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How the *Dobbs* Decision Could Affect U.S. National Security

The *Dobbs v. Jackson* (U.S. Supreme Court, 2022) decision overturned the provision of a constitutional right to an abortion. Since the decision, there has been much discussion about the effects of the ruling on American society, and especially the disproportionate effect that it will have on women (Ahmed, 2022; Barbaro, 2022, Fawcett, 2022; Hesse, 2022; Leonhardt, 2022).¹ Women in the military, who are charged with defending and protecting the United States, are an important group that deserve special consideration in this discussion. For the military, the *Dobbs* ruling is a matter of national security.

Women are an integral part of the military. They comprise 17.2 percent of the active-duty force. They are the fastest-growing subpopulation in the military (U.S. Department of Defense [DoD], 2022). For the past several years, the military services have been deliberately recruiting women, both to fulfill specialized positions and discrete operational needs and because they represent a higher percentage of the recruitable population than their male counterparts (Hunter, 2021; Office of People Analytics, 2018). Although there has been focus on allowing women to serve

in previously closed positions (such as infantry), women have been and are serving in other roles that also are essential to our military readiness. Women in the military play a significant role in health care occupations, electrical and mechanical equipment repair, functional support (such as payroll and supply), and administrative roles. These occupations are foundational for the effective functioning of the military (Brooks and Stanley, 2007; Meadows et al., 2022, Table 2.4).

Women also are essential to the DoD civilian workforce. Women make up nearly one-third of the civilian workforce and hold positions from child care providers to senior executives. In the civilian sector, women play a significant role in administrative and educational roles (U.S. Office of Personnel Management, 2022), which are essential for the day-to-day operations of the U.S. military.

The recent Supreme Court ruling in *Dobbs v. Jackson* will limit service women's and DoD civilian women's access to the full scope of reproductive health care and will have a direct effect on the health of these critical popula-

tions. Understanding the scope of these effects is essential to understanding how *Dobbs* could affect military readiness and therefore national security. Unfortunately, data in this area are limited. For example, there is no single source that tells us how many military service members or DoD civilians have sought abortions as part of their reproductive health care. To better understand the size and scope of the impact of the *Dobbs* decision on these important populations, we integrate data from several sources, including publicly available data and two representative surveys of active-duty service members developed and administered by the RAND Corporation for DoD. We estimate how many military-employed women's reproductive health options have been or might soon be limited, and we identify force readiness-related concerns, such as effects on the military health care, education, and child care systems, as well as on military recruiting and retention.

Abortion Care in the Department of Defense

Since well before *Dobbs*, 10 U.S.C. 1093, a Hyde Amendment-like statute,² prohibited TRICARE, DoD's health care program, from paying for abortions with three exceptions: When the life of the mother would be endangered if the pregnancy were carried to term, if the pregnancy arises from rape, or if the pregnancy arises from incest (we refer to these cases as *covered abortions*) (Burrelli, 2013). The statute also prohibits DoD facilities, including military hospitals and clinics (military treatment facilities, also known as MTFs) from performing noncovered abortions. Insurance as part of the Federal Employee Health Benefits (FEHB) Program, which would include DoD federal

Abbreviations

DHAPI	Defense Health Agency Procedural Instruction
DoD	U.S. Department of Defense
FEHB	Federal Employee Health Benefits
HRBS	DoD Survey of Health-Related Behaviors
IUD	intrauterine device
MHS	Military Health System
MTF	military treatment facility
PHA	periodic health assessment
WRHS	DoD Women's Reproductive Health Survey

employees, also covers abortions only under these circumstances (Bodenheimer, 2022). Service members and DoD employees who seek an abortion for any noncovered reason must rely on their own funds and their local community network of providers. The *Dobbs* decision eliminates or curtails service members' and DoD civilians' ability to access both covered and noncovered abortion care in several states, some of which had already restricted access at the time of the *Dobbs* decision (e.g., Texas and Oklahoma). As of July 2022, there are 21 states restricting abortion care that we are including in this Perspective.³ They do so in one of four ways:

1. total (i.e., not allowed in any circumstance) or partial (e.g., not allowed after six to 12 weeks of gestation, depending on the state) bans currently in effect
2. bans expected to be in effect (i.e., trigger laws that have a set period of time before they are enacted or legislation currently pending a vote)
3. bans that are currently blocked by the courts but might be in effect in the near future
4. gestational limits on abortions up to 18 weeks (New York Times, 2022).

