We appreciate the focus on life and health and hope that the VA will be able to implement the IFR in a way that achieves its goals.

If you have any questions or would like to discuss the information in this comment, please contact Robin Thurston or Maher Mahmood, Democracy Forward Foundation, counsel for Minority Veterans of America, at rthurston@democracyforward.org or mmahmood@democracyforward.org.

Very respectfully,

Lindsay Church
Executive Director

Peter Perkowski
Legal & Policy Director

[58] Ruth Klap et al., *Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care*, 29 Women's Health Issues 107, 112 (2019), https://doi.org/10.1016/j.whi.2018.12.002.
[59] Dep't of Veterans Affs., Off. of Special Revs., *Senior VA Officials' Response to a Veteran's Sexual Assault Allegations* 42 (2020), https://www.va.gov/oig/pubs/VAOIG-20-01766-36.pdf.

EXHIBIT 1

Written testimony of Lindsay Church
for the Open Session Oversight Hearing
Examining Women Veterans' Access to the Full Spectrum of Medical Care
U.S. House of Representatives' Committee on Veterans' Affairs
September 15, 2022

Chairman Takano, Ranking Member Bost, and members of the Committee,

My name is Lindsay Church and I am a veteran of the United States Navy. I traditionally appear before this committee as a representative of Minority Veterans of America, a nonprofit dedicated to creating community belonging and advancing equity for minority veterans, where I proudly serve as Executive Director. Today I am here to share the story of myself and my family.

I served in the Navy from 2008 to 2012 as a Cryptologic Technician Interpretive and specialized in speaking Persian-Farsi. I was born into a family with deep ties to the military. I am a third generation veteran, and one of six in my family to serve. Growing up, the core values of the Navy - honor, courage, commitment and sacrifice - were instilled in me before I ever knew anything about my family's lineage of service.

When I decided to join, I understood that in order to wear the uniform of the United States of America, I would have to sacrifice. I believed my sacrifices were made in support of a mission that was greater than myself: to protect and defend the Constitution that I believed in wholeheartedly. I was willing to give anything, up to and including my life, if it meant that my fellow Americans would enjoy the rights afforded by our country. As a queer service member living under Don't Ask, Don't Tell, I understood that there were some rights that I would not enjoy while in service, but that when I become a civilian, I would be afforded those protections. Among those rights was the right to abortion and to live safely as a queer person.

During my time in service, I experienced complications of a congenital birth defect called pectus excavatum which causes your sternum to be inverted. I learned that my sternum was so far inverted that one of the chambers of my heart could contract, but not expand. I had my first surgery in 2009 where they removed 3 inches from six of my ribs and I spent 30 days hospitalized from complications. By the time I was medically retired in 2012, I had spent 52 days in the hospital, survived three surgeries, had all of the cartilage in my chest removed, and was the proud owner of a 9.5 inch metal bar that spanned the width of my rib cage. Since my medical retirement in 2012, I have had six additional surgeries on my sternum and spine, had four ribs removed, and now live with a spinal cord stimulator and a remote that helps to

control my pain. These surgeries and the impacts to my body changed my life in ways I never imagined.

I returned home to Seattle, WA and began receiving all of my care through the VA. For over 10 years, I have received my care through VA and various Women's Clinics while I have navigated the effects of military service on my mental, physical, and emotional health. I'd like to focus my testimony today on three distinct areas within the Department of Veterans Affairs - infertility and reproductive assistance, abortion care, and the culture of VA for women and gender minority veterans. These aspects deeply impacted me, my family, and continue to impact the broader veteran community

Reproductive Assistance and Service-Connected Infertility

Veterans experience infertility at a higher rate compared to their non-veteran counterparts: among veterans who served since 9/11, the prevalence of lifetime infertility for men was 13.8% and for women was from 15.8%,[1] and in some studies up to 18%.[2] The factors that contribute to this phenomenon are numerous: among veterans, infertility may be due to service-related physical injury, toxic exposures, post-traumatic stress, military sexual trauma, traumatic brain injury, or age (since many serve during peak reproductive years), among other challenges.[3] For racial and ethnic minority women, the rates of reported infertility were as high as 24%.[4]

After my sixth surgery doctors told me that my ribs were completely fused together from the lack of cartilage in my chest, preventing the necessary mobility for pregnancy. I had to face the reality that my physical disabilities prevented my ability to carry a child. I started to understand that, no matter what I wanted, my journey toward having a family was never going to include me becoming pregnant. I was frustrated, angry, and depressed but didn't have the words to share what I was going through. I struggled to make sense of my reality, and needed the support of my health care team, however my VA providers were not trained or able to support my needs.

---

[1] Katon, J., Cypel, Y., Raza, M., Zephyrin, L., Reiber, G., Yano, E. M., Barth, S., & Schneiderman, A. (2014, Feb. 4). Self-reported infertility among male and female veterans serving during Operation Enduring Freedom/Operation Iraqi Freedom. *J Women's Health (Larchmont)*, *23(2)*, 175-183. doi: 10.1089/jwh.2013.4468

[2] Mancuso, A. C., Summers, K. M., Mengeling, M. A., Torner, J. C., Ryan, G. L., & Sadler, A. G., (2020, Mar. 17). Infertility and health-related quality of life in United States women veterans. *J Women's Health*, *29(3)*, 412-419. doi: 10.1089/jwh.2019.7798

[3] Coloske, M. (2021, July 22). The right to serve, but not to carry: Expanding access to infertility treatment for US veterans. *Health Affairs.*

[4] Goossen, R. P., Summers, K. M., Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2019, January 10). Ethnic minority status and experiences of infertility in female veterans. *J Women's Health*, *28(1)*, 63-68. doi: 10.1089/jwh.2017.6731

In 2020, I married my spouse and we began to make plans to start a family. Given my physical disabilities, there was and is no way that I could safely carry a child to full-term without causing extreme distress to the baby or to my already damaged body. VA offers infertility treatment to veterans when the infertility is caused by a service-connected disability. Service-connected in this instance is defined as a "disability that results in the inability of the veteran to procreate without the use of fertility treatment." This means, for women and some nonbinary and transgender veterans, a service-connected injury or illness is one that prevents the egg from being successfully fertilized by sperm.[5] The disabilities I sustained do not meet the requirements for service-connection for infertility treatment and mean that my family is not eligible for reproductive assistance through the Department.

