Women in Uniformed Service for America: Past, Present and Future

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Outline of Discussion

Those Who Serve and Have Served Our Nation in Uniform

The Women Who Served Our Nation

The History of Women’s Service to Our Nation

Active Duty and Veteran Women in the Population

The Health and Well-being of Women Who Serve

Current Trends in Legislation and Research
Learning Objectives

Participants will be able to:

• Understand and describe the historical, social, cultural and psychological factors influencing women’s participation in the uniformed services of the United States.

• Identify the prevalence and population characteristics of women veterans in the United States.

• Understand the unique health and well-being issues and challenges experienced by women who serve and have served in uniform.

• Understand the differences in how health care is structured and administered among groups of eligible uniformed women beneficiaries.

• Have an awareness of current legislative efforts and future research trends which will impact women who serve and have served in the armed forces.
Those Who Serve and Have Served Our Nation in Uniform

Who Are They?
What Comes to Your Mind When You Think About Veterans?

- Vietnam War?
- Older Men, Family Members?
- Memorial Day / Veterans Day Parades or Events?
- World War II Memorial?
- Arlington Cemetery?
- Local VA Hospital / Cemetery?
- Flags on Graves?
- Agent Orange or other War Diseases and Disabilities?
The Women Who Serve Our Nation

Who Are They?
Who Are Our Women Service Members and Veterans?

- Are They Visible?
- What Duties and Jobs Have They Performed and Where? During What Time Period?
- How Do Their Experiences Differ From Their Male Counterparts?
- Are Their Generational Differences?
- What May Be Some of Their Unique Perspectives and Concerns?
- Are There Distinctive Health Status Characteristics?
- What Does the Lifting of Combat Restrictions and Other Occupational Ratings Mean for Women Who Serve Going Forward?
History of Women Who Have Served

Important to Understand Women’s Past Participation in the Military - Provides Context for the Present and Future.
Historical Background of American Women's’ Military Service  (compiled by SWAN 2019)

Officially, women have been serving on active duty in the U. S. military since 1901. *Unofficially, they have been serving since the American Revolution, during which time women like Deborah Sampson dressed as men to enter the Continental Army.*

Others like Margaret Corbin, accompanied their husbands to camp and then onto the battlefield. It was during the Civil War that the U.S. government first recruited women to serve with the armed forces as nurses, albeit without military status.
• **Revolutionary War:** The first woman to receive a disability pension from Congress for wounds incurred during military service was Margaret Corbin. She was wounded after taking over her fallen husband’s cannon during the Battle of Fort Washington in the American Revolution.

• **During the Civil War,** women disguised as men fought on both sides. Women also served as spies and medical personnel. Three of the most famous women were Dr. Mary Walker, a physician and the only woman ever awarded the Congressional Medal of Honor; Clara Barton, who served at the siege of Petersburg and founded the American Red Cross; and Harriet Tubman, who was a volunteer nurse, spy, and scout for the Army of the North.

• In 1862, four Sisters of the Holy Cross and five African American women served aboard one of the Navy’s first hospital ships, the USS RED ROVER, providing medical care.

• Cathay Williams is the only woman known to have served as a Buffalo Soldier. A former slave, she served as Private William Cathay for two years before her actual sex was discovered during treatment for an illness.
History Continued:

- **During World War I,** military nurses served close to the front-lines and some were gassed or wounded. Three were awarded the Distinguished Service Cross.

- **World War II:** More than 200 nurses died while serving in overseas theaters during World War II—in total, 543 American servicewomen died, 16 from enemy fire. Eighty-five women were prisoners of war, all but one in the Pacific theater.

- **Korean War:** Fifty-seven Army nurses arrived in Pusan, Korea, less than 72 hours after the first U.S. troops landed. Within days, they were treating casualties at the battlefield’s perimeter. Army nurses also landed on the beach at Inchon on the day of the invasion. Seventeen military women were killed during the Korean War, mostly in aircraft accidents.

- **Vietnam War:** Eight U.S. servicewomen died while serving in theater during the Vietnam War, including one from hostile fire. Their names are inscribed on the Vietnam War Memorial.