All have exceptions for the life of the woman based on federal law (Associated Press, 2022), although only some have (or will have) exceptions in cases of rape or incest (Jacobson, 2022). Some have restrictions based on the type of provider who can perform abortions, the size of the facility in which an abortion can be performed (Guttmacher Institute, 2022), or wait time requirements that might make it more difficult for women to obtain abortion care (Guttmacher Institute, 2020). Many of the states that have instituted a ban or severe restrictions (or are poised to do

so in the near future) are home to large military installations, including Texas, Georgia, Florida, Oklahoma, South Carolina, and Arizona. Other states, such as North Carolina and Virginia, also have large active-duty populations and are considering changes to their abortion statutes.

Size of the Effects

Just how many service women live in a state where their right to abortion has been severely restricted or lost because of *Dobbs*? According to our calculations using data from DoD's Military One Source *Demographics Profile of the Military* (DoD, 2020), there are roughly 1.16 million active-duty service members, about 201,000 of whom are women stationed in the continental United States.⁴ Roughly 450,000 active-duty service members live in a state that meets the inclusion criteria outlined previously (i.e., existing full or partial bans, soon-to-be in-place bans, court-blocked bans, and gestational limits up to 18 weeks), and of those service members, approximately 80,000 are women. This means that 40 percent of active-duty service women in the continental United States will have no or severely restricted access to abortion services where they are stationed. These women make up 18 percent of the stateside total active-duty force. It is important to note that the vast majority of active-duty women are of reproductive age—95 percent are under age 45 (Meadows et al., 2022, Table S.2).

Additionally, according to FedScope data on the civilian workforce, there are more than 708,000 DoD civilians in the continental United States, over 250,000 of whom are women. Roughly 275,000 DoD civilians live in states with a full ban or extreme restrictions on access to abortion,

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and of those civilians, over 81,000 are women. Similar to their active-duty counterparts, nearly 43 percent of civilian women employed by DoD will have no access to abortion or will have their access severely curtailed in their home states.

Abortions at military facilities are rare (Kime, 2022), and most covered abortions do not occur in a military treatment facility (U.S. House of Representatives Armed Services Committee, 2022). Administrative data concerning TRICARE- and FEHB-covered abortions do not appear to be publicly available. Even these likely would constitute a small fraction of all abortions among DoD-employed women because these data omit abortions sought for reasons other than preservation of the life of the mother, rape, or incest. There are no existing surveys or other data collection efforts that directly ask service women (or women who are DoD civilian employees) whether they have sought an abortion that could provide a reliable population-level

estimate of the number of these women. Therefore, estimates using military facility, TRICARE, or FEHB data likely are significant undercounts of the number of DoD-employed women who have received an abortion.

In the absence of a direct count or estimate, we can use related data points to make logical inferences regarding the number of service women who have abortions. Using data from the DoD Women's Reproductive Health Survey (WRHS), a DoD-wide representative survey of active-duty service women that was fielded in 2020, we estimate that between 2,573 and 4,136 active-duty service women have an abortion annually.⁵ This estimate is based on responses to a question in the survey asked of women who reported having had a pregnancy in the past year. Although the WRHS did not specifically ask about abortion, it asked about the outcome of that pregnancy, and our estimate reflects the number of women who indicated that their past-year pregnancy ended in an outcome other than a live birth or miscarriage. This *other* will include some stillbirths, although DoD medical data indicate that stillbirths in the military are rare (three in every 1,000 births) (Bukowski et al., 2017). It also is possible that some pregnancies that were reported as ending in a miscarriage actually might have been the result of a medication abortion, resulting in an undercount of abortions (Studnicki et al., 2021).

As we have noted, changes in access to legal abortion services will also affect DoD's civilian employees. Of all DoD civilian employees, 146,000 are women between the ages of 18 and 49 (i.e., reproductive age). Using state-level abortion rates from the Centers for Disease Control and Prevention (Kortsmitt et al., 2021) and the Guttmacher Institute (Jones, Witwer, and Jerman, 2019), we can estimate a range for the number of DoD civilians who seek an

abortion annually. Applying these rates, we find that an estimated 2,500 to 3,300 female DoD civilian employees have an abortion annually. Post-*Dobbs*, roughly 43 percent of such women no longer have access to abortion, have severely restricted access, or will soon experience loss of access or severe restrictions based on laws in their home state. Many of these employees had restricted access already if they were dependent on FEHB to cover costs and the abortion they sought was not covered. But those who have other insurance in addition to FEHB, or who can pay out of pocket, are now or soon will be in a more difficult situation if they choose to seek abortion care.