In addition to the limitations to proving that my service-connected disabilities restrict my ability to carry a child, my wife and I are further prohibited from accessing infertility care because we are in a same-sex marriage. VA limits the provision of intrauterine insemination (IUI) and in vitro fertilization (IVF) to legally married veterans with opposite-sex gametes.[6]

As a result of VA's current policies on reproductive assistance, the benefit is available almost exclusively to couples that are both cisgender and heterosexual and eligibility criteria categorically exclude same-sex and same-gender couples, unmarried women, and transgender men who want to conceive, even if their infertility is related to their service. It also excludes individuals and couples with non-service-connected infertility conditions, including some transgender and non-binary veterans.

Stories like mine and my spouse's aren't unique. Veterans such as Khris Goins of Ohio, Kerry Karwan of California, and Toni Hackney of Georgia[7] are among the many who have been denied or cannot access reproductive assistance through the VA as a result of the same regulatory bars that we have faced. Veterans continue to face challenges in accessing fertility care when they are unable to prove service connection, are in same-sex marriages and partnerships, or are unmarried while attempting to start a family. These VA benefits are so restrictive to access that only 567 veterans used them from 2016-2019.[8]

---

[5] Office of Community Care. (2019, April 21). *VA infertility services can help veterans and their families.*https://blogs.va.gov/VAntage/59082/va-infertility-services-can-help-veterans-and-their-families/. Katon et al. (2013).

[6] Veterans Health Administration. (2021, March 21). *VHA Directive 1334(2): In vitro fertilization counseling and services available to certain eligible veterans and their spouses.* Department of Veterans Affairs.

[7] Sokolow, A. (2020, August 21). *The VA doesn't cover fertility treatments for unmarried veterans or same-sex couples. some want to change that.* USA Today. Retrieved September 13, 2022, from https://www.usatoday.com/story/news/nation/2020/08/21/veterans-groups-say-va-should-offer-ivf-unmarried-same-sex-couples/3371635001/

[8] Carr, J. (2019, July 24). Abortion arguments at play in limiting veterans' IVF benefit. *ABC News.*https://abcnews.go.com/Health/wireStory/abortion-arguments-play-limiting-veterans-ivf-benefit-64542147

Abortion Access

In spite of our limited access to care through VA, my wife and I began the process of starting a family last fall. We worked with a fertility clinic to develop a care plan that would allow us to start the family we both dreamed of, which included completing a series of tests and purchasing donor materials from a FDA regulated sperm bank, much of which we paid for out of pocket.

On April 22, 2022, my wife went in for the first attempt at intrauterine insemination. In the time that we had to wait to learn if she was pregnant or if we would need to try again, the draft Supreme Court opinion in the case of *Dobbs v. Jackson Women's Health Organization* was leaked. On May 3, 2022, we joined hundreds of others in protest over the potential overturning of *Roe v. Wade*, all while remaining uncertain of whether or not the procedure had worked.

On May 6, 2022, we learned that Jess was pregnant and celebrated what was both one of the happiest and scariest moments of our lives. We were elated about the baby, but feared what her pregnancy care could look like if the right to abortion under *Roe v. Wade* was no longer in place. We live in Virginia where abortion is currently legal until the end of the second trimester, and in the third when necessary to save the life of the pregnant person. But in the backdrop loomed an effort by our state legislature to ban care at just 15 weeks.

The Supreme Court's decision in *Dobbs* would ultimately be delivered on June 24. Exactly two weeks later, on July 8, 2022, my wife and I discovered through a routine ultrasound that our child's abdomen was distended to the point of concern. We were given the contact information of a perinatal specialist who confirmed that our child had a fetal bladder deformity that would require an amniocentesis for further evaluation, which could not be performed until they were 16 weeks.

When my wife and I began the process of starting a family, we never thought it would look like this. We wanted our baby more than anything in the world but we did not want to imagine a world where all they would know was suffering. As a person born with a genetic deformity who has endured so much pain because of it, I have a unique understanding of what this child's life would be like had we carried the pregnancy to term.

It took 33 days to get the tests required to better understand what was happening with our baby. On August 2, 2022, my wife and I returned to the perinatal specialist only to find that the baby's condition had worsened and that they were unable to produce the amniotic fluid

required for their continued viability and growth. The lack of amniotic fluid meant that they were unlikely to grow lungs and they would not survive.
In that moment, my wife and I made the most painful decision either of us has ever had to make. We made what we believe was the most compassionate choice for the child we loved so much, which was to end the pregnancy.

On August 5, 2022, my wife had the first of two appointments for a dilation and evacuation procedure. We learned during our ultrasound that our baby no longer had a heartbeat and had likely passed the evening of our last appointment. For my wife, the procedure for a miscarriage was the same as it was for an abortion and she would still need to return to the clinic the next day for a surgical procedure to evacuate her uterus.

We were able to access care, not through programs like CHAMPVA which is designed to support caregivers of 100% total and permanent disabled veterans like myself, or TRICARE which she also qualifies for, but through a community-based clinic in Richmond, Virginia that has been providing care to patients in need of abortion and reproductive health services since 1973. She was able to access this care because we are fortunate enough to be able to afford private insurance and have access to non-VA providers, while living in a state that did not restrict her access to these services.

During my wife's pregnancy, there were times when it felt like we were racing a clock to understand what was happening with our child. We knew every day that, even under the best circumstances, we had until early September to make a decision or we may be forced to leave the state to access care. I remember thinking that if we had to leave the state to get access to the essential care that my wife needed, I would never forgive this country. The moral injury of having served a country to protect our Constitution that no longer protected me and the ones I love was, and still is, absolutely devastating.

Earlier this month, VA released an Interim Final Rule on Reproductive Health Services. The new regulation allows veterans, eligible family members, and caretakers to access abortion counseling, and to access abortion care through the VA in cases of rape, incest, and when the pregnancy threatens the life or health of the pregnant person. VA providers can provide this crucial care in order to support the health needs of veterans and their families, regardless of local and state laws.

These measures have the potential to help many veterans and their families across the country who live in states that limit or completely ban access to abortion. Had this policy been

in place just one month earlier, my own family could have turned to VA for care. This policy may not, however, reach the veterans who most desperately need access to reproductive health care, and who are disproportionately impacted by limited access to contraception and abortion bans. Veterans who are racial and ethnic minorities and those who live in poverty are more likely to live in states with restrictive bans and have negative physical, emotional, and economic impacts from unintended pregnancies.

While I am grateful to see the expansion of care that will now reach veterans who previously had limited or no access to care, I have deep concerns that this policy may not have its intended impact. As outlined in my organization's statement for the record for this hearing, veterans are still likely to run into issues in access, including medical providers and hospitals concerned with criminal liability, patients needing to delay their care until their health is dangerously at risk, and providers refusing care even when it is legally allowed. To fully address the abortion crisis for veterans and all Americans, we need comprehensive national health protections for abortion, contraception, and other reproductive health services.

