Issues for Military Women in Deployment: An Overview

Guarantor: LTC Elspeth Cameron Ritchie, MC USA
Contributor: LTC Elspeth Cameron Ritchie, MC USA

The stresses of deployment affect both sexes, but some are either mildly or markedly different for women. These include certain female health and gynecological issues, nursing, and pregnancy. Separation from small children, isolation, the possibility of sexual assault, and risks of combat or being taken hostage are concerns for both genders. All of these issues should be addressed before and during deployment to ensure optimal individual and unit functioning and improve retention. Gynecological infections, redeployment for abnormal Papanicolaou smears, and pregnancy while on deployment can be avoided with proper hygiene and planning. There are resources available in pamphlet form, electronically, and on CD-ROM to help prepare service members, leaders, and health care personnel. Improvements in the ability to maintain personal hygiene and to communicate home should benefit both sexes.

Introduction

Deployment is far more likely now than ever before for the U.S. military. Since 1990, troops have been deployed to the Persian Gulf, Somalia, Haiti, Bosnia, Kosovo, and sites of numerous natural disasters. All of the deployments to these conflict-ridden areas have raised the threat of disease and conflict. Operation Restore Hope in Somalia, for example, changed from a humanitarian mission to one that was designated as a combat tour.

Debate in Congress, the media, and the public has focused on whether the female military member should be allowed to serve in occupational specialties that include combat or on submarines. Relatively little discussion, however, has occurred about the challenges facing military women of any specialty in deployment or other field situations. This article hopes to describe the difficulties that both military women and men encounter in austere and dangerous environments.

In conflicts before 1990, in wars in which the United States was involved, there usually was a designated front line. This was manned by all-male combat troops. The combat service support troops chiefly served in the rear areas. Women were traditionally assigned to combat service support, especially in administrative and medical fields.

The "rear" used to be considered less dangerous. However, missiles, terrorist attacks, and chemical and biological warfare can strike deeply. In the Persian Gulf War, more casualties were sustained from behind the lines than on the front. In conflicts today, there are no longer any "safe" zones.

In the last century, there was intermittently a draft for men. The vast majority of the military were young unmarried men. The Army is now 15% female, and other services have similar percentages (except for the Marines at 6%). Fifty-five percent of the force is married, 46% have children, 6% are single parents, and 8% provide some support to an elderly parent.

More and more women rotate to foreign lands. Tours to the Demilitarized Zone (DMZ) in Korea are usually unaccompanied, for a period of exactly 365 days. Military personnel who are not officially deployed may also go to field training for a period of days to months.

This article attempts to provide an overview of some concerns specific to women in the military in a deployment situation. The topics discussed include the following: personal hygiene and gynecological issues; pregnancy and nursing; separation from children; sexual harassment and assaults; isolation and acclimation to foreign cultures; and the risks of combat, capture, and death. The latter issues are what have gained the most public attention, but the former are what bother most military women more.

The General Accounting Office issued a report in March 1999 entitled "Medical Support for Female Soldiers Deployed to Bosnia." The authors noted that "women in our group interviews emphasized the lack of unit predeployment training on female health and hygiene more than any other issue."[1] There are now a number of efforts to improve training and knowledge in that area, which will be highlighted in this article.

Two caveats follow. The literature and statistics available are scarce on many of these issues, so some of the article is written in an anecdotal form, based on the author's experience and the experiences of those she has interviewed. In addition, the focus is on Army troops, although many of the issues apply to women in the other services.

The emphasis in this article is women. Some state that it is counterproductive to focus on potential difficulties of women in the field, because it could lead to the belief that women should not be in the military. They emphasize the exceptionally good performance of female service members. However, it is this author's belief that identification of potential problems leads to prevention. Some recommendations are made, and further resources are provided. Some problems do not have simple solutions, but an open discussion of them may lead that way.

Personal Hygiene

Newt Gingrich received criticism for his quote, "If combat means living in a ditch, females have biological problems staying in a ditch for thirty days because they get infections."[2] This statement does contain a kernel of truth, however, about the realities of field conditions. The following remarks may sound graphic or tasteless, but they are areas of concern for deployed women and thus for the mission.

> On the Team Spirit exercise, an annual month-long field operation on the DMZ in Korea in 1991, there were four

Program Director, Mental Health Policy and Woman's Health Issues, Department of Defense/Health Affairs, 5111 Leesburg Pike, Skyline 5, Suite 601, Falls Church, VA 22041.

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porta-potties for the main support battalion, about 400 people. These were serviced about once every 4 days (although it was supposed to be more frequent). They stank. They were filled with tracked-in mud. The seats were always filthy with mud, urine, and, occasionally, feces.

