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Research Report

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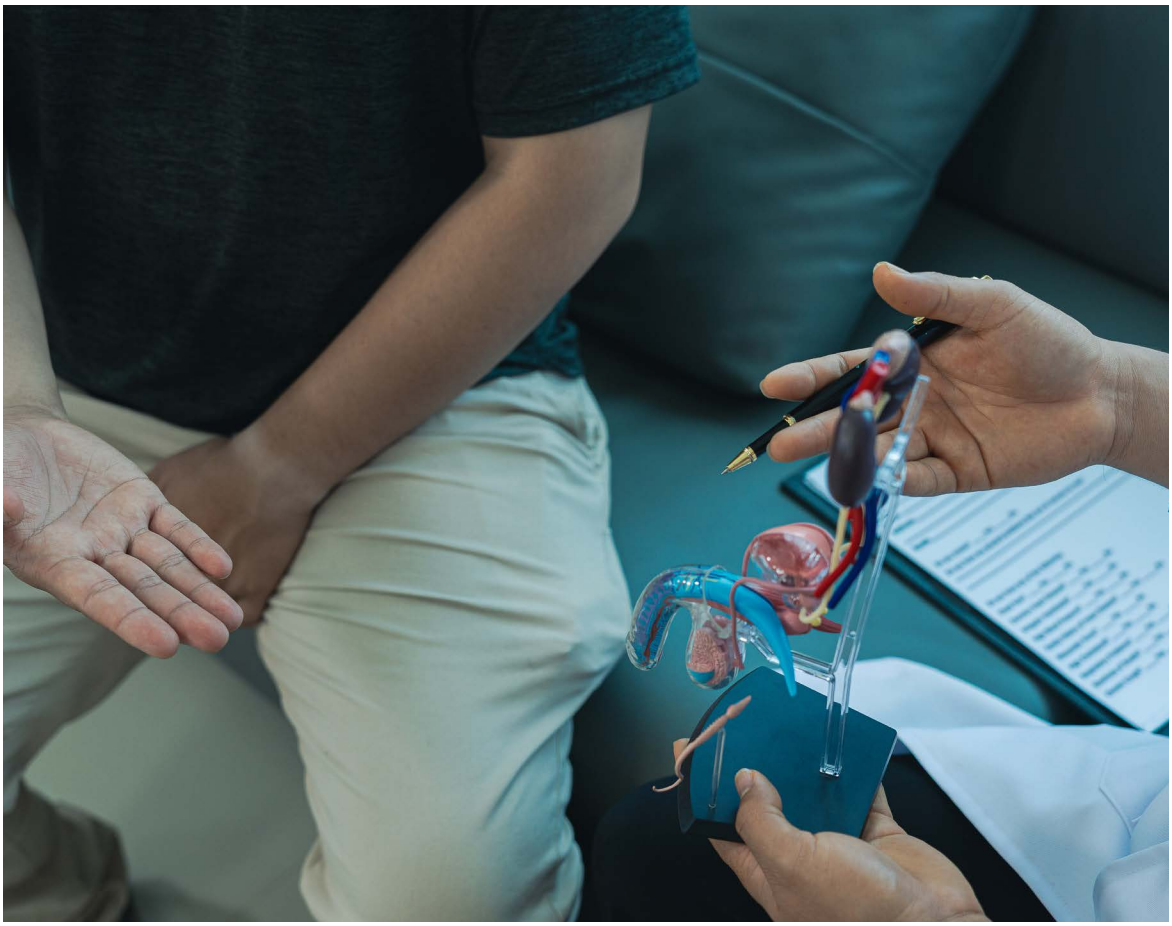
Exploring Contraceptive Care and Access Experiences of Veterans



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About This Report

Practical access to contraceptive care and the ability to choose care that meets one's needs and preferences are important for an individual's health and well-being in the United States. Although a significant amount of research has been done to examine access to contraceptive care, particularly among civilian women, there is significantly less understanding about the needs, preferences, and experiences of veteran men and women. We conducted a mixed-methods study of men and women veterans' access to, knowledge of, and use of contraception and contraceptive care.

Support for this research was provided by Arnold Ventures, a philanthropy focused on closing gaps so that all people can access, afford, and have the freedom to choose the birth control method best for them.

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Summary

Practical access to contraceptive care and the ability to choose care that meets one's needs and preferences are important for an individual's health and well-being in the United States. Although a significant amount of research has been done to examine access to contraceptive care, particularly among civilian women, there is significantly less understanding about the contraceptive needs, preferences, and experiences of veteran men and women.

Issue

Arnold Ventures Contraceptive Choice and Access program is focused on closing gaps in access and choice for all people. Veterans are an often overlooked population in the provision of contraceptive services, and prior research about birth control choice and access among veterans has generally been limited to women's experiences within the Veterans Health Administration (VHA). In this report, we seek to provide unique data-driven insights into the experiences of men and women veterans within and outside VHA that have not been adequately explored.

Approach

Our study aimed to gather a representative sample of U.S. veterans aged 18 to 49 to investigate contraceptive access and choices. We integrated a quantitative survey approach with qualitative interviews to enrich the understanding of our survey findings. Our survey development process included a review of prior validated surveys that are relevant to contraceptive access. We employed weighted analyses to ensure representative data and allow robust comparisons across different groups of veterans. In addition to the survey, we conducted 53 semi-structured interviews to delve deeper into the experiences of veterans regarding contraceptive use and access. The interviews were analyzed using a deductive approach to identify the key themes and factors that influence contraceptive decisions.

Key Findings

Our study resulted in the following key findings:

- Only about one in four veterans reported that they believe hormonal birth control is safe.
- In response to survey questions about contraceptive knowledge, veterans answered fewer than one-half of the questions correctly or indicated that they did not know the answers. Veterans' contraceptive knowledge tended to be stronger about more-general topics, such as that condoms prevent sexually transmitted infections, than about specific methods, such as the timing for vaginal rings.
- Only 10 percent of veterans discussed birth control with their providers in the past year; most of these discussions occurred outside VHA.
- Veterans reported that they trust providers to supply contraceptive information but often must raise the topic themselves.
- More than one in two veterans and their partners reported that it is very important for them not to become pregnant in the next month, and slightly more than one in five veterans are using contraceptives.

- The most used contraceptive methods reported by veterans are condoms and pills, followed by withdrawal and intrauterine devices.
- Most veterans perceived their contraceptive needs as similar to those of civilians, although a subset of veterans mentioned unique factors, such as military-related exposures (e.g., post-traumatic stress disorder, harmful substances, sensitive information), that influence their reproductive decisions.
- Veterans reported few explicit barriers to contraceptive care, although male veterans often reported that contraception is viewed as a female topic and that they are hesitant to raise it with providers.
- Supplemental analyses showed that, when compared with a civilian sample, male and female veterans had higher self-reported sterilization rates; male veterans reported lower condom use.

Recommendations

Our recommendations are as follows:

- VHA or other veteran-serving organizations should establish more-comprehensive education programs that are targeted to veterans of reproductive age and that are not gender-specific. These programs could include different learning opportunities to address common misconceptions and provide accurate information about the benefits and risks of various birth control methods.
- VHA and veteran-serving organizations should enhance communication strategies about the availability of resources and family planning and contraception benefits. By developing clear communications to convey offerings—which could include pamphlets, brochures, or other digital content on websites—VHA and other veteran-serving organizations could ensure that veterans are aware of the services that are available to them after they transition from the military.
- Veterans generally viewed providers as their most trusted source of information about contraception, yet most were not discussing contraception with their providers. VHA could consider expanding comprehensive contraceptive counseling training for providers beyond women's health primary care providers. For non-VHA providers, efforts to improve education and awareness about proactively counseling patients on their options, particularly for male patients, should be explored by medical associations for the provider specialties that would tend to reach these populations (e.g., urology, family medicine, internal medicine).

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CHAPTER 1

Introduction

Practical access to contraceptive care and the ability to choose care that meets one's needs and preferences are important for an individual's health and well-being in the United States. Although a significant amount of research has been done to examine access to contraceptive care, particularly among civilian women, there is significantly less understanding about the needs, preferences, and experiences of veteran men and women.

Contraceptive Care for Veterans

Various contraceptive services and programs are available to veterans through the Veterans Health Administration (VHA) and veteran-serving organizations. VHA provides contraceptive services as part of its medical benefits package for those who are eligible for VHA health care coverage. Benefits cover all U.S. Food and Drug Administration–approved contraceptive methods: hormonal and nonhormonal options, such as oral contraceptives, patches, rings, and injections; long-acting reversible contraceptives (LARCs), such as intrauterine devices (IUDs) and implants; barrier methods; emergency contraception; and sterilization procedures (Yecies et al., 2019). However, veterans can still incur co-payments for contraception provision (such as IUD-insertion visit costs), although many veterans are exempt from these co-payments based on service-connected disability ratings, income levels, or other eligibility factors (Yecies et al., 2019).

VHA has specific efforts to help improve access to comprehensive care. One of the main mechanisms is through VHA's requirement for all women patients to have access to designated women's health primary care providers (WH-PCPs) through one of three models (Yecies et al., 2019). These WH-PCPs receive specialized training in contraceptive counseling and provision. Women veterans' care may be delivered by a WH-PCP in a general gender-neutral primary care space (model one), a separate but shared space (model two), or a separate comprehensive Women's Health Center (model three). Of note, model three is the only model that provides fully on-site gynecological services alongside primary care (U.S. Department of Veterans Affairs, 2025).

VHA also has a Contraception on Demand program that was launched in 2021 to facilitate pharmacist-led contraceptive prescribing. The program allows pharmacists to dispense 12 months of hormonal contraceptives rather than the more common one- to three-month supply. Contraception on Demand is part of VHA's Diffusion Marketplace and has been implemented successfully at different U.S. Department of Veterans Affairs (VA) medical centers (VA Diffusion Marketplace, 2025). Also related to VHA's Diffusion Marketplace efforts is one instance of an initial investment to address men's contraceptive and family planning needs. In 2023, as part of the VHA Innovators Network's Spark-Seed-Spread Innovation Investment Program, a urologist proposed the Male Contraceptive Initiative. The initiative was funded as a "Spark" to bring more awareness to male contraceptive options by working with primary care physicians, facilitating the scheduling of vasectomy appointments, and developing decisionmaking support tools for male patients (Coffey, 2023).

Outside VHA, some veteran-serving organizations offer links to reproductive health care resources and information for specific groups of veterans, such as the Service Women's Action Network, which advocates

for service women and veteran women's reproductive health needs. The Service Women's Action Network also provides case management support and a 24-hour, seven days per week assistance hotline or Veterans in Vitro Initiative grants through the Bob Woodruff Foundation, which offers fertility support services (Bob Woodruff Foundation, 2025; Service Women's Action Network, undated).

Finally, legislative efforts have also been introduced to facilitate improved access to contraception for veterans. Most notably, the Equal Access to Contraception for Veterans Act (H.R. 211, 2025), a bipartisan bill that would prohibit VA from requiring payment from veterans for contraceptive methods that are covered under the Affordable Care Act or through the TRICARE health care program, has been repeatedly introduced but is not yet enacted.

Variations in Access and Choice

Veterans' access to and quality of care may vary based on organizational factors (e.g., whether veterans receive care in a VA facility) and personal demographics (e.g., race/ethnicity, gender identity, mental health status, experiences of homelessness). For example, contraceptive knowledge is generally low: Black and Hispanic women reported lower levels of contraceptive knowledge compared with White women (Rosenfeld et al., 2017).

Location of Care

In the population of veterans accessing care through VHA, contraceptive use and unintended pregnancy rates are similar to the U.S. population overall (73 percent compared with 70 percent and 37 percent compared with 35 percent, respectively) (Borrero et al., 2017; Yecies et al., 2019). However, studies that focused on VHA users show that choice of contraceptive method is closely tied to the quality of counseling that is provided. For instance, a survey of 358 women veterans aged 18 to 44 receiving care within VHA found that those reporting high-quality contraceptive counseling were more likely to undergo LARC placement, whereas those reporting low-quality counseling were less likely to do so (Benson et al., 2025). These results also assume that counseling is taking place. One study found that 56 percent of women veterans had not received contraceptive care or pregnancy counseling within the last year, and around 25 percent reported that they had received that care outside VHA (Quinn et al., 2023).

Questions about veteran men and women's access to and use of contraceptive services within and outside VHA remain largely unexplored. Research that examines veterans' access to health care outside VHA is especially timely because some state policies have attempted to restrict contraceptive access at the same time that abortion access is decreasing (Forouzan and Mariappuram, 2024). Although there have been national efforts to protect access to birth control, these efforts have often overlooked the needs of people with low socioeconomic status who may live in a state where Medicaid and other private insurance options do not cover birth control (Sullivan, 2024). The increase in attacks on state-based Medicaid coverage and the ability of private insurers to limit contraceptive funding (Guttmacher Institute, 2025) may mean that more veterans are relying on VHA to access contraceptive services, especially because all women veterans enrolled in VA health care are eligible for contraceptive benefits, including emergency contraceptives (U.S. Department of Veterans Affairs, 2025). Despite benefit availability, it is unclear whether VHA's infrastructure and providers will be able to support this increased demand (Schultz et al., 2023).

Differences by Sex

Women are the fastest-growing group of veterans in the United States (U.S. Department of Veterans Affairs, 2025). Twenty-eight percent of all women veterans used VHA in 2020, which represents an 11 percent increase

from 2020. Among these users, 41 percent were between the ages of 18 and 44 (Breland et al., 2024). This growing cohort of reproductive-age women veterans represents an increasing demand for clinical services, including reproductive health and contraceptive care. Previous research indicates that women who seek contraceptive care through VHA are generally able to access these services (Wolgemuth et al., 2020), although this care was often associated with access through VHA's Women's Health Clinics. Specifically, women veterans who accessed primary care at a Women's Health Clinic were more likely to receive any reproductive health service than veterans who accessed traditional VHA primary care (Callegari et al., 2022; Quinn et al., 2023). Furthermore, receiving care at a VA Women's Health Clinic is associated with receiving higher-quality contraceptive care (Callegari et al., 2022).

Studies that focused on contraceptive access and care within the VA health system suggest that there are disparities in access for women (Wolgemuth et al., 2020). For example, Hispanic and African American veteran women are significantly less likely to use a method of contraception compared with White women (Quinn et al., 2020). In the veteran population, non-White race/ethnicity and experiences of mental illness have been shown to be negatively associated with an individual using their ideal method of contraception (Judge-Golden et al., 2020). At the same time, Black and Hispanic veteran women have been shown to have lower levels of contraceptive knowledge compared with White veteran women (Rosenfeld et al., 2017).

Male veterans are more likely to use VHA health benefits, but their use of benefits is often limited to men who are older (i.e., of nonreproductive age) (National Center for Veterans Analysis and Statistics, 2023). Even though men make up a larger proportion of the veterans who are of reproductive age, there has been no research that examines their contraceptive experiences. This mirrors a larger lack of knowledge about men's contraceptive use and preferences in the civilian population. The most-recent research relies on data from almost ten years ago and suggests that unmarried men in the general population primarily rely on their female partners for contraceptive use (Daniels and Abma, 2017). Previous work suggests that young men are unknowledgeable about female-controlled contraceptive methods and report feeling disempowered about contraceptive decisionmaking (Carter et al., 2012; Marshall and Gomez, 2015).

Potential Barriers to Comprehensive Contraceptive Care

In addition to such factors as the location of health care services and sex, veterans may face barriers to accessing comprehensive contraceptive services. For example, one study of 32 veterans receiving primary care at VHA showed that women mainly perceived their contraceptive counseling experiences as negative and often felt pressured to choose certain methods (Callegari et al., 2019). Another, larger study of 189 women veterans suggests that 39 percent of women veterans perceived that limited contraceptive counseling and patient education created barriers to their use of contraceptives (Wolgemuth et al., 2020). In contrast, a cross-sectional survey of 506 veterans who received contraceptive services from a VHA primary care clinic shows that women strongly agreed that their providers listen carefully. However, only about one-half suggested that their providers offer more than one contraceptive method (Callegari et al., 2022). To our knowledge, there are no studies that examine the quality or nature of discussions among male veterans or barriers that are specific to men.

System-level factors may also serve as barriers to accessing or using preferred contraceptive methods. VHA facilities with less system-level investment in women's health (e.g., fewer gynecological staff) or with limited LARC method availability have barriers to veterans' accessing their preferred methods of contraception (Pleasure et al., 2025). These findings indicate that contraceptive use and access is affected not only by individual-level choices but also by contraceptive counseling, infrastructure, and other demographic- or health-related factors.

More broadly (i.e., affecting both veterans and civilians), there are increasing restrictions on insurance coverage for contraceptives (e.g., seven states now permit an expansive refusal clause that allows religious organizations, including hospitals, to refuse to provide coverage) or reimbursement challenges.

Study Focus

The body of evidence on veterans' contraceptive use and knowledge of and experiences with contraceptive care shows significant gaps. Additionally, from the evidence that is available, veterans' ability to use their preferred methods of contraception is uneven and influenced by the quality of counseling they receive, the availability of trained providers, and systemic disparities in access. Our study builds on the literature by examining the perspectives of male and female veterans of reproductive age who are receiving health care within and outside VHA and its network of community care providers to better understand veterans' knowledge of, counseling for, use of, and barriers to accessing preferred contraceptive methods.

Specifically, we conducted a mixed-methods study of men and women veterans' access to, knowledge of, and use of contraception and contraceptive care with the following three research aims:

1. to better understand gaps in contraceptive access and choice for veterans of reproductive age in terms of
    a. their knowledge levels about VHA contraceptive benefits and the efficacy and side effects of different contraceptive methods
    b. their engagement in comprehensive contraceptive counseling
    c. their use of and preferences for different contraceptive methods
2. to identify whether and how gaps in contraceptive access and choice might vary based on sex and where veterans receive care (i.e., VHA or non-VHA locations)
3. to determine whether there are specific barriers affecting veterans' ability to choose and access their preferred contraceptive methods within and outside VHA.

Organization of This Report

In this report, we first briefly detail the overarching methods we used to assess the state of contraceptive choice and access among U.S. veterans of reproductive age in Chapter 2. We follow this with a description of these veterans in terms of their sociodemographic and service-related characteristics and general self-reported health care access and coverage in Chapter 3, including veterans' use of VHA services. In Chapter 4, we detail our specific findings for each of the study's three main research goals. In Chapter 5, we highlight veterans' unique contraceptive needs and use. In Chapter 6, we summarize our major findings and takeaways, detail the study's limitations, and highlight policy implications and considerations for future research. In Appendix A, we present some analyses that are designed to assess the robustness of the survey data that we used for our study, and we present our interview protocol in Appendix B.

An annex to this report presents the details of the weighted descriptives for all survey items and is available at www.rand.org/t/RRA3828-1.

CHAPTER 2

Methods

For this study, we gathered a nationally representative survey sample of U.S. veterans of reproductive age (18 to 49), supplemented by qualitative data to provide contextual support to our survey findings. In this chapter, we provide a detailed description of the survey content development process, population and sampling plan, administration, analytic plan, and limitations of the approach. This is followed by a description of the supplemental qualitative interview data collection and analysis effort.

Survey Development, Administration, and Analysis

To develop the survey, we reviewed prior surveys of veterans and nonveterans that addressed contraceptive access and choice. We prioritized the review of prior validated surveys that covered issues related to contraceptive access and choice to identify candidate survey topics and items. The review included comprehensive surveys on contraception, pregnancy and birth, and reproductive health (the National Survey of Family Growth [NSFG] at National Center for Health Statistics, 2025); knowledge about contraceptive methods and side effects (Haynes et al., 2017; Shin et al., 2024); contraceptive beliefs and concerns (Rocca et al., 2024); and provider attitudes (Dehlendorf et al., 2017; Maly et al., 1998). The survey review also included veteran-specific measures, such as the National Survey of Veterans and previous RAND reports (Ramchand et al., 2024; Meadows et al., 2022).

From the content of these validated measures, we developed an item bank of possible survey topics and associated survey items. We reviewed each item individually and as a team until a consensus on which items to include and any necessary revisions was reached. Gaps in topic areas were identified, and we returned to the literature to find existing measures. If none were found, we adapted validated survey questions.

Many of the final questions that we used were drawn from the NSFG. Using the NSFG helped us ensure question validity and facilitated descriptive comparisons across samples. The NSFG also contained questions about how the respondent paid for contraceptives (e.g., insurance, co-payment, Medicaid), which we adapted to include VHA benefits. Sample measures that aligned with our study focus questions included the following:

- **Knowledge levels:** We used the 25-question, multiple-choice Contraceptive Knowledge Assessment tool, which is validated to measure the level of knowledge of contraception.
- **Engagement in contraceptive counseling:** We used section F of the NSFG, which asks about reproductive- and contraceptive-seeking behaviors, and drew from the questions on contraceptive-seeking behaviors, general contraceptive use, and barriers to contraceptive access.
- **Contraceptive preference and use:** We used section E of the NSFG, which measures contraceptive history and pregnancy wantedness for women and men, and drew from questions on use of available contraceptives (e.g., condoms, combined oral hormonal contraceptives, IUDs), date of use, whether use stopped (if used and stopped within the past 12 months), and the reasons for stopping use (if applicable).

We shared an initial draft survey with an internal expert adviser for review. Using that feedback, we revisited specific items flagged by the advisor. We then shared the survey with our survey partners NORC at the University of Chicago and Ipsos, and additional edits were made to items and survey logic. Once NORC and Ipsos programmed the final version of the survey, the survey was tested by a small number of RAND staff who were unaffiliated with the study and by members of our study team.

NORC and Ipsos used their respective well-established panels to target veterans of reproductive age in February and March 2025. We also engaged NORC to provide an additional convenience sample from an external vendor in case the sample sizes for the probability-based panels were insufficient, and the convenience sample was needed to increase the power of the sample. To compensate participants for their responses, respondents received the equivalent of $10. Below, we describe each probability-based panel's processes for data collection.

An overview of the survey methodology is also provided below by vendor. Additional details about survey recruitment, sampling and response, weights, variables, and all analyses are available on request.