Reports have outlined the challenges of TRICARE exceptions policies for veterans, service members, and military spouses.[9] Stories such as those of Bari Wald, an Air Force Reserve officer and Marine spouse, and Lauren Bryar, a veteran spouse, both who learned of fetal deformities in their children and needed access to care. For Wald, the delayed access to care threatened her life and health and resulted in a 105 degree fever, a lacerated cervix and blood poisoning. Abortion bans harm everyone.

VA Culture and Harassment at Facilities

As I mentioned in the beginning of my testimony, for the last 10 years, I've received nearly all of my care through VA. Over the last decade, I've navigated a health system that is unable to see, understand, or serve veterans like myself. It is a common and expected occurrence that, should I choose to use VA for my care, I can expect to be consistently misgendered, treated as though I do not belong or that my issues do not matter, and that I will not be safe while physically navigating VA facilities.

In December of last year, I was harassed for using a women's restroom at the Hunter Holmes McGuire VA Medical Center, where I was accessing care for an injury to my back. Upon entering the restroom and using the facilities, a VA staff member shouted into the bathroom

[9] Montgomery, N. (2022, July 6). *Military women say dod reproductive health care far from 'seamless' in post-Roe Era* . Stars and Stripes. Retrieved September 13, 2022, from https://www.stripes.com/theaters/us/2022-07-06/abortion-fetal-anomalies-6564885.html.

repeatedly that he had heard there was a man in the women's restroom, causing a scene and striking fear, when I was merely trying to use the restroom. When I spoke with him after the incident, he did not apologize and was insistent that he was, "protecting the patients and the staff" to which I replied, "I am the patient."

This was not the first time I have experienced feelings of harassment at VA facilities, but it was what pushed me to seek outside care. I am one of many veterans who have or are in the process of leaving VA care because the Department is not equipped to provide positive patient health experiences to the community of women, gender minorities, and other LGBTQ+ veterans. Intolerance for veterans like us is ingrained in VA culture resulting in harassment and a hostile, sometimes dangerous, environment, while seeking care. The harassment that we face as a result of the culture of VA inflicts lasting damage on those of us who endure the behavior, many without an ability to change their circumstances.

One in four women veterans has reported experiencing sexual assault while seeking care at VA facilities.[10] Actions taken in response to reported sexual assault cases have been performative in nature and provided no measurable difference in the positions the Department takes when addressing reports, or in the known number of incidents that have occurred. A report by the Office of the Inspector General indicated that the Department "has not followed through on promises to take steps to ensure women veterans feel safe and welcomed."[11] It is not yet clear whether the new complaint process, implemented recently by VA in response to the Deborah Sampson Act, will be successful in addressing the problem.

When women, gender minorities, and LGBTQ+ veterans first enter VA facilities they see a motto that does not reflect us as veterans. VA's own motto and mission denies our existence every day with the words, "To care for him who shall have borne the battle, and his widow, and his orphan." It is emblazoned on each and every VA facility across the country as a reminder to all who enter, the Department's perceived mission. This is just the first of many times where we are forced to contort ourselves to be seen and understood. The current motto disparages and undermines our service to our country - and it's a physical representation of the deep and lasting history of invisibility for women and gender minorities in the military and veteran community.

---

[10] Klap, R., Darling, J.E., Hamilton, A.B., Rose, D.E., et al. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs Medical Centers and impacts on delayed and missed care. *Women's Health Issues, 29(2)*, 107-115. National Library of Medicine. doi.org/jwhi.2018.12.002.Epub

[11] Office of Special Reviews. (2020). *Senior VA officials' response to a veteran's sexual assault allegations: Report # 20-01766-36.*Department of Veterans Affairs, Office of Inspector General. www.va.gov/oig/pubs/VAOIG-20-01766-36.pdf

As we look to the future of caring for women and gender minority veterans, we must examine the culture of the Department and how veterans experience their care from the moment they arrive at a VA facility to the moment they leave. Jean McGuire, a professor of practice at Northeastern University's Department of Health Sciences, wrote of the relationship between culture and health: "Our culture informs so much, from how we value healthcare, to what we're looking for in a relationship with a healthcare provider, to our willingness to comply with a treatment regimen. There are so many experiences of identity that shape our cultural lens and our economic and healthcare opportunities."[12]

Minority veterans have a long history of experiencing discrimination and stigmatization within veteran-centric spaces, resulting in our exclusion from needed social support and medical care. This has been true within VA, as well as within nonprofit organizations and those authorized to serve veterans on VA's behalf. In addition to strong anti-discrimination policies, it is crucial that bias, hate, and misinformation about minority veterans be addressed through education initiatives. Successful initiatives of this kind have been developed within the VA through the LGBT Health Program. Research shows that initiatives that encourage non-judgemental provider-patient communication is an important mechanism for ensuring access to services for minority veterans.

Recommendations

- **Reproductive Assistance**: Expand access to reproductive assistance through the Department of Veterans Affairs to veterans regardless of their service connection. Service-connected disabilities look different for each and every veteran and proving that our infertility is related to our service is often impossible. While some might have clearly linked infertility that is related to their reproductive organs, many veterans, like myself, do not meet this bar. This is especially important as the post-9/11 generation of veterans looks to start families after spending over 20 years at war. We have yet to truly understand the impacts of service on our generation and how things like toxic exposure will impact the ability to conceive healthy children. VA must be proactive to meet this moment.
- **Abortion Access**: We aren't truly free unless we can control our own bodies, lives, and futures. Our laws and policies need to uphold the human rights to body autonomy and self-determination, not try to control and dehumanize us. While recent policy changes at the Department of Veterans Affairs will help some veterans and their families, it could still leave many without access to necessary abortion services. A comprehensive national policy that

[12] Doyle, L. (2021, August 11). *Overcoming cultural barriers in healthcare*. Northeastern University Graduate Programs. Retrieved September 13, 2022, from https://www.northeastern.edu/graduate/blog/overcoming-cultural-barriers-in-healthcare/.

protects the reproductive rights and healthcare access of all veterans is needed. The decision to have an abortion should be between the pregnant person and their provider - without government interference. VA has the ability to empower patients and providers to make the best decisions for themselves and their families.