- **First Gulf War:** During the Gulf War, almost 41,000 women served in theater—15 were killed and two were taken as prisoners of war.
Recent and Present Conflicts

• **9/11 - Iraq and Afghanistan**: Fifty American servicewomen died and 383 were wounded in action during Operation Enduring Freedom (Afghanistan), which ended in December 2014.

• One hundred and ten women were killed and 627 were wounded in action during Operation Iraqi Freedom, which ended on 31 August 2010. One woman died and 12 were wounded in action in Operation New Dawn (Iraq), from September 2010 to December 2011.

• As of 2019, five women have died and 68 have been wounded inaction in Operation Inherent Resolve (Iraq and Syria), which began in 2014; and to date four women have died and 12 have been wounded in action in Operation Freedom’s Sentinel (Afghanistan), which began in 2015.

• Two women, both enlisted, have received the Silver Star for heroism—one in Operation Iraqi Freedom and one in Operation Enduring Freedom.
Current DoD Legal and Policy Changes Affecting Women Who Serve

- **Women have come a long way! 1947** Congress passes the Army-Navy Nurse Act (PL-36-80C), which:
  - Establishes the Army Nurse Corps and the Navy Nurse Corps as permanent staff corps in the regular Army and Navy.
  - Integrates nurses into the officer ranks of the regular Army and Navy with Lieutenant Colonel/Commander as the highest permanent ranks. Nurse Corps directors are authorized to hold the temporary rank of Colonel/Captain.

- **To Today…**

- **2015 - SECDEF Ash Carter** announces that women can now enter any MOS and serve in any unit for which they meet the standards. This announcement is made after the Office of the SECDEF reviewed a request submitted by the Commandant of the Marine Corps—to which the Secretary of the Navy did not concur—to keep Marine Corps Infantry and some other MOSs closed to women.

- **2019 - the USMC** announces that women recruits in the incoming 05 January bootcamp class will form one of five platoons in the formally all-male 3rd battalion at Parris Island. The USMC remains the only service that segregates men and women at bootcamp.

- **Bottom Line…women now perform and train in all combatant specialties ranging from attack submarines to special operations units…often in austere environments…**
Active Duty and Veteran Women in the Population

Understanding the Prevalence: Do They Reflect the General Population of Women in America?
Active Duty and the Reserve Components

• The percentage of active-duty troops who are women has increased dramatically from 1.6 percent in 1973 to 17 percent as of 2020 (the draft ended in 1973).

• Today over 210,000 women serve on active duty in the military services of the Department of Defense (Army, Navy, Marine Corps, and Air Force), and another 5,955 serve in the Active Coast Guard, and of the Commissioned Corps of the Public Health Service approximately 3,362 are women.

• The Reserve Components are federal forces. Guard components play dual state and federal roles. These service members flow between active status and civilian status.

• The Reserve and Guard components have an increasing percentage of women in their ranks. As of 2018, 158,090—or 19.8 percent—of all personnel serving in the six DoD Reserve and Guard forces were women.

• Ethnicity: As 2018, nearly 61 percent of the enlisted women in the DoD services are minority women, as are about 38 percent of women officers.

• A significant proportion of U.S. military women are African American; African Americans account for a significantly higher percentage of military women than of military men (25.6 percent versus 14.5 percent).
• Today’s active duty are tomorrow’s veterans...

• Definition: Title 38 of the Code of Federal Regulations defines a veteran as “a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable.”

• Recent change in law for National Guard. Now, under the new law, anyone eligible for reserve component retirement benefits is considered a veteran.

• Anyone who has reached 20 years of service, even if they were never activated on a [federal] order for more than 180 days outside of training, will now be considered a veteran when they retire.

• *Important to understand the distinction between the active / guard and reserve components and veteran status – benefit structures are different!*
Veteran Women

• As women grow in the U.S. armed forces, thus the growth in number and percentage of women who become veterans. Women veterans are the fastest growing cohort

• As of 2019 there are approximately 2 million women veterans, or 10% of the total veteran population

• The population of women veterans differs from that of male veterans in a variety of ways: The average woman veteran is younger (median age 51 vrs. 65 for males) than her male counterpart and more likely to belong to a minority group.