Recruitment

Respondents to our 2025 veteran contraceptive survey were recruited through two probability-based samples of U.S. adults designed to be representative of U.S. households: NORC's AmeriSpeak and Ipsos's KnowledgePanel. AmeriSpeak technical documentation describes the organization as follows:

> Funded and operated by NORC at the University of Chicago, AmeriSpeak® is a probability-based panel designed to be representative of the US household population. Randomly selected US households are sampled with a known, non-zero probability of selection from the NORC National Sample Frame, and then contacted by US mail, telephone interviewers, overnight express mailers, and field interviewers (face to face). AmeriSpeak panelists participate in NORC studies or studies conducted by NORC on behalf of NORC's clients. The panel provides sample coverage of approximately 97% of the U.S. household population. Those excluded from the sample include people with P.O. Box only addresses, some addresses not listed in the USPS Delivery Sequence File, and some newly constructed dwellings. While most AmeriSpeak households participate in surveys by web, non-internet households can participate in AmeriSpeak surveys by telephone. Households without conventional internet access but having web access via smartphones are allowed to participate in AmeriSpeak surveys by web. (NORC at the University of Chicago, 2025)

Ipsos's KnowledgePanel methodology is described as follows:

> KnowledgePanel provides probability-based samples with an "organic" representation of the study population for measurement of public opinions, attitudes, and behaviors. Panel members are randomly selected so that survey results can properly represent the U.S. population with a measurable level of accuracy and a calculable response rate. . . . KnowledgePanel's recruitment process was originally based exclusively on a national random-digit dial (RDD) sampling methodology. In 2009, in light of the growing proportion of cellphone-only households, Ipsos migrated to an ABS [address-based sampling] recruitment methodology via the U.S. Postal Service's Delivery Sequence File. ABS not only improves population coverage, but also provides a more effective means for recruiting hard-to-reach individuals, such as cellphone-only households, non-internet households, young adults, and persons of color. Households without an internet connection are provided with a web-enabled device and free internet service. (Ipsos, 2025)

Sampling and Response Rates

When the survey was conducted in spring 2025, the size of the AmeriSpeak panel was 65,884 panel members who are age 13 and older. The probability sample for our study was made up of all AmeriSpeak panelists who indicated on previous surveys that they had served in the military (n = 1,335). A total of 275 panelists completed the screener questions that determined survey eligibility. Among those panelists, 206 were determined to be eligible based on their responses. The median time to complete the survey online and by phone was 16 minutes.

Ipsos also administered our 2025 veterans contraceptive survey to its KnowledgePanel. KnowledgePanel targeted 484 known veterans and 180 panelists who were profiled as active-duty panelists from its probability sample. A total of 369 known veterans and 138 from those profiled as active duty completed the screener questions. After data checks, the number of qualified survey completions was 340 (315 from the known veteran sample and 25 from the active-duty sample, indicating that a small portion had transitioned from active duty to civilian life). The cumulative response rate was 4.4 percent. After additional data checks, we removed four respondents from the sample. The median completion time of the web-based survey was 14 minutes.

Weights

Weights were applied to our analyses to account for the probability of selection in the study and to adjust responses so that they reflected the population of U.S. veterans aged 18 to 49. Respondents from the individual panels (KnowledgePanel and AmeriSpeak) were weighted separately, and then a different set of weights was created and applied to the data from both panels when combined. The processes we used to create the weights are described below. The U.S. Census Bureau's Current Population Survey (CPS) was used to construct population benchmarks (U.S. Census Bureau, 2024b). NORC and Ipsos created the weights that were applied to their respective panels.

AmeriSpeak weights: To weight the respondents from the AmeriSpeak panel, NORC first constructed *panel weights* to account for selection into the panel. To do this, household-level nonresponse weights were constructed as the inverse of the probability of selection from the NORC National Frame. These were then adjusted using weighting classes defined by some household characteristics. Household nonresponse weights were post-stratified to match the number of households per census division obtained from the most recent CPS. Person-level weights were then adjusted to compensate for nonresponding adults within a recruited household. The nonresponse-adjusted person-level weights were then raked to population totals associated with age, gender, census division, race/ethnicity, education, housing tenure, household phone status, the interaction of age and gender, and the interaction of age and race/ethnicity.

We constructed a set of *study-specific weights* to ensure that the final analytic sample of U.S. veterans aged 18 to 49 represented its respective population. This step effectively adjusted the base weights for nonresponse. These adjustments were made across the same set of variables that were used to create the base weights. Extreme weights were trimmed to reduce the impact of individual cases.

KnowledgePanel weights: Study weights were applied to KnowledgePanel respondents using similar procedures. First, we developed panel weights by adjusting the entire KnowledgePanel to match benchmarks from the U.S. Census Bureau's American Community Survey (ACS) and CPS across the following dimensions: gender, age, race/ethnicity, education, census region, household income, home ownership, household size, metropolitan area, Hispanic origin, and language dominance.

The base weights were then adjusted to benchmarks that are specific to the U.S. veteran population aged 18 to 49, as taken from the 2023 ACS data. We used the characteristics of gender, age, race/ethnicity, census region, metropolitan status, education, and household income. (Note that benchmarks for metropoli-

tan status were taken from the CPS August 2023 Veterans Supplement at U.S. Census Bureau, 2024a.) The KnowledgePanel weights were trimmed to reduce the influence of extreme weights.

Final Weights

The KnowledgePanel and AmeriSpeak weights yielded comparable results when applied to respondents from their respective panels (see Figure A.1 in Appendix A). However, differences were seen in household income, which is not surprising given that the AmeriSpeak respondents were not weighted across income. Therefore, we elected to create a final set of weights, which involved applying a calibration procedure to the concatenated AmeriSpeak and KnowledgePanel data while using their respective weights as input. This procedure used the benchmarks from the KnowledgePanel weighting. The top and bottom 1.5 percent of the resulting weights were trimmed, yielding the final weights. The benchmarks and diagnostics of the various sets of weights we discussed are presented in Table 2.1.

Analyses

We conducted descriptive survey analyses to identify contraceptive knowledge, preferences, use, and barriers among veterans. We also used statistical testing to help identify areas of significant differences between variables of interest identified a priori (i.e., VHA or non-VHA care, sex) and age group on two contraceptive outcomes of interest:

- **Contraceptive use:** For the contraceptive use outcome and comparing differences between groups, we relied primarily on self-reported use. However, in cases in which self-reported use was not reasonable or likely accurate (i.e., for men, birth control pills, IUDs, injectables, hormonal implants, female condoms, cervical caps, and emergency contraception use; for women, male condoms and withdrawal), this was replaced by a response about the partner's use. For responses from both genders (e.g., fertility awareness methods, spermicides), self-reported use and partner use were combined.
- **Engagement in contraceptive counseling:** This outcome used individual responses to a multi-select item on the survey to understand whether providers engaged with veterans in discussions about birth control, condom use, and the human papillomavirus (HPV) vaccine or whether providers had no discussions.

Sex was already dichotomized from the survey responses. To better understand the groups who are potentially accessing VHA and non-VHA care, we developed a proxy variable drawn from those who accessed health care services in the past 12 months and distinguished those who reported enrollment in VA health benefits from those who did not report enrollment. This proxy measure was used because of interpretation issues for a different item in the survey that asked about the location of health care services accessed in the past year (i.e., within VHA and the Community Care Network or outside VHA and the Community Care Network). Specifically, respondents sometimes selected that they received health care services outside VHA, but when the interviewer clarified those responses, the interviewer determined that sometimes these services were referrals to VA community care, often to see specialists. Thus, although enrollment is a rough proxy for access to VHA care (because it may not mean that someone is actually using VHA care), after a review of the data, we had more confidence in the reliability and validity of this item. This is discussed further in the "Limitations" section in Chapter 6. For age, we dichotomized younger and older veterans of reproductive age. We used age 35 and older as the cutoff point for those considered of older reproductive age, drawing primarily from definitions of advanced maternal ages. These analyses were intended to isolate the effects of individual characteristics that we anticipated might affect access and choice. It is likely that, if looked at in combination (i.e., younger females), the effect estimates would be larger, but this presented feasibility challenges given the lower number of younger veterans and female veterans.

TABLE 2.1

Benchmarks and Diagnostics of the Various Sets of Study Weights

Characteristic	Benchmarks (%)	NORC Weights (%)	Ipsos Weights (%)	Combined Untrimmed (%)	Final (trimmed) (%)
Gender					
Male	81.8	81.1	80.5	81.8	81.4
Female	18.2	18.9	19.5	18.2	18.6
Age					
0–34	33.3	28.2	37.3	33.3	32.5
35–39	21.1	23.0	20.2	21.0	21.3
40–44	23.5	24.7	21.9	23.5	23.6
44–49	22.3	24.2	20.6	22.2	22.7
Race/ethnicity					
White	61.0	59.9	60.0	61.0	60.8
Black	13.9	14.3	14.2	13.9	14.0
Other	10.2	10.3	10.5	10.2	10.3
Hispanic	14.9	15.5	15.4	14.9	14.8
Education					
Less than high school or high school	24.1	21.1	24.8	24.1	23.4
Some college	41.4	41.8	41.3	41.4	41.5
Bachelor's or higher	34.5	37.1	34.0	34.5	35.1
Census region					
Northeast	10.6	11.4	11.3	10.6	10.7
Midwest	18.0	18.9	19.1	18.0	18.3
South	48.1	45.2	46.8	48.1	47.4
West	23.4	24.5	22.7	23.4	23.7
Metropolitan status					
Non-metro	12.9	13.9	16.1	12.9	12.9
Metro	87.1	86.1	83.9	87.1	87.1
Income					
Under $25,000	5.3	5.4	12.1	5.3	5.4
$25,000 to $49,999	9.6	10.0	16.7	9.6	9.5
$50,000 to $74,999	13.8	14.7	12.0	13.8	13.9
$75,000 to $99,999	14.2	15.2	16.7	14.2	14.4
$100,000 to $149,999	26.1	23.4	27.6	26.1	26.2
$150,000 and above	31.0	31.2	14.9	31.0	30.6
Design effect	—	1.89	1.93	2.38	2.24

All analyses were conducted using weighted analyses in R. Comparisons between populations were conducted using weighted differences in means. Missing data were not imputed and listwise deletion was used in inferential analyses.

Interviews

We conducted 53 semi-structured interviews with purposively sampled survey respondents who agreed to be contacted in their survey responses.[1] We developed a semi-structured interview guide based on the research questions. The interviews were intended to provide descriptive data about men and women veterans' experiences with contraceptives and the contraceptive counseling process (see Appendix B for the interview guide). To incentivize participation in the interviews, we provided the equivalent of $100 compensation to those who completed the interview.

We contacted potential participants via email to invite them to complete an interview and sent up to three reminder emails over the three-month field period. We reached a total of 120 potential participants to complete 53 interviews (a 44 percent interview completion rate). Fifty-seven people did not respond to our emails, two declined to participate, four did not meet eligibility requirements (i.e., they were still on active duty or in the reserves and never activated), and four were not able to be contacted (i.e., our email was undeliverable or the email address was incomplete).

All interviews were conducted via Zoom from April 2025 to May 2025, and the interviews averaged 38 minutes each. An interviewer and a notetaker were present for all interviews, and all interviews were recorded and transcribed with the participants' consent. The transcripts were then reviewed and cleaned to ensure that they were accurate and contained no personally identifiable information.

A RAND team of seven interviewers conducted the interviews. The team met to review the interview protocol before the start of data collection and then met weekly during the field period to discuss questions and make minor refinements to the protocol.

We only received identifiable information from respondents who agreed to be contacted for a semi-structured interview. Otherwise, NORC and Ipsos provided de-identified survey responses that were kept as raw data files on an internal RAND SharePoint site. Contact information was kept on an internal RAND SharePoint site that only members of our team, who have requisite human subjects protection training, could access. These data, along with a codebook that links respondent identification to survey and interview data, were kept separate from interview recordings and transcript data. The recordings were deleted once the transcripts were confirmed complete.

Analyses

We used a deductive approach to analyze the interviews (Fife and Gossner, 2024). An initial coding book was created with a focus on the key research questions (e.g., knowledge of contraception options, factors that influenced contraceptive choice) and literature. Each interview was coded by at least one team member using Dedoose (undated). Some interviews were coded twice to develop a coding consensus among team members. To allow a mixed-methods analysis, key demographic and contraceptive use answers from the survey (i.e., descriptive information) were uploaded to Dedoose. After coding was complete, coding excerpts,

[1] The interviews included three participants who were not included in our main survey analysis; we conducted an additional three interviews beyond the 50 planned interviews to assess some of the potential comparability of our convenience sample. We opted to retain the data from those interviews for qualitative insights because there were no apparent differences in the types of experiences and perspectives reported.

along with the corresponding descriptive information, were downloaded into a Microsoft Excel spreadsheet. We further analyzed themes within each code (e.g., the influence of partners on contraceptive choice). For some constructs, we also used RAND's internal artificial intelligence chatbot to confirm themes identified by the analysts. Descriptive information was used to identify whether certain key themes resonated more among respondents who identified as male or female, used specific contraceptive methods or were sterilized, discussed contraception with their doctors, were partnered or married, and were enrolled in VHA care and accessed or did not access health care services within the past 12 months.

For key themes that pertained to the research questions, we used the thresholds in Table 2.2 to describe the qualitative interview responses.

TABLE 2.2
Thresholds for Reporting Qualitative Data, by Interview

Category	Description
Few	Fewer than 10 percent of interviews
Some	10 percent or more but fewer than 40 percent of interviews
Many	40 percent or more but fewer than 75 percent of interviews
Most	75 percent or more but fewer than 95 percent of interviews
Almost all	All focus groups (95 percent or more of interviews)

NOTE: In describing all veterans, the number of total interviews (n = 53) is the denominator. However, in describing particular groups of veterans (e.g., male veterans), the denominator is calculated based on those who participated with that particular descriptive.

CHAPTER 3

Demographics and Health-Seeking Behaviors Among Veterans

In this chapter, we detail some key descriptives about the combined weighted survey panel sample and provide additional details and comparison points for our interview sample (n = 53 and a subset of the overall sample).[1] In the annex to this report, which is available separately, we present the details of the weighted descriptives for all survey items, disaggregated by sex and overall.

Sociodemographic Characteristics

Approximately 80 percent of the veterans we surveyed were male. The age range was limited to those of *reproductive age* (defined as 18 to 49), with the largest age group in the 35 to 44 age range (45 percent), followed by the 25 to 34 age range (31 percent) and the 45 to 54 age range (23 percent). The majority of the surveyed veterans were White and non-Hispanic (61 percent). Most surveyed veterans spoke only English at home (83 percent). About one-third identified as disabled or as a person with a disability. Most survey participants (about 75 percent) completed some college or completed their bachelor's or an advanced degree. By region, about one-half of the sample (47 percent) lived in the South, followed by 24 percent in the West. Table 3.1 details the specific demographic characteristics.

[1] Sample sizes are not included because such information can be misleading for weighted samples when presented as either weighted or unweighted values.

TABLE 3.1
Individual Demographics

Characteristic	Percentage (%)
Sex	
Male	81
Female	18
Transgender	<1
Does not identify as male, female, or transgender	<1
Age group	
18–24	1.8
25–34	31
35–44	45
45–54	23
Race/ethnicity	
White, non-Hispanic	61
Black, non-Hispanic	14
Hispanic	15
Other, non-Hispanic	10
Speak a language other than English at home	
Yes	17
No	83
Not answered	<0.1
Identify as a disabled person or a person with a disability	
Yes	31
No	69
Education level	
Less than high school	3
High school graduate or equivalent	20
Some college or associate's degree	41
Bachelor's degree	20
Postgraduate study or professional degree	15
Region	
Northeast	11
Midwest	18
South	47
West	24

NOTE: The percentages do not add to 100% because of rounding.

The survey also captured key variables about marital status and household characteristics (see Table 3.2). Most of the surveyed veterans were married (73 percent) and more than one-half (60 percent) were the parents or guardians of minors. Almost one-half (48 percent) of surveyed veterans lived in households of four or more people. More than one-half (57 percent) reported household incomes of $100,000 or higher.

TABLE 3.2
Marital Status and Household Characteristics

Item	Female (%)	Male (%)	Total (%)
Marital status			
Married	75	72	73
Not married but living together with a partner	7	6	6
Widowed	2	2	2
Divorced or annulled	7	7	7
Separated	1	2	2
Never married	9	11	10
Parent or legal guardian of any minors under the age of 18			
Yes	65	58	60
No	35	42	40
Household size (including children)			
One person (lives by themselves)	6	13	11
Two persons	28	20	21
Three persons	18	19	19
Four persons	22	28	27
Five persons	18	13	14
Six or more persons	9	7	7
Household income			
Under $10,000	2	2	2
$10,000 to $24,999	6	3	4
$25,000 to $49,999	12	9	10
$50,000 to $74,999	9	15	14
$75,000 to $99,999	16	14	14
$100,000 to $149,999	30	25	26
$150,000 or more	24	32	31

NOTE: The percentages do not add to 100% because of rounding.

Interview participants included veterans who lived in large cities or urban areas. When those veterans were asked specifically about distance to health care facilities, they noted that they are in close proximity to health care facilities (e.g., five minutes to 20 minutes). Although traffic could add time to travel to health care facilities, those who lived in suburban areas estimated that they spent 20 minutes to 30 minutes driving to their health care appointments. Those who lived in smaller towns or more-rural or remote areas noted that they sometimes needed to travel up to four hours to reach the nearest health care facility.

Military- and Veteran-Related Characteristics

All survey respondents were required to indicate that they at one point served on active duty and were no longer on active duty at the time of the survey. Veterans served across all branches of service; the largest proportion served in the U.S. Army (34 percent), followed by the U.S. Navy (17 percent), U.S. Army National Guard (16 percent), U.S. Marine Corps (15 percent), and U.S. Air Force (14 percent). Out of those who self-identified as having a disability, about one in three (34 percent) reported a service-connected disability. Forty-four percent reported serving in a combat or war zone, and 47 percent reported likely or definite exposure to environmental hazards during their military service (see Table 3.3).

The veterans in our interview sample served across all military branches (i.e., Army, Air Force, Navy, Marine Corps, and National Guard) with lengths of service ranging from one year to 20 years or more. Some participants reported being deployed (e.g., Iraq, Afghanistan, Kuwait) for varying durations, and some participants reported being deployed for multiple tours. Interview participants held various roles while in service, including medic, military intelligence, logistical support, and administrative positions. Overall, interview participants had a variety of military service experiences prior to transitioning to civilian life.

Health Care Access and Coverage

Seventy-five percent of surveyed veterans had used health care services in the past 12 months. Forty percent indicated that those health care services were received at a VHA facility or through VA community care, and 49 percent reported that the health care services were received outside VHA.[2] Almost all veterans (97 percent) had health insurance coverage of some kind; this tended to be coverage through a current or former employer (54 percent), VHA (43 percent), or TRICARE (15 percent). Most veterans (87 percent) indicated that they were the primary insurance holder. About three in ten veterans reported more than one type of coverage (30 percent for females and 29 percent for males). Details are provided in Table 3.4.

Accessing Care Through the Veterans Health Administration

When veterans were prompted for reasons they did not access VHA health care in the past 12 months, the most common reasons were not needing care (27 percent) and using other sources of

[2] Although we observed relatively similar numbers of veterans seeking care through VHA and outside VHA, subsequent interviews with some respondents revealed that they may have misinterpreted this item. Specifically, some respondents received care through VA's Community Care Network, and that was the only care they received "outside VHA." Thus, we caution interpretations based on this item given validity concerns.

TABLE 3.3

Characteristics Related to Military Service for Service Participants

Item	Female (%)	Male (%)	Total (%)
What branch(es) of service were you a part of?			
Army (active component)	46	31	34
Navy (active component)	15	17	17
Army National Guard	9	18	16
Marine Corps (active component)	8	17	15
Air Force (active component)	14	14	14
Army Reserve	7	7	7
Air National Guard	6	3	3
Air Force Reserve	3	3	3
Coast Guard	4	3	3
Marine Corps Reserve	1	2	1
Coast Guard Reserve	1	2	1
Navy Reserve	0	2	1
Space Force	<1	<1	<1
Do you have a service-connected disability rating?			
Yes (such as 0%, 19%, 20% . . . 100%)	61	67	66
No	39	33	34
Did you ever serve in a combat or war zone?			
Yes	23	48	44
No	77	52	56
During your military service, were you ever exposed to environmental hazards, such as Agent Orange, chemical warfare agents, burn pits, ionizing radiation, or other potentially toxic substances?			
Definitely yes	15	29	26
Probably yes	27	20	21
Probably no	12	18	17
Definitely no	25	21	22
Don’t know	21	12	14

TABLE 3.4
Access to General Health Care Services and Coverage

Item	Female (%)	Male (%)	Total (%)
Are you currently covered by any of the following types of health insurance or health coverage plans?			
Insurance through a current or former employer or union (of yours or another family member)	55	53	54
VA	36	44	43
TRICARE, TRICARE for Life, or other military health care	21	14	15
Medicaid, Medical Assistance, or government-assistance plan for those with low incomes or a disability	12	7	8
No health insurance	6	6	6
Any other type of health insurance or health coverage plan	3	3	3
Insurance purchased directly from an insurance company (by you or another family member)	2	2	2
Medicare, for people 65 and older or people with certain disabilities	1	1	1
Indian Health Service	0	1	1
Are you the primary insured or are you covered by someone else's insurance?			
I am the primary insurance holder	63	93	87
My partner is the primary insurance holder	35	6	12
My parent is the primary insurance holder	<1	<1	<1
Other	2	1	1
In the past 12 months, did you use any health care services?			
Yes—I received health care services at a VA facility or clinic or through VA's Community Care Network	36	41	40
Yes—I received health care services outside VA	59	47	49
No—I did not receive any health care services	16	27	25

care (27 percent). These reasons were followed by veterans not believing they were entitled to or eligible for care and concerns about the quality of care at VHA. Additional reasons are detailed in Figure 3.1.

When we examined access to VA health care services more closely (see Table 3.5), more than one-half of veterans (59 percent) reported enrolling in VHA health benefits at some point. For those who indicated that they had *never* used VHA health benefits, the most-common reasons mirrored the reasons of those who did not access care in the past 12 months (i.e., not needing care [33 percent] and using other sources for care [22 percent]). These reasons were followed by a lack of awareness about VHA health benefits (18 percent), concerns that VHA care would not be as good as care in other settings (17 percent), and never considering getting care from VHA (16 percent).

