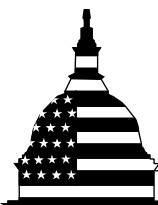


January 2013

MILITARY PERSONNEL

DOD Has Taken Steps to Meet the Health Needs of Deployed Servicewomen, but Actions Are Needed to Enhance Care for Sexual Assault Victims



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Why GAO Did This Study

The roles for women in the military have been expanding and evolving. Servicewomen today are integral to combat, combat support, and counterinsurgency operations, and serve in many roles they previously did not hold. Pub. L. No. 112-81, § 725 (2011) mandated that GAO conduct a review of the female-specific health care services provided by DOD to female servicemembers, including the treatment of servicewomen who are victims of sexual assault. In this report, GAO evaluates the extent to which (1) DOD is addressing the health care needs of deployed servicewomen; (2) female-specific health care services are available to deployed servicewomen; and (3) medical and mental health care are available to servicewomen who are victims of sexual assault. GAO reviewed pertinent DOD policies, guidance, and data. GAO also met with health care providers, servicewomen, and others during site visits to 18 locations where servicewomen are currently serving or deployed, including 15 installations in Afghanistan and Navy vessels.

What GAO Recommends

To enhance the medical and mental health care for servicewomen who are victims of sexual assault, GAO recommends that DOD (1) develop department-level guidance on the provision of care to victims of sexual assault; and (2) take steps to improve first responders' compliance with the department's requirements for annual refresher training. DOD did not concur with the first recommendation, but cited steps it is taking that appear consistent with the recommendation. DOD concurred with the second recommendation.

View [GAO-13-182](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

MILITARY PERSONNEL

DOD Has Taken Steps to Meet the Health Needs of Deployed Servicewomen, but Actions Are Needed to Enhance Care for Sexual Assault Victims

What GAO Found

The Department of Defense (DOD) is taking steps to address the health care needs of deployed servicewomen. For example, DOD has put in place policies and guidance that include female-specific aspects to help address the health care needs of servicewomen during deployment. Also, as part of pre-deployment preparations, servicewomen are screened for potentially deployment-limiting conditions, such as pregnancy, and DOD officials and health care providers with whom GAO met noted that such screening helps ensure that many female-specific health care needs are addressed prior to deployment. GAO also found that DOD components have conducted reviews of the health care needs of servicewomen during deployments and are collecting data on the medical services provided to deployed servicewomen.

At the 15 selected locations GAO visited in Afghanistan and aboard Navy vessels, health care providers and most servicewomen indicated that the available health care services generally met deployed servicewomen's needs. In Afghanistan and aboard Navy vessels, health care providers said they were capable of providing a wide range of the female-specific health care services that deployed servicewomen might seek, and servicewomen GAO spoke with indicated that deployed women's needs were generally being met. Specifically, based on information provided by the 92 servicewomen GAO interviewed, 60 indicated that they felt the medical and mental health needs of women were generally being met during deployments; 8 indicated they did not feel those needs were generally being met during deployments; an additional 8 indicated a mixed opinion; and 16 said they did not have an opinion. For example, some servicewomen told GAO that they were satisfied with their military health care, given the operating environment. Among those who expressed dissatisfaction with their military health care, GAO heard a concern about difficulty in obtaining medications. Among those who expressed mixed views, a comment was raised that junior health care providers were limited in the types of procedures they could perform and lacked practical experience.

DOD has taken steps to provide medical and mental health care to victims of sexual assault, but several factors affect the availability of care. For example, this care can vary by service and can be impacted by operational factors, such as transportation and communication challenges, that are inherent to the deployed environment. Further, military health care providers do not have a consistent understanding of their responsibilities in caring for sexual assault victims because the department has not established guidance for the treatment of injuries stemming from sexual assault—which requires that specific steps are taken while providing care to help ensure a victim's right to confidentiality. Additionally, while the services provide required annual refresher training to first responders, GAO found that some of these responders were not always aware of the health care services available to sexual assault victims because not all of them are completing the required training. Without having a clearer understanding of their responsibilities, health care providers and first responders will be impeded in their ability to provide effective support for servicewomen who are victims of sexual assault.

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Abbreviations

DACOWITS Defense Advisory Committee on Women in the Services
DOD Department of Defense

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United States Government Accountability Office
Washington, DC 20548

January 29, 2013

Congressional Addressees

The roles for women in the military have been expanding and evolving, particularly since the Persian Gulf War more than 2 decades ago. Formerly, servicewomen served primarily in supportive roles in overseas U.S. military operations. Today, servicewomen are integral to combat support and counterinsurgency operations, and they serve in many roles they previously did not hold. In late 2011, for example, women began serving aboard Navy submarines. In early 2012, the Department of Defense (DOD) announced that changes to its assignment policies would result in more than 14,000 additional positions being opened to women, including positions in select direct ground combat units. Further, while sexual assault victimization is not unique to women, the presence of women in new roles suggests that continued vigilance with respect to this issue is needed. Given the expanding and evolving role of women in the military, the health and wellness of servicewomen plays an important role in overall military readiness.

The National Defense Authorization Act for Fiscal Year 2012¹ required GAO to conduct a review of various aspects of the female-specific health care services provided by DOD to female servicemembers. In response to the act, this report focuses on female-specific health care services provided by DOD to deployed servicewomen, as well as the medical and mental health care available to servicewomen who are victims of sexual assault. Specifically, it evaluates the extent to which (1) DOD is addressing the health care needs of deployed servicewomen; (2) female-specific health care services are available to deployed servicewomen; and (3) medical and mental health care are available to servicewomen who are victims of sexual assault. In a separate report,² GAO is focusing on the availability of female-specific health care services provided to female servicemembers in the United States.

¹Pub. L. No. 112-81, § 725 (2011).

²*DOD Health Care: Domestic Health Care for Female Servicemembers*, GAO-13-205 (Washington, D.C.: Jan. 29, 2013).

To determine the extent to which DOD is addressing the health care needs of deployed servicewomen, we reviewed pertinent DOD and service-specific policies and guidance and interviewed knowledgeable officials within the Office of the Assistant Secretary of Defense for Health Affairs and the medical commands of the Army, the Navy, and the Air Force. We also reviewed relevant guidelines, such as those issued by the American College of Obstetricians and Gynecologists,³ and prior related GAO reports.⁴ We also obtained information on reported patient encounters for deployed servicemembers for fiscal year 2012. To assess the reliability of these data, we contacted cognizant DOD officials in order to understand the processes used to collect these data and any known limitations of the data. We determined that these data were sufficiently reliable for the purposes of our report—that is, to provide context for the approximate number of reported patient encounters for servicewomen during fiscal year 2012 and the frequency with which such encounters specifically concerned women’s health by summarizing the top 25 diagnoses.⁵ In addition, we visited seven military installations in Afghanistan and eight Navy vessels at their home ports in the United States. The locations we visited in Afghanistan included forward operating bases and military installations with more robust infrastructures, and were selected because they allowed us to visit each of the levels of health service support in Afghanistan. The Navy vessels we visited were selected because they allowed us to visit different types of vessels within both the U.S. Atlantic and U.S. Pacific Fleets where women are an integrated part of the crew. During our site visits we met with health care providers, military commanders, and a total of 92 female servicemembers from various pay grades and from all services. Although the results of our

³The American College of Obstetricians and Gynecologists is a national organization that develops guidelines for clinical practice for women’s health care services.

⁴See, for example, *VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes*, [GAO-10-287](#) (Washington, D.C.: Mar. 31, 2010); *Defense Health Care: Health Care Benefit for Women Comparable to Other Plans*, [GAO-02-602](#) (Washington, D.C.: May 1, 2002); and *Gender Issues: Medical Support for Female Soldiers Deployed to Bosnia*, [GAO/NSIAD-99-58](#) (Washington, D.C.: Mar. 10, 1999).