Combining the ranges that we estimated, roughly 5,000 to 7,400 active-duty service women and DoD-employed civilian women who seek abortion services in any given year could face additional challenges in obtaining these services under *Dobbs*. These women will have to choose from three possibilities should they seek an abortion. First, they could request and take leave to travel to get an abortion in a state where it is legal. Second, they could have the procedure in a state where abortion is illegal, which could result in significant risks to their physical health and put them in legal jeopardy. Third, they could seek a medication abortion in a state with a full or partial ban and risk judicial punishment. If none of these options is viable to active-duty service women, they will carry their pregnancies to term in an environment where pregnancy is perceived to be stigmatized, child care is often difficult to obtain, and having a child at the wrong time could have serious implications for career trajectories (Gaddes et al., 2019). All of these options have costs for DoD because they involve lost work time (from days to years), reduced health, and increased stress.

Furthermore, men who support DoD's mission as military members and as civilian employees will be affected. Over 40 percent of male service members are married to a civilian woman who is a TRICARE dependent (DoD, 2020). Ten percent of active-duty service members have children of reproductive age who also will face access issues if they reside in a state with a total abortion ban or severe restrictions. One-fifth of active-duty service women are married to a fellow service member which means that they, too, will be directly affected by their spouses' access to abortion services (DoD, 2020). And, of course, active-duty service men might be responsible for pregnancies among women who are not DoD dependents but who might be unable to obtain an abortion. Decisions around these pregnancies will involve the same limited choices as pregnancies among women employed by DoD: travel and leave, illegal abortion, or unwanted births, and the same ill effects for force operations and readiness.

Scope of the Effects

The full effects of *Dobbs* on military readiness are yet to be known, but based on previous work on women's recruitment and retention, military culture, and military family planning, we can make logical inferences and hypothesize about several potential effects. Service women are already more likely to leave service than their male peers (Farrell, 2020). Frustration with family planning in the context of a military career and gender bias and discrimination often are cited as reasons for their separation (Farrell, 2020). It is not unreasonable to expect that both women's propensity to serve and their subsequent retention intentions will decrease as *Dobbs* adds to and complicates these issues.

While, in theory, *Dobbs* affects only women serving in states where abortions are banned or severely restricted, women (and men) who sign up for a military career are agreeing to serve where they are needed. Service women have little or no say about where they are stationed. By joining or remaining in service, women are agreeing to live under whatever state restrictions might be imposed. Some might opt out of military service under this new reality (Mann, 2022). To estimate the effect of the *Dobbs* decision on recruitment and retention requires additional research, and doing so will be important to DoD's ability to remain at full force strength and readiness should *Dobbs* disrupt service intentions among women.

Although we do not yet know whether such disruptions will occur, we do know that active-duty women who want an abortion but are serving in a state where abortion is partially or totally banned face substantial obstacles. Abortion often will result in lost work time. Medication abortion might be possible to use at home but might also involve obtaining medication from a source in an international jurisdiction or different state to circumvent rules

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in states where abortions are banned or restricted (White House, 2022). Medication abortion also requires some time away from the physical demands of military training (Medline Plus, 2021). Moreover, women who pursue abortion could face criminal prosecution. As a consequence, active-duty service members and female DoD civilian employees seeking abortion care could incur anywhere from a few days of limited or missed work to discharge from the military or loss of a civilian job, among civilians who are criminally charged.

Even pre-*Dobbs*, service women cited cost as a barrier for seeking abortion care (Fix et al., 2020), and in the post-*Dobbs* environment, costs might be exacerbated. As women are seeking noncovered abortion care in states with prohibitions or extreme restrictions, the percentage of women for whom the financial cost of obtaining an abortion exceeds their ability to pay will increase. As an example, a junior enlisted service woman (between the pay grades of E1 and E3) assigned to Fort Hood, located in Texas, would have to travel approximately 508 miles to Wichita, Kansas (the city and state with the nearest legal abortion clinic)—where the right to an abortion was upheld by a recent ballot measure—to obtain the procedure legally (Smith, 2022). If one assumes that a service woman has access to a car that consumes gas at a rate of 20 miles per gallon and gas is \$4.15 per gallon (roughly the midpoint between the average price in Texas and Kansas in July 2022), she would spend roughly \$210 for the round trip. According to Planned Parenthood, the cost of an abortion can reach \$750 (Planned Parenthood, 2022). Presumably, the service woman would need to spend at least two nights in a hotel to account for the 24-hour waiting period required in Kansas and to recover after the procedure, which we assume will cost

\$100 per night. Summing these expenses, this service woman would spend just over \$1,100 to obtain this legal abortion. The base pay for a junior enlisted service member is between \$1,800–2,200 per month before taxes, depending on pay grade and years of service (DoD, 2021). In other words, it is not unreasonable to expect that some service women who want a safe, legal abortion could pay more than half their monthly pre-tax salary for the procedure.