FIGURE 3.1

Reasons for Not Accessing U.S. Veterans Health Administration Services in the Past 12 Months

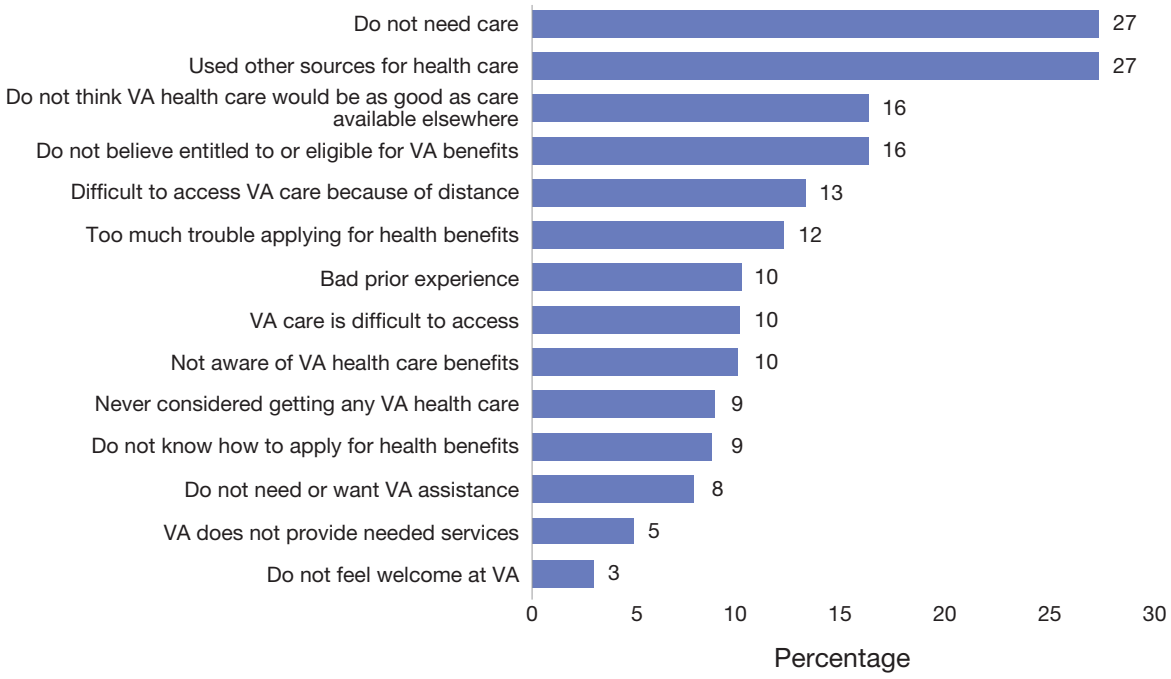


TABLE 3.5

Access to U.S. Veterans Health Administration Health Care Services

Item	Female (%)	Male (%)	Total (%)
Have you ever been enrolled in VA health care?			
Yes	54	60	59
No	36	35	35
Don't know	10	5	6
What are the reasons you never used any VA health care benefits?			
Did not need any care	18	36	33
I use other sources for health care	25	16	22
Not aware of VA health care benefits	22	12	18
Do not think VA health care would be as good as that available elsewhere	8	12	17
Never considered getting any health care from VA	6	14	16
VA care is difficult to access (parking, distance, appointment availability)	12	15	15
Too much trouble or red tape	25	15	14
Not entitled to or eligible for health care benefits	12	18	13
Did not need or want assistance from VA	37	19	13
Do not know how to apply for health care benefits	7	17	12
Applied, but was told that I am not eligible	1	9	8

All veterans were asked about their level of agreement with the care available from VHA (see Figure 3.2). Most (56 percent) reported that if health care costs increased, they would use VHA more. More than one-half (52 percent) reported having a health care provider outside VHA whom they really trusted.

In interviews, veterans reflected on their experiences—or lack thereof—with VHA care. Those who accessed VHA shared a variety of experiences, some positive and some negative. Some veterans reflected on the differences they perceived between VHA, VA community care, and care outside the VHA network.

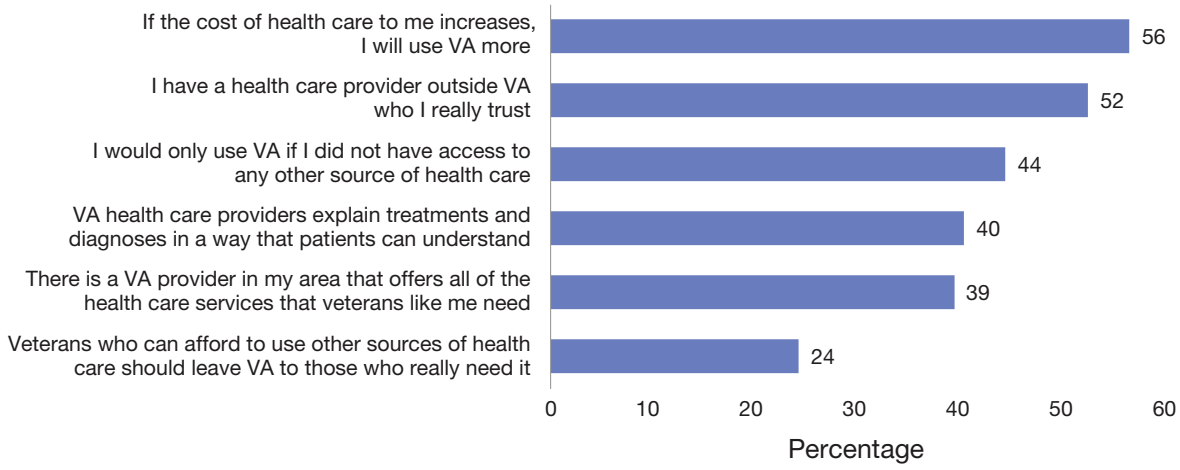
> It's definitely a different atmosphere getting seen as a civilian. . . . I feel like it's quicker, definitely quicker, on the civilian side. I feel like there's more education on the civilian side than there is on the VA side. I do like the respect though. I will say, like the respect that we're given in the VA. . . . I feel like the mental health piece is big in the VA too and that's not really on the civilian side of things. —*Female, 35–39, Received care through VHA and outside VHA*

> I have this medical condition, and I needed to see a specialist, and they referred me to community care to see the specialist. . . . They're pretty good with linking you up with the care that you need if they're unable to do it at the VA. —*Female, 40–44, Received health care through VA community care*

> Access and availability through the VA is a little complicated. . . . If you want condoms or vasectomy services, the coverage, the referral process, the follow-up care, it's pretty difficult. . . . So, say if you want counseling on shared contraception responsibility, there's none of that. When you meet with your care providers, you're the one that has to be the one to do the follow-ups. And if you want extra care, you're the one that has to go above and beyond, and they don't actually provide it. . . . General health care is fine . . . most of the treatments you get have to do with connective service. So, any injuries you've got during your service is what they mostly continue. So as pertains to me, I got hit with an IED [improvised explosive device]. So, I'm color-blind, and then I have injuries to my knee, my ankle, my legs, so they continuously do care for that. Because of COVID [coronavirus disease], I'm actually dealing right now with blood clots, so that's a very difficult transition. —*Male, 35–39, Received health care at VHA*

FIGURE 3.2

Perceptions of Veterans Health Administration Care and Use



Sexual and Reproductive History

Survey respondents completed details about their sexual and reproductive history (e.g., number of sexual partners by sex, pregnancy intention and pregnancy history (females only), and ability to have or father a child). Veterans also reported on the current importance of not being pregnant. These data help provide needed context for the reported access to and use of contraceptive-related care and methods discussed in Chapter 4.

In terms of sexual history, 93 percent of women had had sexual intercourse with a man in their lives (and 10 percent of men reported doing so), and 94 percent of men had had sexual intercourse with a woman in their lives (and 26 percent of women reported doing so). Veterans had an average (median) of one sexual partner in the past 12 months.

One-half of veterans (50 percent) reported that it was very important for them or their partner to avoid becoming pregnant in the next month; 34 percent indicated that it was not important or not very important. Two percent of female veterans were pregnant at the time of the survey. The majority of female veterans (86 percent) reported being pregnant one or more times in their lives (see Table 3.6).

Finally, veterans shared details about whether it was possible for them or their partners to have or father a child (see Table 3.7). A little more than one in four (28 percent) of male veterans had had an operation to make it impossible to have a child (among those respondents, 97 percent noted a vasectomy, and 3 percent noted a different operation). Overall, 12 percent of veterans had undergone a sterilizing operation in the past 12 months. On average, 4 percent of veterans had reversed their sterilizing operation (8 percent for females and 2 percent for males).

TABLE 3.6
Pregnancy Intention and History Among Veterans

Item	Female (%)	Male (%)	Total (%)
How important is it for you or your partner to avoid becoming pregnant in the next month?			
Very important	59	48	50
Somewhat important	9	12	12
Not very important	2	6	5
Not important at all	26	30	29
Don't know	4	4	4
Number of times pregnant in life *(females only)*			
0	12	N/A	12
1	19	N/A	19
2	21	N/A	21
3	22	N/A	22
4 or more	24	N/A	24

NOTE: N/A = not applicable. The percentages do not add to 100% because of rounding.

TABLE 3.7
Reported Ability to Have or Father a Child Among Veterans

Item	Males (%)	Females (%)
Have you ever had a vasectomy or any other operation that makes it impossible for you to father a child? *(males)* or Have you ever had any operation that makes it impossible for you to have a or another baby (e.g., tubal ligation, hysterectomy, ovaries removed)? *(females)*		
Yes	28	38
No	72	62
As far as you know, has your partner ever had an operation that made it impossible for her to have a baby? *(males)* or Has your partner ever had a vasectomy or any other operation that would make it impossible for him to father a baby in the future? *(females)*		
Yes	23	38
No	73	62
Don't know	4	0
Where was your vasectomy or your sterilizing operation performed?		
VA hospital	13	5
VA health care clinic	0	1
Family planning clinic (e.g., Planned Parenthood)	8	0
Non-VA health care clinic (e.g., a doctor's office)	52	5
Non-VA hospital	23	76
Some other place	3	14
Please select all of the ways in which the bill for this operation was paid. [Select all that apply]		
Insurance	27	71
Co-payment or out-of-pocket payment	0	47
Medicaid	4	25
No payment required	19	4
Some other way	2	2

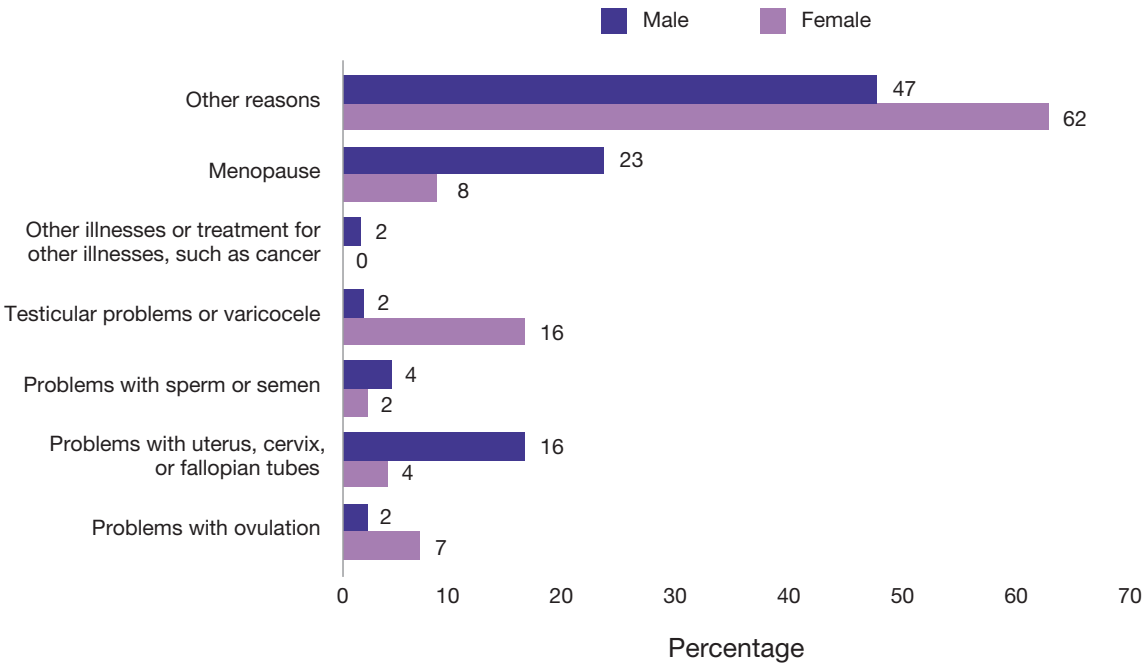
NOTE: The percentages do not add to 100% because of rounding.

In addition to past history of sterilization procedures, veterans were asked whether it was physically possible for them or their sexual partner to have a baby or another baby. Twelve percent indicated that it was not possible.[3] As shown in Figure 3.3, the top two most common reasons it was not possible were "Other reasons" and "Menopause," followed by "Problems with uterus, cervix, or fallopian tubes."

[3] This question had a high proportion of unanswered responses (44 percent). This may be due to the lack of a "Don't know" option.

FIGURE 3.3

Reasons Reported for It Being Impossible for the Veteran or Their Partner to Have a Child, by Sex



CHAPTER 4

Findings by Research Aim

This study was designed with the following research aims:

1. to better understand gaps in contraceptive access and choice for veterans of reproductive age, in terms of
    a. their knowledge levels about VHA contraceptive benefits and the efficacy and side effects of different contraceptive methods
    b. their engagement in comprehensive contraceptive counseling
    c. their use of and preferences for different contraceptive methods
2. to identify whether and how gaps in contraceptive access and choice might vary based on sex and where veterans receive care (i.e., VHA or non-VHA locations)
3. to determine whether there are specific barriers affecting veterans' ability to choose and access their preferred contraceptive methods both within and outside VHA.

In this chapter, we detail the findings from our survey and supplemental interviews in accordance with each of these research aims. Our survey findings are generally presented first, followed by additional context from the interview sample. Percentages for all survey items and responses are provided in the annex to this report, which is available separately; in this chapter, we present selected findings from all items.

Research Aim 1: Gaps in Contraceptive Access and Choice for Veterans

With our first research aim, we sought to better understand gaps in contraceptive access and choice for veterans of reproductive age in terms of their knowledge levels about VHA contraceptive benefits and the efficacy and side effects of different contraceptive methods. In this section, we detail overall takeaways and patterns. We follow this with details of variations by variables, such as sex or source of contraceptive care (i.e., VHA or non-VHA), in the next section.

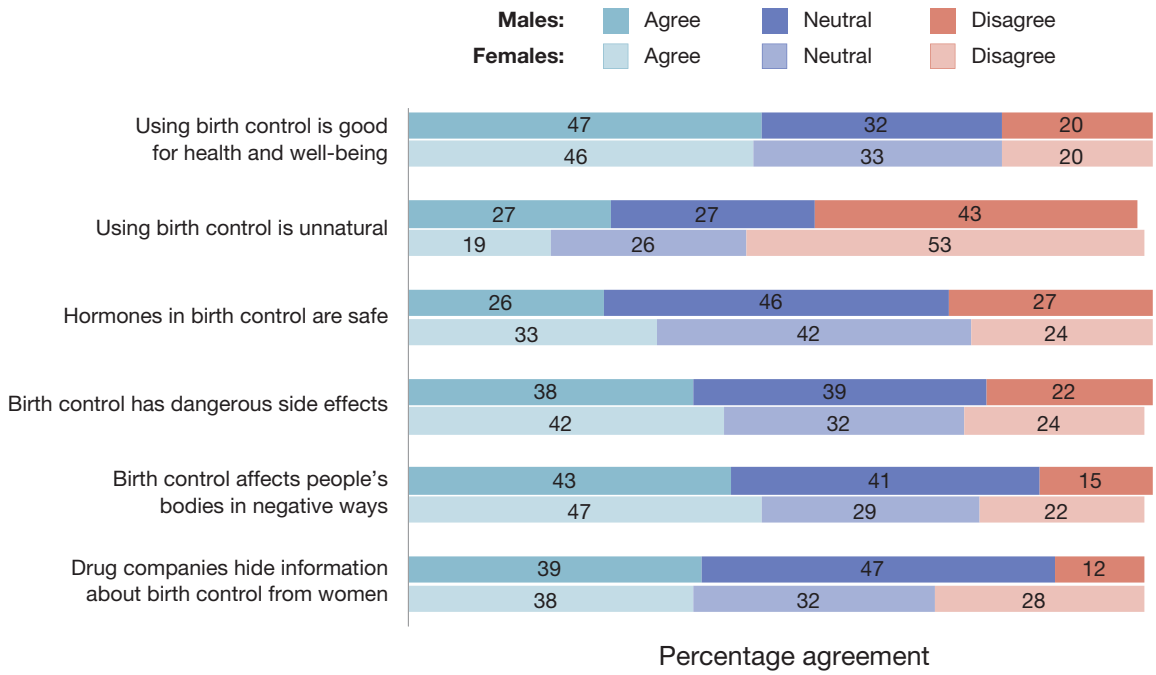
Knowledge Levels

The survey assessed several aspects of veterans' knowledge of and perceptions of contraception and how it may affect the people who are taking it. In our assessment of the general perceptions of birth control, there tended to be mixed views, and many veterans reported being neutral on certain aspects. For example, just under one-half (48 percent) of veterans agreed or strongly agreed that using birth control is good for health and well-being, and a similar but slightly smaller proportion (44 percent) of veterans agreed that birth control affects people's bodies in negative ways (see Figure 4.1).

We also included 19 multiple-choice questions for all participants to gauge their knowledge levels about contraception and specific methods. The median score of correct responses was eight of 19 (42 percent),

FIGURE 4.1

Veterans' Perceptions of Birth Control for Males and Females



NOTE: Percentages do not add to 100 percent because some individuals did not respond.

with females (median = 11.0, 58 percent) scoring higher than males (median = 7.0, 37 percent). Participants scored highest when asked (1) which birth control method helps prevent sexually transmitted infections (STIs) (80 percent correctly selected male and female condoms), (2) which statement about withdrawal is true (76 percent correctly selected that semen may be released before ejaculation), and (3) which birth control method is not easily noticed by a partner (68 percent correctly selected IUD) (see Table 4.1). Participants scored lowest when asked (1) how long the vaginal ring should stay in place before changing it (8 percent correctly selected three weeks), (2) whether emergency contraceptive pills can end a pregnancy in its earliest stages (15 percent correctly answered false), and (3) whether women must have a pelvic exam to receive the birth control pill (18 percent correctly answered false). Notably, only 54 percent correctly identified that birth control pills are not effective if a woman does not take them for two or three days in a row (compared with 7 percent who said that birth control pills are effective even if not taken several days in a row and 38 percent who said that they did not know). Among the 11 percent of veterans who reported using birth control pills (self or partner use), the percentage of participants answering correctly rose to 60 percent.

We examined differences in contraception knowledge levels by sex for these items, particularly because some items are specific to female-only contraceptive methods (see Figure 4.2). Overall, women tended to have higher knowledge levels across all items with significant differences in 12 of 19 items.

Finally, we included an assessment of veterans' perceptions of side effects from various forms of birth control (see Table 4.2). More than one-half reported side effect frequencies in an accurate range (i.e., a range aligned with the reported frequency of estimates in the medical literature). The least accurate item was about mood changes as side effects for hormonal birth control; 27 percent of veterans selected that mood changes frequently occur with hormonal birth control use.

TABLE 4.1

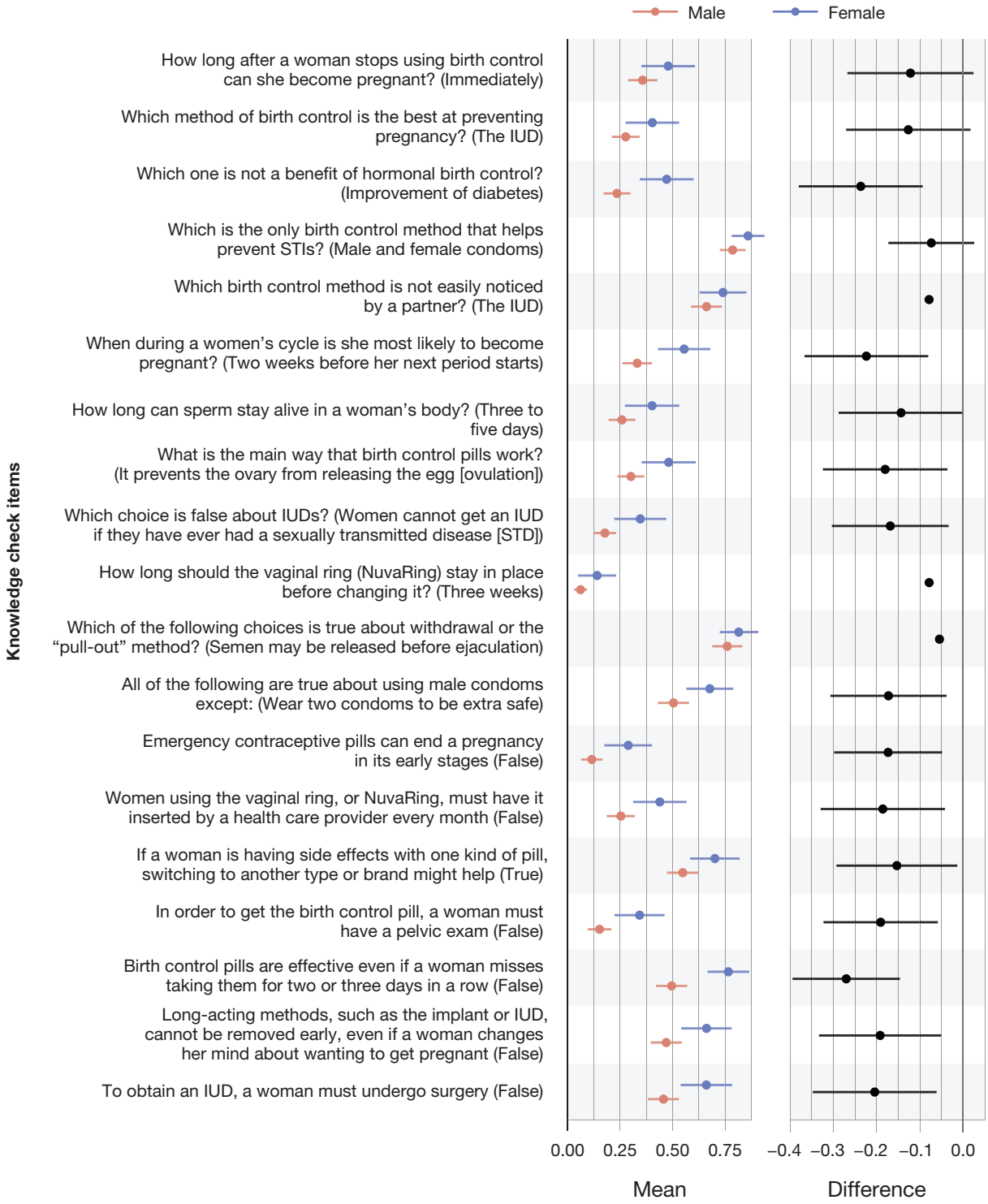
Knowledge Check Findings Across 19 Items

Item and Correct Answer in Parentheses	Correct (%)	Incorrect (%)	Don't Know (%)
How long after a woman stops using birth control can she become pregnant? (Immediately)	38	26	35
Which method of birth control is the best at preventing pregnancy? (The IUD)	30	38	32
Which one [answer] is not a benefit of hormonal birth control? (Improvement of diabetes)	28	19	53
Which is the only birth control method that helps prevent STIs? (Male and female condoms)	80	3	17
Which birth control method is not easily noticed by a partner? (The IUD)	68	9	23
When during a woman's cycle is she most likely to become pregnant? (Two weeks before her next period starts)	37	33	30
How long can sperm stay alive in a woman's body? (Three to five days)	28	40	31
What is the main way that birth control pills work? (It prevents the ovary from releasing the egg [ovulation])	33	31	35
Which choice is false about IUDs? (Women cannot get an IUD if they have ever had a sexually transmitted disease [STD])	21	23	54
How long should the vaginal ring (NuvaRing) stay in place before changing it? (Three weeks)	8	19	72
Which of the following choices is true about withdrawal or the "pull-out" method? (Semen may be released before ejaculation)	76	6	17
All of the following are true about using male condoms except: (Wear two condoms to be extra safe)	53	25	21
Emergency contraceptive pills can end a pregnancy in its early stages (False)	15	54	31
Women using the vaginal ring, or NuvaRing, must have it inserted by a health care provider every month (False)	28	12	58
If a woman is having side effects with one kind of pill, switching to another type or brand might help (True)	57	4	38
In order to get the birth control pill, a woman must have a pelvic exam (False)	18	24	57
Birth control pills are effective even if a woman misses taking them for two or three days in a row (False)	54	7	38
Long-acting methods, such as the implant or IUD, cannot be removed early, even if a woman changes her mind about wanting to get pregnant (False)	50	10	39
To obtain an IUD, a woman must undergo surgery (False)	49	8	42

NOTE: Percentages do not add up to 100 percent because the number of participants who did not answer (answer was missing) is not included. Occurrences of participants who did not answer were low (ranging from 0 percent to 2 percent), likely because of the inclusion of the "Don't Know" option.

