



**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**

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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.”<sup>1</sup> 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.

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<sup>1</sup> 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].<sup>2</sup>

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.<sup>3</sup> Currently numbering over two million, women are expected to make up 18% of the veteran population by 2040.<sup>4</sup> In addition, an estimated over one million veterans are lesbian, gay, or bisexual,<sup>5</sup> and about 134,000 veterans are

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<sup>2</sup> World Health Organization. (n.d.). *Abortion*. [https://www.who.int/health-topics/abortion#tab=tab\\_1](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”).

<sup>3</sup> 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](https://www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf)

<sup>4</sup> 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>

<sup>5</sup> 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.<sup>6</sup> 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].<sup>7</sup>

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).”<sup>8</sup> 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.”<sup>9</sup> Yet many found VA system “difficult to navigate” in many ways, including (1) a difficulty obtaining appointments, with long waits to

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

<sup>7</sup> 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>

<sup>8</sup> 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

<sup>9</sup> 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.<sup>10</sup> 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."<sup>11</sup> 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.<sup>12</sup>

*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."<sup>13</sup> 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.<sup>14</sup> 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.<sup>15</sup> 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

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<sup>10</sup> Wolgemuth et al. (2020).

<sup>11</sup> Wolgemuth et al. (2020).

<sup>12</sup> Wolgemuth et al. (2020).

<sup>13</sup> Wolgemuth et al. (2020).

<sup>14</sup> Wolgemuth et al. (2020).

<sup>15</sup> Wolgemuth et al. (2020).

men’s club,” and others suggest that women are considered “second-class citizens” and thought to be “malingerers.”<sup>16</sup>

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.<sup>17</sup>

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.<sup>18</sup> The rate is similar for veterans.<sup>19</sup> 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.”<sup>20</sup>

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

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<sup>16</sup> Wolgemuth et al. (2020).

<sup>17</sup> Wolgemuth et al. (2020).

<sup>18</sup> 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>

<sup>19</sup> 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

<sup>20</sup> 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."<sup>21</sup> 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.<sup>22</sup> The Rule also states that the "[a]ssessment of the conditions, injuries, illnesses, or diseases that will qualify for this care

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<sup>21</sup> AR-57, Interim Final Rule – Reproductive Health Services, 87 Fed. Reg. 55,287, 55,288 (Sept. 8, 2022).

<sup>22</sup> 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.”<sup>23</sup> 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”<sup>24</sup>—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?

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<sup>23</sup> 87 Fed. Reg. 55,294.

<sup>24</sup> 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<sup>25</sup> and the same percentage of women<sup>26</sup> 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%,<sup>27</sup> and in some studies up to 18%.<sup>28</sup> 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.<sup>29</sup> For racial and ethnic minority women, the rates of reported infertility were as high as 24%.<sup>30</sup>

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

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

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

<sup>27</sup> 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

<sup>28</sup> 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

<sup>29</sup> 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/doi/10.1377/forefront.20210715.658223/full/>

<sup>30</sup> 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<sup>31</sup>—according to some studies half as likely.<sup>32</sup> 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.<sup>33</sup> Surrogacy, donor eggs, donor sperm, and donor embryos are not covered.<sup>34</sup> As a result, the benefit is available almost exclusively to couples that are both cisgender and heterosexual.<sup>35</sup> 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.<sup>36</sup>

#### 4. Gender-affirming surgeries

VA’s LGBT Health Program has made significant improvements to the health care provided to transgender<sup>37</sup> veterans.<sup>38</sup> But VA policies still prohibit the provision and funding of gender affirmation surgeries.<sup>39</sup> This policy violates international standards of transgender health care that describe these surgeries as “essential and medically necessary”

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<sup>31</sup> Goossen et al. (2019).

<sup>32</sup> 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

<sup>33</sup> 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/>

<sup>34</sup> Katon et al. (2013).

<sup>35</sup> 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.

<sup>36</sup> 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>

<sup>37</sup> 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.

<sup>38</sup> 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

<sup>39</sup> 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](http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=6431)

procedures.<sup>40</sup> These international standards of care are based on decades of evidence,<sup>41</sup> and transgender people who receive this medically necessary care show significant improvement in depression and anxiety.<sup>42</sup> Gender affirmation surgeries are a medically necessary part of transgender health care, and, given the socioeconomic disparities within the transgender community,<sup>43</sup> 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.

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<sup>40</sup> 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](http://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?t=1613669341)

<sup>41</sup> 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.").

<sup>42</sup> 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

<sup>43</sup> 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](http://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.<sup>44</sup> We applaud this development and hope that patients will be able to receive all aspects of comprehensive reproductive health care—from prenatal to postpartum 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.<sup>45</sup> 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%.<sup>46</sup> Yet Black and Latina women face socioeconomic disparities, health inequities, and housing instability at a higher rate than white women,<sup>47</sup> as do unmarried women. Similarly, LGBTQ+ veterans face economic, housing, and health insecurities,<sup>48</sup> 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.

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<sup>44</sup> 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.

<sup>45</sup> 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](https://www.hsrd.research.va.gov/publications/internal/forum04_13.pdf)

<sup>46</sup> 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>

<sup>47</sup> Office of Health Equity. (n.d.). *Racial and ethnic minority veterans*. Department of Veterans Affairs. [https://www.va.gov/HEALTHY/Race\\_Ethnicity.asp](https://www.va.gov/HEALTHY/Race_Ethnicity.asp)

<sup>48</sup> 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.<sup>49</sup> 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.”<sup>50</sup> 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,<sup>51</sup> for example, and research shows that provider communication is an important mechanism for ensuring access to services for minority veterans.<sup>52</sup> Proper and

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<sup>49</sup> 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

<sup>50</sup> 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](http://www.va.gov/oig/pubs/VAOIG-20-01766-36.pdf)

<sup>51</sup> 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

<sup>52</sup> 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.<sup>53</sup> Further research reveals that only 13 VHA facilities (about 1% of facilities) are named after a minority veteran.<sup>54</sup> 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."<sup>55</sup> 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<sup>56</sup> 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.

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

<sup>53</sup> See [www.va.gov/directory/guide/allstate.asp](http://www.va.gov/directory/guide/allstate.asp)

<sup>54</sup> Ibid.

<sup>55</sup> See 2020 Report of the Department of Veterans Affairs Advisory Committee on Women Veterans. [www.va.gov/womenvet/docs/acwv/acwvReport2020.pdf](http://www.va.gov/womenvet/docs/acwv/acwvReport2020.pdf)

<sup>56</sup> 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.

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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,

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