Although there are many reasons why people obtain abortions, many abortions involve unintended pregnancies. Thus, another possibility is that the number of unintended pregnancies carried to term will increase post-*Dobbs*. An *unintended pregnancy* is defined as one that occurs when a woman wanted to become pregnant in the future but not at the time she became pregnant (i.e., the pregnancy occurred too soon), or one that occurs when she did not want to become pregnant at any time (i.e., the pregnancy was unwanted). Data from civilians indicate that, annually, 4.5 percent of women have an unintended pregnancy (Finer and Zolna, 2016). Data from the WRHS found that 5.9 percent of active-duty service women reported an unintended pregnancy in a one-year period. Another military survey produced a similar estimate. Data from the 2018 DoD Survey of Health-Related Behaviors (HRBS), a representative, self-report survey on service members' health and health behaviors, found a past-year unintended pregnancy rate of 5.5 percent among active-duty service women (Meadows et al., 2021). Although two data points cannot tell us anything about trends over time, it is reasonable to hypothesize that unless DoD makes a concerted effort to prevent unintended pregnancies, these rates will not change. Additionally, the survey asked service men if they had caused or been responsible for an unintended

pregnancy in the past year: 2.4 percent indicated that they had, highlighting the broader effect that the *Dobbs* decision could have on all service members' ability to serve.

Applying these rates of unintended pregnancy to civilian women employed by DoD (ages 18–49), we estimate that roughly 6,600 unintended pregnancies occur annually and 11,000 to 11,900 unintended pregnancies (depending on the data source, HRBS or WRHS, respectively) occur annually among active-duty service women. Looking at only women in states where women no longer have access to abortion services, have severely restricted access, or will soon experience loss of access or severe restrictions, the numbers are 2,800 female DoD civilian employees with unintended pregnancies annually, and between 4,400 (HRBS) and 4,700 (WRHS) active-duty service women with an unintended pregnancy each year.

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If more of these unintended pregnancies are carried to term, DoD will need to provide care to women during pregnancy, delivery, and the postpartum period. The resulting children will be military dependents and DoD will be responsible for their health care for as long as at least one parent remains in the military. This has implications for DoD across several domains. First, the Military Health System (MHS) will have to respond to increased demand either through direct or purchased care. Direct care would include physicians and other providers who work directly for DoD and, in this case, provide reproductive, postnatal, and child health care; purchased care would include any care that is received outside the MHS in the civilian world but is ultimately paid for through TRICARE. DoD is already facing a shortage of obstetricians, gynecologists, and pediatric specialists (Kime and Toropin, 2022). Ultimately, this could raise DoD health care costs.

Second, the DoD Child Care program might need to expand to accommodate any additional births that occur as a result of women having children that they might not have had otherwise. DoD spends over \$1.2 billion annually on child care costs (Larin, 2020). And while DoD does have on-base subsidized child care facilities (child development centers), over 44 percent of military children are in off-base care because of a lack of availability in the child development centers. While the government does subsidize some off-base care, in several areas with a large military presence—especially higher cost-of-living areas, such as Southern California or the National Capital Region—families are still paying an average of \$700 per month per child over DoD subsidies (Larin, 2020). This puts more strain on the child care system, drives up costs, and affects the financial readiness of service members.

Third, the DoD Educational Activity, which provides schooling for DoD dependents who live on some installations, might need to plan for a potential increase in the student population. Again, this could result in increased cost if projections of new students outpace the capacity of existing teachers and facilities.

Finally, in addition to the need to care for women and children, there will be an operational impact if more unintended pregnancies are carried to term. When a service woman becomes pregnant, she often is removed from her unit or has her duties restricted or limited in some way (e.g., to remove exposure to toxic chemicals). Pregnant women also are not able to deploy. Although there is an individual cost to pregnant women in terms of medical readiness, there is a collective cost to operational readiness.

