Australia's servicewomen and female veterans: do we understand their health needs?

Australian female veterans are an emerging but largely invisible group with unique health needs

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Australian women have served in overseas military operations since the Boer War. Over the past two decades, an increasing number of women have deployed, often repeatedly, in Australian Defence Force (ADF) operations. Among this group are peacekeepers, reservists and veterans of conflict in Iraq and Afghanistan. In 2011, there were 1033 women (10.2% of the total personnel) deployed across these three major operations. In addition, the roles and tasks undertaken by women have become more diverse, including service as helicopter pilots, surgeons, logisticians and explosive ordinance experts. Women have participated in combat-related activities including accompanying combat patrols in close support and communications roles. Significantly, the cohort of servicewomen who have deployed now also includes mothers with dependent children. Further, ADF gender restrictions have recently been lifted, allowing Australian women to be involved in every aspect of military service, including frontline combat.[1]

The health consequences of operational service, including the environmental risks involved in humanitarian, peacekeeping and conflict operations, are well documented. Australian women have sustained serious injuries during recent ADF operations, including combat-related injuries. Three Australian servicewomen have died on operational service: a doctor in the Western Sahara and two medical staff in the Nias Island helicopter accident.

Women are also not immune to the "unseen wounds of war". Psychological injuries of service, including depression and post-traumatic stress disorder (PTSD), often become apparent only many years after service.[2] Health personnel are often exposed to extremely traumatic events, and may be a particularly vulnerable group.

As the number of women in the ADF increases, the health issues affecting servicewomen and female veterans can also be expected to increase. Similarly, as women's roles change, the profile of service-related injury is expected to change.[3] Expanded roles for women bring new physical demands, such as those that come with wearing heavy body armour on active patrols, and potentially new mental health issues.[4,5]

Gender-specific health effects of service

It is important to understand the gender-specific health impacts of both the training environment and operational service within the Australian context. To date, the understanding of these issues and their correlates has been heavily dependent on research from United States military populations.[4,5]

There are few published data relating to health outcomes in Australian women who served in World War II. Most relate to the specific cohort of female prisoners of war. Similarly, there are limited data relating to health issues confronted by Australian women returning from Vietnam and peacekeeping operations. In 1998, Department of Veterans' Affairs (DVA) data were published on the health outcomes of the Australian Vietnam veteran female cohort.[6] While this was a landmark study, the results should be interpreted with caution as the sample size was small and only 46% of eligible female veterans responded.

Despite these limitations, the study reported a statistically significant increase in a number of conditions including:

- asthma, eczema and dermatitis;
- depression, panic attacks;
- live births with labour complications, stillbirths, hydatidiform mole; and
- overall total of cancers, including breast cancer.

This suggests that there may be gender-specific health consequences of service and deployment.

One of few Australian studies to address health issues facing contemporary female veterans identified significant barriers to accessing existing support services, and gaps in knowledge that affect health and wellbeing.[7] These included perceptions of a lack of:

- an authentic veteran identity (seen by self and others to be a legitimate veteran);
- trust or confidence in DVA- or ADF-funded services; and
- understanding of gender-specific issues such as maternal separation and parenting, reproductive health and military sexual trauma.

Extrapolation from US data suggests that there are three main areas that require further investigation in terms of gender-specific health risk:

- physical performance standards and training;
- sexual and reproductive health; and
- mental health and wellbeing, and maternal relationships.

Physical standards and training

In parallel with the ADF expanding roles for women, there has been a move away from gender-specific physical performance standards to "fitness for task" assessments. The physiological, biomechanical and health impacts of soldiery impact differently on female and male bodies, and conditioning and training requirements therefore differ. Female soldiers are at risk

of developing osteoporosis, amenorrhoea and stress fractures.[4] Military load carriage requirements are significant (ranging between 40 kg and 60 kg in Afghanistan for example). Such loads can result in increased rates of musculoskeletal injury and, in women, pelvic floor instability, contributing to long-term incontinence.[8] Both primiparous and multiparous women are at increased risk. The duration of this risk is currently the subject of ongoing research. The risk of musculoskeletal injuries, particularly pelvic injuries, also increases when attempting to match male stride length and frequency, and can be exacerbated by inadequately fitted equipment such as body armour.[4,9]