- **Culture of the Department** -
  - VA must take measures to improve its culture for women and gender minorities. Facilities are not safe and continue to show that VA is not equipped to serve our community. Cultural symbols such as the Department's motto must be changed immediately, whether through action by the Secretary or this Congress.
  - Proper and ongoing training regarding best practices and cultural competency training on minority veterans should be mandatory for VA staff and providers, Veteran Service Organizations, and contractors. This training should be developed and provided to all VA points of entry to ensure that proper investigative procedures are conducted, and that no veteran is harmed while trying to access their earned benefits.
  - In order to best serve the unique needs of gender and sexual minority veterans, VA should establish LGBTQ+ Health Centers. These centers would reduce barriers to accessing services and allow members of the LGBTQ+ veteran community to receive care free of harassment.

* * *

Chairman Takano, Ranking Member Bost, and distinguished members of the Committee, thank you for the opportunity to testify today. I look forward to working with you and your offices on these critical issues.

Respectfully Submitted,

Lindsay Church (they/them)
US Navy Veteran

EXHIBIT 2

Statement for the Record

Serving Women and Gender Minority Veterans: A Commitment to Equity

For the Open Session Oversight Hearing
to Examine Women Veterans' Access to the Full Spectrum
of Medical Care

Provided for:

U.S. House of Representatives'
Committee on Veterans' Affairs

September 15, 2022

Prepared by:

Lindsay Church (they/them), Executive Director
Peter Perkowski (he/him), Legal and Policy Director
Kara Stiles (she/ella), Policy Analyst

Chairman Takano, Ranking Member Bost, and Members of the Committee,

Minority Veterans of America (MVA) works to create belonging and advance equity for our nation's historically marginalized and underserved veterans: racial and ethnic minorities, women, LGBTQ-identifying, and (non)religious minorities. We work on behalf of more than 10.2-million veterans and directly serve thousands of veteran-members—many of whom have never been, and may never be, recognized or heard individually—across 49 states, three territories, and three countries. We strive to be the most diverse, inclusive, and equitable veteran-serving organization in the country, and believe that through creating an intersectional movement of minority veterans, we can build a collective voice capable of influencing critical change.

Our work puts us in contact with many veterans from historically underserved populations whose healthcare needs are not being fully met by the Veterans Health Administration (VHA): women and other individuals who can become pregnant, transgender and non-binary veterans, and lesbian, gay, and bisexual veterans. The testimony below is rooted in the lived experiences of individuals in these populations, reflecting the historical exclusion from the institutions designed to serve them and their loved ones. It is offered in the hope that it may inform and improve this subcommittee's work.

We are grateful for the opportunity to provide our community's perspective and concerns on these legislative matters. We appreciate the efforts that this committee continues to take in acknowledging and addressing the gaps and barriers that confront the underserved populations we represent.

Introduction

VA has declared a mission of "serv[ing] Veterans by providing the highest quality health care available anywhere in the world," because "America's Veterans deserve nothing less."[1] In many ways, VA has fallen short of its mission when it comes to serving veterans in historically underserved and marginalized communities—including women, transgender and non-binary veterans, and lesbian, gay and bisexual veterans.

VA's recent Interim Final Rule on Reproductive Health Services is a significant step in improving access to the full spectrum of medical care by women veterans and other veterans who may become pregnant. Despite this important step, additional barriers to full access remain, particularly for minority veterans.

[1] Department of Veterans Affairs. (n.d.). *The Affordable Care Act, VA, and you.* https://www.va.gov/health/aca/enrolledveterans.asp

Areas of Discussion

We focus our statement on the following areas of discussion: (A) comprehensive reproductive health care, including contraception, abortion counseling and care, and reproductive assistance; (B) the disproportionate reliance on community care and contract providers; and (C) providing a safe, secure, and welcoming environment for women and LGBTQ+ veterans.

A. Comprehensive reproductive health care for veterans

Comprehensive reproductive health care, including abortion care, is a necessary aspect of the complete health of any individual who can become pregnant:

> Making health for all a reality, and moving towards the progressive realization of human rights, requires that all individuals have access to quality health care, including comprehensive abortion care services—which includes information, management of abortion, and post-abortion care. Lack of access to safe, timely, affordable, and respectful abortion care poses a risk to not only the physical, but also the mental and social, well-being of women and girls [and others who can give birth].[2]

Among veterans, those most in need of comprehensive reproductive health care are gender, sexual, racial, and ethnic minorities. According to VA's own statistics, nearly 10% of our nation's veterans identify as women—representing the fastest growing demographic of veterans eligible for health care.[3] Currently numbering over two million, women are expected to make up 18% of the veteran population by 2040.[4] In addition, an estimated over one million veterans are lesbian, gay, or bisexual,[5] and about 134,000 veterans are

---

[2] World Health Organization. (n.d.). *Abortion*. https://www.who.int/health-topics/abortion#tab=tab_1. *See also* American Public Health Association. (2015, November 3). *Restricted access to abortion violates human rights, precludes reproductive justice, and demands public health intervention*. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights ("access to the full range of reproductive health services, including abortion, is a fundamental right").

[3] Office of Data Governance and Analytics. (2017, February). *America's women veterans: military service history and VA benefit utilization statistics*. National Center for Veterans Analysis and Statistics. Department of Veterans Affairs. https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf

[4] Department of Veterans Affairs. (n.d.) *Women veterans in focus.* https://www.womenshealth.va.gov/WOMENSHEALTH/docs/VHA-WomensHealth-Focus-Infographic-v20-sm-508b.pdf

[5] Gates, G. (2010, May). *Lesbian, gay, and bisexual men and women in the US military: Updated estimates.* The Williams Institute. https://escholarship.org/uc/item/0gn4t6t3

transgender.[6] Collectively, millions of these veterans and their family members find themselves unable to obtain critical comprehensive reproductive health care from VHA.