How DoD Could Respond

Women play an integral role in the U.S. military. A threat to their health and well-being is a potential threat to our national security. The reproductive health of our active-duty service women and their civilian peers who work for DoD is directly tied to force readiness. So how can DoD ensure that service women and DoD civilians have access to wanted reproductive health care? So long as DoD is not legally allowed to provide abortion services to active-duty service women and other TRICARE dependents except under certain circumstances, there are limitations in how DoD can respond. Given the existing restrictions, our recommendations are focused on areas that would benefit the reproductive health care needs of women more broadly, such as improving understanding of policies and increasing access to contraceptive counseling. Both would provide

service women and DoD civilians with the resources and information they need to make informed decisions both before and after a pregnancy occurs.

We know from the WRHS that almost two-thirds of service women notify their supervisors within two weeks of learning that they are pregnant (Meadows et al., 2022). Requirements about notification vary by service branch: The Air Force policy indicates that women should notify their supervisors as soon as the pregnancy is confirmed, and the Navy requires notification with two weeks of an individual having confirmed a pregnancy (Department of the Air Force Manual 48-123, 2020; Naval Military Personnel Manual 1300-1306, 2018). This policy largely is intended to alert supervisors to the fact that pregnant service members might require different working conditions (e.g., avoidance of hazardous materials) and accommodations given their medical status. Although we do not advocate for forcing women to tell their supervisors of a pregnancy that they do not intend to keep, this is an existing mandatory touch point where information about reproductive health care, including abortion, could be provided. DoD could consider preparing commanders with information and training about available reproductive health care services and leave policies for their service members given their locations and state-level restrictions on provision of abortion services (Cisneros, 2022), and it also could train leaders on how to provide that information to their service members. This training also would need to clearly address how commanders who might have moral or religious objections to abortion can still meet the needs of their service members.

Efforts to lower the unintended pregnancy rates among service women and DoD civilians could both reduce the

demand for abortion and improve reproductive health. The WRHS found that among active-duty service women who experienced a prior-year unintended pregnancy, 28.8 percent had a birth control method that failed, 24.2 percent were not properly using their birth control method, and 56.2 percent were not using any birth control just before the pregnancy occurred. The 2018 HRBS found that 63.3 percent of service women who had an unintended pregnancy were not using any form of contraception just before the pregnancy and 32.8 percent were using a form of contraceptive that is not considered to be highly effective

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(e.g. condoms, oral contraceptives) (Meadows et al., 2022). Only 3.9 percent of women who experienced an unintended pregnancy were using a highly effective method (e.g., an implant or intrauterine device [IUD]) at the time of the pregnancy. We do not have explicit data on DoD civilian women, but data on women broadly in the United States can give some insights. Approximately 45 percent of pregnancies among U.S. women are unintended (Sawhill and Guyot, 2019), and of those women, 52 percent report not using contraceptives. An additional 43 percent use them inconsistently or ineffectively (Tanne, 2008).

Why are so many women using less effective methods or none at all? One reason might be discomfort with obtaining contraceptives from the MHS. The WRHS found that one-fifth of active-duty service women did not feel comfortable getting contraceptives from an MHS provider, and one-third said that they would feel more comfortable going to an outside provider. These sentiments were more likely to be endorsed by junior enlisted (E1-E4) service members, who are of prime reproductive age and report general discomfort in talking to MHS providers about reproductive health (Gaddes et al., 2019). In addition, service women might be reluctant to seek contraceptives from the MHS because they perceive pressure to use a specific type that might not align with their preferences. Looking at the data from the WRHS, 20 percent of service women indicated that they had been pressured by an MHS provider to use a certain type of contraceptive.

A second reason why women might be using less effective forms of contraception is limited knowledge of the different options available and of the varying effectiveness rates across methods and reasons for this variation (i.e., whether a method like an implant is passive and is

“always working” or whether it is a type of contraception that requires the individual to remember to use it, as is true of oral contraception). Having this information can help women and men choose the method that is right for them and their needs. Indeed, comprehensive contraceptive counseling has been shown to significantly reduce the rate of pregnancy among women who do not wish to become pregnant (Harper et al., 2015). As of the time of this writing, DoD is required to provide active-duty service women with annual comprehensive contraceptive counseling. According to Defense Health Agency Procedural Instruction (DHAPI) 6200.02 (2019), this counseling must include “counseling on the full range of contraceptive methods, including its use for menstrual suppression when medically appropriate” (p. 6). The procedural instruction defines the *full range of contraceptive methods* to include short- and long-acting methods—specifically “copper containing IUD; levonorgestrel IUD; implant; injectable; combined hormonal birth control pills; progestin-only pills; Standard Days [fertility awareness–based method]; emergency contraception; [and] female/male sterilization” (DHAPI 6200.02, 2019, p. 18). Although not mandated in the policy, DoD could consider including information about abortion resources in addition to what is already provided to service women during these provider interactions.