Sexual and reproductive health

Sexual and reproductive health issues include contraception and management of menstruation or menopausal symptoms in a deployed environment. There is currently limited literature about the consequences of operational service on fertility.[3] In particular, the impacts of service on risk factors known to decrease fertility, such as smoking and obesity, as well as potential effects of the environment on fertility, such as exposure to toxic substances, are poorly documented or understood. Current data suggest that 21% of women separate from the ADF immediately or within a year of taking maternity leave.[1] This means that information about delayed health effects can only be obtained by prospective linkage of health information.

Mental health and wellbeing, and maternal relationships

Servicewomen are at increased risk of mental health problems in comparison with their male counterparts.[10] In particular, US studies report increased rates of:

- binge drinking among female veterans;
- PTSD compared with male veterans; and
- female veteran homelessness, particularly among single mothers.[5]

Of concern is a consistent view among overseas researchers that women are up to four times more likely to develop a mental health disorder after deployment, and servicewomen with children are particularly vulnerable to the stresses of deployment because of their additional family responsibilities.[11]

However, the Australian experience may not replicate that of the US. A recent Australian study suggests that serving mothers deployed with the ADF Middle East Area of Operations were at no greater risk of psychological distress, post-traumatic symptoms, alcohol misuse or somatic illness after deployment, compared with other serving women without dependent children (Alexander McFarlane, Director of the Centre for Traumatic Stress Studies and Professor of Psychiatry, University of Adelaide, personal communication, July 2013). However, this study was based on self-reported data and may reflect a selected subgroup. An expanded study is currently underway, but these findings underscore the need for Australian-specific data, rather than extrapolation from foreign military services.

> “The physiological, biomechanical and health impacts of soldiery impact differently on female and male bodies”

Health service equity

Veterans and ex-serving personnel access a complex set of health services. These include federal government-funded services such as those provided by the DVA, Medicare and state and territory health systems, as well as the services of private providers and a range of non-government organisations. There is a clear need for integration of care, to ensure equity and access for all members of the veteran community. Efforts are in place to provide greater linkage between ADF and DVA health datasets and to minimise the risks of “falling between the gaps”. However, subpopulations who may not identify or be identified as part of the veteran cohort and may be otherwise at risk may be vulnerable to exclusion. Servicewomen and female veterans may be overrepresented in this so-called “missing cohort”.

Failure to track such issues or appreciate linkages to service has significant implications. For the individual, access to benefits or to specialised veteran mental health programs is relevant. From a community perspective, failure to recognise the service-related effects dilutes the appreciation of the impact of ADF service on its constituents. This underscores the importance of employment history. In the US, the Department of Veterans Affairs has spent considerable effort redesigning its health services to be gender friendly — with links to women’s health sites and resource investment to ensure equity of access.

Conclusions

As we approach the centenary of ANZAC, it is appropriate to reflect on the lessons of history and the changing nature of the ADF. As the number of female soldiers and veterans increases, and their roles expand, it is important that the Australian medical profession, including primary health care physicians, women’s health specialists and psychiatrists in particular, are aware of the gender-specific health effects of service on this emerging female veteran cohort.

A critical appraisal of the health risks specific to servicewomen and female veterans will allow government programs to:

- increase visibility of services for and experiences of female veterans;
- develop targeted support and resources for female veterans;
- develop and implement appropriate gender-specific education and/or health mitigation strategies; and
- develop best-practice guidelines for the treatment of female veterans.

The lessons from this group also have wider community applicability — for example, the Australian police force, fire services and emergency services are also

seeking to increase female participation rates. In doing so, they are likely to face similar gender-specific health issues related to training and deployment.

As the veteran community continues to change, new and emerging health issues will be identified. As more women are included within the contemporary veteran cohort, it is important that health professionals understand the service-specific impacts on their current and future health.

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