1. Contraception

The American College of Obstetricians and Gynecologists describes the importance of easy and affordable access to contraception in stark terms:

> Unintended pregnancy and abortion rates are higher in the United States than in most other developed countries, and low-income women have disproportionately high rates. Currently, 49% of pregnancies are unintended. The human cost of unintended pregnancy is high: women must either carry an unplanned pregnancy to term and keep the baby or make a decision for adoption, or choose to undergo abortion. Women and their families may struggle with this challenge for medical, ethical, social, legal, and financial reasons. Additionally, U.S. births from unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008. *Facilitating affordable access to contraceptives would not only improve health but also would reduce health care costs, as each dollar spent on publicly funded contraceptive services saves the U.S. healthcare system nearly $6. The most effective way to reduce abortion rates is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception* [emphasis added].[7]

VA offers the full range of contraceptive methods, either directly through providers at VA facilities, or through referrals to contracted providers. "Despite coverage of the full range of effective contraceptive methods through VA, however, women veterans experience a high burden of unintended pregnancy, with proportions comparable to the general U.S. population (Borrero et al., 2017)."[8] Studies have identified several barriers to women veterans accessing contraceptive care through VA:

Efficiency of care: Over half of surveyed veterans "identif[ied] efficiency and convenience as important aspects of contraceptive care."[9] Yet many found VA system "difficult to navigate" in many ways, including (1) a difficulty obtaining appointments, with long waits to

---

[6] Gates, G.J., & Herman, J.L. (2014, May). *Transgender military service in the United States*. The Williams Institute. https://escholarship.org/uc/item/1t24j53h

[7] The American College of Obstetricians and Gynecologists. (n.d.). *Access to Contraception.* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception

[8] Wolgemuth, T. E., Cuddeback, M., Callegari, L. S., Rodriquez, K. L., Zhao, X., & Borrero, S. (2020, Jan.-Feb.) Perceived barriers and facilitators to contraceptive use among women veterans in the ECUUN study. *Womens Health Issues, 30(1)*, 57-63. doi: 10.1016/j.whi.2019.08.005

[9] Wolgemuth et al. (2020).

see a provider for contraceptive refills; (2) the availability of only one-month supply of oral contraceptives because three-month prescriptions were not offered; (3) geographic limitations of a women's health primary care provider (WH-PCP) or women's health clinic; and (4) limited office hours.[10] To address these issues, VA should increase the use, availability, and awareness of telemedicine; facilitate increased access to WH-PCPs; make gynecological care or visits to a women's health provider available without a referral from a PCP (or increase awareness that such a referral is not necessary); and make a three-month supply of oral contraception routinely available.

Lack of frequent and high-quality counseling and education: Many women veterans did not receive routine contraceptive counsel during regular health-maintenance visits to VA providers; others noted that "they lacked the information necessary to make informed contraceptive choices and would have benefited from provider guidance."[11] VA must increase efforts to make contraceptive counseling and discussion a routine part of medical visits for female veterans, such as regular screening for medical conditions. Educational and awareness options include brochures and posters in VA waiting rooms.[12]

Lack of awareness of services: Similarly, many women veterans "identified a lack of awareness about VA contraceptive services among veteran women or suggested increased advertising of these services."[13] Again, VA must do more to communicate these services.

Provider-behavior barriers: A significant number of women veterans described negative interactions with providers, including disrespect or criticism, as a barrier to contraceptive access.[14] Poor communication could be borne out of provider discomfort with the topic or lack of specific training on women's health, particular by male providers, or by lack of experience with women patients.[15] Increased provider training is recommended.

Unwelcome environment: Unfortunately, many women and gender minorities do not feel comfortable at VA facilities, representing another barrier to accessing care:

> [M]any participants' experiences left them feeling that VA is an unwelcoming environment for women, and that "women veterans are considered outsiders." Another patient noted, "It feels like when you go into the VA it's a

[10] Wolgemuth et al. (2020).
[11] Wolgemuth et al. (2020).
[12] Wolgemuth et al. (2020).
[13] Wolgemuth et al. (2020).
[14] Wolgemuth et al. (2020).
[15] Wolgemuth et al. (2020).

men's club," and others suggest that women are considered "second-class citizens" and thought to be "malingerers."[16]

Having a separate space—within a larger VA facility or separate from it—was identified as one way to make women more comfortable accessing care.[17]

This issue affects more than just women veterans; transgender men and non-binary veterans also need to access VHA for comprehensive reproductive health care. Our experience talking with transgender and non-binary veterans mirrors the experiences of woman: many do not feel safe or welcome in VA facilities. As discussed more fully below, the problems encountered include repeated misgendering, harassment, policing of spaces VA must provide culture competency training to providers and employees, as well as implement clear policies and procedures for interacting with transgender and non-binary veterans.

2. Abortion counseling and care

Again, in the United States, an estimated 49% of pregnancies are unintended.[18] The rate is similar for veterans.[19] In addition, veterans share many risk factors for unintended pregnancy found in civilian populations and are also disproportionately affected by post-traumatic stress, depression, and other mental health issues that increase the risk of unintended pregnancy.

Interim Final Rule. We applaud and support VA's recent Interim Final Rule through which VA will provide abortion counseling and services to pregnant veterans and CHAMPVA beneficiaries in instances of rape, incest, or to protect the health or life of the pregnant person. According to the American College of Obstetricians and Gynecologists, "[d]octors and clinicians must be able to provide unbiased, factual information to patients regarding reproductive health care options. And people must be able to use their expertise in their own lives to make decisions for themselves and their families."[20]

Prohibition of abortion-options counseling (and abortion care) endangers the lives of veterans. Allowing pregnancy-options counseling will bring VA in line with evidence-based

---

[16] Wolgemuth et al. (2020).
[17] Wolgemuth et al. (2020).
[18] Committee on Health Care for Underserved Women. (2019, December). *Access to contraception.* The American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception
[19] Schwarz, E. B., Sileanu, F. E., Zhao, X., Mor, M. K., Callegari, L. S., & Borrero, S. (2018, January). Induced abortion among women veterans: data from the ECUUN study. *Contraception, 97(1)*, 41-47. doi: 10.1016/j.contraception.2017.09.012
[20] The American College of Obstetricians and Gynecologists. (2022, May 23). *Understanding ACOG's Policy on Abortion*. https://www.acog.org/news/news-articles/2022/05/understanding-acog-policy-on-abortion

health care being practiced in exam rooms across the nation. Options counseling provides evidenced-based health information to pregnant veterans and discusses continuation of pregnancy with intention to parent; continuation of pregnancy with intent to adopt; and pregnancy termination through abortion. Resources for care are provided based on the veteran's choice from these options.

We have several concerns related to the Interim Final Rule and its implementation.

a. "Exceptions-based" policies are inadequate and harmful

By its terms, the Interim Final Rule makes abortion counseling and care available to eligible veterans "if determined needed by health care professional, when the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term or the pregnancy is the result of rape or incest."[21] While this policy appears to be broad, we want to be clear: exceptions-based policies are inadequate, because bans harm everyone. While the Interim Final Rule will help some veterans who will receive care under it, even some veterans who qualify under the Rule will *not* receive care.