⁵During these assessments we learned that not all medical encounter data are documented electronically during deployments to Afghanistan and aboard Navy vessels, and therefore may be underreported. DOD officials noted this, and an official from the Office of the Navy Surgeon General identified steps the Navy is taking to increase electronic documentation of data on servicemembers’ medical encounters aboard Navy vessels.

discussions with servicewomen cannot be generalized across DOD, a service, or any single location we visited, the results do provide insight into the perspectives of servicewomen regarding DOD's efforts to address the health care needs of deployed servicewomen.

To determine the extent to which female-specific health care services are available to deployed servicewomen, we reviewed DOD and service-specific requirements and obtained information from health care providers during our site visits regarding the availability of select female-specific health care services at each location. Specifically, these female-specific health care services included clinical breast examination; screening mammography; diagnostic mammography; pelvic examination; PAP smear; treatment of patients with abnormal PAP smear; treatment for disorders of the female genitals; treatment for disorders of menstruation; pregnancy test; and contraceptives, or contraceptive counseling.⁶ We also focused on female-specific behavioral health care services, to include mental health and substance abuse counseling. If female-specific health care services were not available, we sought to understand how situations requiring the need for such services would be handled during deployments.

To determine the extent to which medical and mental health care are available to servicewomen who are victims of sexual assault, we obtained and analyzed various documents, including legislative requirements and DOD's policies and guidance for the prevention of and response to sexual assault, and interviewed knowledgeable officials from DOD's Sexual Assault Prevention and Response office. We also reviewed DOD's Annual Report on Sexual Assault in the Military Services to identify the department's efforts to provide medical and mental health services to the 2,420 females who in fiscal year 2011 reported to DOD that they had been victims of sexual assault. We conducted site visits to three military installations in the United States in addition to the seven military installations in Afghanistan and eight Navy vessels we visited for our larger review, in order to assess the availability of medical and mental

⁶We did not focus on abortion services because, by law, funds available to DOD may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest. Additionally, by law, no DOD facility may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest. See 10 U.S.C. §1093.

health care services for victims of sexual assault in the military. The three locations we visited in the United States were selected because they enabled us to meet with military personnel who have served as Sexual Assault Response Coordinators both while deployed and while at a military installation in the United States. During our site visits we met with Sexual Assault Response Coordinators, Victim Advocates, and health care providers.

We conducted this performance audit from April 2012 through January 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Further details about our scope and methodology can be found in appendix I.

Background

DOD's Military Health System

DOD's health care system, known as the Military Health System, is one of the largest and most complex health care systems in the nation. Operationally, DOD's Military Health System has two missions: supporting wartime and other deployments, known as the readiness mission, and providing peacetime care, known as the benefits mission. The readiness mission provides medical services and support to the armed forces during military operations and deployments, including deploying medical personnel and equipment throughout the world, and ensures the medical readiness of personnel prior to deployment. Within DOD's Office of the Under Secretary of Defense for Personnel and Readiness, the Office of the Assistant Secretary of Defense for Health Affairs oversees the Military Health System and also issues guidance to DOD components on medical matters. The Departments of the Army and the Navy each have a medical command, headed by a Surgeon General, who manages each department's respective military treatment facilities and medical personnel. The Navy's Bureau of Medicine and Surgery supports both the Navy and the Marine Corps. The Air Force Surgeon General, through the role of medical advisor to the Air Force Chief of Staff, exercises similar authority to that of the other Surgeons General.

DOD's Sexual Assault Prevention and Response Program

The Under Secretary of Defense for Personnel and Readiness also has the responsibility for developing the overall policy and guidance for the department's sexual assault prevention and response program except for criminal investigative policy matters assigned to the DOD Inspector General and legal processes in the Uniform Code of Military Justice. DOD Directive 6495.01 defines sexual assault as "intentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority, or when the victim does not or cannot consent. Sexual assault includes rape, forcible sodomy (oral or anal sex), and other unwanted sexual contact that is aggravated, abusive, or wrongful (including unwanted and inappropriate sexual contact), or attempts to commit these acts."⁷

DOD's directive provides active duty servicemembers with two options for reporting a sexual assault: (1) restricted and (2) unrestricted. DOD's restricted reporting option allows sexual assault victims to confidentially disclose an alleged sexual assault to select individuals, including health care personnel, and receive medical treatment without initiating an official investigation. In cases where a victim elects restricted reporting, first responders—including health care providers—may not disclose confidential communications or information on the forensic examination to law enforcement or command authorities unless certain exceptions apply, and improper disclosure of confidential communications and medical information may result in discipline pursuant to the Uniform Code of Military Justice or other adverse personnel or administrative actions. In contrast, DOD's unrestricted reporting option allows sexual assault victims to receive medical treatment and request an official investigation of the allegation using existing reporting channels, such as their chain of command or law enforcement.

DOD's directive also identifies the various types of support, to include the coordination of medical and mental health care services, that shall be provided to victims of sexual assault. Specifically, the directive specifies that sexual assault victims shall receive timely access to comprehensive medical treatment, including emergency care that shall consist of emergency medical care and the offer of a sexual assault forensic

⁷Department of Defense Directive 6495.01, *Sexual Assault Prevention and Response (SAPR) Program* (Jan. 23, 2012). According to DOD's Sexual Assault Prevention and Response office, the department has proposed a revision to the definition of sexual assault in the directive to align it with the changes made to the Uniform Code of Military Justice by section 541 of the National Defense Authorization Act for fiscal year 2012.

examination consistent with Department of Justice protocols.⁸ Further, sexual assault victims shall be advised that even if a forensic examination is declined, the victim is encouraged (but not required) to receive medical care, psychological care, and victim advocacy.

Since 2008 we have issued a series of reports examining DOD's implementation of its Sexual Assault Prevention and Response Program and made a total of 25 recommendations with which DOD has generally concurred and taken actions to implement to varying degrees. These reports include reviews of DOD's sexual assault prevention and response programs for the military academies; programs for the active components of DOD, including during deployments; and processes for investigating and adjudicating allegations of sexual assault. For further information on these reports as well as our prior recommendations, see the summary we issued in March 2012.⁹

DOD Is Taking Steps to Help Address the Health Care Needs of Deployed Servicewomen

DOD has developed policies and guidance that include female-specific aspects to help address the health care needs of female servicemembers during deployment. Prior to deploying, servicewomen are screened for potentially deployment-limiting conditions. According to DOD officials and health care providers with whom we met, such pre-screening helps ensure that many female-specific health care needs are addressed prior to deployment. Further, DOD components have conducted reviews of the health care needs of servicewomen during deployments. DOD also collects health care data on the medical services provided to deployed servicewomen in Afghanistan and aboard Navy vessels.¹⁰

⁸U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* (September 2004).

⁹*Military Personnel: Prior GAO Work on DOD's Actions to Prevent and Respond to Sexual Assault in the Military*, [GAO-12-571R](#) (Washington, D.C.: Mar. 30, 2012).

¹⁰DOD also conducts medical screening and collects health care data on the medical services provided to deployed servicemen. The focus of this report, however, is on the health care services provided to deployed servicewomen.