FIGURE 4.2

Weighted Means of Knowledge Items, by Sex with the Difference in Means, All with 95 Percent Confidence Intervals



Respondents in the interviews expressed that they felt confident in their knowledge levels about contraception or they were able to easily find the information they needed.

> I don't think there was a time where I felt that information was lacking. If I had questions, I was able to ask the questions and receive answers. *—Female, 40–44, Received birth control pills at VHA*

> I guess I'm saying when it comes down to contraception for myself, there was kind of only the two options of either you wear a condom or you get a vasectomy, both of which are pretty straightforward. So, to be uninformed, I mean, I guess the vasectomy had some things to look up, but the information was both readily available and presented to me multiple times. *—Male, 30–34, Received a vasectomy at VHA more than 12 months ago*

Some, mainly men, suggested that they lacked information about their contraceptive options (see the box on the next page). These men could list some contraceptive options that are available for both men and women but did not fully understand the mechanisms and efficacy of each method.

> I'm aware of some because I just pick up on what other people are doing and have done and so I hardly ever would, like, sit down and do my own research about what all can we do. *—Male, 30–34, Receives health care at non-VHA facility, uses condoms and withdrawal*

> I've heard of those. Yeah, I've heard of it. So, the IUD, is that where it's put inside of the woman? And then I've heard of the patch, but I don't know much about it. Is it kind of like a monthly thing, where instead of taking a pill every day, it just releases into your skin? *—Male, 45–49, Receives health care at VHA, partner is sterilized*

TABLE 4.2
Perceptions of Contraceptive Method Side Effects

Statement	Range in Literature	Accurate (%)	Inaccurate (lower, %)	Inaccurate (higher, %)	Missing (%)
Weight gain is a side effect of the shot	Rarely to occasionally	62	10	22	7
Breast cancer is a side effect of using combined hormonal birth controls	Never to rarely	64	N/A	29	7
Mood changes are a side effect of using hormonal birth control	Rarely to occasionally	51	14	27	8
Headaches are a side effect of using a long-acting reversible contraceptive	Rarely to occasionally	63	15	15	7
Pelvic infection is a side effect of using an IUD	Never to rarely	62	N/A	31	8
Infertility is a side effect of using an IUD	Never to rarely	64	N/A	28	7
A heavy menstrual period is a side effect of using the copper IUD	Rarely to occasionally	63	22	8	7

NOTE: N/A = not applicable. Some rows do not add to 100 percent because of rounding.

Reflections on Contraceptive Method Health Education During Active Duty

Interview participants highlighted a lack of comprehensive health education about contraceptive methods while in the military. Many shared that protection during sex was emphasized and so access to condoms tended to be easy, but participants reported that they often felt uninformed about other options for themselves or their partners. These participants pointed to a lack of understanding about these other options and limited time to discuss options and any potential side effects (e.g., the implications of certain medications) for themselves or their sexual partners with providers.

Engagement in Comprehensive Contraceptive Counseling

Ten percent of all veterans reported that a health care provider discussed birth control methods with them in the past 12 months. Among veteran women, 27 percent (about one in four) reported such discussions, but only 6 percent of men did. Among these veterans, most received counseling in non-VHA settings (58 percent at a non-VHA health care clinic, 18 percent at a non-VHA hospital, and 2 percent at a non-VHA family planning clinic; 2 percent indicated "other") and fewer received counseling in VHA settings (18 percent at a VHA hospital and 10 percent at a VHA health care clinic). Of the veterans who were not already sterilized more than a year ago, 5 percent reported receiving counseling or information about getting sterilized in the past 12 months.

Despite the low rates of counseling about contraception, veterans reported high confidence about having productive conversations with their providers about contraception from the following five questions: knowing what questions to ask, getting a provider to answer these questions, making the most of their visit, getting a provider to take a chief concern about contraception seriously, and getting a provider to address this chief concern. Veterans were asked to rank their levels of confidence on a scale from 1 (not at all confident) to 5 (very confident). The average confidence score across all five questions was 4.2 out of 5.

During the interviews, many male and almost all female veterans reported that their health care providers helped guide their decisions about what type of contraception they should consider using. Many veterans enrolled in VHA benefits who had received health care in the past 12 months suggested that health care providers are an important source of information about contraceptives because health care providers receive specific education that makes them experts.

> I have always grown up trusting doctors, and it has not changed now. . . . I know they're not a hundred percent infallible. I have friends from college who are doctors. And so, I know, they'll fully admit that there are times they go Google answers just like [us], but the difference is [that] they, in my mind, they have the access and, as part of their normal job, they review that kind of information, whether it's studies or the best procedures or the outcomes or whatever the information is. *—Male, 40–44, Receives care both inside and outside VHA*

> I just feel like they're the most knowledgeable about that. Especially talking to that pharmacist, I didn't think about the different pieces of kidney function or depression or things like that. *—Female, 35–39, Receives care both inside and outside VHA*

However, the interviews also revealed a variety of counseling experiences. Many male veterans reported that they did not receive any contraceptive counseling. Many males who were not sterilized shared that their providers did not initiate discussions about contraceptives and focused mainly on routine care questions. Although many male veterans did not receive contraceptive counseling, some said that they would feel comfortable initiating conversations with their providers if they had questions concerning contraception or if their providers brought it up with them.

> I'm pretty comfortable asking my provider any type of question that I might have in my head. —*Male, 35–39, Receives care at VHA*

> I would be comfortable raising that. It would, like I said, it would just be kind of whenever we feel like the right time is. Then I would bring it up, and we'd talk to whoever we need to talk to about it. But I don't think it'd be an issue now. —*Male, 30–34, Receives care outside VHA*

Unlike the male veterans, almost all female veterans described receiving contraceptive counseling in the past 12 months. Most suggested that they were satisfied with the counseling they had received regardless of whether they were enrolled in VHA benefits. Female veterans' satisfaction was driven by feeling heard by their providers, having their questions answered, and having their contraceptive needs met.

> They did mention [that] a hysterectomy could also help with the pain. They asked me how I felt about it. . . . They asked if I wanted kids in the future. They did consider that as well. And I did voice my opinions on the whole hysterectomy. There was no pressure. It's not like they were trying to pressure me to get a hysterectomy. So, I did appreciate that. —*Female, 40–44, Receives health care at VHA and through VA community care*

> They met my needs and preferences every time I've gone. Normally, I don't get any of them. I listen to the options. I listen all over again to see if anything's changed, but for the most part, I normally say no, and they respect it, and they're like, OK. But here are the options if you do want them. They're here for you. That's certainly how it ends. —*Female, 18–29, Received contraceptive counseling at VHA*

Other veterans, especially female veterans, shared negative contraceptive counseling experiences. These negative experiences were driven by a provider not respecting their contraceptive choices, a provider not listening to their concerns about contraception, and the hurdles they faced when trying to set up an appointment.

> It was a bit frustrating at times with my OB-GYN [obstetrician-gynecologist] from the VA. I explained everything. We tried a different medication, or a shot actually, to stop my cycles completely. And it did stop but just the side effects. I couldn't continue to go through with the hot flashes, the extreme hot flashes. So, I was kind of like, what happens next? And she really didn't have any answers. So, I was very frustrated. —*Female, 40–44, Received contraceptive counseling at VHA*

> They said I could [get the IUD placed at a VHA facility], but it was [not] going to be [until] the end of July. That was like three months, three, four months, four months to get seen. —*Female, 35–39, Received an IUD through VA community care*

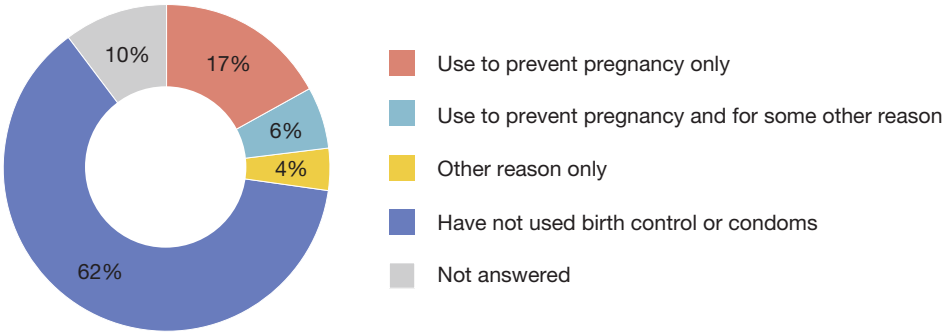
Use of and Preferences for Different Contraceptive Methods

Among veterans who had engaged in any sex in the previous 12 months, 23 percent had used contraceptives to prevent pregnancy (see Figure 4.3), and 4 percent had used contraceptives for other reasons, such as managing a medical condition.[1] Of the 27 percent of veterans who had used contraceptives in the past year for any reason, only 17 percent had visited a health care provider about that method.[2] Consistency of use was low: 29 percent had used a contraceptive method every time they had had sex with their partner.

[1] Veterans were asked if they had used birth control or condoms in the past 12 months to only prevent pregnancy or to prevent pregnancy and for some other reason.

[2] These denominators exclude some participants who indicated that they had been sterilized but did not report sterilization as a method of birth control in this question.

FIGURE 4.3
Reported Use of Birth Control or Condoms in the Past 12 Months for Any Reason



NOTE: The percentages do not add to 100% because of rounding.

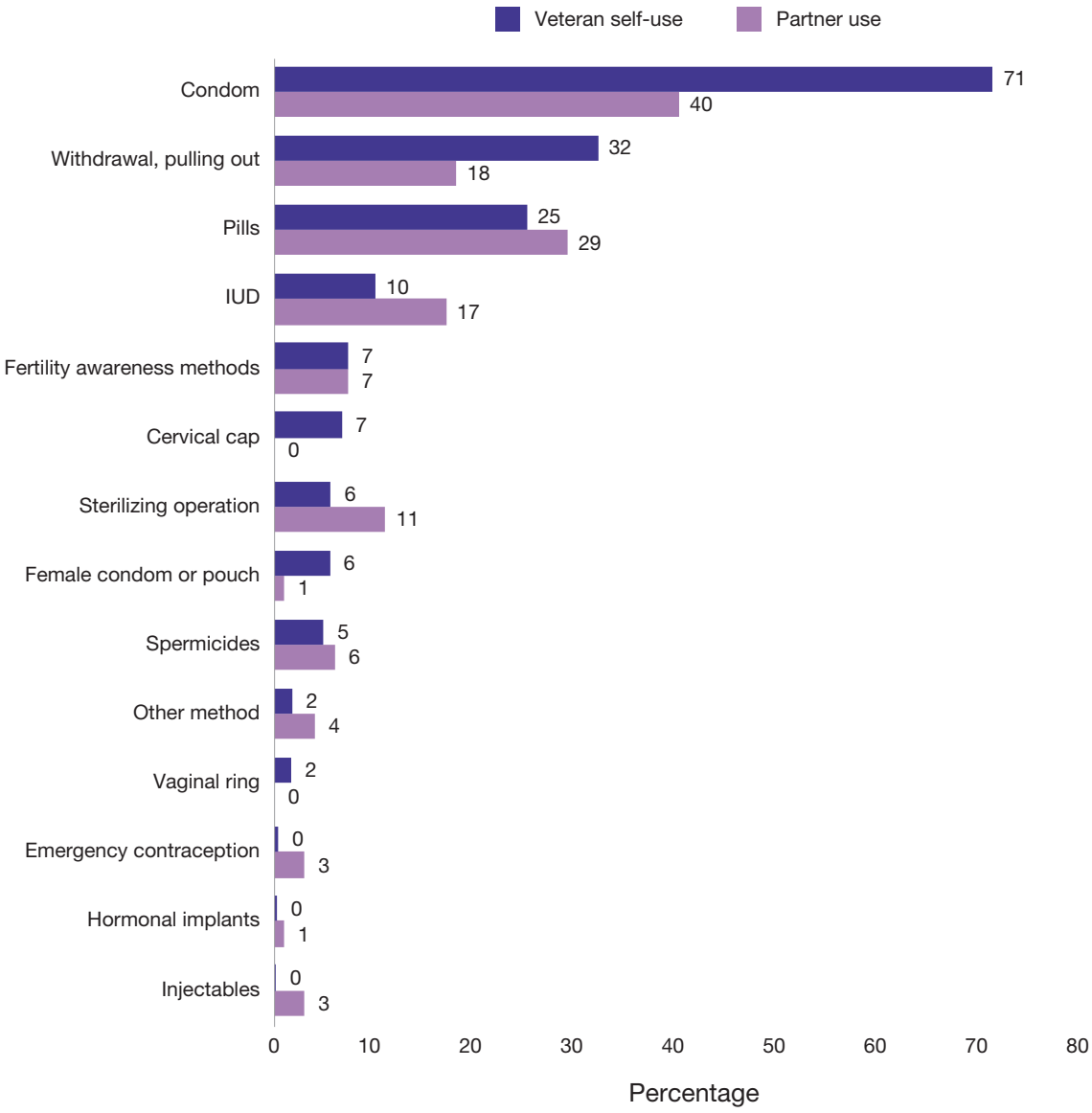
As we noted in the "Sexual and Reproductive History" section (Chapter 3), 43 percent of veterans reported that they or their partner had undergone a sterilizing operation. Veterans were asked about which methods they were using for pregnancy prevention, and a much smaller number reported using sterilization in this context. Figure 4.4 shows the most-common contraceptive methods veterans and their partners reported using in the past 12 months. Among veterans, the top three methods were condoms (71 percent), withdrawal (32 percent), and pills (25 percent). For their partners, the same three methods were the most common but in different proportions: condoms (40 percent), pills (29 percent), and withdrawal (18 percent). It is important to note that, despite the survey explicitly asking about specific methods used by "you" or "yourself" and then about partner use, some veterans reported using methods that do not align with their biological sex (e.g., men reported using birth control pills, women reported using withdrawal). Therefore, these numbers should be interpreted with caution because they likely reflect methods used by either the veteran or their partner. Among veterans who did not use any method of birth control in the past 12 months, most indicated that they did not believe that they could become pregnant.

Among female veterans who reported using birth control pills and provided information about where they obtained those pills, the most common source was a non-VHA health care clinic (33 percent), followed by a VHA health care clinic (13 percent), a VHA hospital (7 percent), and a non-VHA pharmacy (5 percent). Most (66 percent) received at least a three-month supply of a method at a time.

A similar proportion of men and women (30 percent and 26 percent, respectively) indicated that they would use a different contraceptive method from the one they were using if that method were available to them. When asked why they were not using their preferred contraceptive method, women most often selected "other" (39 percent), followed by ability to get an appointment to access their preferred method and concerns about side effects (5 percent). For men, the most common reason for not using their preferred method was that their partner wanted them to use a different method (27 percent) or their health care provider recommended a different method (25 percent); 6 percent of men indicated that method cost was a factor, and 4 percent cited side effects. A small proportion of veterans (4 percent) reported stopping a method in the past 12 months because of dissatisfaction with the method. The most commonly stopped method of contraception was birth control pills (see Figure 4.5). The reasons for dissatisfaction varied and included the side effects (43 percent), method cost (20 percent), and partner's dislike of the method (16 percent) (see Figure 4.6 for the full list).

FIGURE 4.4

Reported Use of Birth Control or Condoms in the Past 12 Months, by Method



NOTE: There was no reported use of the diaphragm, sponge, or patch.

FIGURE 4.5

Methods Stopped Because of Dissatisfaction

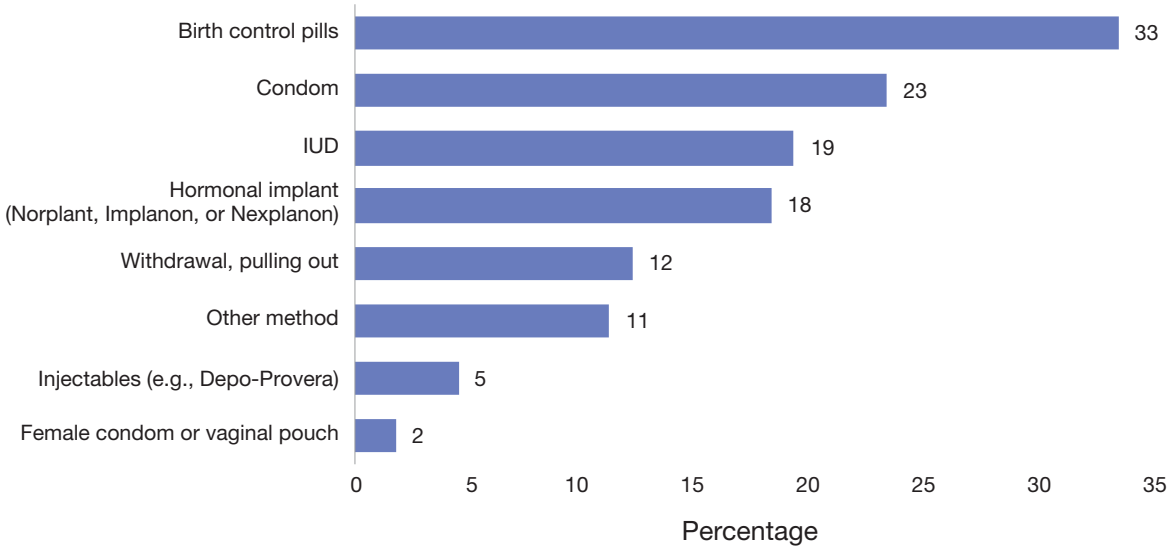
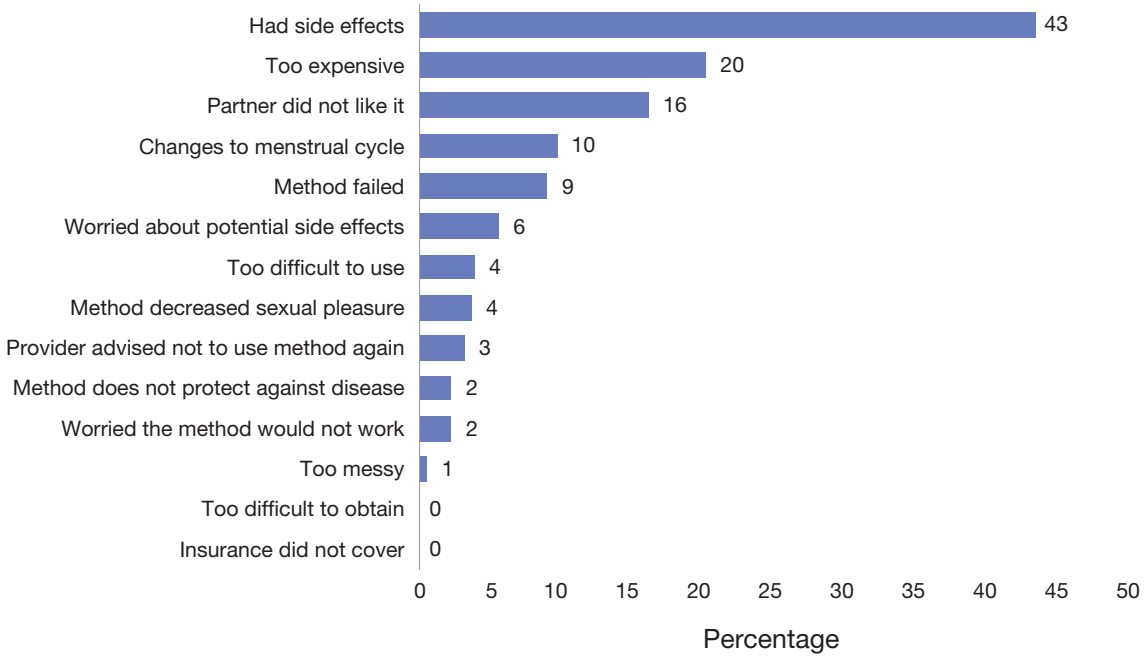


FIGURE 4.6

Reasons for Dissatisfaction Behind Stopping a Method



In the interview sample, some veterans spoke about their and their partners' current and previous use of condoms. Because males have fewer contraceptive options they can use, it is unsurprising that male veterans spoke about condom use more than female veterans.

Some veterans who responded in the survey that their providers had not talked to them about wanting to get pregnant told us in interviews that they had been sterilized, and a few suggested that their partners had been sterilized. Some veterans who reported in the survey that they did not use contraceptives and had not had a conversation about contraceptives with their health care provider in the past 12 months talked about using a wider variety of methods during the interviews.

Factors Affecting Contraceptive Use

Veterans spoke about a variety of factors that affected their contraceptive use, including partner input, the place they were at in their family building journey, potential side effects, and the ease of using the method.

Partner role: Most veterans said that their partner plays a large role in their decisionmaking processes. This was especially true for many male veterans, who reported feeling like they had fewer contraceptive options and wanted their partner to take the lead when it came to making decisions about contraceptives.

> She didn't want to do IUDs or birth control. So, I was like, all right. I'll just wear a condom, no problem. *—Male, 40–44, Received care at VHA*

> I would have left this entirely up to her. If she wanted me to keep using condoms, I would have done that. . . . So, the only one that she felt comfortable using was the IUD. I said, "Okay. Well, whatever you need [from] me." *—Male, 40–44, Received care at VHA*

Others talked about having a conversation with their partner about which methods would work best for both of them and coming to a joint decision about this use. The discussions that these mostly married couples had with one another often centered around their desire to have children now or in the future and the types of contraceptives one partner preferred.

> It's kind of a 50-50 thing. But, I mean, out of the available options, most of what works out there is going to be just what's most comfortable for both of us. *—Male, 18–29, Received care outside VHA*

> I'm always open with her and she's open with me. We discuss about everything, and there's no, like, shyness. We're very open with each other. We discuss everything, whether it's good or bad. *—Male, 35–39, Received care at VHA*

Timing in family building journey: The types of contraceptives veterans preferred often depended on where they were in their family building processes. Some veterans who had completed their family building journeys were often looking for a permanent way to prevent pregnancy. For some veterans, sterilization became their preferred method of contraception. Many veterans who talked about sterilization suggested that this decision was made jointly.

> Just, I wanted it to be permanent. So, that was pretty much it. I didn't really care if it was irreversible. I just really didn't want to have the risk of having a kid this late in life. *—Male, 35–39, Received VHA care and VA community care, received a vasectomy through a private health clinic*

> I got back on birth control after I had that baby, just to make sure we didn't have any other ones. I went on the pill, and then I'm not very consistent with it. So, that's why we kind of decided again to go the vasectomy route. *—Female, 35–39, Received contraceptive counseling through TRICARE*

For those who chose a vasectomy, the ease and safety of the procedure often played a role in their decision. Female forms of sterilization were sometimes used when women veterans wanted to maintain control over their fertility, were counseled by a physician to have a sterilization procedure after a high-risk birth, or perceived the absence of menstruation as a benefit.