The problems with exceptions-based policies are evident from media accounts of how those policies work in states that currently have them: medical providers and hospitals, concerned about criminal liability, debate whether the medical condition of their pregnant patients meet an exception, often delaying or denying care until the danger to the "life or health" is serious or critical. Some medical providers—or the criminal justice systems that govern them—question whether rape or incest actually occurred. In many states, law enforcement does not hesitate to insert itself into the provider-patient relationship by demanding medical records and questioning providers. Even more disturbing, medical providers themselves often report patients to law enforcement when their own suspicions—correct or not—lead them to conclude that a miscarriage or still birth was actually an attempt to self-terminate a pregnancy.

These scenarios are not hypothetical. Each of them demonstrates the harm and inadequacy of exceptions-based policy like that in the Interim Final Rule. Our comments below address how VA may limit the harmful effects of an exceptions-based policy.

The Interim Final Rule modifies existing regulations to permit abortions when the life or health of the pregnant veteran would be endangered.[22] The Rule also states that the "[a]ssessment of the conditions, injuries, illnesses, or diseases that will qualify for this care

[21] AR-57, Interim Final Rule – Reproductive Health Services, 87 Fed. Reg. 55,287, 55,288 (Sept. 8, 2022).
[22] 87 Fed. Reg. 55,294; *see also* 38 C.F.R. § 17.38(c)(1)(i); 38 C.F.R. § 17.272(a)(64)(i).

will be made by appropriate health care professionals on a case-by-case basis."[23] Clear guidance must be provided to providers so that abortion care is not denied on the grounds that a pregnant veteran (or family member) is not sick enough or affected enough by the pregnancy. Clear guidance must also be provided so that providers may not deny care under the mistaken belief that state law would apply to them if they performed the procedures.

We urge the Committee to question VA about its planned communications to VA providers who will be providing this care.

b. Infrastructure and delivery issues

The VHA currently provides medical care through a network of medical systems, centers, clinics, and programs, which are supplemented by contract (non-VA) providers. Though VA health facilities are geographically dispersed, many of them will not have the necessary providers qualified to do abortion procedures. At the same time, preemption protections will not apply to contract providers, who are not VA employees. This means that large portions of the United States—particularly rural areas—will continue to be abortion-care "deserts," and the burden of this lack of access will fall disproportionately on veterans who are already underserved.

Accordingly, we urge the Committee to question VA about its plans for implementing the Interim Final Rule in a way that covers all eligible veterans and their eligible family members. Some issues are:

Telemedicine: Does VA intend to use telemedicine to limit the burden on patients in terms of appointment wait times, travel to appointments, and time-from-work issues?

Travel: Will VA provide funding or other assistance for eligible veterans and family members to travel to the nearest VA facility where abortion services will be available?

Medication abortion: Some states have enacted restrictions on medication abortion, likely because more people are relying on this critically important health care. Following two decades of safe and effective use, "in 2020, medication abortion accounted for 54% of all US abortions"[24]—powerfully illustrating that the method has gained broad acceptance from both abortion patients and providers. Does the VA have a plan for ensuring that its VA patients will have access to this important medication, even in states in which it is restricted by state law?

---

[23] 87 Fed. Reg. 55,294.

[24] Jones, R.K., Nash, E., Cross, L., Philbin, J., Kirstein, M. (2022, Feb.). *Medication abortion now accounts for more than half of all US abortions.* Guttmacher Institute. https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions

Increasing availability of care: What are VA's plans for increasing the number of abortion providers directly employed by VA, and for putting them in areas where the care is needed and in sufficient numbers to meet demand?

c. Limitation to VHA-eligible veterans and CHAMPVA beneficiaries

Only veterans who are qualify for VHA care, and CHAMPVA beneficiaries, are eligible for abortion care under the Interim Final Rule. In states with abortion restrictions, this means that many women and other pregnant people—including veterans—will still be unable to find and receive abortion care without significant burdens. We urge VA and the Committee to consider additional options to further expand the delivery of necessary health care services.

3. Infertility and reproductive assistance

Infertility is an issue for many Americans: approximately 10% of men[25] and the same percentage of women[26] experience infertility issues. Veterans experience infertility at a higher rate compared to their non-veteran counterparts: among veterans who served since 9/11, the prevalence of lifetime infertility for men was 13.8% and for women was from 15.8%,[27] and in some studies up to 18%.[28] The factors that contribute to this phenomenon are numerous: among veterans, infertility may be due to service-related physical injury, post-traumatic stress, military sexual trauma, traumatic brain injury, or age (since many serve during peak reproductive years), among other challenges.[29] For racial and ethnic minority women, the rates of reported infertility were as high as 24%.[30]

Despite the higher prevalence of infertility, veterans are comparatively less likely than

---

[25] Cleveland Clinic. (n.d.). *Male Infertility*. https://my.clevelandclinic.org/health/diseases/17201-male-infertility

[26] Office on Women's Health. (n.d.). *Infertility*. https://www.womenshealth.gov/a-z-topics/infertility

[27] Katon, J., Cypel, Y., Raza, M., Zephyrin, L., Reiber, G., Yano, E. M., Barth, S., & Schneiderman, A. (2014, Feb. 4). Self-reported infertility among male and female veterans serving during Operation Enduring Freedom/Operation Iraqi Freedom. *J Women's Health (Larchmont)*, *23(2)*, 175-183. doi: 10.1089/jwh.2013.4468

[28] Mancuso, A. C., Summers, K. M., Mengeling, M. A., Torner, J. C., Ryan, G. L., & Sadler, A. G., (2020, Mar. 17). Infertility and health-related quality of life in United States women veterans. *J Women's Health*, *29(3)*, 412-419. doi: 10.1089/jwh.2019.7798

[29] Coloske, M. (2021, July 22). The right to serve, but not to carry: Expanding access to infertility treatment for US veterans. *Health Affairs.* https://www.healthaffairs.org/do/10.1377/forefront.20210715.658223/full/

[30] Goossen, R. P., Summers, K. M., Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2019, January 10). Ethnic minority status and experiences of infertility in female veterans. *J Women's Health*, *28(1)*, 63-68. doi: 10.1089/jwh.2017.6731

their non-veteran counterparts to receive infertility care[31]—according to some studies half as likely.[32] VA eligibility barriers significantly contribute to this disparity: to qualify for the benefit, (1) veterans must be legally married and (2) have a service-connected condition causing the infertility, and the veteran or spouse must (3) have an "intact uterus" and at least one functioning ovary or own cryopreserved eggs, and (4) be able to produce sperm or own cryopreserved sperm.[33] Surrogacy, donor eggs, donor sperm, and donor embryos are not covered.[34] As a result, the benefit is available almost exclusively to couples that are both cisgender and heterosexual.[35] Eligibility criteria categorically exclude same-sex and same-gender couples, unmarried women, and transgender men who want to conceive, even if their infertility is related to their service. It also excludes individuals and couples with non-service-connected infertility conditions, including some transgender and non-binary veterans.