• There are 19 million veterans in the United States representing less than 10% of the total population (data from the VA and Dept of Labor)

• To put this into context....
Of 100 adults in the overall population:

- 7 are male veterans
- 41 are male nonveterans
- 1 is a woman veteran
- 51 are women nonveterans

Number of veterans in the United States in 2019, by gender

- **18 to 34**: 1,000,000
- **35 to 54**: 3,000,000
- **55 to 64**: 2,000,000
- **65 to 74**: 4,000,000
- **75 and older**: 4,000,000

- Male
- Female
Number of Enlisted Recruits, 2018

California had the largest number of people enlist in the services, with 19,504 recruits.

At 18,670, Texas had the second-largest number of recruits.

Washington, DC, had the fewest recruits, at 93.

Notes: Coast Guard data not available.
The Health and Well-Being of Women Who Serve

Ask Each and Every Person “Have you ever served in the military?”
The Health of Women Who Have Served

- The report analyzes 23 health measures from three publicly-available data sources: the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS) and National Health Interview Survey (NHIS), and the Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (NSDUH).

- The measures included are indicators of behaviors, health outcomes, clinical care, community and environment, and policy.

Key Results

Women who have served have a **16% higher rate of arthritis, cancer, and cardiovascular disease, a 19% higher rate of COPD, and a 29% higher rate of functional impairment** than those who have not served.
“Despite being more highly educated and having higher incomes, women with military service face a greater burden of many health concerns than civilian women.”
A Few Differences Between Women and Men...

How Do Women and Men Who Have Served Compare on Mental Health Measures?

The 2016 America's Health Rankings® Health of Those Who Have Served Report revealed that in 2013-2014, women who have served reported higher rates of depression (25.5% vs. 14.7%) and frequent mental distress in the past 30 days (14.5% vs. 10.3%) than men who have served.

How Do Women and Men Who Have Served Compare on Health Behaviors?

The 2016 America's Health Rankings® Health of Those Who Have Served Report revealed that in 2013-2014, women who have served reported lower overall rates of excessive drinking (12.8% vs 21.7%), smoking (17.5% vs. 22.7%), and obesity (25.1% vs. 29.0%) than men who have served. They reported similar rates of insufficient sleep (42.5% vs. 43.4%). While both men and women who have served were less physically inactive than those who have not served, rates of physical inactivity were higher for women than men (21.9% vs. 19.3%).
• Those who have served continue to report a more positive outlook on their health, compared with those who have not served. However, for the first time, the percentage reporting very good or excellent health has declined.

• Those who have served continue to report higher rates of chronic disease than their civilian counterparts.

• The percentage of those who have served who received a flu vaccination has decreased.

• Rates of mental health challenges, such as depression and frequent mental distress, are increasing at a faster rate among those who have served than those who have not.

• Rates of mental health challenges differ among men and women who have served.

• Those who have served report lower rates of avoiding care due to cost.
What Resources Do Service Women and Veterans Need and Want?

BRIEF #2:
Coronavirus (COVID-19) Climate Snapshot Poll:
TOP RESOURCE NEEDS OF VETERANS AND ACTIVE DUTY SERVICE MEMBERS

L. Euto, R. Maury, N. Armstrong, B. Stone, & R. Linsner
Institute for Veterans and Military Families (IVMF) at Syracuse University
TOP RESOURCE NEEDS OF VETERANS AND ACTIVE DUTY SERVICE MEMBERS

ACCESS TO RESOURCES

VETERANS REPORTED NEEDING THE MOST HELP FINDING RESOURCES IN:
- Financial Assistance
- Community Support
- Legal Services
- Employment & Career Development

ACTIVE DUTY REPORTED NEEDING THE MOST HELP FINDING RESOURCES IN:
- Family & Children Services
- K-12 Education
- Community Support
- Benefits & Claims Assistance

ACTIVE DUTY SERVICE MEMBERS REPORTED HIGHER % OF NEED IN KEY RESOURCE AREAS COMPARED TO VETERANS

TOP RESOURCE NEEDS BY GENDER

MORE FEMALE VETERANS (79%) THAN MALE VETERANS (77%)

MORE ACTIVE DUTY MALES (69%) THAN ACTIVE DUTY FEMALES (66%)

OTHER TOP KEY RESOURCES NEEDS

FEMALE VETERANS
- Community Support
- Benefits & Claims Assistance
- Post-Secondary Education & Training

FEMALE ACTIVE DUTY
- Family & Children Services
- K-12 Education
- Community Support

MALE VETERANS
- Community Support
- Benefits & Claims Assistance
- Financial Assistance

MALE ACTIVE DUTY
- K-12 Education
- Community Support
- Post-Secondary Education & Training

TOP RESOURCE NEEDS BY AGE GROUP

MEDICAL CARE #1 RESOURCE NEED REPORTED BY ACTIVE DUTY IN ALL AGE GROUPS

NUMBER ONE RESOURCE NEED REPORTED BY VETERANS (18-34) WAS POST-SECONDARY EDUCATION AND TRAINING.