DOD Policies Addressing the Health Care Needs of Deployed Servicemembers Include Female-specific Aspects

DOD components have put in place policies and guidance that include female-specific aspects to help address the health care needs of servicewomen during deployment. DOD and service officials told us that while the department's policies are generally gender-neutral and focus on addressing the health care needs of all servicemembers, some of the policies and guidance include female-specific aspects such as pregnancy, pelvic examinations, and screening mammography. In certain instances, the services' policies reflect clinical practice guidelines that come from outside the department, such as those from the American College of Obstetricians and Gynecologists. For example, we found that the Army changed its pre-deployment screening requirements due to a change in American College of Obstetricians and Gynecologists guidelines for cervical cytology screening. Additionally, we found that Navy guidelines require the provision of standbys—individuals who could be present during sensitive or potentially compromising physical examinations—during medical examinations when female genitalia or breasts are exposed or examined by a medical provider, in accordance with Joint Commission guidelines.¹¹

According to DOD and service officials, although there may be some gender differences for particular diagnoses, behavioral health care services—that is, mental health care and substance abuse counseling—are not gender-specific. The treatment of servicemembers' behavioral health care needs and the availability of services to treat those needs, therefore, do not vary based on gender.

Pre-deployment Screening Processes Help Ensure That Many Female-specific Needs Are Addressed Prior to Deploying

DOD has established a medical tracking system for assessing the medical condition of servicemembers to help ensure that only those who are medically and mentally fit are deployed outside of the United States. According to service officials and health care providers with whom we met, pre-deployment screenings help ensure that many women's health care needs are addressed prior to deployment. As part of DOD's pre-deployment screening process, servicemembers of both sexes are screened for potentially deployment-limiting medical conditions that would render them unsuitable to perform their duties during deployment. Servicemembers of both sexes are also required to complete a pre-

¹¹The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

deployment health assessment questionnaire. DOD requires that servicemembers' questionnaires be reviewed by a health care provider to determine whether the servicemember is fit to deploy. Service officials we spoke with told us that this screening also provides servicemembers an opportunity to discuss and address with a health care provider any health concerns they may have prior to deploying. The officials said they rely on the questionnaires, reviews of servicemembers' medical records, and physical examinations to identify an individual's health care needs prior to deployments.

Some deployment-limiting conditions are female-specific: for example, each of the military services defines pregnancy as a deployment-limiting condition. Each of the services has also established a postpartum deferment period—6 months for the Army, the Air Force, and the Marine Corps, and 12 months for the Navy. During this period, servicewomen are not required to deploy or redeploy, so as to enable mothers to recover from childbirth and to bond with their children. However, each of the military services has a policy that allows servicewomen to voluntarily deploy before the period has expired. Typically, during deployment servicewomen who are confirmed to be pregnant may not remain deployed. For example, servicewomen who are confirmed to be pregnant in Afghanistan may not remain in theater and must notify their military chain of command or supervisor immediately. They are required to be redeployed within 14 days of receipt of notification. Navy guidance prohibits a pregnant servicewoman from remaining aboard a vessel if the time required to transport her to emergency obstetric and gynecological care exceeds 6 hours. Servicewomen who are confirmed to be pregnant at sea are to be sent at the earliest opportunity to the closest shore-based U.S. military facility that can provide obstetric and gynecological care. Navy medical providers we met with during our site visits stated that pregnant servicewomen are typically transferred off the vessel within days of confirmation of their pregnancy. Further, we found that female-specific deployment-limiting conditions sometimes depend on the deployed environment: for example, women with conditions such as recurrent pelvic pain or abnormal vaginal bleeding are disqualified from submarine service.

DOD Has Also Conducted Some Reviews of the Health Care Needs of Servicewomen during Deployments

DOD components have conducted reviews of the health care needs of servicewomen while they are deployed. For example:

- As part of a review the Army Surgeon General's office initiated in 2011, the Army issued a white paper entitled "The Concerns of Women Currently Serving in the Afghanistan Theater of Operations."

This white paper outlined a number of concerns over such things as lack of education about birth control, menstrual cycle control, and feminine hygiene during deployment. The paper included a total of 23 recommendations to the Army Surgeon General aimed at improving women's health during deployments. Subsequently, in December 2011 the Army Surgeon General established a women's health task force to evaluate issues faced by servicewomen both in theater and in the continental United States. According to Army task force officials, the Army's white paper served as the starting point for their initial efforts, and the task force is taking steps to address each of the 23 recommendations made in the paper. For example, the Army Surgeon General's office is working to develop a kit to address a recommendation that female soldiers be provided training and tools to promote self-diagnosis and care of common urinary tract and vaginal infections. Task force officials told us that the kits should be available by the end of 2013.

- For 2012 the Defense Advisory Committee on Women in the Services¹² (DACOWITS) has focused on the health care needs of deployed servicewomen. As reported in the quarterly meeting minutes of its March 2012 proceedings, "DACOWITS is interested in health concerns of deployed women, particularly since women are increasingly deployed in operational field environments, taking on ground combat roles." DACOWITS last reported on deployed women's health issues in its 2007 annual report. DACOWITS expects to issue its 2012 annual report to the Secretary of Defense in early 2013.
- The TriService Nursing Research Program¹³ is currently funding a Women's Health Research Interest Group that is reviewing the available literature to identify research gaps on health issues affecting servicewomen. Officials from the Women's Health Research Interest Group told us that once they complete their review they plan to develop a Web-based community repository of research in the area of

¹²The Defense Advisory Committee on Women in the Services was established in 1951 and is composed of civilian women and men who are appointed by the Secretary of Defense to provide advice and recommendations on matters and policies relating to the recruitment and retention, treatment, employment, integration, and well-being of highly qualified professional women in the Armed Forces.

¹³The TriService Nursing Research Program funds and supports scientific research in the field of military nursing in order to advance military nursing science and optimize the health of military members and their families.

military women's health. The program is also funding research efforts focused on deployed women's health issues, including the use of female urinary diversion devices and a review of the health education provided to servicewomen before they deploy.

DOD Is Capturing Data on the Medical Services Provided to Deployed Servicewomen

DOD is collecting health care data on the medical services provided to deployed servicewomen, as well as servicemen, in Afghanistan and aboard Navy vessels. According to service officials, data that health care personnel enter into electronic systems on servicemen and women's encounters with providers are accessible by commanders in order to allow them to track the medical status of units and individuals.¹⁴

According to information provided by service officials in Afghanistan, the total number of reported patient encounters in U.S. Central Command's area of operations¹⁵ during fiscal year 2012 was around 460,000. Of these, servicewomen accounted for about 62,000 patient encounters. For U.S. Central Command's area of operations, DOD's fiscal year 2012 data show that the most frequent diagnosis for servicemembers, based on International Classification of Diseases codes,¹⁶ was lumbago, or, lower back pain. Of the top 25 diagnoses, none were related specifically to women's health issues. According to information provided by the Office of the Navy Surgeon General, the total number of reported patient encounters aboard Navy vessels during fiscal year 2012 was approximately 69,000, of which servicewomen accounted for about 21,000. For Navy vessels, based on International Classification of Diseases codes the Navy's data show that the most frequent diagnosis during fiscal year 2012 for servicemembers was lumbago. Of the top 25 diagnoses, only one—urinary tract infection—was commonly associated with women's health.

¹⁴The service components utilize a variety of systems to capture information from medical encounters during deployments. However, not all information from medical encounters is documented electronically, and some information is accessible only by reviewing an individual's paper medical record.

¹⁵U.S. Central Command's area of operations include Afghanistan, Bahrain, Egypt, Iran, Iraq, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Syria, Tajikistan, Turkmenistan, United Arab Emirates, Uzbekistan, and Yemen.

¹⁶The International Classification of Diseases codes are designed to promote comparability in the collection, processing, and classification of diseases and are used in assigning coded diagnoses associated with inpatient, outpatient, and physician office utilization.