Bathrooms, or lack thereof, are always an issue. Unlike on a camping trip, one cannot merely "pee in the woods." There is very little privacy or space between tents or buildings. Relieving oneself other than in latrines in the camp area is discouraged to avoid disease and other unpleasant surprises. Men often urinate outside covertly, but this is more difficult for women. Thus, women may avoid drinking fluids.

In the field, soldiers wear battle dress uniform plus their gear. This includes load-bearing equipment and, possibly, a flak vest, field jacket, protective or "gas" mask, and a personal weapon. For a woman to relieve herself, she has to first take off all of her outer gear. Then she has to find a place to hang it inside the stall where it will not become filthy or find a friend to hold it. Gear must not be left outside because of the risk of theft. (If a soldier loses a protective mask or weapon, his or her future military career could be jeopardized.) Once free of those items, she unbuttons her battle dress uniform pants, may strip down long underwear, and is supposed to sit on the seat. The lines for the stalls may be quite long, so there is pressure to "do your business" quickly. Given the typical field menu of Meals Ready to Eat and other constipating food, sometimes being quick is difficult. (Men, of course, have to follow the same procedure for defecation.)

When there are special latrines set aside for women, there may be only a few, especially early in a deployment. For example, in Somalia, during the first days of Operation Restore Hope, there were PVC pipes and "crappers" arranged for the men all over, either totally exposed or only partially concealed by camouflage netting. But in the whole Mogadishu embassy complex there were only three latrines for women. Initially, that number sounds appropriate in view of how relatively few women were there. But if one was being cleaned (e.g., oil can contents being burned) and the other was being used by someone who was constipated, that left long lines for the third.

There may be no available latrines at all. On a long convoy, service members may not be able to stop, get out, and find a safe, private place to urinate. The General Accounting Office report cited above stated that in Bosnia, more than half of the female survey respondents reported that there were times during the deployment when they encountered obstacles to urinating. Of these women, about 20% said that this problem had occurred on a daily basis.[1]

There should be facilities for washing hands located before the mess tents, but there may be few or none outside of the latrines. Because of poor hygiene, and because women avoid drinking adequate fluids to decrease the need to urinate, there are higher rates of urinary tract infections in the field. Another hazard is the consequent higher risk of dehydration.

After 1 or 2 days of field life, most women long for a shower, as do the men. Shower tents are usually set up within a few days or weeks of the beginning of the deployment. Because there are usually relatively few women, the bulk of the shower time is for men. Women might have the shower tent allotted to them for 1 hour per day, which is adequate as long as other duties allow one to make that specific time.

Service members who have been deployed before learn what to pack. Baby wipes should be mandatory. A camping shower or an upended can full of water hung between two ponchos may dramatically improve hygiene, individual mood, and unit morale. Some advocate bringing a discreet bathing suit to wear if privacy will be a problem.

Gynecological Issues

Tampons and sanitary napkins may be scarce in an immature theater. Women should be warned before deployment to bring an adequate supply in a waterproof bag. Even if there is a "PX" or military store set up, supplies can be limited or nonexistent. There are increasing efforts to have "push-pacs" (a bag of tampons, sanitary napkins, etc.) available. More mature theaters should have better stocks of supplies. Nevertheless, to have one's period out in the field, with no running water, is distasteful. Try changing a tampon in a tank roaring across the desert, as some women had to do in the Persian Gulf War. (Yet they managed.)

There are other solutions. To decrease or stop a period, one can be on either a continual supply of a birth control pill or a long-acting preparation such as medroxyprogesterone acetate (Depo-Provera). Most gynecologists agree that suppression of the period for 6 months or so is safe (although there may be some spotting). The military is exploring the idea of urinary devices so women can urinate discreetly on a long trip.

The perception of lack of confidentiality may be a barrier to effective treatment of gynecological infections. Ryan-Wenger and Lowe reported that the typical health care provider whom military women would encounter at their home duty station is a male or female enlisted medic or corpsman. During deployment, the provider is even more likely to be an enlisted person, rather than a physician assistant, nurse practitioner, or physician. In the study by Ryan-Wenger and Lowe, more than half of the women reported that they were not comfortable going to this health care provider for gynecological symptoms during deployment, and nearly one-quarter would not go at all.[3]

An opened-ended survey question was used to ask for reasons why women would not want to see the available health care provider for diagnosis and treatment of genitourinary symptoms, either at the home duty station and when deployed. The most common reasons were as follows: embarrassment; lack of trust in confidentiality of the visit; the provider was usually male; the provider was not qualified or knowledgeable about gynecological problems; and having to go through the chain of command to visit the provider (thus "having to tell too many people what the problem is"). Of the deployed women, 90% gave reasons for not wanting to see the health care provider for gynecological problems during deployment.[3] (Of course, men may also be hesitant about seeking help for intimate health care needs.)