NUMBER ONE RESOURCE NEED REPORTED BY VETERANS (35-54) AND VETERANS (55 AND OLDER) WAS MEDICAL CARE.

TOP RESOURCE NEEDS BY RACE/ETHNIC MINORITIES

HIGHER % OF NEED IN KEY RESOURCE AREAS WAS REPORTED BY VETERAN AND ACTIVE DUTY MINORITY WHEN COMPARED TO THEIR NON-MINORITY COUNTERPARTS

NUMBER ONE RESOURCE NEED REPORTED BY ACTIVE DUTY MINORITY WAS POST-SECONDARY EDUCATION AND TRAINING.

NUMBER ONE RESOURCE NEED REPORTED BY ACTIVE DUTY NON-MINORITY WAS COMMUNITY SUPPORT.

ACTIVE DUTY MINORITY AND ACTIVE DUTY NON-MINORITY ALSO INCLUDED K-12 EDUCATION AND FAMILY AND CHILDREN SERVICES AS TOP RESOURCE NEEDS.

TOP RESOURCE NEEDS REPORTED BY BOTH VETERAN MINORITIES AND VETERAN NON-MINORITIES
- Medical Care
- Community Support
- Benefits & Claims
Access to Health care

• **Active-Duty and Active-Duty Family Members:**
  - Generally, receive and access health care on military bases at military hospitals and clinics (MTFs).
  - May use the civilian TRICARE network when services are not available at the MTF, or Active-Duty family members may choose to enroll in TRICARE (many sub-plan categories e.g. TRICARE Overseas, TRICARE Prime Remote...)

• **National Guard and Reserve Components:**
  - May have employer sponsored civilian health care...but go on TRICARE when activated for reserve or guard duty. Or have purchased a TRICARE Reserve Select or TRICARE Retired Reserve for themselves and their families.

• **Veteran Status:**
  - Enrollment in the VA health care system is based primarily on veteran status (i.e., previous military service), service-connected disability, and income. Veterans can apply to enroll in VA health care by mail, telephone, and in person at a VA medical facility.
  - Of the total population of about 2.03 million women veterans, 755,807 were enrolled in the VA health care system in FY2019. The states where the largest numbers of women veteran VHA enrollees resided in FY2019 were Texas, Florida, California, Georgia, and Virginia
Current Trends in Legislation and Research

TSNRP
Fostering Excellence in Military Nursing

RESEARCH INTEREST GROUPS
Collaboration, Mentorship, and Education

HONORING our PACT ACT
Promise to Address Comprehensive Toxics
Objectives
1. Identify mechanisms of musculoskeletal injury due to heavy load carriage.
2. Identify the influence of modifiable risk factors, such as muscle strength, on injury risk.
3. Provide gear and training recommendations to mitigate individual injury risk.

Accounting for the biomechanical effects of muscle strength, body size and body mass variation across the population of military service members can greatly inform injury risk for women in combat.

Background & Motivation
- Musculoskeletal injury accounts for ~60% of all injuries sustained in military operations.
- Women are particularly susceptible to injury during military training exercises.
  - Though male and female service members sustain similar types of injuries, percentages for females are higher since women generally have lower muscle strength and physical endurance compared to men.
  - Quantifying internal joint and muscle loading is critical to determine mechanisms of musculoskeletal injury.
  - Modeling approaches can be used to estimate the load on muscles and identify factors that increase injury risk.

Approach
Experimental Protocol
- A minimum of 20 active duty service members are involved
- Isometric and isokinetic muscle strength measurements
- Dynamic tests of load carriage while walking on level, uphill and downhill slopes
- Kinematics, kinetics, electromyography, and pressure/load distribution collected during movement

Preliminary Results
Preliminary analyses of backpack load configuration during walking suggest that load sharing between pack attachment points can substantially influence biomechanical metrics associated with injury risk.