> The only other one that we could think of was very invasive on her, whereas this, the vasectomy is very localized and it's low risk. So yeah, it was more like, do we have a localized microscopic surgery, or do we have an actual surgery where it could cause complications? The vasectomy is a very low-risk procedure. So, I think I was there for like an hour. He talked to me for a little bit and then I stumbled out. *—Male, 40–44, Was sterilized more than 12 months ago at a non-VHA facility*

> One big selling factor [of the hysterectomy] that they told me about was that I would not ever have a period again. And I was A-OK with that. So, that was just a bonus. *—Female, 45–49, Received health care at VHA*

Others who had not completed their family building journeys talked about wanting nonpermanent methods of contraception. Male veterans lamented the lack of options for themselves. Some talked about their reliance on condoms until they were married or in a serious monogamous relationship. Many male veterans who were not married suggested that they used condoms instead of solely relying on a female method of contraception because condoms prevented the transmission of STIs.

> It seemed to be the best choice because it's both prophylactic against infection and contraceptive. *—Male, 18–29, Received health care at VHA*

> It [using condoms] was a, it was a protection thing to protect from STDs and STIs in the dating scene. They're not something that I usually wear all the time, but, like I said, now it's more of a protection thing just because diseases are rampant, and I'd rather just protect myself as best as I can anyway. *—Male, 35–39, Received health care at VHA*

Method side effects and ease of use: For some male and female veterans, condoms remained their preferred option regardless of partner status because they wanted to minimize side effects—most of which they associated with hormonal methods. For many of these veterans, not having to put something in their bodies was an important reason for choosing a nonhormonal method of contraception.

> Normally it ends up going back to the same. . . . I don't want to put that in my body. So, we're like, okay, we agree. Okay, yeah, let's just stick with condoms for now. *—Female, 18–29, Received contraceptive counseling at VHA*

> Condoms are just about as effective as birth control. They're both 99.9 percent effective if you use them correctly. And then the other benefit of condoms is that they actually protect against STDs, whereas birth control does not provide any protection against STDs. So, for me, I prefer knowing I don't want to have to take something that's altering my hormones. *—Male, 30–34, Received health care at VHA*

Some veterans who relied on condoms suggested that condoms are easy to use because they do not require a prescription and are readily available.

> Condoms because . . . they're pretty secure. And they're in the moment and it's not going to mess with you . . . it's not like a doctor thing. Easy access, I guess, would be that one. *—Female, 40–44, Received health care at VHA*

Many veterans who used hormonal methods suggested that not wanting a child drove their contraceptive use. However, they did not necessarily see these methods as easy to use. For instance, they discussed the need

to remember to take the pills or track their cycles as burdensome. Only one veteran raised ease of use with a hormonal method (specifically about Depo-Provera).

> [Depo-Provera] was the easiest. I didn't gain weight really. When I first started, I gained a little bit of weight when I was on it, and then I went to Seasonale, the pill, when I was deployed. And then, when I got home, I got back on [Depo-Provera] and it was, yeah, I, it's just, it's just the easiest for me. I don't have to remember the pill and I kind of, I do have mood swings when I'm on it, but it's just the easiest one for me. *—Female, 35–39, Received health care outside VHA*

> [My doctor] talked me through the ring. She was telling me how the ring was a bit different from, like, taking the pill, because you still get your period. But for me, I don't track my period. . . . I don't want to . . . have to know, like, when my period's coming to take this thing out. I was like, that's just too much work. I already don't track it. Every month, I'm surprised, it's a surprise. It is what it is. So, for me, I was like, that's complicated. I don't want to do that. *—Female, 30–34, Received contraceptive counseling at VHA*

Method cost: The cost of the method rarely emerged as an important factor that drove decisionmaking. When it did, veterans talked about how their health coverage through VHA allowed them access to a supply of pills or the availability and cost-effectiveness of condoms.

> Basically, they were cheap, and their fail rate is remarkably low, especially if you're making sure to use them correctly. I don't know, they're just convenient to keep on hand. And the statistics surrounding them are just really good. The IUD was more of a backup, more than anything. *—Male, 35–39, Received health care at VHA*

Influence of other information sources: Many veterans said that the experiences of family and friends also informed their decisions about which contraceptive method to use. These veterans suggested that others' negative experiences with a certain method may dissuade them from using a specific form of contraception. At the same time, many veterans who were sterilized spoke about the importance of hearing about friends' and family members' experiences with sterilization before having the procedure themselves.

> For most people, this is painless. For most people, that blah, blah, blah. Well, that's great. But I also have a sister who got her tubes tied and has had so many problems with that. *—Female, 35–39, Received contraceptive care at VHA*

> My dad's had a vasectomy, so that kind of, it was a normalcy in that sense. *—Male, 40–44, Received vasectomy outside VHA*

> I think just through friends, just time, being around friends, people getting older, my friends having kids and then not wanting to have kids, hearing stories from them about what they're using and things like that. *—Female, 35–39, Received care outside VHA*

Unsurprisingly, some veterans also reported using the internet to find additional information about contraception to supplement or replace the information that they received from their health care providers and friends. A few veterans said that they relied on medical websites, such as the VHA website, and a few veterans said that they relied on information from social media to learn about others' experiences.

> I think the difference is that you don't get opinions on paper pamphlets or experiences. When you read the pamphlet, you mainly just get, like, the medical version of this is what might happen, and then if you want to have a look at other things, like on the internet, it's just kind of opinions. *—Female, 18–29, Received health care at VHA*

> We've got the internet at our disposal. So, anything that doesn't get answered in my brain goes on Mr. Google. So, that's really what the more information outside the VA [is]. It would just be like my own searching. I'm a trained intel [intelligence] analyst, so I know how to find things. *—Female, 40–44, Received health care at VHA*

Still, some veterans reported that their own experiences and their partners' experiences served as important pieces of information that drove their contraceptive use. They spoke about how their personal beliefs and information that they gleaned from a variety of sources, including their partners' health care providers, drove their contraceptive use.

> I think it's, personally, it's under my control and me and my wife, actually, to be honest with you. So, it's basically our decision, nobody else can sort of influence us. *—Male, 40–44, Received health care at VHA*

> My wife described it well, and yeah, I guess if I really, yeah, I wanted to know more, I guess I could ask my own doctor or WebMD or something. *—Male, 35–39, Was referred outside VHA for a vasectomy*

Pressure to Use Contraceptives

Many veterans did not report feeling pressured to use contraceptives when asked explicitly in interviews. Instead, veterans reported feeling like the use of contraceptives was their choice. Regardless, if they were enrolled in VA health benefits, many veterans suggested that they felt comfortable talking to their providers about their contraceptive options.

> I really appreciate the nonjudgmental approach to women and getting birth control. . . . I need it for my health. And I really appreciate my doctor knowing that. And there was no judgment. And it's very easy to get it. *—Female, 35–39, Receives birth control pills outside VHA*

> To me, it is important that I do feel listened to and that I don't feel like they're just trying to push, like, a pill on me. *—Female, 40–44, Received contraceptive care at VHA and was sterilized outside VHA more than 12 months ago*

Although only some veterans talked about feeling pressure to use contraceptives, those who did mostly spoke about pressure from providers. These feelings of pressure were only expressed by those who were enrolled in VA health benefits and had accessed any care within the previous 12 months. A few reported that this pressure came from a physician demanding that they use a specific contraceptive because of a requirement of a different medication, a provider framing contraception or sterilization as a postpartum need, or simply the veteran's belief that the provider had an agenda to have everyone use contraception. However, veterans also acknowledged that providers would often voice their opinions about a preferred contraceptive method without forcing them to choose a method.

> [One nurse practitioner] was like, "Well you know we need to make sure you get on something." They make you do a pregnancy test. I understood why because, you know, you don't want to get pregnant on something, but I felt like, "Oh I better find something to be on, or I'm not going to get this medication." *—Female, 35–39, Received contraceptive counseling through VHA and VA community care*

> They weren't pushing for a particular option, but they wanted to make sure that I was leaving with a plan. So, they're not pressuring me towards, like, a particular, like, "We think this plan is best." *—Male, 18–29, Receives health care at VHA and outside VHA*

> My provider is a little pushy towards the contraceptives. She definitely is kind of like, "You sure you don't want to use them? You sure you don't want to use them?" But when I did express, like, "No, no, I'm good,"

she would be like, "Okay, all right, I'm here." She would back down. —*Female, 18–29, Received contraceptive counseling at VHA*

Other sources of pressure for veterans were sexual partners. Veterans said that they often felt that their partners demanded that they use certain methods of contraception so that they or their partners would not become pregnant. This sentiment was voiced mainly among men, who spoke about sexual partners wanting them to use or not use condoms based on the method of contraception they were using.

I've been in different relationships where, even though they were longer-term relationships, there was a very heightened sense of, like, "I cannot get pregnant, so you will wear condoms." —*Male, 35–39, Received care at VHA*

I mean, there was a little bit of pressure from her. She's like, "Are you sure? I'm on the pill. You don't need to [use a] condom." I'm like this, yeah. But I don't know. I just feel better using it. —*Male, 40–44, Receives care outside VHA*

Research Aim 2: Variations in Access and Choice

In our second research aim, we explored whether there might be variations in veterans' ability to access and choose contraceptive care based on certain characteristics. A priori, we expected that there might be differences in contraceptive outcomes (i.e., self-reported use of contraceptive methods, engagement in contraceptive counseling with providers, and self-reported sterilization) based on sex and whether veterans are enrolled in VHA coverage. The following analyses cover these two variables and an assessment of differences by reproductive age (i.e., younger [ages 18 to 34] and older [ages 35 to 49]).

Variations by Enrollment in Veterans Health Administration Coverage

Among those who had accessed health care services in the past 12 months, there were no statistically significant differences in contraceptive use (including sterilization) or contraceptive counseling between those who were enrolled in VA health care coverage and those who were not enrolled in VA health care coverage (see Figure 4.7).

Although no statistically significant differences emerged, we did hear varying experiences about veterans' perceptions of access to contraceptive care at VHA compared with care outside VHA. During the interviews, almost all veterans reported that VHA should support contraceptive access for veterans. They suggested that reproductive and contraceptive health care was an important part of health and thus should be a service that VHA covers. This support was voiced by many younger (under age 35) and almost all older (age 35 and older) male and female veterans, even if they had already completed their family building journeys.

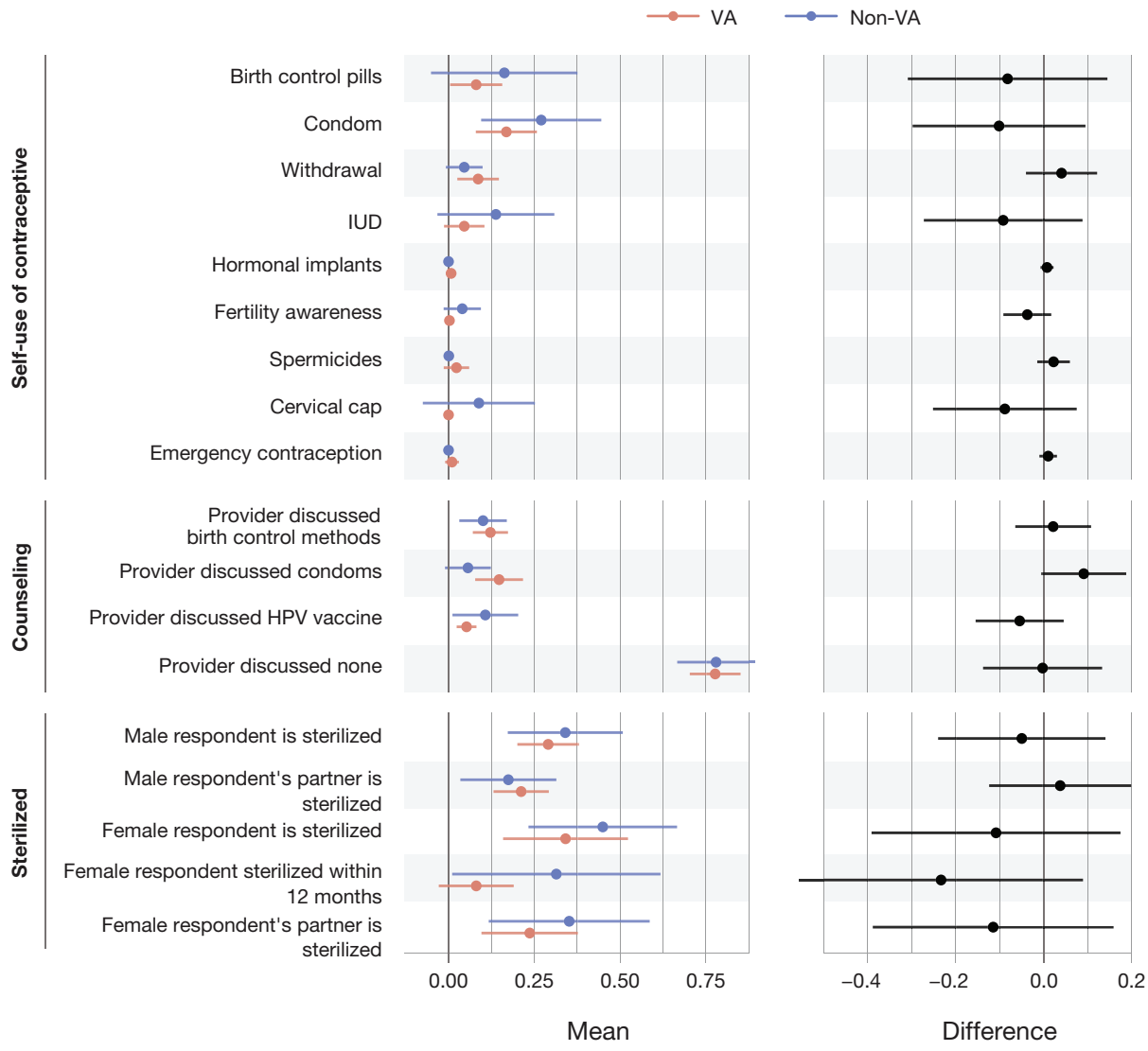
I mean, sexual health is part of health care. . . . If your health care is covered by the VA, that should include [contraceptive benefits]. —*Male, 35–39, Received health care at VHA*

One of the things the VA's job is [to do is] to ensure that we have access to health care. I feel like it should include the total person. —*Female, 30–34, Received health care at VHA*

I think contraception should be available for everyone. They should be able to provide an IUD, they should be able to provide contraception methods, be it [the] birth control pill, condoms, all of it. —Male, 35–39, *Receives health care outside VHA*

FIGURE 4.7

Weighted Means of Contraceptive Outcomes, by U.S. Veterans Health Administration Coverage Enrollment Status with the Difference in Means, All with 95 Percent Confidence Intervals



NOTE: The figure shows self-reported use of contraceptive methods for preventing pregnancy in the past 12 months, which is reported here among only males for condoms and withdrawal, among both genders for fertility awareness and spermicides, and among only females for all remaining methods.

However, many veterans reported that they lacked knowledge about VHA contraceptive benefits, even though some of them were enrolled in VA health benefits and had received health care services within the past 12 months. This was especially true for many of the male veterans we interviewed. Male veterans often assumed that contraceptive benefits are available at VHA, but they did not know the types of contraceptive benefits they could receive, nor did they know what coverage VHA provides. Although many of these veterans were enrolled in VA health coverage and had accessed care somewhere in the past 12 months, both male and female veterans said that their providers did not discuss contraceptives with them, and thus, they remained largely unaware of VHA's contraceptive benefits.

> I'm not sure what access they offer because that's not something that they've ever discussed with me. So, I can't really speak to that. *—Male, 35–39, Received health care at VHA*

> I honestly don't know whether they do or not. I've not been made aware if they did. I wouldn't be surprised if they did. We got a ton of programs I've never known about before, and I find out about them one day. *—Male, 40–44, Received health care outside VHA*

> I don't really know. I guess I would think that if a veteran goes there for that purpose that they would offer it. I guess I can't see why they wouldn't because a big part of health care is reproductive care. *—Male, 35–39, Received health care outside VHA*

Veterans may have lacked knowledge about VHA benefits because many male and some female veterans reported during the interviews that they did not receive information about contraceptives from VHA or their providers. A few veterans suggested that talking about contraceptives at VHA was viewed as taboo and that they specifically had to ask about the contraceptive benefits they could receive.

> No, no, they never mentioned [contraception]. It's a taboo subject. Because my impression is, for example, if I go and see my provider, if I mention about that subject [contraception], they think that, oh, I don't have PTSD [post-traumatic stress disorder], I don't have a TBI [traumatic brain injury], I don't have lower back pain. *—Male, 45–49, Received health care at VHA and through VA community care*

> I wish that they were a little bit more vocal about it. . . . But being in the VA system, I know that it's there. If you asked about it, you want to get educated about it, you can get prescribed it. But I don't think it's really just talked about a whole lot. I guess that's the best way to put it. *—Male, 35–39, Received health care at VHA*

On the other hand, a few respondents talked about the benefits offered by VHA and the ease with which they could get a contraceptive method. These veterans suggested that they could easily ask their primary care provider for a method of contraception and that the method would be provided.

> From what I've been told, it's still pretty straightforward. It's similar to being seen when you're on active duty. It's just, you go to the doctor if you need a certain something like an IUD or the shot, they do the medical workup. And then, as long as it's not going to cause any issues, they're pretty up front with it. It's not like they're denying it for cost-effectiveness or something like that. *—Male, 35–39, Received health care at VHA and through VA community care*

> Based on conversations I've had with my doctor, it seems like we have full access to all of that. I haven't run into any issues. *—Female, 40–44, Received health care through VHA and through VA community care*

There were mixed reports on whether VHA proactively advertised the contraceptive benefits that were available to both male and female veterans. A few veterans suggested that there was information on a website, on an app, or at VHA, although others mentioned that, if this information existed, it was difficult to find.

> They [VHA] always have things that are out on the tables, or they have the bulletins and the posters and stuff, and I don't remember ever really seeing any of that [information about contraceptives]. —*Female, 35–39, Previously received health care at VHA, currently receives health care through private practice*

> So, information-wise, you just get referred to a website, or you can look at stuff on [an app], because VA has an app, so . . . you can look at prescription information. —*Female, 40–44, Received health care at VHA*

> I've seen some kind of pamphlets in different literature. Probably not as much, I think, now as previously, just because the technology has progressed to the point where now a lot of it is online, and providers might be more apt to suggest access to online publications rather than handheld paper ones. I don't know that I recall there being like a bucket of condoms laying around in any offices that I've been in, but I think that if I were to ask, "Hey, do you have any of these?" they would probably be happy to provide them. —*Female, 35–39, Sterilized at a VHA clinic within the past 12 months*

Variations by Sex

The proportion of females and males who reported self or partner use of each contraceptive method to prevent pregnancy, including sterilization, did not statistically differ (see Figure 4.8). Contraceptive counseling showed the largest differences between sexes: The proportion of female veterans who had had discussions about birth control with their providers was greater than the proportion of male veterans who had had birth control discussions.

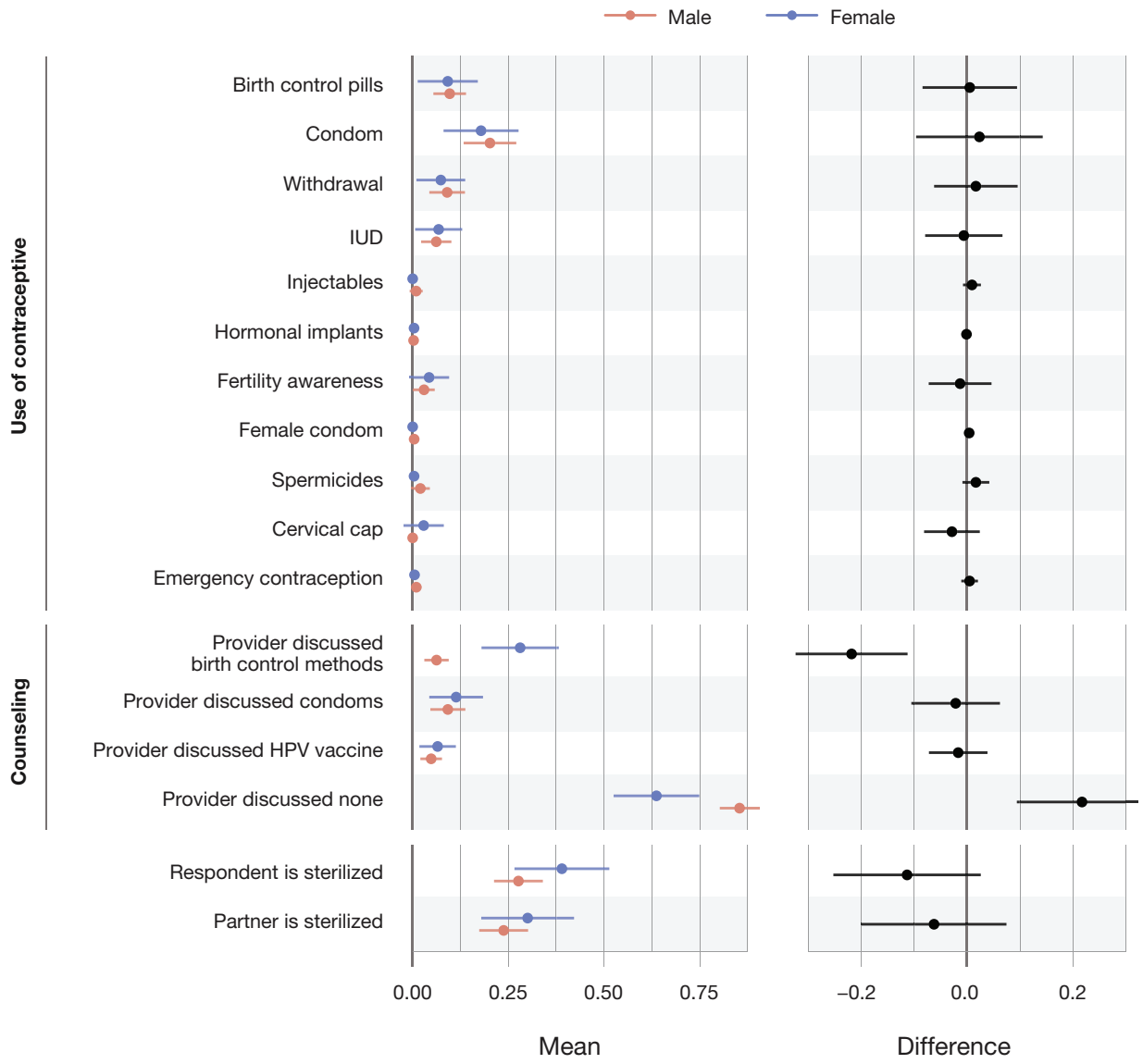
Variations by Age

The final analysis explored differences between veterans of younger reproductive age (aged 18 to 34) and older reproductive age (aged 35 to 49). The results are provided in Figure 4.9, in which self-reported use of contraceptives is defined analogously to how it was defined in Figure 4.6. In Figure 4.9, we see significant differences in condom use: A greater proportion of veterans aged 18 to 34 use condoms compared with veterans aged 35 to 49. Although the 5 percent level of statistical significance was not reached, the proportion of veterans aged 34 and under who use birth control pills is greater than the proportion of veterans aged 35 and older ($p = 0.069$). The rate of self-reported sterilization is higher for older veterans than for younger veterans among both males and females, and the rate of sterilization reported by male partners is also higher for older veterans (although the difference in self-reported sterilization among males is not statistically significant at the 5 percent level).