The deployed women were also asked about factors that increase their risk of developing vaginal or urinary tract infections during deployment. More than half of the women reported en-

vironment (excessive heat), lack of privacy, limited or no shower facilities, limited or no handwashing facilities, and unsanitary latrines.[3]

A potential reason for evacuation from theater is for definitive evaluation of abnormal cervical cytology among women whose last routine Papanicolaou (Pap) smear had not been examined and for results reported before deployment. In the Persian Gulf War, this was the second most common reason for women to be redeployed, after pregnancy.[4-7] The issue was that often the report of abnormal results took several months to reach the deployed female soldier. Because there was no ability to perform colposcopy in the field, the soldiers were usually returned to Europe or the United States for the workup.

All of the challenges discussed above are surmountable with planning and foresight. Ensuring that women have their annual Pap smears at least 1 month before a potential deployment can minimize this issue. In addition, new techniques for the detection of dysplasia are being researched. These new technologies offer a much more rapid turnaround time than the routine Pap smear, the results of which may take several weeks to reach the patient even in the United States. Their use in military medical facilities is under review. Lowe and Ryan-Wenger are in the process of developing two self-diagnosis kits for the detection of vaginal yeast or bacterial infection and for the detection of urinary tract infection.[8]

There is now an electronic "Female Soldier Readiness: A Leader's Guide" to help both women and commanders know how to prepare for the field.[9] The guide is available electronically, and the authors of that manual plan to develop and maintain a World Wide Web site. In addition, the Army's Center for Health Promotion and Preventive Medicine will soon publish a pamphlet for both sexes: "U.S. Army Guide to Staying Healthy."[10]

An exceptional new resource for the practitioner in the field is the Operational Obstetrics and Gynecology CD-ROM, "The Health Care of Women in Military Settings."[11] This self-contained resource covers the diagnosis and treatment of many conditions, including abdominal pain, urinary problems, and sexual assault. It is oriented toward the general medical officer or independent duty corpsman who may have limited familiarity with gynecological diseases. Service-specific regulations and phone numbers of consultants in major military treatment facilities are also included. It is available through the Navy Operational Medicine Institute.

Pregnancy

Each service has its own regulations on pregnancy, but pregnancy policies with regard to deployment are relatively consistent. If a woman is pregnant, she is not deployed to an austere environment. If she is found to be pregnant on a deployment, she is returned home. If she is on a ship, she may be retained until 20 weeks at the discretion of the commander, depending on the availability of medical services (secondary to concerns about ectopic pregnancies and miscarriages). After 20 weeks, she is returned to port. If she is stationed unaccompanied overseas in Korea, normally she stays until about the 34th week and then may return home.

Pregnancy on deployment may cause morale issues. A positive pregnancy test was the most common reason for women to be evacuated from the theater in the Persian Gulf War.[4-7] Some men resented women diagnosed as pregnant during the Persian Gulf War or other deployments, believing that they deliberately became pregnant to avoid duty. In reality, the majority of the women who were evacuated out of theater because of pregnancy unknowingly deployed into the theater while pregnant.

Replacing women who are redeployed secondary to pregnancy is a readiness issue as well as a morale problem. An estimated cost per pregnant woman for evacuation is $10,000.[12] This argues for consistent routine pregnancy screening before deployment to minimize the risks to mother and fetus and to reduce the potential costs of evacuation.

The number of unintended pregnancies is a serious concern for the military. Although most unintended pregnancies happen in garrison, some do begin in the field. A woman may not think to bring a 6-month supply of birth control pills on the deployment. She may not feel comfortable with the lack of privacy in going to a battalion aid station and requesting a resupply, or other forms of birth control, especially if intimate contact is officially discouraged.

Nursing is a difficult issue. The American Academy of Pediatrics currently recommends breast-feeding for 1 year. There are service-specific regulations that exempt new mothers from field duty or temporary duty elsewhere for 4 months. Obviously one cannot continue to nurse if deployed.

Separation from Family

The services have a dilemma. Deploying the primary caretaker of small children is an immense stress on the families, and mothers are still usually the primary caretakers. Yet, women cannot be exempted from deployment simply because they have children. This would not be fair to men, nor would it support the current mission requirements of the armed services.

Current policy provides for maternity leave of 6 weeks and 4 months of exemption from temporary duty elsewhere. After that, women are eligible for deployment or field duty. Although many commanders will try to avoid deploying new mothers, this is often not feasible.

Some women want to leave the service after having children. Enlisted women in the Army and Air Force may request a discharge when pregnant. In the Navy and Marines, although a request for discharge may be made, it is not usually granted unless there are extenuating circumstances. For officers, who often have obligations to the service academies or for other schooling, commitments cannot be waived simply because of pregnancy.