Expected Outcomes
Individualized assessments of:
- Internal forces on spinal and lower-limb joints
- Muscle forces and fiber dynamics
- Functional roles of muscles

Effects of muscle strength, body composition and size on biomechanical quantities that indicate injury risk will be evaluated.

We are looking for translation partners!
Please contact us if these analyses can inform your training and/or gear implementation or you are interested in partnering.

References
INTRODUCTION
Posttraumatic stress disorder (PTSD) is a significant mental health concern. Among service members, PTSD can also negatively impact unit cohesion and operational readiness.

Although there is considerable research on PTSD in military samples, there is limited research on sex differences in PTSD.

PTSD IN WOMEN
Compared to males, a majority of research on PTSD and sex differences shows:
- Female service members have a significantly greater risk of developing PTSD after experiencing a trauma (Phinney et al., 2016; Countermine & Acierno, 2018).
- Female service members experience higher rates, increased severity and distress, and longer duration of PTSD symptoms (Phinney et al., 2014; Hack et al., 2015).

WHY STUDY SEX DIFFERENCES IN PTSD?
- More rapid/accurate identification of symptoms
- Help to identify differences in treatment-seeking behavior and response
- Can inform whether PTSD treatment approaches need to be tailored

METHOD
A scoping review of sex differences in PTSD symptom presentation and treatment-related variables among females and males in military/veteran samples. This scoping review is being conducted using a PREMIS method. Initial results are presented.

RESULTS

TRAUMA TYPE
- Sexual trauma in veterans is associated with PTSD and linked to a higher number of co-occurring symptoms.
- Female veterans are more likely to experience sexual trauma than males.
- Men and women veterans with PTSD and trauma history show greater PTSD severity than those without.
- PTSD symptoms are higher for female veterans with PTSD than males.
- PTSD symptoms are higher for female veterans with PTSD than males.
- PTSD symptoms and severity may differ between males and females.
- Differences may exist based on the type of trauma endured.

TRAUMA STRESSORS
- PTSD symptoms may differ between males and females.
- Differences may exist based on the type of trauma endured.

CONCLUSIONS
- PTSD treatment may benefit from tailoring approaches to women and men; Treatment modifications based on sex may or may not be necessary.
- Run to female veterans’ higher likelihood of experiencing sexual trauma, they may present with more combat-related than non-combat-related PTSD.
- PTSD symptoms and severity may differ between males and females.
- Differences may exist based on the type of trauma endured.

- PTSD treatment may benefit from tailoring approaches to women and men; Treatment modifications based on sex may or may not be necessary.
- Differences may exist based on the type of trauma endured.

DIFFERENCES BETWEEN SERVICEMEN AND MEN
- Differences between servicemen and men exist in terms of trauma type, comorbid disorders, and treatment-seeking factors.
- Research suggests that PTSD treatment marketing may benefit from tailoring approaches to women and men; Treatment modifications based on sex may or may not be necessary.
- Differences may exist based on the type of trauma endured.

COMORBIDITIES
- Mental health conditions associated with PTSD are more common among females than males.
- Mental health conditions associated with PTSD are more common among females than males.
- Mental health conditions associated with PTSD are more common among females than males.
- Mental health conditions associated with PTSD are more common among females than males.

TREATMENT SEEKING FACTORS
- Differences in treatment-seeking behaviors may exist between males and females.
- Differences in treatment-seeking behaviors may exist between males and females.
- Differences in treatment-seeking behaviors may exist between males and females.
- Differences in treatment-seeking behaviors may exist between males and females.

TREATMENT RESPONSE
- Differences in treatment response may exist between males and females.
- Differences in treatment response may exist between males and females.
- Differences in treatment response may exist between males and females.
- Differences in treatment response may exist between males and females.