The current policies are not only prohibitive to historically marginalized, minority veterans, but restrictive for the entire veteran community. Only 567 eligible married couples have received IVF services from the Department of Veterans Affairs since 2016.[36]

4. Gender-affirming surgeries

VA's LGBT Health Program has made significant improvements to the health care provided to transgender[37] veterans.[38] But VA policies still prohibit the provision and funding of gender affirmation surgeries.[39] This policy violates international standards of transgender health care that describe these surgeries as "essential and medically necessary"

---

[31] Goossen et al. (2019).

[32] Katon, J. G., Cypel, Y. S. & Zephyrin, L. C. (2013, November). Serving during Operation Enduring Freedom/Operation Iraqi Freedom. *J Women's Health, 23(2)*, 1-9 (Table 2). doi:10.1089/jwh.2013.4468

[33] Office of Community Care. (2019, April 21). *VA infertility services can help veterans and their families.* https://blogs.va.gov/VAntage/59082/va-infertility-services-can-help-veterans-and-their-families/

[34] Katon et al. (2013).

[35] A couple comprising a transgender man and transgender woman might qualify for the benefit, if neither has undergone a medical procedure that has rendered them incapable of producing their own sperm or egg. In many cases, however, gender-affirming medical treatment can cause infertility in transgender men and render them unable to carry a pregnancy full term.

[36] Carr, J. (2019, July 24). Abortion arguments at play in limiting veterans' IVF benefit. *ABC News*. https://abcnews.go.com/Health/wireStory/abortion-arguments-play-limiting-veterans-ivf-benefit-64542147

[37] As used here, the term transgender includes transgender, non-binary, and other gender non-conforming individuals who do not identify in whole or in part with their sex assigned at birth.

[38] Lehavot, K., Katon, J.G., Simpson, T.L., & Shipherd, J.C. (2017). Transgender veterans' satisfaction with care and unmet health needs. *Medical Care*, *55(9 Suppl 2)*, S90–S96. doi:10.1097/MLR.0000000000000723

[39] Veterans Health Administration. (2020, June 26). *VHA Directive 1341(2): Providing health care for transgender and intersex veterans*. Department of Veterans Affairs. www.va.gov/vhapublications/ViewPublication.asp?pub_ID=6431

procedures.[40] These international standards of care are based on decades of evidence,[41] and transgender people who receive this medically necessary care show significant improvement in depression and anxiety.[42] Gender affirmation surgeries are a medically necessary part of transgender health care, and, given the socioeconomic disparities within the transgender community,[43] the current policy effectively forces transgender veterans to navigate multiple healthcare provision frameworks or forego medically necessary health care.

We urge the Committee to question the VA on the status of proposed changes to the medical benefits package that would allow for gender affirmation surgeries.

5. Economic barriers to health-care access

Financial burdens are often cited as a chief deterrent from receiving medical care, including contraception. For those already struggling to meet life's basic needs, an inadvertent pregnancy can add secondary stressors and severely limit their agency. Marginalized veterans are currently living through both a national pandemic and an unprecedented epidemic of income loss, as well as the effects of high inflation.

It is widely recognized that those who experience systemic biases, which have arguably been amplified by the present pandemic, have diminished access to adequate healthcare and experience increased obstacles to contraceptives and economic hardship. Historically, women who have less economic opportunity and stability are less likely to take contraception or continue usage due to out-of-pocket costs. And again, the rate of unintended pregnancy is much higher for Latinx and Black women than it is for white women.

For many, a copay can be the difference between receiving care and not. The burden falls disproportionately on women veterans of color. No veteran should go without contraception or necessary health care because they can't afford it.

---

[40] The World Professional Association for Transgender Health [WPATH]. (2012). *Standards of care for the health of transsexual, transgender, and gender non-conforming people, Version 7*. www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341

[41] WPATH (2012) ("Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function.").

[42] Owen-Smith, A.A., Gerth, J., Sineath, R.C., Barzilay, J., et al. (2018). Association between gender confirmation treatments and perceived gender congruence, body image satisfaction and mental health in a cohort of transgender individuals. *J of Sexual Med., 15(4)*, 591–600. doi:10.1016/j.jsxm.2018.01.017

[43] James, S.E., Herman, J.L., Rankin, S., Keisling, M., et al. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. www.transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. ("Nearly one-third (29%) [of transgender individuals] were living in poverty, more than twice the rate in the U.S. population (12%).").

B. Disproportionate reliance on community providers

Historically, many veterans have had to seek reproductive health care services from outside VA, requiring them to navigate additional medical systems. The Interim Final Rule means that that administrative burden will no longer be necessary for many veterans and CHAMPVA beneficiaries.[44] We applaud this development and hope that patients will be able to receive all aspects of comprehensive reproductive health care—from prenatal to post-partum care—directly from VA.

In fact, requiring patients to navigate multiple healthcare systems is not ideal for health outcomes: Research shows that veterans who receive their healthcare exclusively through VA had better health profiles than their counterparts who received piecemeal care between two or more frameworks.[45] On top of this administrative burden is cost: many veterans don't have the means to pay for non-VA health care, especially services as expensive as reproductive healthcare services like IVF and abortion.

These administrative and financial burdens are disproportionately impact populations that already experience disparities. For example, the rate of unintended pregnancy for white women sits at 33%, while for Latina women it is 58% and Black women it is 79%.[46] Yet Black and Latina women face socioeconomic disparities, health inequities, and housing instability at a higher rate than white women,[47] as do unmarried women. Similarly, LGBTQ+ veterans face economic, housing, and health insecurities,[48] yet same-sex couples who want to build a family are excluded from accessing VA programs and services that will help them afford that.

One way to address these disparities is for Congress to remove barriers to VHA eligibility and eliminate restrictions on the care VA may provide. As discussed above, to accomplish the goals of the Interim Final Rule, VA will need an implementation plan that meets the demand for services in all areas where abortion is restricted or unavailable due to state law.

---

[44] In fact, patients receiving abortion care under the Interim Final Rule must use VA providers, not community care, in order for the preemption protections of the Rule to come into play.