Age seemed to be a factor in contraceptive counseling discussions. There were statistically significant differences between younger veterans and older veterans in terms of those who discussed birth control methods with their providers, discussed condoms with their providers, or had no discussions with their providers. Specifically, those aged 18 to 34 were more likely than those aged 35 to 49 to discuss birth control methods and condoms with providers.

FIGURE 4.8

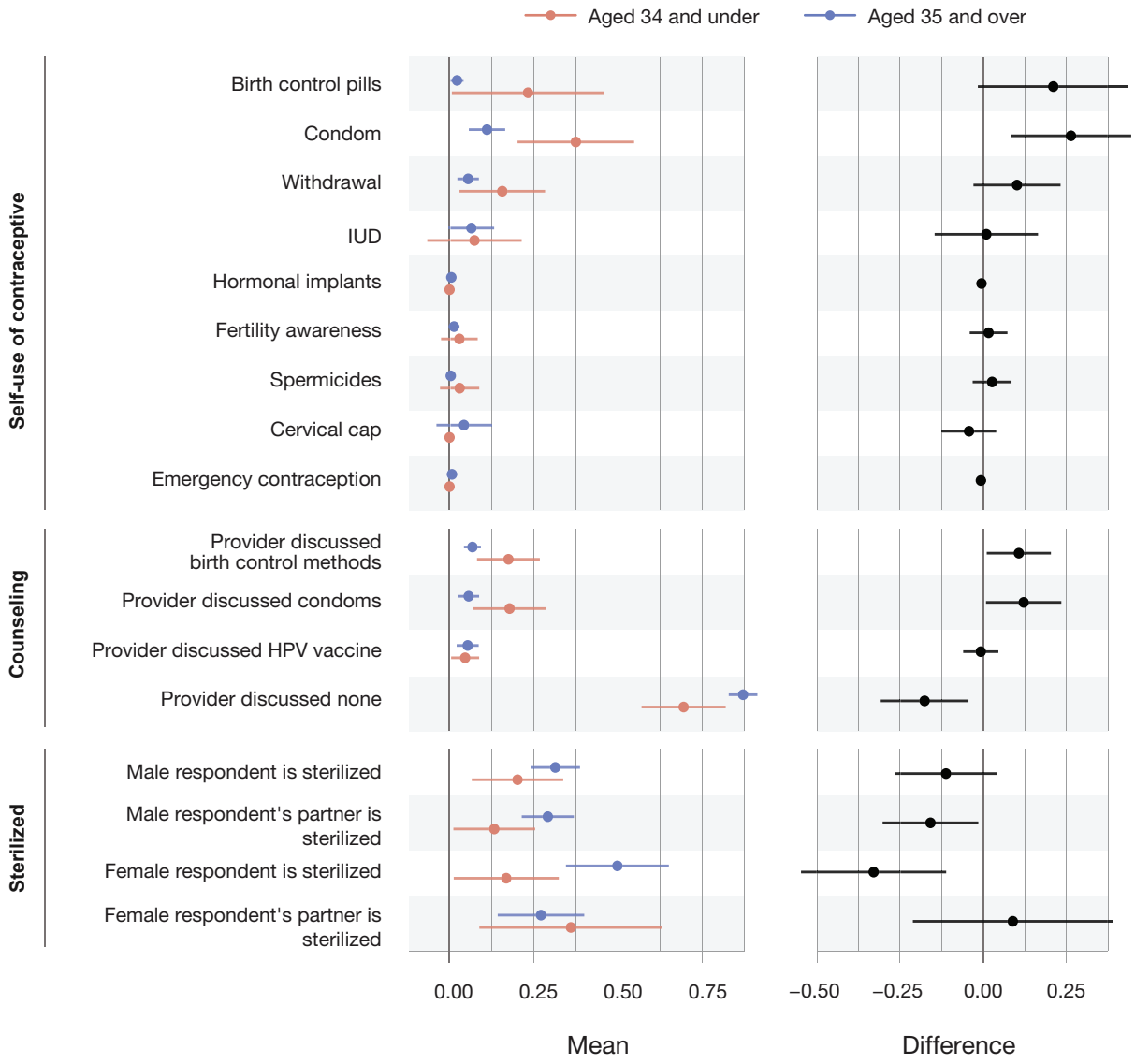
Weighted Means of Contraceptive Outcomes, by Sex with the Difference in Means, All with 95 Percent Confidence Intervals



NOTE: For some methods of contraception (condoms and withdrawal), the figure compares self-reported use by males with partner-reported use by females. For other methods (fertility awareness and spermicides), self-reported and partner-reported use is compared between males and females. For the remaining methods, self-reported use by females is compared with partner-reported use by males.

FIGURE 4.9

Weighted Means of Contraceptive Outcomes, by Age Group with the Difference in Means, All with 95 Percent Confidence Intervals



Research Aim 3: Barriers to Choice and Access

In our final research aim, we focused on determining whether veterans face specific barriers that affect their ability to choose and access their preferred contraceptive methods within and outside VHA. Because of the nuanced nature of barriers and important contextual factors that affect an individual's experience choosing and accessing care, this section relies on data from our interview sample.

Factors Unique to the Veterans Health Administration

Veterans did not perceive large barriers to receiving contraceptive care at VHA. Those who spoke about barriers mainly spoke about informational barriers, and veterans suggested that they did not feel comfortable discussing their contraceptive options. Notably, only male veterans shared a perception that contraception was not something they could talk about with their primary care physicians. These veterans suggested that it was assumed that they did not need information about contraceptives because they are male and said that discussions about contraception and sterilization were rarely brought up.

> You know, being a veteran, they treat us like dead people. They thought that we don't have the need. —*Male, 45–49, Received health care at VHA and through VA community care*

> I think because I'm a male, I feel like maybe there's kind of like a bias, where they kind of look at it like . . . maybe they thought it was more like a female type of thing, like an issue or something that you'd have a conversation with a female. —*Male, 35–39, Received health care through VHA*

> I can see there being more hesitancy from a male perspective for veterans and stuff. . . . And I think destigmatization, if you would, or even just talking about it at all is kind of something that's lacking. So, I've tried to be open about it. But yeah, there's a whole lot of machismo around it, where it's like, can't cut my balls off. —*Male, 30–34, Received health care through VHA and VA community care*

When males wanted to discuss the option of sterilization with their providers, a few noted that they faced barriers. One barrier was that health care providers were hesitant to discuss sterilization with younger veterans or veterans without children. A couple of veterans suggested that they were unable to receive their vasectomies inside the VHA system because vasectomies were not offered to them or were easier to receive outside VHA.

> That's kind of what I was saying, like, it's funny the VA doesn't offer that. We offer so many different things for people, for a variety of different bizarre things sometimes, and then something so simple, and—anyway, yeah, they don't cover hardly any of that. —*Male, 40–44, Received health care at VHA*

> I talked to the VA to get it done, to make an appointment. Again, you had to see them in person. They wouldn't do that at a local clinic. They wouldn't give me a referral. They basically said, like, "You haven't had kids, so why are you doing this?" I felt like it was—it was just really weird. —*Male, 35–39, Received health care at VHA and through VA community care*

Many veterans said that they wanted VHA to provide them with more information, either through explicit advertisements on the VHA website or in pamphlets that they could receive from their doctor's offices or at their care appointments. Some veterans reported feeling that their VHA health care providers should explicitly discuss all the contraceptive options that are available to them and their partners, even if they are not going to choose a method.

> Obviously, in the offices, having pamphlets, brochures, things like that, like the posters that are up in the hallway and not just in an area where you would go for women's health care, if that's a separate area, but in a general area. *—Female, 35–39, Previously received VHA health care*

> Having [contraceptive information] posted around the hospital with a QR [quick response] code on it where to, what is, how to scan—not how to—but to scan, bring you to a specific piece of the website that might explain it to you or where to find the help or the service. Just, you know, a QR postcard or whatever. *—Male, 35–39, Received VHA health care*

One male veteran spoke about the need to discuss female forms of contraception with male veterans so that male veterans can better understand how those forms of contraception work and are better informed to help make contraceptive decisions with their partners.

> Even if your partner isn't being seen by the VA, having information about what's going on, you know, with their body is that [it] does affect you too. So, having that mentioned, like, "Hey, are you sexually active?" If they answer that their partner has an IUD, even if the doctor was just like, "Hey, those do need to be changed out every couple of years," even if it was just, like, mentioned in passing. Just might be some good information to toss out there. *—Male, 35–39, Receives VHA health care*

Some male and female veterans suggested that physicians at VHA could improve the information that is provided to veterans so that veterans are more aware of all their options and not just the contraceptive options that their providers prefer.

> I believe that the VA hospital and the military facilities don't educate you enough. And, like I said before, you have to go out of the way to educate yourself, look up all the information, and then see what options are available. *—Male, 35–39, Receives VHA health care, uses condoms*

> I talked about the education piece, that I think that's something that could be done, because I can't think of a single time when I was in or at the VA where I've ever had anyone provide that kind of education. *—Male, 35–39, Currently does not use VHA care but went to a VA facility in the past, had a vasectomy outside VHA*

> Just have a casual conversation, and they can check a box saying, "Hey, we went over this with this veteran, and we gave them all these options if they were interested." *—Male, 40–44, Uses VHA services, received a vasectomy through VA community care*

> Let women know about it [contraception]. I had to inquire about it. I don't know if it was really offered to me. I really wanted it for myself, so I asked about it. *—Female, 40–44, Uses VHA services, received an IUD at a VHA facility*

Another suggestion made by some male veterans and a few female veterans was for VHA to provide support to new veterans as they transition out of military service. These veterans suggested that providing information about contraceptives to new veterans as they transition to civilian life is important because new veterans would likely be younger and maybe in greater need of discussions about family planning.

> Maybe in a briefing, when people are transitioning, list it as one of the things that they [VA] do provide. When military members leave, they have to do a [transition], a whole two weeks of transition brief. And maybe that would be in one of the briefs is what the VA provides regarding contraceptive care. *—Female, 30–34, Uses TRICARE and uses birth control pills when husband is home from deployment*

A few veterans suggested that VHA providers should raise contraceptive care only if the veterans ask for it; one older male veteran said that VHA's responsibility is to the former soldier rather than the veteran's family.

> The VA is there to take care of the veteran that served this country. Not necessarily to take care of the family part of it. . . . "Your family didn't come in your sea bag" was said a lot in the military. We brought you into the military, and then you started your family later for the most case. I don't know, maybe it would be, that should probably be handled by their medical civilian world. —*Male, 45–49, Receives VHA health care but does not use contraception*

Factors Unique to U.S. Department of Veterans Affairs Community Care or Care Outside the U.S. Veterans Health Administration

Almost all of the veterans with whom we spoke during the interviews were enrolled in VHA coverage and had accessed health care in the past year. There were some veterans who reported that they were not enrolled through VHA, and almost all of those veterans did not access health care in the past 12 months. Thus, there were few recent experiences of veterans attempting to access contraceptive care outside VHA in our interview sample. A few veterans reported accessing contraceptive services, especially sterilization procedures, outside VHA. These veterans often were referred to community health providers for this procedure, because they were already getting obstetrical care outside VHA or because VHA did not offer sterilization.

One veteran noted that when she was trying to obtain a tubal ligation, her VHA physician put in a referral to see a VA community care doctor. However, the veteran attributed the wait time she experienced before she could be seen by a VA community care doctor to not already being in the civilian system.

> It's nice that I can go to my primary for anything like birth control, patches, pills, shots, or getting a referral to an OB [obstetrician]. Getting their referral is the easy part. It's waiting on community care to put it through. And you don't really get a choice in your doctor. You get to tell them, "I want male, female, or I don't care," and then it's kind of a crapshoot on if you get a good doctor or a bad doctor. —*Female, 30–34, Uses VHA for contraceptive care, currently uses birth control pills*

Some veterans who were already sterilized suggested that, at the time of the procedure, their VA community care physician or their referring VHA physician did make them fully aware of the permanency of the procedure or the possibility that the procedure could fail. One female veteran who received a tubal ligation at non-VHA facility after childbirth years ago shared that she was not provided with information about alternative options.

> They didn't say, like, "This is irreversible." They were just kind of like, "It's a permanent thing." Using words that like, when someone has their tubes tied, "It's permanent," but like, "It can't be undone" as well. . . . I didn't realize that they were cutting them or whatever it was that they did. I thought they were tying them, and I'm sure that they probably used some fancy word that I didn't realize was a significant difference. —*Female, 30–34, Received sterilization outside VHA*

A male veteran who underwent a vasectomy in the past year reported that, in his discussions about the procedure with both his VHA primary care doctor and a urologist seen through VA community care, neither physician adequately disclosed the potential failure rates of vasectomies.

> The only thing on the vasectomy, I don't know what it is. I guess you know they're listening—when I say "they," I mean social media and telephone—but a lot of things have come up that vasectomies are not a 100 percent, it's not like a 100 percent thing. I know IUDs are not 100 percent as well. But that information was not given. —*Male, 40–44, Received contraceptive care at VHA and sterilization through VA community care*

A female veteran who sought information about permanent sterilization in the past year shared that her VHA provider lacked information about the topic. When she consulted a VA community care physician, she was only provided information about tubal ligation (getting her tubes tied).

> When I was trying to talk to my doctor about getting a partial hysterectomy versus getting my tubes tied or birth control, I felt like it just wasn't a conversation that [the] doctor wanted to have. So, he only wanted to give me information about getting my tubes tied because that's what he specialized in and that's what he did. I was like, but that's not what I want to talk about. He just straight up shut down any talk about the partial hysterectomy. —*Female, 30–34, Received contraceptive care at VHA and sterilization counseling through VA community care*

CHAPTER 5

Unique Contraceptive Needs and Patterns and Reflections from Military Service

Although it was not an explicit research aim, we also explored whether participants believe they have unique contraceptive needs compared with the civilian population. Furthermore, we compared the veteran population for this study with a civilian sample from the NSFG to see whether there were any major differences in patterns of contraceptive use or considerations for further study. During our interviews, many veterans spoke about their experiences with contraceptive care and use during their military service and how those experiences shaped some of their perspectives on contraceptive use since they transitioned to civilian life. Finally, we also explored other veteran reproductive health care needs. This chapter details these supplemental analyses and findings.

Uniqueness of Contraceptive Needs for Veterans

We queried veteran interview participants about whether they believe they have unique contraceptive needs or considerations post–military service (see the box on the next page). Veterans tended to report that their needs are similar to those of civilians post-service and that any unique aspects of contraceptive needs that are related to being in active service fade quickly. A small number acknowledged that some veterans may have concerns or unique needs related to previous military traumas, such as PTSD or exposure to harmful substances, and that those needs might influence reproductive health choices.

> I definitely feel like I've been exposed to a lot of nasty stuff throughout the military. I don't know how much it will carry on, but it's still concerning. And then, same thing with, like, PTSD. It might be difficult to deal with raising a child if you're struggling mentally. *—Male, 30–34*

> Given the amount of things that I may have been exposed to and discussions I've had with doctors and other professionals before I got out [of the military], I think that if I had waited to have children, I would still be questioning that, just because I've had colleagues who had strange exposures—specifically the males, where they had testicular heating issues with radiation that they had been exposed to, and we do know that that can cause irregularities in the sperm. So, that's the only thing I could say about it really is, as a veteran, we do have unusual experiences and that could definitely or should inform our decisions concerning contraceptive and birth control. *—Female, 40–44*

One participant shared that they did not want to have children because of information they were exposed to in their job:

> I had a Top Secret security clearance. . . . I personally choose not to have a child. . . . I don't want to also have a child grow up in this world either. So, I think it does impact it. I have a friend that, she's kind of the same way. Her and her husband are ex-prior army, and they don't want to have kids again. Like, they both have kids outside of their relationship. They're all grown and full, but they're like, "We don't want to expose them to any of this anymore." —*Female, 40–44*

Comparison with a Civilian Sample

A comparison of our veteran sample with an NSFG civilian sample points to some clear differences and some similarities (see Figures 5.1 and 5.2 for an analysis for females and males, respectively). As expected, our veteran sample has a distinctly larger proportion of males (81.8 percent of veterans are male compared with 48.7 percent of civilians). Other (perhaps expected) demographic differences are also apparent. For example, the veteran population is older and experiences higher income levels and higher marriage rates.

Birth control pill and IUD use did not statistically differ between our veteran sample and the civilian sample. Because few female veterans use the patch, a vaginal ring, or emergency contraception, we did see a small but significant difference between the proportion of veterans who use these methods and the proportion of non-veterans who use these methods. A larger proportion of female veterans reported a sterilizing procedure for themselves and their partners compared with the civilian population, and male veterans reported higher rates of sterilization for themselves and their partners compared with the civilian population. In contrast, a greater proportion of civilians reported condom use.

Comparisons with the NSFG civilian sample are restricted, for example, by the fact that males in the NSFG sample are not asked about hormonal contraceptive use. Because the comparisons presented in Figures 5.1 and 5.2 involve comparing our sample with data collected at different points in time with different methods, robustness checks are warranted. Figures A.2 through A.5 in Appendix A provide comparisons of our veteran sample with a military (veteran and active-duty) sample from the NSFG. We see some differences between the samples; however, these are mostly explained by differences in age. Nonetheless, our sample reports consistently higher levels of sterilization than the NSFG samples, a difference that is not explained by age differences.

Reflections on Choice During Active Duty

Veterans reflected on unique challenges related to their deployment schedules and unpredictable missions, which influenced their contraception choices. For instance, some participants noted a preference for contraceptive methods that require less daily management, such as LARCs (e.g., IUDs or injections), to avoid issues while on missions or in the field; others pointed to concerns about specific side effects influencing their choices (e.g., using the shot, which could lead to weight gain). There were some concerns about the pressures and stigma that surround reproductive choices within military culture, which possibly affects how service members approach contraception compared with civilian peers. Furthermore, some veterans noted that military experiences might lead to anxiety about future family responsibilities and concerns about the viability of being present for children if deployed.

FIGURE 5.1

Weighted Means of Female Veterans in the RAND Survey and of Female Civilians from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals

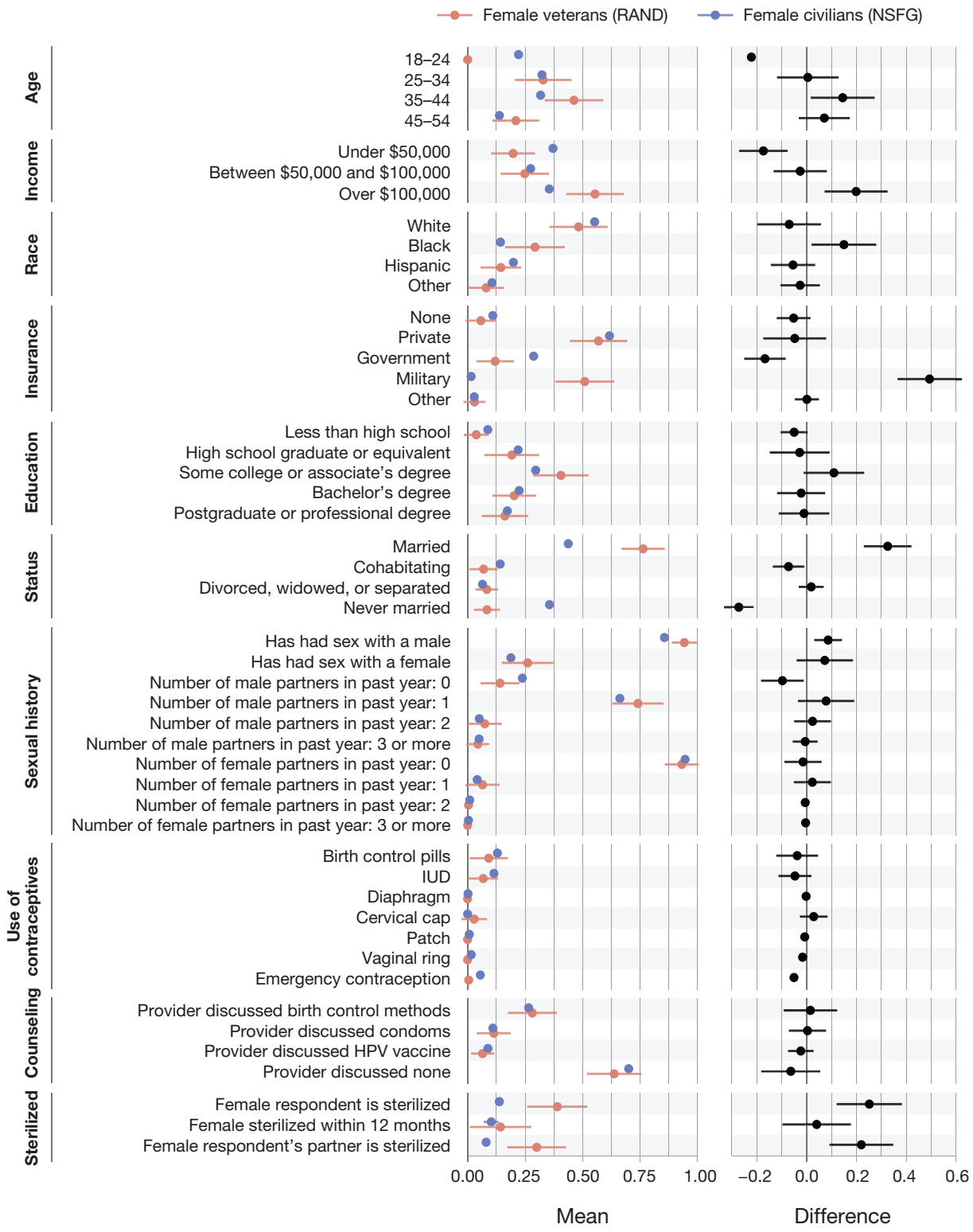
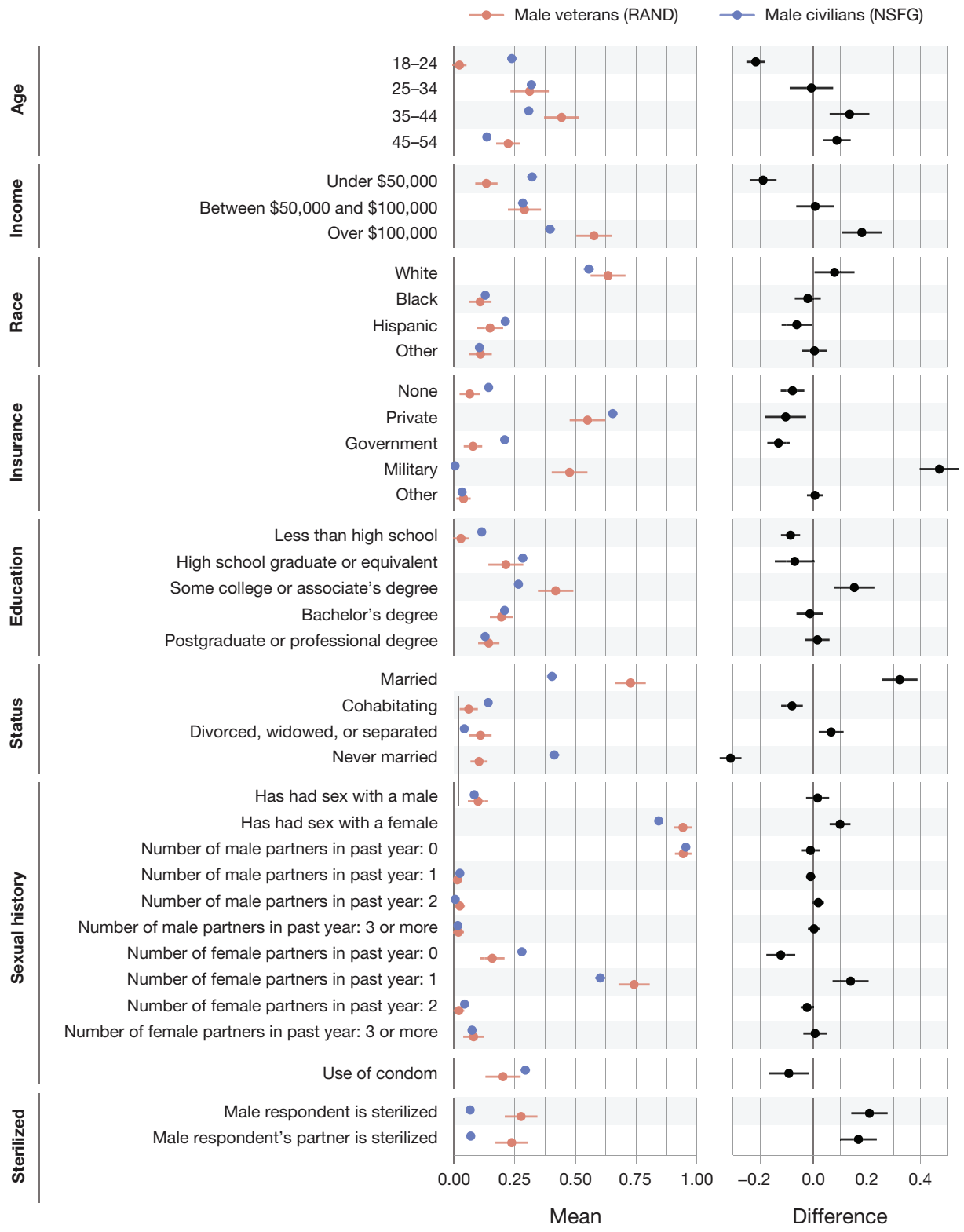