The department also uses the data to develop reports that address broader health issues. For example, the Armed Forces Health Surveillance Center¹⁷ has issued reports that provide, by service, data on deployment-related conditions of special interest, such as traumatic brain injury, amputations, and severe acute pneumonia, among other data. While these reports generally do not separate data by gender, the Armed Forces Health Surveillance Center has issued two reports since December 2011 focusing on women’s health issues. For example, a July 2012 report presented data on the incidence of acute pelvic inflammatory disease, ectopic pregnancies, and iron deficiency among active duty women, as well as data on selected conditions among women after initial and repeated deployments to Afghanistan and Iraq. According to these reports, from January 2003 through December 2011, based on International Classification of Diseases codes, 50,634 servicemembers—comprising 6,376 females and 44,258 males—were evacuated from Iraq and Afghanistan for medical reasons. The most frequent causes of medical evacuations for females were mental disorders, musculoskeletal disorders, “signs, symptoms, and ill-defined conditions,” and non-battle-injuries, whereas the most frequent causes of such evacuations for males were battle injuries, musculoskeletal disorders, non-battle injuries, and mental disorders.

¹⁷The Armed Forces Health Surveillance Center was established in February 2008 by the Deputy Secretary of Defense to be the central epidemiological health resource for the U.S. Military.

Servicewomen's Perceptions Suggest that Health Care Services Available to Deployed Servicewomen Generally Meet Needs

A Variety of Health Care Services Are Available to Servicemembers Deployed to Afghanistan and at Sea

The health care services, and in turn the female-specific health care services available to deployed servicewomen, vary depending on the deployed environment. DOD provides three levels of health service support to servicemembers deployed to Afghanistan. The most basic level of care is provided at "Role 1" facilities, which include primary care facilities and outpatient clinics. "Role 2" facilities provide advanced trauma management and emergency medical treatment. The highest level of care that DOD provides in Afghanistan is at "Role 3" facilities. These facilities are equivalent to full-spectrum hospitals and are staffed and equipped to provide resuscitation, initial wound surgery, and post-operative treatment. As of November 2012, there were 143 facilities in Afghanistan providing Role-1 level care, 24 facilities providing Role-2 level care, and 5 facilities providing Role-3 level care.¹⁸ According to senior medical officials with U.S. Forces Afghanistan and the International Security Assistance Force Joint Command, most gynecological care is provided at Role 1 facilities, and infantry battalions and most forward operating bases and combat outposts in Afghanistan can at a minimum provide Role 1-level care.

We found that servicewomen while deployed at sea have access to providers of primary care, although the health care services that are available aboard Navy vessels largely depend on the type and class of vessel. Larger vessels generally offer a wider range of services—including specialized services—than do smaller vessels, due largely to their more robust crew levels and capabilities. The medical department of an aircraft

¹⁸The Role-3 facilities include one facility run by the Air Force, one by the United Kingdom, and three under the auspices of the North Atlantic Treaty Organization.

carrier, for example, typically consists of more than 40 billets, including a family practitioner, a physician's assistant, and a clinical psychologist. Similarly, the medical department of a WASP-class amphibious assault ship consists of more than 20 billets, including a medical officer. For cruisers, destroyers, and frigates, the medical department typically consists of only a handful of billets, including an Independent Duty Hospital Corpsman,¹⁹ but no medical officer. For Ohio-class submarines, the sole source of medical care aboard is an Independent Duty Hospital Corpsman. Each of these classes of vessels is capable of providing health care services to servicemembers of both sexes.

Health Care Providers and Servicewomen Said DOD Generally Meets Women's Health Care Needs during Deployments

At the 15 selected locations we visited in Afghanistan and Navy vessels, health care providers and servicewomen told us that the health care services available to deployed servicemembers generally meet the needs of servicewomen. Health care providers we spoke with in Afghanistan and aboard Navy vessels told us they were capable of providing a wide range of female-specific health care services—including treating certain gynecological conditions such as urinary tract infections and conducting clinical breast examinations—that women might seek while deployed.²⁰ They also told us that servicemembers had access at least to basic mental health care services. Some female-specific services—such as treatment for an abnormal PAP smear result, or mammography services—were not always available, but providers told us that conditions resulting in the need for more specialized services were routinely addressed prior to deployment. For example, providers with an expeditionary medical group we met in Afghanistan told us that in their experience PAP smears are rarely performed in theater except for women who had received abnormal PAP smear results prior to deploying and needed follow-up checks after 6 months. Those providers also told us that screening mammography is not provided in theater because screening mammography is generally preventative care, which is conducted as part

¹⁹Independent Duty Hospital Corpsmen are enlisted personnel who, when certified, serve as health care providers under the indirect supervision of a physician.

²⁰Specifically, during our site visits we asked health care officials about the availability of the following female-specific health care services: clinical breast examination; screening mammography; diagnostic mammography; pelvic examination; PAP smear; treatment of patients having abnormal PAP smear results; treatment for disorders of the female genitals; treatment for disorders of menstruation; pregnancy test; and contraceptives, or contraceptive counseling.

of a woman's annual exam prior to deployment. Health care providers from multiple Navy vessels we visited also told us that a number of female-specific health care services—from performing PAP smears to treating patients with abnormal PAP smear results to mammography services—were not needed during deployments at sea because such services were provided prior to deploying.

According to health care officials and providers with whom we met, women who developed acutely urgent conditions during deployments, to include female-specific conditions, would typically be transferred to a locale offering access to more specialized services. Health care providers with whom we met were able to identify their available options for referring individuals with acutely urgent conditions for specialized care elsewhere if necessary—in Afghanistan, typically, to a higher level of care; during deployments at sea, to another vessel or a shore-based facility. Providers also noted that in some cases they could consult with other health care providers if necessary, including providers specializing in women's health care. For example, at one Role 1 facility we visited in Afghanistan, health care providers noted that their Deputy Command Surgeon specialized in obstetrics and gynecology and was available to consult on cases if they needed assistance. As another example, Navy Independent Duty Hospital Corpsmen told us that they could consult with their physician supervisor if necessary during deployments at sea.

At each of the locations we visited we found that a variety of steps were being taken to help ensure that servicewomen had a reasonable amount of privacy during examinations as well. For example, each of the locations we visited offered at a minimum a medical examination room with privacy curtains that could be drawn. In most instances, doors with locks were available as well. We also observed that signs could be posted indicating that an examination was in process. Further, health care providers told us that a standby—individuals who could be present during sensitive or potentially compromising physical examinations—was available at each location we visited. Figures 1 through 3 show photographs of the medical examination rooms at selected locations we visited.

Figure 1: Medical Examination Rooms at Selected Facilities A and B in Afghanistan



Source: GAO.

Figure 2: Medical Examination Rooms at Selected Facilities C and D in Afghanistan



Source: GAO.

Figure 3: Medical Examination Rooms Aboard Selected Navy Vessels A and B



Source: GAO.

Based on information provided by the 92 servicewomen we interviewed at selected locations in Afghanistan and aboard Navy vessels, the responses from 60 indicated that they felt the medical and mental health needs of women were generally being met during deployments, whereas the responses from 8 indicated they did not feel the medical and mental health needs of women were generally being met during deployments. The responses from an additional 8 servicewomen suggested that they had a mixed opinion as to whether the medical and mental health needs of women were being met during deployments, and 16 told us they did not know or did not have an opinion. Servicewomen who indicated during our interviews that the medical and mental health needs of women were generally being met during deployments offered a variety of reasons for their responses. At one location we visited in Afghanistan, a female Airman told us that if she had a health problem, the medical facility at her location could treat her or send her elsewhere if needed. She further noted that if the problem were serious enough she could be evacuated. Similarly, a female Army soldier we met at another location told us she felt some of the best care that she has received in her life has been military health care. At another location, a female Marine told us that the care provided to her was

as good as she could imagine, given the operating environment. Aboard one Navy vessel we visited, a female sailor told us that even though mental health care was not available aboard her ship, it was available ashore, and the ship could handle emergencies at sea.