[45] Vanderberg, P., Uppal, G., Barker, A., & Flemming, D. (2013, May). *The impact of the Affordable Care Act on VA's Dual Eligible Population*. Health Services Research & Development Service. Department of Veterans Affairs. https://www.hsrd.research.va.gov/publications/internal/forum04_13.pdf

[46] Taylor, J., & Mhatre, N. (2017, October 6). *Contraceptive coverage under the Affordable Care Act*. Center for American Progress. https://www.americanprogress.org/issues/news/2017/10/06/440492/contraceptive-coverage-affordable-care-act

[47] Office of Health Equity. (n.d.). *Racial and ethnic minority veterans.* Department of Veterans Affairs. https://www.va.gov/HEALTHEQUITY/Race_Ethnicity.asp

[48] Mahowald, L. (2022, April 28). *LGBTQ+ military members and veterans face economic, housing, and health insecurities.* Center for American Progress. https://www.americanprogress.org/article/lgbtq-military-members-and-veterans-face-economic-housing-and-health-insecurities/

C. Providing a welcoming environment for women and LGBTQ+ veterans

We are grateful that the Committee is concerned about the extent to which VA is achieving the goal of ensuring a safe, welcoming environment of care within its medical facilities for women veterans and LGBTQ+ veterans. We offer these comments on that issue:

1. Addressing sexual assault and harassment at VA facilities

One in four women veterans reported experiencing sexual assault while seeking care at VA facilities.[49] Methods taken in response to reported sexual assault cases have been performative in nature and provided no measurable difference in the positions the Department takes when addressing reports, or in the known number of incidents that have occurred. A report by the Office of the Inspector General indicated that the Department "has not followed through on promises to take steps to ensure women veterans feel safe and welcomed."[50] It is not yet clear whether a new complaint process, implemented recently by VA in response to the Deborah Sampson Act, will be successful in addressing the problem.

Creating a safe and welcoming environment at VA facilities must begin with ending sexual assault and harassment. We urge the Committee to monitor this issue closely.

2. Training on LGBTQ+ cultural competence

Minority veterans have a long history of experiencing discrimination and stigmatization within veteran-centric spaces, resulting in effective exclusion from necessary social support and medical care. This has been true within VA, as well as within non-governmental organizations and those authorized to serve veterans on VA's behalf. In addition to strong anti-discrimination policies, it is crucial that ignorance and misinformation about minority veterans be addressed through education initiatives.

Successful initiatives of this kind have been developed within the VA through the LGBT Health Program,[51] for example, and research shows that provider communication is an important mechanism for ensuring access to services for minority veterans.[52] Proper and

---

[49] Klap, R., Darling, J.E., Hamilton, A.B., Rose, D.E., et al. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs Medical Centers and impacts on delayed and missed care. *Women's Health Issues, 29(2)*, 107-115. National Library of Medicine. doi.org/jwhi.2018.12.002.Epub

[50] Office of Special Reviews. (2020). *Senior VA officials' response to a veteran's sexual assault allegations: Report # 20-01766-36.* Department of Veterans Affairs, Office of Inspector General. www.va.gov/oig/pubs/VAOIG-20-01766-36.pdf

[51] Shipherd, J.C., Kauth, M.R., Firek, A.F., Garcia, R., et al. (2016). Interdisciplinary transgender veteran care: Development of a core curriculum for VHA providers. *Transgender Health, 1(1)*, 54–62. doi:10.1089/trgh.2015.0004

[52] Ruben, M.A., Livingston, N.A., Berke, D.S., Matza, A.R., Shipherd, J.C. (2019). Lesbian, gay, bisexual, and transgender veterans' experiences of discrimination in health care and their relation to health

ongoing training regarding best practices and cultural competency training on minority veterans should be mandatory for VA staff and providers, Veteran Service Organizations (VSOs), and contractors. This training should be developed and provided to all VA points of entry to ensure that proper investigative procedures are conducted, and that no veteran is erroneously dismissed from accessing their earned benefits.

3. Equity and inclusion in language

As VA itself recognizes, the current Department motto is disclusionary, as it does not reflect the diversity of our veteran community, nor our country. With nearly 25% of the nation's veteran community identifying as other than white, cisgender, heterosexual men, it is time VA's motto makes clear that the Department serves all who have served. We urge the Committees to question VA on the status of a proposed amendment to the existing mission statement to include the verbiage "to fulfill President Lincoln's promise to care for those 'who shall have borne the battle' and for their families, caregivers, and survivors."

Similarly, of the 1,255 health care facilities managed by the Department of Veterans Affairs, only one is named after a woman veteran.[53] Further research reveals that only 13 VHA facilities (about 1% of facilities) are named after a minority veteran.[54] As the Committee knows, the 2020 Report of the VA Advisory Committee on Women Veterans included a recommendation of inclusive naming for Department facilities. The Advisory Committee suggested that such a change would "demonstrate to women veterans that their service matters."[55] VA indicated its agreement with the Advisory Committee's findings and insisted that Congress is charged with the naming of such facilities.

A review of existing VA facilities and other installations should take place, ensuring that those facilities named after discriminatory and violent movement leaders[56] are rebranded. Such proactive efforts would directly address past inequities and injustices committed by otherwise celebrated veterans and send a reparative signal to our minority veteran communities that VA is actively working towards ensuring that all veterans feel safe and comfortable when accessing due benefits and services at their local facilities.

---

outcomes: A pilot study examining the moderating role of provider communication. *Health Equity*, *3(1)*, 480–488. doi:10.1089/heq.2019.0069

[53] *See* www.va.gov/directory/guide/allstate.asp

[54] Ibid.

[55] *See* 2020 Report of the Department of Veterans Affairs Advisory Committee on Women Veterans. www.va.gov/womenvet/docs/acwv/acwvReport2020.pdf

[56] It has been noted that Fort Rucker was named after a Confederate General; Fort Wayne was named after a General responsible for the indigenous genocide at the Three Rivers in Indiana; and Richmond, Virginia's VA medical center was named after a Confederate surgeon and eugenics movement leader.

We again urge an intersectional approach be taken in the naming of future facilities and in the renaming of existing facilities. In addition to women, veterans of color, those living with differing abilities, and members of the LGBTQ+ community should be appropriately represented.

* * *

Thank you again for the opportunity to submit this statement. My colleagues and I look forward to working with you and your offices, and to support your efforts in serving our nation's underserved veteran populations.

Respectfully Submitted,

Minority Veterans of America

Lindsay Church (they/them)
Executive Director & Co-Founder

Peter Perkowski (he/him)
Legal & Policy Director

Kara Stiles (she/ella)
Policy Analyst