FIGURE 5.2

Weighted Means of Male Veterans in the RAND Survey and of Male Civilians from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals



Other Reproductive Health Care Needs of Veterans

When veterans were asked about other reproductive health care needs, they spoke about the need for STI testing, cancer screenings, and general obstetrical and gynecological care. A few veterans said that they needed to ask specifically about STI testing because it was not something that was routinely provided or offered to them.

> I don't think I've ever been asked if I wanted to be STD tested. . . . When I'm sexually active, I message my doctor every three months to put in an order, but I don't think my doctor, I don't recall ever a time when a doctor has asked me if I wanted to be [screened]. —*Female, 30–34*

> Sometimes when I engage [in discussions about STI testing] as far as, like, well, "Do you think you can just test me for everything, just to be—just to know and just to be good about it?" I feel like it's, like, you're bothering them. —*Male, 30–34*

Some veterans agreed that cancer screening is an important part of reproductive health, and some female veterans spoke about getting regular pap smears. However, there was variation in knowledge levels and how often veterans reported being screened for cancer.

> I'm actually more worried of, like, potentials of, like, cancers, and I'm very on top of [that] through the VA, like, getting screened for just different things. . . . I feel like maybe I'm a little bit more careful about it than I think a lot of other people are. —*Male, 35–39*

> Well, I can say I've never been screened for cancer before. So, I guess that would be one. —*Male, 35–39*

One veteran lamented that obstetrical and gynecological care is not more readily available within the VHA system and that they need to use VA community care for maternity care.

> I still shouldn't have had to go to university to get maternity care, to see a gynecologist, to see a doctor. You know what I mean? I shouldn't have to do that. We're in 2025, women can now be in the infantry. So, they should have more options at the VA for women. —*Female, 35–39*

CHAPTER 6

Summary and Policy Implications

In this chapter, we summarize our key findings, first by the three main research aims and then by the additional findings from our supplemental analyses. We then detail the limitations, policy implications, and potential for future research.

Key Findings

Our primary goals were to better understand gaps in contraceptive access and choice for U.S. veterans of reproductive age and how these gaps might vary by certain characteristics, such as sex or where veterans receive or access care. In addition, we examined potential barriers that could affect veterans' ability to seek or access this care. We also explored whether veterans have unique contraceptive care needs and learned how military experiences may have influenced veterans' past and current contraceptive choices.

Gaps in Access and Choice

We assessed gaps in access and choice by knowledge, contraceptive counseling, and the use of specific methods.

Gaps in knowledge: Overall, more than one-quarter of veterans (28 percent) believe that hormones in birth control are safe, and a little more than one-half of veterans (52 percent) believe that birth control is beneficial to their health, which suggests that many veterans may not feel comfortable with hormonal contraceptive methods. This discomfort may stem from veterans' lack of knowledge about contraceptives.

Veterans selected the wrong answer or did not know the answer for more than one-half of the knowledge-based items on our survey. Across all items, women had higher knowledge scores than men, with significant differences in 12 of 19 items. Because many survey items referenced female-specific contraceptive methods, such as IUDs or the vaginal ring, these sex differences in knowledge levels are somewhat unsurprising. Although veterans seemed to have higher knowledge levels about some survey content areas (e.g., condoms help prevent STIs, semen can be released before ejaculation), veterans had lower knowledge scores about specific contraceptive methods (e.g., how long the vaginal ring can stay in place before it should be changed). Although veterans had low levels of knowledge about contraceptive use, which potentially led to their discomfort with using some contraceptive methods, their knowledge of the side effects of certain methods appeared to be better. The majority of veterans selected contraceptive method side effect frequencies within ranges that are aligned with the medical literature. However, veterans' selections for side effect frequencies for certain contraceptive methods (e.g., higher perceptions of infertility rates or pelvic infections associated with IUDs) suggest that there is some misinformation among veterans that could be negatively affecting their contraceptive choices.

Gaps in contraceptive counseling: The provision of comprehensive contraceptive counseling seems to be one of the biggest gaps in access reported by veterans and particularly by male veterans. Only 10 percent of veterans of reproductive age discussed birth control methods with their providers in the past year, and most of these discussions (72 percent) occurred outside VHA. About two-thirds (67 percent) of these veterans who

discussed birth control were enrolled in VA health coverage. One consideration for interpreting this gap is that veterans may have had fewer discussions about family planning and birth control given their higher rates of sterilization and older reproductive ages. However, we also heard in our interviews that many providers were not raising these topics with veterans (both sterilized and not sterilized). Although males in our interview sample recognized that many contraceptive methods were for female rather than male use, they believed that it was important for them to have these conversations with their providers so that they can be informed about the options that are available for their partners.

Many veterans felt confident in their providers' ability to take their contraceptive concerns seriously, and veterans in general noted their providers as a trusted source of information about contraceptive methods. Through the interviews, veterans elaborated on these discussions (or lack thereof) and noted that discussions were often initiated by the veteran rather than the provider. Veterans' provider interactions included a mix of positive experiences (i.e., felt heard and listened to, needs and preferences were met) and negative experiences (e.g., frustrated by a lack of answers, long contraceptive appointment wait times).

Gaps in the use of contraceptive methods: Only 22 percent of veterans are using contraceptives, yet more than 50 percent of veterans indicated that it is very important for them to not be pregnant in the next month. However, veterans' general levels of contraceptive use (about one in five) align with estimates from the general population. Veterans most commonly tended to use condoms and pills, followed by withdrawal and IUDs.

Variations in Access and Choice

There were few variations in contraceptive use by health care enrollment type (VHA, non-VHA), sex, or age. The greatest variations in contraceptive use were by age: Older female veterans are more likely to be sterilized than their younger counterparts. In addition, younger veterans are more likely to use condoms.

There was also variation in who received contraceptive counseling: More male veterans and older veterans reported not having discussions about birth control methods with their providers. Although contraceptive methods are often targeted at younger female veterans, it is important for providers to discuss contraceptive methods with all age groups and sexes. Because veterans reported that they rely on their health care providers for information about contraceptives, these discussions may provide useful information that veterans can use to inform their family building. However, these discussions may be less relevant for veterans who are sterilized and, thus, do not need ongoing discussions with their providers.

Barriers to Access and Choice

In general, the veterans with whom we spoke did not perceive significant barriers to contraceptive care access or choice. However, male veterans shared that providers generally did not raise family planning or contraceptive discussions with them; some male veterans expressed discomfort about raising or discussing contraceptive options, feeling that the topic may not be seen as relevant to them or too female-centric. Veterans in our study said that having more-explicit discussions and making educational materials more-readily available in VHA health care facilities would be valuable to make contraceptive services and offerings more accessible. Some veterans suggested that emphasizing family planning and contraceptive offerings when veterans transition from military to civilian life would also be helpful, particularly because this timing may be better aligned with the ages at which veterans may have greater family planning needs.

Uniqueness of Veteran Needs and Access

We also gathered and assessed information on the potential unique needs of veterans through discussions and a comparison of veteran responses with a civilian sample. During discussions, most veterans shared that they believe their needs are similar to those of civilians. A small subset of veterans acknowledged or spoke about some of the unique exposures or conditions that veterans experience during military service (e.g., PTSD, exposure to harmful substances, knowledge of sensitive information) that affect their decisions on whether to have children and other reproductive health choices.

In a comparison of differences between veterans and a civilian sample, sterilization rates tended to be higher among female and male veterans compared with the civilian population. However, condom use was lower among male veterans compared with the civilian population.

Limitations

Our sampling and weighting strategy was designed to obtain a sample that is representative of veterans of reproductive age. Both survey vendors sampled veterans from their nationally representative panels of U.S. respondents, limited to respondents who previously indicated on surveys that they had served in the military. However, it is possible that some veterans were missed in this sampling strategy. In addition, because veterans tend to be older, the survey responses, although representative, capture fewer veterans of younger reproductive age who may actively be planning their families. This issue is exacerbated by the fact that survey panels tend to underrepresent younger individuals. Weighting is designed to account for this underrepresentation, although it remains possible that associated confounding persists. The lack of younger veterans may explain the low rates of nonpermanent forms of contraception, including LARC methods. However, the rate of LARC methods did not differ statistically between our sample and the civilian population.

Furthermore, the number of veterans who used some contraceptive methods was small, which made it challenging to understand whether there were differences in access to certain contraceptive types between subgroups of veterans. For example, we could not examine whether veterans who are enrolled in VA health coverage and access health care services have more or fewer challenges getting an IUD removed compared with veterans who are not enrolled in VA health coverage and access health care services. It also made it challenging to analyze how veterans pay for contraceptives by subgroup.

Although we used existing questionnaires (e.g., the NSFG) for many of the survey items, some of the questions had not been fully validated in a sample of veterans. In addition, this study was one of the first to ask male and female veterans neutral questions about contraceptive method use. Therefore, some items may have been confusing to participants or presented potential validity issues, particularly concerning self-reports of use, for which reports could often conflate an individual's use with their partner's use during sex. Although these items presented interpretation challenges, they also provided insight into how respondents conceptualize the use of contraceptive methods (e.g., responding to use for a couple instead of an individual and often a sex-specific method).

Cognitive interviewing may have reduced some of the errors in responses for these and other items. For example, our question asking about where veterans received health care services in the past year did not seem to be well understood by our sample based on discussions in our follow-up interviews. Specifically, when prompted about what care an interview respondent received outside VHA based on their survey response, some respondents referenced referrals to VA community care to see a specialist. Future research could establish more-reliable ways to measure whether veterans have health care that is paid for by VHA but received in the community.

Our comparison with the civilian population also carried some limitations. Although we used many questions from the NSFG, we were unable to compare responses across all categories of questions because of a misalignment in branching patterns between our survey and the NSFG. In addition, the NSFG is administered via a trained interviewer, which may help reduce respondent errors. Despite data collection and branching differences, we were still able to compare our veteran sample with the civilian sample on key survey items (e.g., contraceptive use).

Although respondents in the in-depth interviews were primarily drawn from the probability-based sample, they self-selected to participate in the interviews. Thus, their perspectives are not representative of all veterans. When we selected interviewees to participate, we attempted to ensure that participants had a variety of contraceptive use experiences. However, we did oversample those who reported receiving VHA care because we believed that they may have more insight into the types of information that VHA is providing and could provide to veterans. However, this aspect made it challenging to understand whether individuals who received care outside VHA or through VA community care were different from those who received care at VHA facilities. One area in which we did notice a potential difference between the interviewees and those who only took part in the survey was knowledge levels. It seems that those who had more knowledge about contraceptives may have been more willing to participate in the interview.

Policy Considerations and Recommendations

Our findings from this study suggest a few major gap areas, particularly in terms of veteran knowledge levels and gaps in comprehensive contraceptive counseling. What follows are our policy considerations and recommendations.

Establish more-comprehensive education programs that are not gender-specific and are targeted to veterans of reproductive age. VHA and other veteran-serving organizations might consider implementing educational programs to improve veterans' knowledge about contraceptive methods and associated health implications and aid in veterans' decisionmaking about whether and what contraceptive methods may be appropriate for them. VHA could support the education of enrolled veterans, and other veteran-serving organizations would be better positioned to educate veterans who are not using VHA. These programs could include different learning opportunities to address common misconceptions and provide accurate information about the benefits and risks of various birth control methods. Given the influence of partners on decisionmaking, these campaigns should be targeted to men and women veterans to increase overall knowledge levels.

Enhance communication strategies around the availability of resources and benefits for family planning and contraception. Veterans, particularly male veterans, who receive care at VHA facilities reported seeing little information at these facilities or during their transitions to civilian life about the availability or offering of contraceptive services despite being eligible for such services. Although many veterans assumed that these services were available to women, they were not always sure about the extent of the offerings and what might be available to male veterans. This perception is seemingly reinforced by most information about contraceptive care for veterans being housed on websites under the category of women's health. Furthermore, some veterans assumed that health care services provided by VHA must be for service-related needs (e.g., PTSD, pain management). By developing clear communications to convey offerings—which could include pamphlets, brochures, or digital content on websites—VHA and other veteran-serving organizations could ensure that veterans are aware of the services that are available to them after they transition from the military.

Expand comprehensive contraceptive counseling training for providers. Veterans reported that their health care providers are their most trusted source of information about contraception, yet most veterans also reported not having discussions about contraception with their providers. This disconnect suggests an

opportunity to expand training for health care providers at VHA, beyond WH-PCPs, to equip these providers with the skills to proactively counsel patients on their options, accurately convey the benefits and risks of different methods, and discuss how the benefits and risks align with patients' needs and preferences. Given the number of veterans who reported having contraceptive discussions outside VHA, there is also a need for broader training and awareness for primary care physicians or other relevant specialties (e.g., family medicine, internal medicine, urology) on contraceptive counseling and how to approach conversations with men on goals and options when it comes to family planning. Professional organizations that are affiliated with primary care or other relevant specialties—or groups that reach a broad swath of providers, such as the American Medical Association—might be best suited to help address this gap.

Future Research

This study was one of the first to comprehensively examine contraceptive access and choice among male and female U.S. veterans of reproductive age. This comprehensive assessment included representative panel surveys and a supplemental qualitative component to better understand the specifics of veterans' experiences to inform policy recommendations and considerations. On the basis of lessons learned from this study and the findings, we present the following recommendations for future research or research considerations.

- **Expand studies on contraceptive access and choice to include men.** Including men in more studies on contraception is essential. Men's perspectives and experiences play a significant role in contraceptive decisionmaking within partnerships. Additionally, involving men in contraception studies can help identify barriers that are specific to men regarding access to and use of contraceptive methods. Historically, fertility control has predominantly focused on women and, in the process, has often neglected men's roles and responsibilities in family planning. A better understanding of men's experiences and attitudes toward contraception can lead to tailored educational interventions that meet men's specific needs.
- **Include more-precise measurements of certain contraceptive constructs in web-based surveys.** Several survey items in this study were seemingly misinterpreted—most importantly, reported self-use of contraceptives and the settings in which health care services were received in the past 12 months. However, conducting in-person data collection that appropriately probes and clarifies respondents' intended meanings on a large scale, like the NSFG does, can be time- and resource-intensive. Efforts to develop and test survey items to more accurately assess where veterans are accessing care and how these services are paid for without significantly increasing the number of questions asked would be useful for future work. These measurement advances should involve the cognitive testing of items to ensure question clarity and relevance to both men and women (where applicable), provide a more expansive understanding of contraceptive use, specify the location of contraceptive discussion or method receipt, and facilitate comparisons with other data sources.

Conclusion

In this report, we highlighted significant gaps in contraceptive access and choice among U.S. veterans of reproductive age. The findings reveal that many veterans lack comprehensive knowledge about contraceptive methods, and misconceptions and misinformation affect their choices. Additionally, there is a notable deficiency in contraceptive counseling, particularly among male veterans, which further exacerbates these gaps. Despite these challenges, veterans generally trust their health care providers, which indicates that there is an

opportunity to enhance provider training and health care system communication strategies to better address veterans' contraceptive needs.

The findings also underscore the importance of education and clear and more-expansive communication about available resources and benefits related to family planning and contraception for veterans (either at VHA facilities or in the community). By addressing these gaps, there is potential to significantly improve contraceptive access and choice for veterans, which will ultimately support their reproductive health and well-being.

APPENDIX A

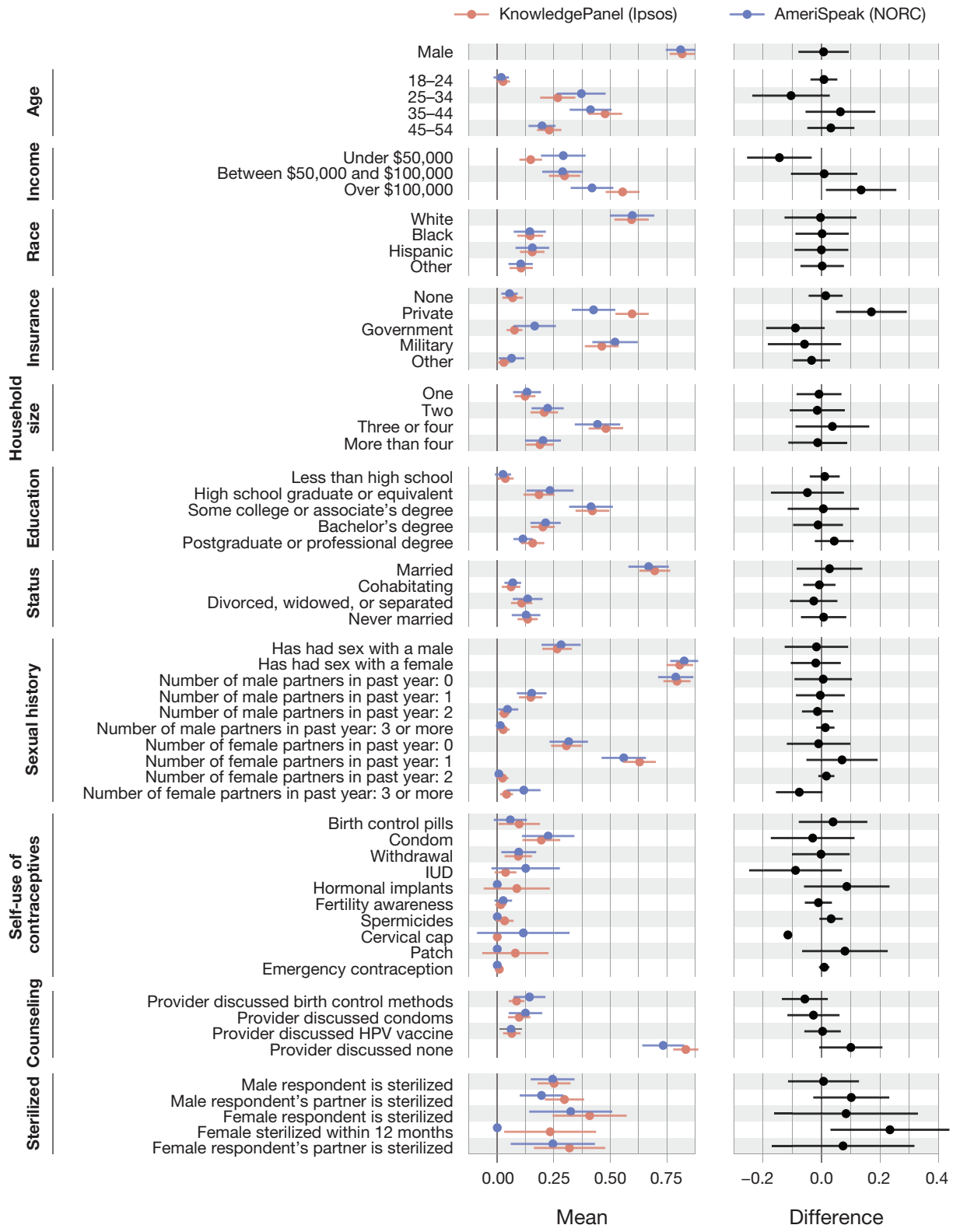
Robustness Checks

In this appendix, we present some analyses that are designed to assess the congeniality of the different data sources.

First, we note that our veteran sample was sourced from two separate survey panels (AmeriSpeak and KnowledgePanel). Therefore, it is prudent to compare demographic characteristics and survey outcomes between respondents from the two panels. These comparisons were performed using the weights developed for the individual panels (as opposed to the final sets of weights that are used only when the data from the panels are used in tandem). The results are shown in Figure A.1. We see differences in income levels between the respondents from the two panels, which is unsurprising given that the AmeriSpeak panel was not weighted on income. There are a pair of minor unexpected differences between the panels (e.g., respondents from the KnowledgePanel reported higher rates of private insurance); however, these differences are not statistically significant following a correction for multiple testing using a false discovery rate.