Servicewomen we interviewed who indicated that they felt the medical and mental health needs of women were generally not being met during deployments offered a variety of reasons for their responses as well. At one location we visited in Afghanistan, a female airman told us that she believed the military was trying to meet the health needs of women, but still had work to do—noting, for example, that a medication she was prescribed had given her yeast infections. At another, a female Army soldier told us that she had experienced difficulty obtaining sleep medication. In the case of deployments at sea, one female sailor expressed concern that a mental health provider was not aboard. Of servicewomen who offered a mixed opinion, one female sailor told us that she felt junior health care providers were limited in the types of procedures they could perform and lacked practical experience.

Several Factors Affect the Availability of Medical and Mental Health Care to Sexual Assault Victims

DOD has taken steps to address the provision of medical and mental health care for servicemembers who are sexually assaulted, but several factors affect the extent to which this care is available. Specifically, the branch of military service and the operational uncertainties of a deployed environment can affect the ready availability of medical and mental health care services for victims of sexual assault. Additionally, care is in some cases affected because military health care providers do not have a consistent understanding of their responsibilities in caring for sexual assault victims who make restricted reports of sexual assault. Further, first responders such as Sexual Assault Response Coordinators and Victim Advocates are not always aware of the specific health care services available to sexual assault victims at their respective locations.²¹

²¹ According to DOD Directive 6495.01, Sexual Assault Response Coordinators are the single point of contact at an installation or within a geographic area who oversees sexual assault awareness, prevention, and response training; coordinates medical treatment, including emergency care, for victims of sexual assault; and tracks the services provided to a victim of sexual assault from the initial report through final disposition and resolution. Victim Advocates are personnel who shall provide non-clinical crisis intervention, referral, and ongoing non-clinical support to adult sexual assault victims, including providing information on available options and resources to victims.

Availability of Medical and Mental Health Care for Sexual Assault Victims Can Vary by Service and Operational Uncertainties

Each military service offers medical and mental health care resources to servicemembers who have been sexually assaulted, including those serving in a deployed environment. However, as we have noted in our prior work, the availability of such resources for victims can vary based on a number of factors, including branch of military service and the operational uncertainties associated with serving in a deployed environment.²² For example, the availability of deployed medical providers who are trained to conduct a sexual assault forensic examination varies across the military services because each service has a different process for deploying personnel. Specifically, we spoke with Army officials who told us that the Army requires each brigade to deploy with a health care provider who is trained to conduct a forensic examination, whereas the Air Force deploys trained health care providers based on the medical needs at specific locations. Navy medical providers we spoke with told us that the Navy does not require that its vessels deploy with a provider trained to conduct a forensic examination, and will instead transfer a victim to the nearest trained provider, whether at sea or ashore. Navy medical providers also told us that if a transfer is not possible they would do their best to conduct the forensic examination using the instructions provided with examination kits.

Additionally, operational factors that are inherent to the deployed environment can have an impact on the provision of medical and mental health services to victims of sexual assault. Specifically, DOD reported in its fiscal year 2011 Annual Report on Sexual Assault in the Military that transportation and communication challenges, as well as the propensity of military personnel to form close communities, made the provision of forensic examinations and the maintenance of restricted reporting confidentiality more difficult during deployment.²³ DOD added, however, that it was taking steps, such as establishing memoranda of understanding between the military services in joint environments, to resolve these issues. Similarly, we reviewed sexual assault standardized operating procedures for an Army Treatment Medical Clinic in Afghanistan that identified factors such as weather and other unforeseen conditions that can limit the ability to fly a victim off of a base for

²²GAO, *Military Justice: Oversight and Better Collaboration Needed for Sexual Assault Investigations and Adjudications*, [GAO-11-579](#) (Washington, D.C.: June 22, 2011).

²³Department of Defense, *Fiscal Year 2011 Annual Report on Sexual Assault in the Military* (April 2012).

treatment. To mitigate these limitations, the Army included a primary and alternate evacuation protocol in its standardized operating procedures, to help ensure that servicemembers who are sexually assaulted during deployment have access to care.

Guidance Has Not Been Developed for the Provision of Specialized Medical and Mental Health Care for Sexual Assault Victims

DOD has established policies and procedures for its sexual assault prevention and response program that address, among other things, the provision of medical and mental health care for servicemembers who are sexually assaulted. Specifically, in October 2005 DOD published a directive that contains its comprehensive policy for the prevention of and response to sexual assault.²⁴ While generally applicable to all servicemembers and locations, DOD's directive calls for the sexual assault prevention and response program to be gender-responsive, culturally competent, and recovery-oriented; and for an immediate, trained sexual assault response capability to be available in deployed locations. For example, DOD requires care for sexual assault victims to be linguistically appropriate; sensitive to gender-specific issues such as pregnancy; and supportive of a victim's ability to be fully mission-capable and engaged.

In June 2006, DOD's Office of the Under Secretary of Defense for Personnel and Readiness issued an instruction that provides guidance for implementing its policy and specifies roles, responsibilities, and required training for program personnel such as health care providers who may be involved in responding to victims of sexual assault.²⁵ For example, DOD's instruction identifies various types of health care providers who, depending on their training, may be eligible to conduct sexual assault forensic examinations; and directs the military services to establish a multi-disciplinary case management group and include provisions for continuity of victim care when a victim has a temporary or permanent change of station, or is deployed. Additionally, DOD's instruction identifies required categories of training for program personnel on topics that include victim advocacy and medical treatment resources, sexual assault response policies, and the sexual assault examination process.

²⁴Department of Defense Directive 6495.01, *Sexual Assault Prevention and Response (SAPR) Program* (Oct. 6, 2005). DOD released revisions to its Directive in January 2012.

²⁵Department of Defense Instruction 6495.02, *Sexual Assault Prevention and Response Program Procedures* (June 23, 2006).

Although DOD issued this overarching instruction that provides guidance for implementing its sexual assault prevention and response policies to personnel such as health care providers, we found that the Office of the Assistant Secretary of Defense for Health Affairs—the organization responsible for ensuring the effective execution of the department’s medical mission—has not, in turn, developed more specified guidance to address the military services’ responsibility to provide specialized medical and mental health care to victims of sexual assault. According to DOD Directive 5136.01, the Assistant Secretary of Defense for Health Affairs is required to, among other things, exercise authority, direction, and control over DOD medical policy, and to establish policies, procedures, and standards that govern the management of DOD health and medical programs.²⁶ The Office of the Assistant Secretary of Defense for Health Affairs has performed these responsibilities for some medical issues in DOD, but it has not established guidance for the treatment of injuries stemming from sexual assault—a crime that requires a specialized level of care to help ensure that forensic evidence is properly collected, medical care is provided in a way that minimizes the risk of revictimization, and a victim retains the right to disclose the assault with confidentiality.

Absent department-level guidance from DOD’s Office of the Assistant Secretary of Defense for Health Affairs, the services have, to varying degrees, revised their respective medical guidance to address care for victims of sexual assault. For example, at one location we visited we reviewed a command’s medical policy and found that while the policy addressed some responsibilities of health care providers in responding to sexual assault incidents, it had not been updated to identify how care should be modified for restricted reports of sexual assault. For example, the policy addressed topics such as when and where forensic examinations should be conducted, and health care provider responsibilities for transferring evidence to law enforcement. However, it did not mention DOD’s policy on restricted reporting or provide guidance, for example, on the use of non-identifying information to label and store evidence collected from restricted reports of sexual assault. At another location, we found that a command’s medical policy contained requirements for health care personnel that conflicted with their

²⁶Department of Defense Directive 5136.01, *Assistant Secretary of Defense for Health Affairs (ASD(HA))* (June 4, 2008).

responsibilities under restricted reporting. The policy required the command's medical department representatives to document all injuries and referrals of personnel for care, and to keep the commanding officer and chain of command informed of medical conditions that affect the health, safety, and readiness of all command personnel. However, the policy was silent on the issue of sexual assault and did not identify exceptions to these requirements or offer health care providers alternative procedures for documenting and reporting medical issues associated with restricted reports of sexual assault. Accordingly, we found that military health care providers do not have a consistent understanding of their responsibilities in caring for sexual assault victims. We met with senior medical personnel from the command who confirmed that provisions in their medical policy conflicted with other command policy and had created confusion for health care providers regarding the extent of their responsibility to maintain the confidentiality of victims who choose to make a restricted report of sexual assault. These inconsistencies can put DOD's restricted reporting option at risk, undermine DOD's efforts to address sexual assault issues, and erode servicemembers' confidence. As a consequence, sexual assault victims who want to keep their case confidential may be reluctant to seek medical care.