Unfortunately, not all service women are receiving this counseling. Data from the WRHS show that fewer than one in five women received comprehensive contraceptive counseling prior to a recent deployment. Approximately one in four active-duty service women discussed the benefits, side effects, and risks of different types of birth control with a military health care provider during their annual periodic health assessment (PHA) in the past year, which might

reflect the fact that the PHA simply asks service women whether they “wish to receive contraceptive counseling,” without any description of what it actually entails or how it could benefit them. Even if we assume that these two populations are mutually exclusive—that is, none of these service women received contraceptive counseling both during a pre-deployment visit and during their annual PHA—less than half of service women are receiving the required counseling. Ensuring that service women get the knowledge they need from military health care providers to make informed decisions about contraceptive options is critical for reducing the rate of unintended pregnancies in the military and enabling DoD to assure not only service women’s well-being but also force readiness in a post-*Dobbs* America.

DoD civilian women do not have a similar requirement for comprehensive contraception counseling. However, new provisions that require FEHBs to (1) cover the full cost of contraceptive care, (2) include emergency contraception, and (3) increase counseling and education on available types of contraception and their efficacy are encouraging (Bodenheimer, 2022). Providing no-cost contraceptive care has been shown to increase that care’s uptake and lower rates of unintended pregnancy in civilian populations (Mostafavi, 2020). Individuals covered by FEHBs often do not have access to DoD health care facilities (including hospitals and pharmacies). In states where there is concern about access to certain types of contraceptives or abortion as a result of the *Dobbs* decision, as DoD decides how to ensure that the full range of health care options remains open to service women, it also should consider making it easier for DoD civilian women to access contraceptive medication and other services through MTFs, including pharmacies.

Conclusion

Women are an integral part of the U.S. military and DoD civilian workforce. As we have shown, thousands of active-duty service women and female civilian employees are faced with the reality that the full scope of reproductive health care might be much more difficult to obtain. The possible costs to DoD are wide-ranging, including increased attrition and decreased accessions; more duty-restricted and non-deployability scenarios; and higher health care, child care, and education costs. Ultimately, the most important effect might be a decrease in force readiness and our national security. Training and education on relevant policies, increased access to and uptake of comprehensive contraceptive counseling across the workforce, and expansion of access to MTFs to civilian employees for the purposes of reproductive health all are viable responses that DoD could explore.

Ultimately, the most important effect [of the *Dobbs* decision] might be a decrease in force readiness and our national security.

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Notes

- ¹ Although we use the term *woman* or *women* throughout this piece, we recognize that these terms are not necessarily inclusive of all individuals who might seek abortion services.
- ² The Hyde Amendment restricts the use of federal funds to pay for abortion unless the mother's life is jeopardy or the pregnancy is the result of rape or incest; the amendment typically is included as a legal rider in funding legislation. See Salganicoff, Sobel, and Ramaswamy, 2021.
- ³ The 21 states are Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming.
- ⁴ For the purposes of this Perspective, only active-duty service members stationed in the continental United States were considered. This excludes the over 1 million reservists and nearly 500,000 members of the National Guard who serve and the over 160,000 service members permanently stationed overseas. Additional research is needed to understand the effect of the *Dobbs* decision on these populations and any implications for DoD overall.
- ⁵ The Defense Health Agency asked RAND to develop, field, and analyze the WRHS.

About This Perspective

In this Perspective, we use existing publicly available data to provide an estimate of the size and scope of the effects of the *Dobbs v Jackson* U.S. Supreme Court decision on the health and readiness of the U.S. armed forces. Specifically, we provide an estimate of how many active-duty service women and female Department of Defense (DoD) civilian employees might be directly affected by a full or partial ban on abortion. Furthermore, in this Perspective, we outline possible implications for reproductive health; the military health care, education, and child care systems; and on recruiting and retention. Finally, we offer a few concrete actions that DoD can take to address possible implications for women's reproductive health and ultimately for force readiness.

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