FIGURE A.1

Weighted Means of Veterans in Ipsos KnowledgePanel and NORC AmeriSpeak Panel with the Difference in Means, All with 95 Percent Confidence Intervals



To assess the congeniality between our data and data from the NSFG (which was used to compare veterans with civilians), Figures A.2 and A.3 provide comparisons of our veteran sample with a military (veterans and active duty) sample from the NSFG for females and males, respectively. (The NSFG did not include questions that would allow us to differentiate veterans from those who are serving on active duty.) We see differences in age between the samples: The veteran sample is older, and there are some remaining differences that may be explained by age. For example, veterans have higher levels of income, higher rates of marriage, and higher sterilization levels.

FIGURE A.2

Weighted Means of Female Veterans in the RAND Survey and of Female Veterans and Active Duty (Military) Personnel from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals

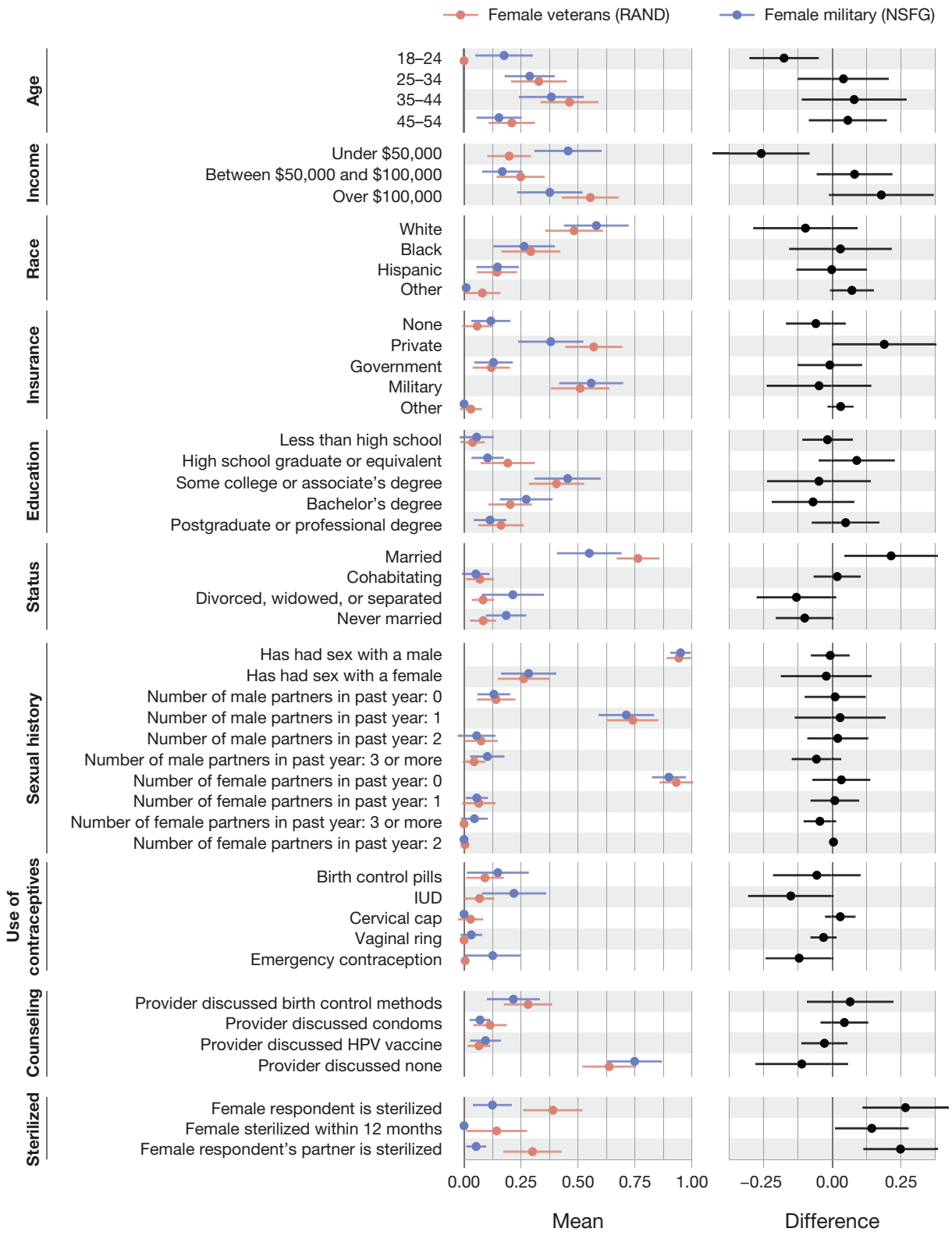
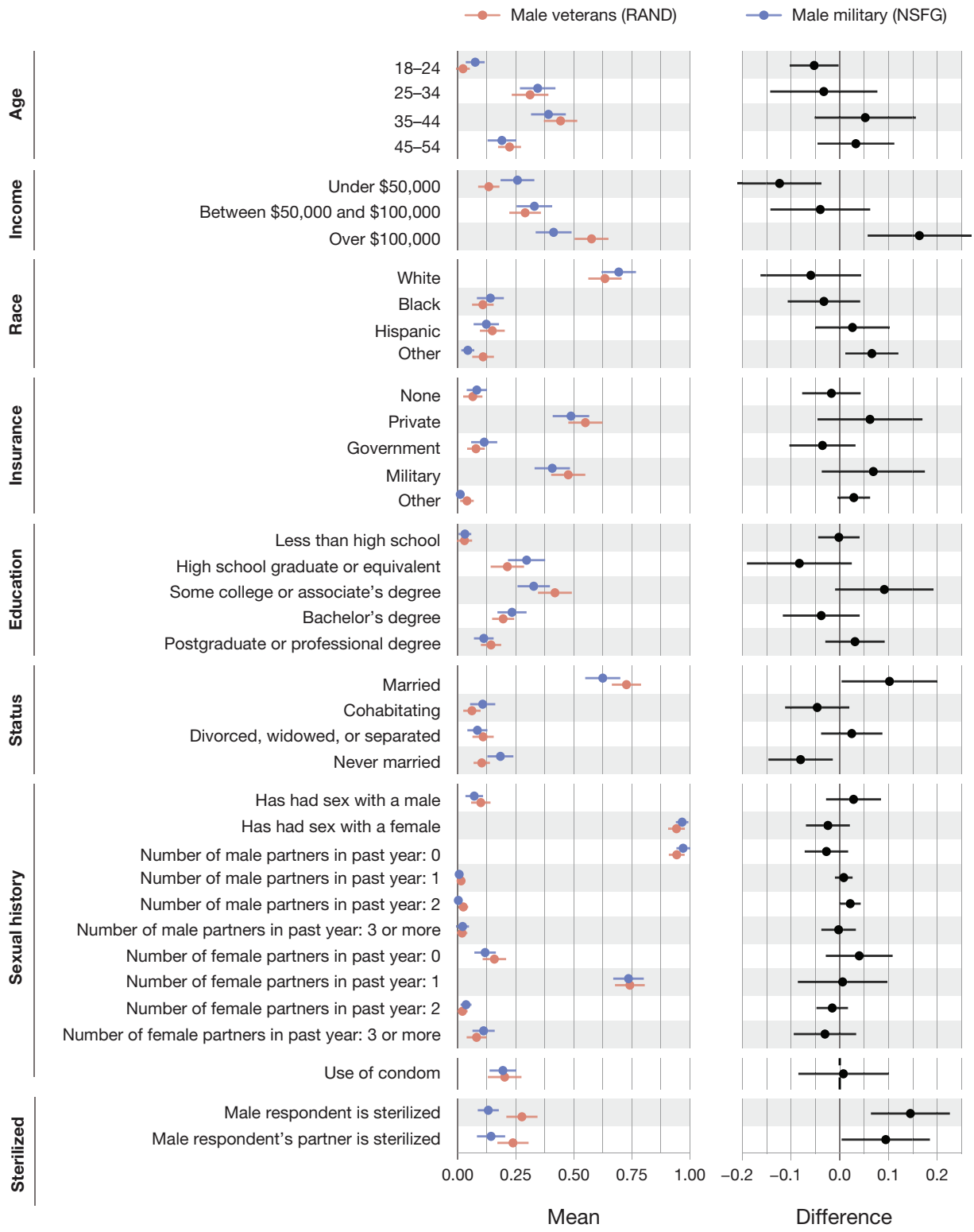


FIGURE A.3

Weighted Means of Male Veterans in the RAND Survey and of Male Veterans and Active Duty (Military) Personnel from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals



Figures A.4 and A.5 provide analogous comparisons following propensity score weighting adjustments for age differences. We see that some of the differences are removed or reduced following age adjustments; however, our sample reports consistently higher levels of sterilization than the NSFG samples, which are not explained by age differences.

FIGURE A.4

Weighted Means of Female Veterans in the RAND Survey and of Age-Adjusted Female Veterans and Active Duty (Military) Personnel from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals

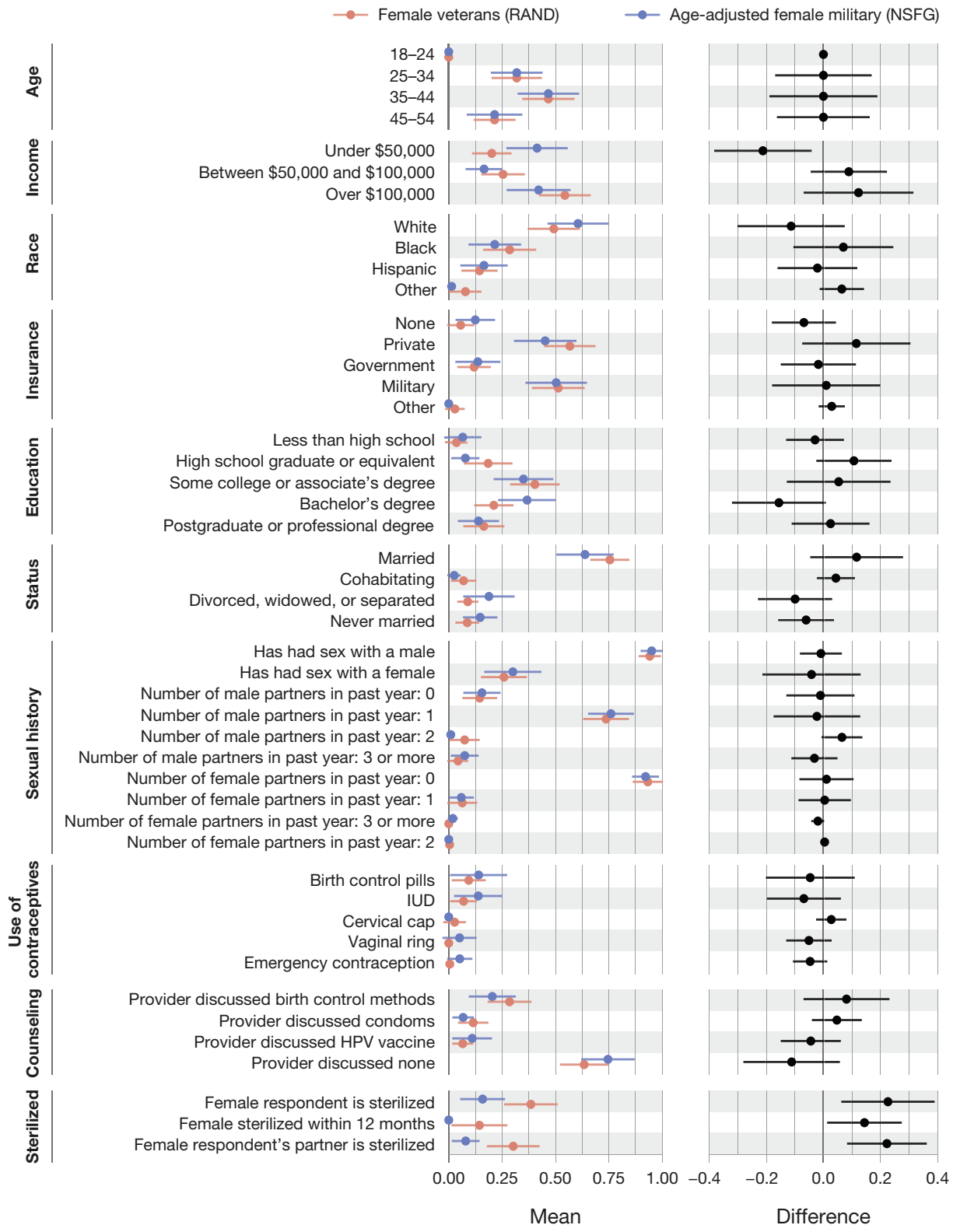
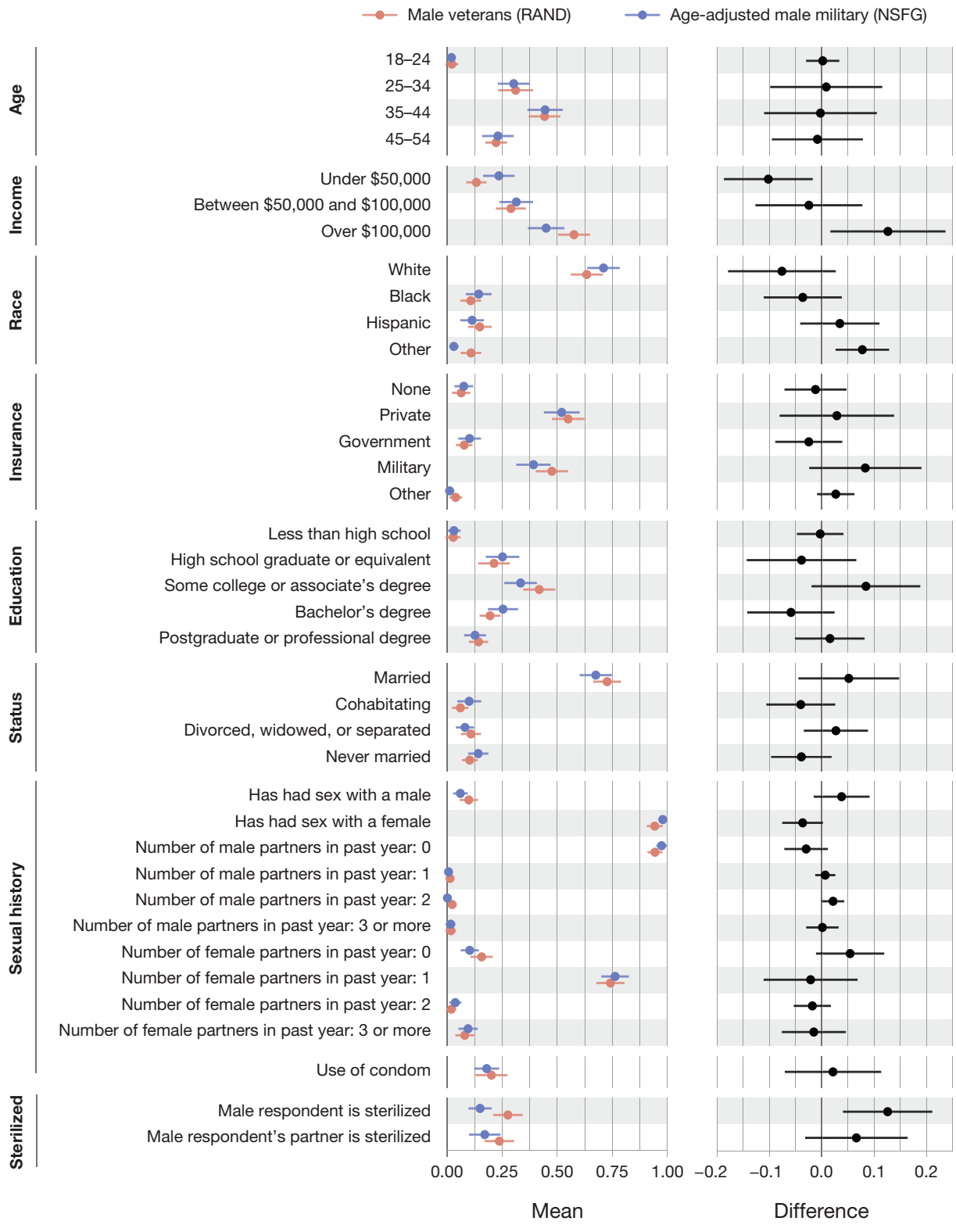


FIGURE A.5

Weighted Means of Male Veterans in the RAND Survey and Age-Adjusted Male Veterans and Active Duty (Military) Personnel from the National Survey of Family Growth with the Difference in Means, All with 95 Percent Confidence Intervals



APPENDIX B

Interview Discussion Guide

In this appendix, we present our interview protocol. This protocol is presented without revision.

Pre-Discussion/Consent Questions

Can you please confirm that you have read the informed consent informational sheet that we sent before the interview?

Y/N —> *If N, verbally talk through informed consent sheet.*

Are you okay with being recorded?

Y/N —> *If Y, start recording.*

Do you have any questions before we begin?

Y/N

Background and Access to VA Services

1. We'd like to begin with understanding a bit more about your military service. How long did you serve? Have you ever been deployed; if yes, where and for how long? How long has it been since you transitioned from active duty?
   Can also probe on most recent branch of military service, particularly if multiple selected in survey.
2. Can you tell me about the area where you currently live—would you say it's a small town or a big city?
3. From your survey, we understand that you [use or do not use] VA healthcare services. Can you tell me more about:
   a. [For VA users] . . . your experiences accessing services at the VA?
      Probe for the types of services accessed, ease of access, and proximity to a VA facility
   b. [For non-VA users] . . . why do you receive healthcare services outside of the VA?
      Probe for whether they have tried to access VA services in the past and were unsuccessful; ease of access to healthcare at VA, and proximity to a VA facility.

Perceptions of VA and Contraceptive Care Access

As we explained earlier, we are interested in veterans' access to and choices about contraceptive care. We will be asking questions about contraceptives or birth control. We include things like condoms, pills, the shot, IUD, ring, patch, and implant, and female and male forms of sterilization like vasectomies and hysterectomies in our definition of contraception.

4. We know that Veterans may have unique health and healthcare needs based on their military service experiences or exposures. Do you think Veterans may have unique needs when it comes to contraception or birth control – or decisions about contraception compared to the civilian population?

Some veterans may have delayed decisions on having a child, may have concerns about toxic exposures, concerns about PTSD or other traumas and certain methods, etc. These can be offered up if the respondent does not understand the question.

a. If yes, can you share more about what you see as being unique to veterans?
b. If no, can you tell me more about why you don't feel there are any differences from your civilian counterparts?

5. What role, if any, do you think the VA should play in supporting veterans' access and choice around contraception?
6. What role, if any, do you think the VA is *currently* playing in supporting veterans' access contraceptives?
   Probe: Do you know what types of contraceptive coverage the VA provides?
7. Have you ever received information about contraceptive care and/or benefits from the VA?
   a. What kind of information did you receive?
   b. How did you use the information?
   c. How useful was this information compared to other information that you may receive from other sources?

   Probe: Social Media? Google?
8. What (if anything) could the VA do to improve contraceptive access for veterans?

Experiences with Contraceptive Care Within or Outside of the VA

Now we'd like to talk more about your specific experiences getting contraceptive-related care.

9. *[If contraceptive care at VA]* We understand from your survey response that you have received contraceptive-related care at VA. Can you tell me about that experience?
   Probe: Did you seek out care? Did you experience delays in getting an appointment? Did you see a provider in-person or through telehealth?
   a. Was this visit part of a routine primary care or pharmacy visit that included other concerns, or whether it was a dedicated visit just for contraception?
   b. Who initiated the discussion?
   c. How would you describe your interactions with your provider?
      Probe: Did you feel listened to and heard? Did they talk through options?
   d. Did the discussion include plans to have or not have a child?
   e. What was most important to you in that discussion?
      Probe: Did you feel heard re: preferences and questions you had around use or side effects?
   f. In what ways did the services provided at VA meet your contraceptive needs and preferences?
   g. In what ways did the services *not* meet your contraceptive needs and preferences?
   h. Are there things that could be improved for a better or easier experience?

10. *[If received contraceptive care outside VA]* We understand from your survey response that you [also] received contraceptive-related care outside of VA. What prompted you to get this care outside of the VA?
    a. Did you try to access contraceptive care at the VA before going outside VA for this care?
       i. If yes, why did you end up getting care outside of VA?

b. Can you tell me more about your experiences receiving this care outside the VA? Who provided you with this care?
Probe for facility type, provider type, etc.; whether it was in-person or through telehealth; experiences getting an appointment.
c. Who initiated the discussion (around contraceptive needs)?
d. Did your provider ask if you were a veteran?
Probe: How do you feel when a non-VA provider asks about your military service, does it feel like important info for your doctor to have, why or why not?
e. How would you describe your interactions with your provider?
Probe: Did you feel listened to and heard? Did they talk through options? Did the conversation include any discussion or plans to have or not have a child?
f. What was most important to you in that discussion?
Probe: Did you feel heard re: preferences and questions you had around use or side effects?
g. In what ways did the services provided outside of VA meet your contraceptive needs and preferences?
h. In what ways did the services not meet your contraceptive needs and preferences?

11. *[If received care at both VA and outside VA (i.e., questions 9 and 10 apply)]* How would you describe the differences between your conversations at the VA and outside the VA?
Probe for factors that may have made the respondent more or less comfortable.

Experiences with and Attitudes Towards Contraceptive Methods

Now we'd like to talk more about your specific experiences with contraception as well as use (or partner use) of contraceptive methods.

12. We understand that you currently use/your partner currently uses [insert based on survey response/don't use contraceptive]. Can you tell me about your decision to use this method?
13. What was important to you when choosing a method? Why?
Prompt for concerns about effectiveness of method; reasons beyond pregnancy prevention (e.g., STI prevention, menstruation regulation, painful menstruation, mood regulation); and side effects.
a. Had you or your partner used other methods in the past?
b. *[If stopped method due to dissatisfaction in survey]* You also said that you stopped [X] method because [REASON FOR DISATISFACTION]. Can you tell me a little bit more about that decision?

14. Who did you talk to when making the decision to use [insert method]?
Clarify if needed whether it was a provider, sexual partner, family member, friend, etc.
a. *[If sexual partner not raised]* Can you tell me why you don't talk to your partner about contraception?
15. You said in the survey that [X] is the most important source of information on contraception. Can you tell me more about how you've come to rely on this source of information?
16. What or who do you think influences your attitudes towards contraception or specific contraceptive methods? If so, who and how?
17. How do you think being a veteran has impacted your choice of contraceptives, if at all?
a. How has your previous military experience impacted your contraceptive choice?

18. Have you ever felt pressured to make a decision about contraception? If so, can you tell me more about that?
    a. Who would you say has the most say about which method you might use?
    Prompt if needed re: partner, family member, physician, church.
19. Can you tell me about a time where you felt like you didn't have all the information to make an informed decision about all of your contraception options?

Closing

20. Is there anything else you would like to tell me about your experiences or perspectives around contraceptive choice or access as a veteran?

Abbreviations

ACS	American Community Survey
CPS	Current Population Survey
HPV	human papillomavirus
IUD	intrauterine device
LARC	long-acting reversible contraceptive
NSFG	National Survey of Family Growth
PTSD	post-traumatic stress disorder
STD	sexually transmitted disease
STI	sexually transmitted infection
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration
WH-PCP	women's health primary care providers

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