First Responders Are Not Always Aware of the Health Care Services Available to Sexual Assault Victims

DOD requires that personnel designated as first responders²⁷ to sexual assault incidents, whether in the United States or in deployed environments, receive initial and annual refresher training on topics that include available medical and mental health treatment options. Although DOD provides this required training, we found that first responders we met with were still unsure of the health care services available to sexual assault victims at their respective locations. This was particularly the case among first responders we met with during visits to selected locations in the United States, in part because of the increased medical and mental health care options that were available to them. For example, we regularly found that Sexual Assault Response Coordinators, Victim Advocates, and health care personnel differed in their understanding as to where to take a sexual assault victim for a forensic examination—a potentially problematic issue, given that the quality of forensic evidence diminishes the later it is collected following a sexual assault. The

²⁷DOD identifies first responders as personnel in the following disciplines or positions: Sexual Assault Response Coordinators, Victim Advocates, health care personnel, law enforcement personnel, judge advocates, and chaplains.

Department of Justice's National Protocol for Sexual Assault Medical Forensic Examinations identifies 72 hours after an assault occurs as the standard cutoff time in many jurisdictions for collecting evidence (except for blood alcohol determinations, which should be done within 24 hours of ingestion of alcohol), but notes that evidence collection beyond that point is conceivable. Additionally, we found that not all first responders fulfill the requirement to annually complete refresher training on tasks DOD deems essential to their role in responding to incidents of sexual assault. According to DOD's instruction, first responders are required to complete periodic refresher training on a variety of topics that include management of restricted and unrestricted reports of sexual assault and local protocols and procedures. DOD reported in its fiscal year 2011 Annual Report on Sexual Assault in the Military that while each of the military services continued to implement sexual assault prevention and response training for first responders, not all first responders had completed the required training. For example, DOD reported that for fiscal year 2011, the Army trained only about 6,000 of the more than 17,000 personnel who served as Sexual Assault Response Coordinators or Victim Advocates. Further, DOD's report noted that only 69 percent of Department of Navy Victim Advocates—which include Navy and Marine Corps personnel—completed the required training, and the report also noted that some of the training for Air Force first responders was overdue.²⁸

Conclusions

As women continue to assume an expanding and evolving role in the military it is important that DOD be well positioned to meet the health care needs of deployed servicewomen and ensure their readiness. To the department's credit, DOD components have taken positive steps toward addressing the female-specific health care needs of deployed servicewomen, and we note that at the selected locations we visited during the course of our review the responses from most servicewomen we spoke with indicated that they felt the medical and mental health needs of women were generally being met during deployments. DOD also has taken positive steps in making medical and mental health care services available to sexual assault victims of both sexes. However, DOD's limited health care guidance on the restricted sexual assault reporting option and first responders' inconsistent knowledge about

²⁸Department of Defense, *Fiscal Year 2011 Annual Report on Sexual Assault in the Military* (April 2012).

available resources are factors that affect the quality and availability of that care. Left unaddressed, such factors can undermine DOD's efforts to address the problem of sexual assault in the military by eroding servicemembers' confidence in the department's programs and decreasing the likelihood that victims of sexual assault will turn to the programs or seek care and treatment when needed.

Recommendations for Executive Action

To help ensure that sexual assault victims have consistent access to health care services and the reporting options specified in DOD's sexual assault prevention and response policies, we recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to direct the Assistant Secretary of Defense for Health Affairs to develop and implement department-level guidance on the provision of medical and mental health care to victims of sexual assault that specifies health care providers' responsibilities to respond to and care for sexual assault victims, whether in the United States or in deployed environments.

To help ensure that Sexual Assault Response Coordinators, Victim Advocates, and health care personnel have a consistent understanding of the medical and mental health resources available at their respective locations for sexual assault victims, we recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in collaboration with the military departments, to take steps to improve compliance regarding the completion of annual refresher training on sexual assault prevention and response.

Agency Comments and Our Evaluation

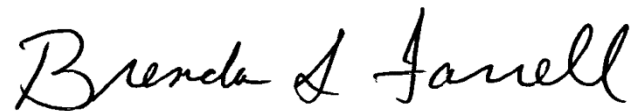
In written comments on a draft of this report, DOD stated in its cover letter that, overall, the department did not concur with the report's findings and conclusions. However, DOD's cover letter did not provide an explanation for this comment. In an enclosure to its letter, DOD stated that it did not concur with our first recommendation that the Assistant Secretary of Defense for Health Affairs develop and implement department-level guidance on the provision of medical and mental health care to victims of sexual assault that would specify health care providers' responsibilities to respond to and care for sexual assault victims, whether in the United States or in deployed environments. DOD's justification of its assessment, however, did not make clear why the department did not concur. Instead, DOD provided examples of steps it has been taking that may help to address the findings in this report. Specifically, DOD stated that, while the second version of DOD Instruction 6495.02, entitled "Sexual Assault

Prevention and Response (SAPR) Program Procedures” has been in coordination for nearly 2 years and is not yet published, the revised instruction will be comprehensive and will contain two medical enclosures. According to DOD, the first medical enclosure will address health care provider procedures and direct the Surgeons General of the military services to carry out responsibilities related to the coordination, evaluation, and implementation of care, while the second medical enclosure will address health care providers’ responsibilities related to Sexual Assault Forensic Examination kits. During the course of this review, we met with DOD officials who had knowledge of and were involved in the instruction’s revision, but these officials did not discuss or share their draft revisions with us when we presented our findings to them. We cannot verify, therefore, whether the enclosures referenced in DOD’s comments will address our recommendation. However, we plan to review the instruction when DOD finalizes it to determine whether it meets the intent of our recommendation. Finally, DOD stated that the department meets its oversight responsibilities with regard to sexual assault response through training in graduate medical education and through monitoring and oversight of the process that governs credentialing and privileging of providers. However, it is not clear why this statement is applicable to our recommendation. We did not address these points in the finding that led to this recommendation, and our recommendation is focused on the need for additional guidance.

DOD concurred, without comment, on our second recommendation that the Under Secretary of Defense for Personnel and Readiness, in collaboration with the military departments, take steps to improve compliance with completing annual refresher training on sexual assault prevention and response. DOD’s comments are reprinted in appendix II.

We are sending copies of this report to the Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Health Affairs, and appropriate congressional committees. In addition, this report will also be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink that reads "Brenda S. Farrell". The signature is written in a cursive style with a large initial "B".