TREATMENT SUPPORT
- Differences in treatment support may exist between males and females.
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- Differences in treatment support may exist between males and females.
Lived Experience of Military Women with Chronic Pain: Providers’ Bias & Sexual Trauma

Sandra Peppard, PhDc, MSN, RN; Joseph Burkd, DNsC, CRNA, RN
Jane Georges, PhD, RN; Judy Dye, PhD, ANP-BC, RN

BACKGROUND
- Chronic pain is a widespread problem among active-duty service members and veterans.
- Women are considered a minority – 17% of military.
- 1,500,000 military women had been deployed to Iraq and Afghanistan supporting Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn since the inception of these wars.
- Following deployment, 25% of military women are at risk for chronic pain.
- 25% of military women serving have been sexually assaulted, and up to 80% have been harassed.
- Mental health issues, PTSD, and Military Sexual Trauma (MST) are higher than male counterparts.
- Paucity of research on the daily lived experience of military women with chronic pain, perception of health care provider’s bias, and MST.

METHODS
This qualitative design utilized van Manen’s approach to investigate women’s lived experience with pain.
- Thirteen participants were recruited through the Women Warriors, including active duty, retired, and/or veteran women.
- Biopsychosocial model served as the underpinning of this study, a holistic framework that integrates the whole person with the mind and body perspective.
- Semi-structured, digitally-recorded Zoom interviews and demographic data information were compiled. Sample size was adjusted to achieve saturation.
- Data incorporated field notes, reflections, and analytic memos to assist in the data analysis.

RESULTS
- Self-perception of health care providers’ bias in health disparities: pain is not understood.
  - “Being an African American person, I don’t get treated medically the best I could, is my opinion.”
  - “I am a female, and I am a minority and when I go and say I’m in pain, how I am viewed just like with the unconscious bias – as I said – because I’m a very small segment of a pretty large population.”
  - “My husband gets better health care than I do. I have to fight and push to get better care.”
- Pain of military sexual trauma not reported
  - “I was raped overseas by my superior – so dealing with a lot now and a lot sexual assault issues. I saw how bad the system was when it came to people reporting things. So, I never reported it.”
  - “I was sexually assaulted; I do not want to talk about it.”
- Operational readiness: ethical, legal, and social implications/new knowledge for Force Health Protection (a) fit and operational readiness force, (b) pre-to-post deployment care for women warriors, and (c) access to health care.

DISCUSSION – MILITARY SEXUAL TRAUMA
- Research studies reported that sexual abuse continues in the military services.
- Four participants in this study acknowledged experiences with MST but did not report it; another described harassment.
- Fear that reporting sexual trauma would lead to stigma, lack of confidentiality, discharge, or the damage done would end military career.
- Pain of MST compounded chronic pain/PTSD from military injuries and combat experiences.
- Screening/designating disclosure for MST could help improve understanding military woman’s chronic pain experience, the pain of MST, and provide gender-specific health care.

DISCUSSION – PROVIDER BIAS
- Literature supported these study participants’ observation in disparity of treatment.
- Provider bias can be gender-related anti/ethnic/cultural mindsets.
- Believability – because provider not listening/ignoring concerns. If nothing shows up on x-ray, then pain is not real and complaints were disregarded.
- Two participants in this study stated their military spouses (males) received better health care and they did; received a hand-aid approach.
- Gender-specific health care would improve patient-provider communication.

PURPOSE
The purpose of this study was to describe the lived experience of military women living with chronic pain. This presentation will review two out of eight themes revealed in this phenomenological study.

AIMS
This study (a) explored a military woman’s typical day with chronic pain and (b) examined life’s main hazard through the lived experiences of each military woman diagnosed with chronic pain.
- What is it like to live with pain?
- Military women describe a typical day in their lives, including factors associated with their pain and how their quality of life had been affected.

DISCLAIMER: The views and opinions expressed in the presentation are those of the author and do not necessarily reflect the official policy of any agency or organization. There is no conflict of interest.
The Women Warriors of the Future...
Helpful References

- WIC Speaker and Poster Gallery | TSNRP (triservicenurse.org)
- https://www.triservicenurse.org/
- SWAN (servicewomensactionnetwork.org)
- Center for Women Veterans (CWV) (va.gov)
- Home - Institute for Veterans and Military Families (syracuse.edu)
- PsychArmor – Training a Nation
- 2020 Health Of Those Who Have Served Report | AHR (americashealthrankings.org)
- Defense Advisory Committee on Women in the Services (DACOWITS)
- Military Women's Memorial | Military Women's Memorial Website (womensmemorial.org)