Single parents are not supposed to enlist unless they transfer custody of their children to another responsible adult. In the past, this was often waived. Now it is enforced much more rigorously.

Both men and women may become single or custodial parents after enlistment. These single parents, and families with two parents who are service members, are supposed to have a family care plan, i.e., someone who can care for their children if they are deployed. However, in the event of a rapid call-up, that surrogate caretaker may not be available immediately. Child care for extended periods may be problematic.

An assignment to the DMZ in Korea in the Army is normally a 1-year unaccompanied tour. Single parents stationed there

leave small children in the United States, usually with a grandparent. Even with a 1-month mid-tour leave, a year is a long time to be away.

Communication home during deployments is also challenging, depending on the maturity of the theater. Mail can be very slow. Phone calls are expensive and often unsatisfying. However, e-mail and the Internet are used increasingly. The services are experimenting with using videoconferencing to link up families. Currently, in Kosovo, this technology is widely available to soldiers. Anecdotally, this has been found to be helpful.

Isolation, Sexual Harassment, and Assaults

> In the beginning of Operation Restore Hope in Somalia, the Marine Corps general in charge decreed that men and women should sleep in different tents. One of the preventive medicine teams was split into a 2-woman and a 10-man set-up. One of the women always needed to be around the tent to guard against theft. At one point, the men were warned about upcoming tensions and probable gunfire. When the bullets came flying over the wall, the men retreated into the walled university complex. The two women, who did not have access to the same information, were left outside in the tent.

Smaller units may have only one or two females. Consequent feelings of isolation and being in a "glass bowl" can be difficult. The lopsided ratio may also lead to harassment or sexual tensions. There may also be issues of safety, especially if males and females are separated.

For many troops, exposure to foreign cultures can be difficult. In Muslim cultures, women have different restrictions than in the United States. Women may be heckled by the locals or restricted from driving.

Intense media coverage about certain highly publicized cases has focused attention on harassment and sexual assault. For most women, the military offers more opportunity for advancement than the civilian world. Accurate data on the rate of sexual trauma is notoriously difficult to achieve, partly because of underreporting. Sexual assault may actually be less common on deployment than in garrison because of the lack of available alcohol and privacy.

Risk to Life, Limb, and Honor

Far more is made of the risks of combat by the press than seems to bother most military service members. Men and women take the danger in stride. The risk to life and limb is less of an issue than the inability to leave a post or camp because of that threat; thus, boredom is the irritant.

Both sexes have to carry a firearm when deployed. All service members have had some training in handling and firing weapons. However, for many troops in combat support jobs, where the bulk of the women are, this training has been minimal. To be on guard duty in a hostile environment when the locals are teenagers with large weapons who are chewing qat can be tense.

There is the risk of capture. Colonel Rhonda Cornum, an Army pilot and physician whose plane was shot down in the Persian Gulf War, suffered the indignity of an attempted sexual assault while she had two broken arms. She described the assault as trivial compared with the deaths of her comrades in the airplane crash. She also emphasized that the likelihood of sexual assault is not gender specific.[13]

In the Canadian videotape about their Rwandan experience, "Witness the Evil," service members describe how they were detained while Rwandans tried to barter for one of their female medics, offering a chicken in return. After that experience, the women were generally restricted to camp.[14]

Obviously, there are also risks of being shot, gassed, tortured, or blown up, or of developing malaria or dengue fever. These risks do not differentiate by gender. The recent terrorist bombing of the *U.S.S. Cole*, the detention of the crew of the damaged surveillance plane in China and the bombing of the Pentagon illustrate these dangers. Military women were both killed and captured. Fortunately, the media and public attention did not inappropriately focus on the women.

Conclusion

This discussion has progressed from the mundane issues of keeping clean to the dramatic issues of being shot or captured. For women and men, it is the petty annoyances of daily life in the field that cause the most immediate discomfort, but separation from small children causes the most anguish.

The military is working hard to obviate the issues that most affect woman's health in the field through an emphasis on hygiene, pregnancy screening, earlier Pap testing, better information given to the troops, increased availability of good medical care, and increased research into women's health on deployments.[9-11,15,16] For both sexes, improvements can be made in confidentiality of health care, increased availability of birth control, better field hygiene (bathrooms, handwashing stations, showers), and increased availability of e-mail and video teleconferencing.

Women on deployment do a wonderful job in focusing on the mission. Discreet attention paid to certain of their needs will contribute to further mission success. As more women reach the senior ranks, there should be more mentors available for advice and guidance. Given the current operational tempo, there is little that can be done about the numerous extended separations from home.

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