Brenda S. Farrell
Director
Defense Capabilities and Management

List of Addressees

The Honorable Carl Levin
Chairman
The Honorable James Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Chairman
The Honorable Thad Cochran
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Howard P. "Buck" McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable C.W. Bill Young
Chairman
The Honorable Pete Visclosky
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

Determining the Extent to Which the Health Care Needs of Deployed Servicewomen Are Being Addressed and Female-specific Health Care Services Are Available

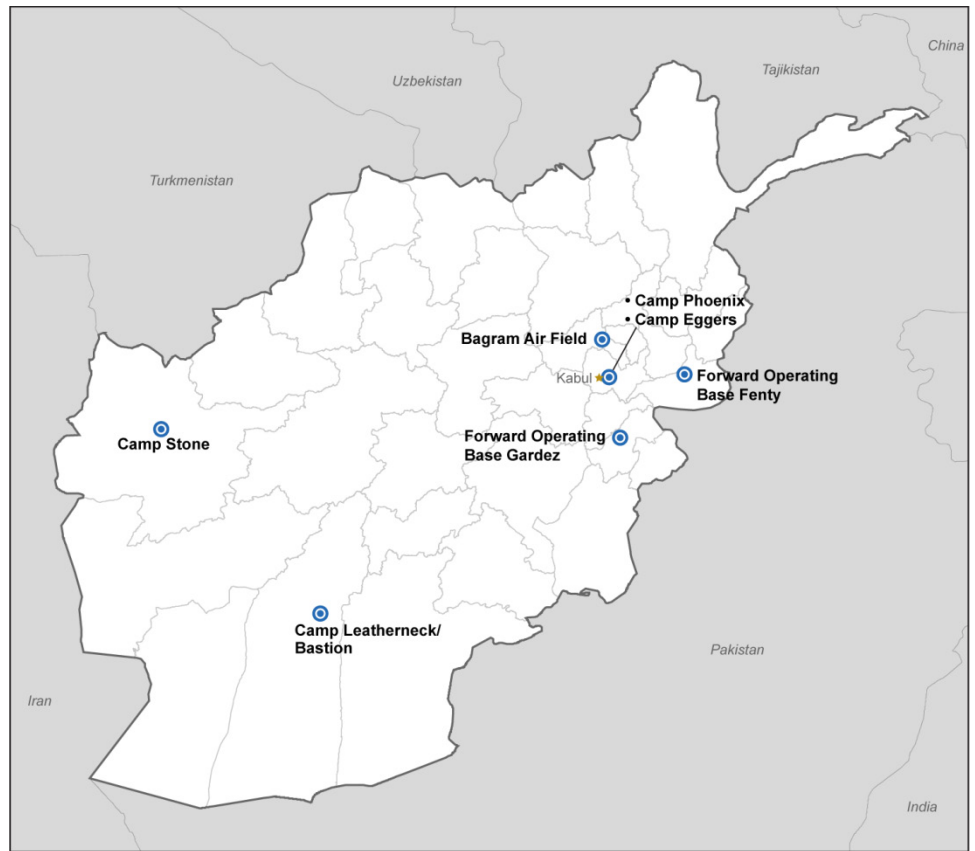
In our review of female-specific health care services provided by DOD to deployed servicewomen, our scope included each of the military services. We focused our work in conducting this review on the health care services available to servicewomen deployed to Afghanistan or aboard Navy vessels at sea.

To determine the extent to which DOD is addressing the health care needs of deployed servicewomen, we reviewed legislative requirements and pertinent DOD and service-specific policies and guidance. We also interviewed responsible officials within the Office of the Assistant Secretary of Defense for Health Affairs, each of the services' medical commands, and the TriService Nursing Research Program and its Women's Health Research Interest Group. We reviewed guidelines specifically applicable to women, such as guidelines issued by the American College of Obstetricians and Gynecologists, and prior GAO reports. We also obtained information on reported patient encounters for deployed servicemembers for fiscal year 2012 collected by U.S. Central Command and the Navy's Office of the Surgeon General. To assess the reliability of these data, we contacted cognizant DOD officials in order to understand the processes used to collect these data and any known limitations of the data. We found that while the data likely underreported the total number of patient encounters, these data were sufficiently reliable for the purposes of our report—that is, to provide context for the approximate number of reported patient encounters for servicewomen during fiscal year 2012 and the frequency with which such encounters specifically concerned women's health by summarizing the top 25 diagnoses.¹ In addition, we conducted a total of 15 site visits where we met with health care providers, military commanders, and female servicemembers to obtain their perspectives on DOD's efforts to address the health care needs of deployed servicewomen. In Afghanistan we visited 7 military installations, selected so as to enable us to visit each of the three levels of health service support across Afghanistan. Figure 4 shows the locations in Afghanistan we visited during the course of our review, which included Bagram Air Field, Camp Eggers, Camp

¹During our assessments we learned that not all medical encounter data are documented electronically during deployments to Afghanistan and aboard Navy vessels, and therefore may be underreported. DOD officials noted this, and an official from the Office of the Navy Surgeon General identified steps the Navy is taking to increase electronic documentation of data on servicemembers' medical encounters aboard Navy vessels.

Leatherneck/Bastion, Camp Phoenix, Camp Stone, Forward Operating Base Fenty, and Forward Operating Base Gardez.

Figure 4: Locations in Afghanistan Visited during GAO's Review



Sources: GAO; Map Resources (map).

We also visited 8 Navy vessels at their home ports in the United States, selected so as to enable us to visit different types of vessels on which women are an integrated part of the crew, for both the U.S. Atlantic and U.S. Pacific Fleets. The Navy vessels we visited included the USS George H.W. Bush (CVN 77), USS Boxer (LHD 4), USS Carl Vinson (CVN 70), USS Chancellorsville (CG 62), USS Georgia (SSGN 729), USS McClusky (FFG 41), USS Mesa Verde (LPD 19), and USS Truxtun (DDG 103). Table 1 provides information on the composition of the crew for each of the Navy vessels we visited.

Table 1: Crew Composition for Navy Vessels Visited

Vessel (hull number)	Type	Home port	Number of personnel assigned ^a		
			Women	Men	Total
USS George H.W. Bush (CVN 77)	Nimitz-class Aircraft Carrier	Norfolk, Virginia	464	1670	2134
USS Boxer (LHD 4)	WASP-class Amphibious Assault Ship	San Diego, California	187	827	1014
USS Carl Vinson (CVN 70)	Nimitz-class Aircraft Carrier	San Diego, California	448	2350	2798
USS Chancellorsville (CG 62)	Ticonderoga-class Guided Missile Cruiser	San Diego, California	43	258	301
USS Georgia (SSGN 729)	Ohio-class Guided Missile Submarine	Kings Bay, Georgia	4	151	155
USS Mesa Verde (LPD 19)	San Antonio-class Amphibious Transport Dock Ship	Norfolk, Virginia	88	282	370
USS McClusky (FFG 41)	Oliver Hazard Perry-class Frigate	San Diego, California	4	199	203
USS Truxtun (DDG 103)	Arleigh Burke-class Destroyer	Norfolk, Virginia	55	218	273

Source: GAO and DOD.

^aNumber of personnel assigned is as of the time of GAO's visit.

To determine the extent to which female-specific health care services are available to deployed servicewomen, we focused on the following female-specific health care services: clinical breast examination; screening mammography; diagnostic mammography; pelvic examination; PAP smear; treatment of patients having abnormal PAP smear results; treatment for disorders of the female genitals; treatment for disorders of menstruation; pregnancy test; and contraceptives, or contraceptive counseling. We also focused on female-specific behavioral health care services, to include mental health and substance abuse counseling.² To determine availability of the services, we obtained information from health care providers during our site visits regarding the availability of these services at that location. If female-specific health care services were not available, we sought to understand how situations requiring the need for such services would be handled during deployments. In the case of the Navy, we also obtained information from senior officials from the Navy

²We did not focus on abortion services because, by law, funds available to DOD may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest. Additionally, by law, no DOD facility may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest. See 10 U.S.C. §1093.

Type Commands responsible for overseeing health care units supporting air craft carriers, surface ships, and submarines.

To obtain female servicemembers' perspectives on women's health and wellness issues, we conducted 92 one-on-one structured interviews with servicewomen from various pay grades and from all services during our site visits to 7 military installations in Afghanistan and 8 Navy vessels. Our objective in using this approach was to obtain female servicemembers' perspective on a range of women's health and wellness issues, such as specific health issues and challenges women might face in seeking medical care while deployed. Although the results of our discussions are not generalizable and therefore cannot be projected across DOD, a service, or any single location we visited, the results of our discussions provide insight into the perspectives of servicewomen regarding DOD's efforts to address the health care needs of deployed servicewomen. Because of the sensitivity of some of the information we were seeking, we took steps to assure a confidential environment and encourage an open discussion during these interviews. Only female GAO analysts conducted these interviews.

Determining the Availability of Medical and Mental Health Care to Servicewomen Who Are Victims of Sexual Assault

To determine the extent to which medical and mental health care are available to servicewomen who are victims of sexual assault, we obtained and reviewed various documents, including legislative requirements and DOD's and the military services' policies and guidance establishing requirements for the prevention of and response to sexual assault. We also interviewed knowledgeable officials, including officials from DOD's Sexual Assault Prevention and Response office. We also reviewed DOD's Annual Report on Sexual Assault in the Military Services to identify the department's efforts to provide medical and mental health services to the 2,420 females who in fiscal year 2011 reported to DOD that they had been victims of sexual assault. We conducted site visits to 3 other military installations in the United States in addition to the 7 military installations in Afghanistan and the 8 Navy vessels we visited for our review, in order to assess the availability of medical and mental health care services for servicewomen who are victims of sexual assault in the military. To select the additional locations, we requested the military services' respective Sexual Assault Prevention and Response offices to identify locations that met select criteria. The locations we visited included Camp Pendleton, California; Davis-Monthan Air Force Base, Arizona; and Joint Base San Antonio, Texas. These locations were selected because they enabled us to meet with military personnel who have served as Sexual Assault Response Coordinators both while deployed and while at

a military installation in the United States. During our site visits we met with Sexual Assault Response Coordinators, Victim Advocates, and health care providers.

We visited or contacted the following organizations during our review:

Department of Defense

- Defense Advisory on Women in the Services, Washington, D.C.
- Office of the Under Secretary of Defense for Personnel and Readiness
 - Office of the Assistant Secretary of Defense for Health Affairs, Arlington, Virginia
- Sexual Assault Prevention and Response Office, Arlington, Virginia

Department of the Army

- Office of the Army Surgeon General, Falls Church, Virginia
 - Army Medical Command, Fort Sam Houston, Texas
 - Army Medical Research and Materiel Command, Fort Detrick, Maryland

Department of the Air Force

- Office of the Secretary of the Air Force
 - Office of the Assistant Secretary of the Air Force for Manpower and Reserve Affairs, Washington, D.C.
- Office of the Air Force Surgeon General
 - Air Force Medical Support Agency, Falls Church, Virginia

Department of the Navy

- Office of the Surgeon General, Washington, D.C.
 - Bureau of Medicine and Surgery, Office of Women's Health, Washington, D.C.
- Bureau of Naval Personnel
 - Office of Women's Policy, Washington, D.C.
- Commander Naval Air Force, U.S. Atlantic Fleet, Norfolk, Virginia
- Commander Naval Air Force, U.S. Pacific Fleet, San Diego, California

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- Commander Naval Surface Force, U.S. Atlantic Fleet, Norfolk, Virginia
 - Commander Naval Surface Force, U.S. Pacific Fleet, San Diego, California
 - Commander Submarine Force, U.S. Atlantic Fleet, Norfolk, Virginia
 - Commander Submarine Force, U.S. Pacific Fleet, Pearl Harbor, Hawaii
 - Navy and Marine Corps Public Health Center, Portsmouth, Virginia
 - Sexual Assault Prevention and Response Office, Washington, D.C.

United States Marine Corps

- Headquarters, U.S. Marine Corps (Health Services), Arlington, Virginia
- U.S. Marine Corps Sexual Assault Prevention and Response Office, Quantico, Virginia

In Afghanistan, we visited or contacted the following organizations:

- International Security Assistance Force Joint Command, Afghanistan
- Task Force Medical-Afghanistan, Afghanistan
- U.S. Forces Afghanistan, Afghanistan

We conducted this performance audit from April 2012 through January 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JAN 17 2013

Ms. Brenda S. Farrell
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G. Street N.W.
Washington, DC 20548

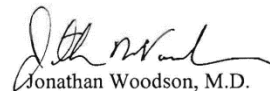
Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the GAO Draft Report, GAO-13-182, 'MILITARY PERSONNEL: DoD Has Taken Steps to Meet the Health Care Needs of Deployed Servicewomen, but Actions Needed to Enhance Care for Sexual Assault Victims,' dated December 14, 2012 (GAO Code 351718)."

Thank you for the opportunity to review and comment on the draft report. Overall, the department does not concur with the findings and conclusions of the draft report. The department's response to the recommendations contained in the draft report is enclosed.

My points of contact on this issue are CAPT Michael Colston (functional) at (703) 681-3611 and Mr. Gunther Zimmerman (audit liaison) at (703) 681-4360.

Sincerely,


Jonathan Woodson, M.D.

Enclosures:
As stated

GAO Draft Report Dated December 14, 2012
GAO-13-182 (GAO CODE 351718)

**“MILITARY PERSONNEL: DOD HAS TAKEN STEPS TO MEET THE HEALTH
NEEDS OF DEPLOYED SERVICEWOMEN, BUT ACTIONS NEEDED TO ENHANCE
CARE FOR SEXUAL ASSAULT VICTIMS”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION**

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, to direct the Assistant Secretary of Defense for Health Affairs, to develop and implement department-level guidance on the provision of medical and mental health care to victims of sexual assault which specifies health care providers’ responsibilities to respond to and care for sexual assault victims, whether in the United States or in deployed environments.

DoD RESPONSE: DoD does not concur with this recommendation that the Assistant Secretary of Defense for Health Affairs (ASD-HA) develop and implement department-level guidance as specified in the finding. Coordination of the second version of DoD Instruction 6495.02 “Sexual Assault Prevention and Response (SAPR) Program Procedures” has been ongoing for nearly two years. This comprehensive instruction contains two medical enclosures. Enclosure 7, “Healthcare Provider Procedures,” directs the Surgeons General of the Services “to coordinate timely access to emergency, follow-up, and specialty care” and “evaluate and implement, to the extent feasible, processes linking the medical management of the sexually assaulted patient to the Primary Care Manager.” Enclosure 8 addresses healthcare providers’ responsibilities with regard to Sexual Assault Forensic Examination (SAFE) kits. Healthcare addenda were vigorously studied and reviewed by medical specialists, administrators, and legal counsel throughout DoD and the Services. The instruction will be published as an Interim Federal Rule, and will soon be added to the CFR. Finally, ASD-HA meets its oversight responsibilities in regard to sexual assault response through training in graduate medical education and through monitoring and oversight of the process that governs credentialing and privileging of providers.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in collaboration with the military departments, to take steps to improve compliance with completing annual refresher training on sexual assault prevention and response.

DoD RESPONSE: DoD concurs with Recommendation 2.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

Acknowledgments

In addition to the contact named above, key contributors to this report include David E. Moser (Assistant Director), Wesley A. Johnson, Ronald La Due Lake, Kim Mayo, Amanda Miller, Sharon Reid, Cheryl A. Weissman, and K. Nicole Willems. In addition, Carole F. Coffey, Kasea Hamar, David W. Hancock, and Tamiya R. Lunsford provided assistance during site visits.

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