No. 22A902

In the Supreme Court of the United States

U.S. Food & Drug Administration, *et al.*,
Applicants,

v.

Alliance for Hippocratic Medicine, *et al.*

To the Honorable Samuel Alito, Associate Justice of the United States Supreme Court and Circuit Justice for the Fifth Circuit

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On Application to Stay the Judgment Entered by the United States District Court for the Northern District of Texas, Amarillo Division

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BRIEF OF LEGAL VOICE AS *AMICUS CURIAE* IN SUPPORT OF STAY APPLICATION

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STATEMENT OF AMICUS INTEREST AND SUMMARY OF ARGUMENT[1]

Amicus curiae Legal Voice is a non-profit, non-partisan public interest legal organization with a mission to advance gender justice in the Pacific Northwest. In pursuit of its mission, Legal Voice uses a combination of litigation, policy advocacy, and community education to advance economic justice, eradicate gender discrimination, ensure access to health care, protect reproductive freedom, and end gender-based violence. Legal Voice frequently works in coalition with advocacy groups and legal services organizations that serve survivors of intimate partner violence ("IPV"). Legal Voice brings a unique perspective as an organization that works to both improve protections for survivors of IPV and advance reproductive rights.

The district court has taken drastic action that, if left unchecked, will have immediate and severe negative effects on survivors of IPV. The district court ordered a stay of the Food and Drug Administration's ("FDA") decades-old decision to approve mifepristone despite plaintiffs' lack of standing, insufficient factual and scientific support for plaintiffs' claims, and negligible legal precedent. *See* Memorandum Opinion and Order, *Alliance for Hippocratic Medicine v. Food & Drug Admin.*, No. 2:22-cv-00223-Z (N.D. Tex. Apr. 7, 2023), ECF No. 137 [hereinafter Order]. The district court also ordered a stay of the FDA's subsequent actions modifying restrictions on mifepristone, specifically the 2016 modifications, the 2019 generic

[1] No counsel for a party authored this brief in whole or in part and no counsel or party made a monetary contribution intended to fund the preparation of submission or the brief. No person other than amicus curiae and its counsel made a monetary contribution to fund the preparation of the brief.

approval, and 2021 actions related to the in-person dispensing requirement. *Id.* at 67. The Fifth Circuit stayed application of the Order's stay of the original, 2000 mifepristone approval but declined to stay the Order's stay of the more recent FDA actions. Order, *Alliance for Hippocratic Medicine v. Food & Drug Admin.*, No. 23-10362 (Fifth Cir. Apr. 12, 2023), ECF No. 183-2 at 42. If the Order's stay of those more recent mifepristone decisions goes into effect, it will immediately interfere with interstate distribution of mifepristone and reinstate needlessly burdensome, antiquated requirements for in-person dispensing this safe and effective medication. These changes will have one clear and certain effect: Drastically reducing access to medication abortion across the United States. Such a change is wholly unwarranted and undermines the FDA's expert assessment of mifepristone's safety.

Restricting access to mifepristone will cause irreparable harm to the many Americans who face IPV and need abortions to protect their own health and safety. One way abusive partners exert control over survivors of IPV and maintain power within the relationship is by undermining survivors' autonomy to make reproductive decisions, limiting access to health care, and forcing pregnancy. Being forced to carry an unintended pregnancy to term for lack of access to abortion care exposes survivors of IPV to a higher likelihood of further violence, including homicide, poses significant health risks, and increases their risk of being trapped in violent relationships. The consequences of such entrapment range from heightened abuse during pregnancy to death. As difficult as it is for all survivors of IPV to escape abusive relationships and exercise their reproductive autonomy, IPV survivors of color—who already experience

disproportionately high rates of unintended pregnancy and increased health risks—face systemic inequities that make doing so all the more difficult.

The district court's radical decision to alter the status quo and undermine the FDA's scientific decision-making jeopardizes the health and safety of IPV survivors. The significant deficiencies and errors in the district court's reasoning and the serious risk of harm if the decision is permitted to go into effect warrant a stay of the Order in full.

ARGUMENT

I. Survivors of intimate partner violence are at greater risk of unintended pregnancy, which creates significant risks for survivors' health and safety.

A. Many people in the United States experience intimate partner violence.

Nearly half of the women in the United States have been affected by IPV, which the World Health Organization defines as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors."[2] Almost *60 million* American women[3] report that they have experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetimes.[4] The

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[2] *Violence Against Women*, World Health Organization (March 9, 2021), https://www.who.int/news-room/fact-sheets/detail/violence-against-women; *see also* Claudia Garcia-Moreno et al.; *Understanding and Addressing Violence Against Women: Intimate Partner Violence* 1 (2012), World Health Org., http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf.

[3] People of many gender identities can become pregnant and people of many gender identities experience IPV. This brief specifically references "women" where the underlying research or quoted material focuses on women.

[4] Ruth Leemis et al., *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence* 1, 14 (2022), Ctrs. for Disease Control & Prevention, https://www.cdc.gov/violenceprevention/pdf/nisvs/NISVSReportonIPV_2022.pdf.

numbers are even starker for women of color: More than half of all multi-racial, Native, and Black people in the United States reported experiencing IPV in their lifetimes.[5] Rates of IPV are also disproportionately high for Asian and Latina immigrant women who face additional structural barriers including language difficulties, immigration status, and lack of faith in or resources about the legal system, all layered on top of the overall stress of assimilation.[6]

B. Abusers use "coercive control" to create the conditions for unwanted pregnancy, and systemic inequities exacerbate those conditions.

Physical abuse is only one aspect of IPV. Abusers also exert control by isolating survivors from family and friends and monitoring their whereabouts and relationships,[7] limiting their financial resources, tracking their use of transportation and time away from home,[8] and threatening to harm or kidnap children, among other tactics.[9] This "coercive control" limits survivors' access to the resources necessary to escape the abusive relationship. Economic coercive control may include sabotaging employment or restricting access to money.[10] Together, these actions position the abuser to use violence with relative impunity because the survivor's support system, economic security, and resources to seek safety from abuse are compromised.

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[5] *Id. See also* Jamila K. Stockman et al., *Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups*, 24 J. Women's Health 62 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302952/.

[6] Stockman, *supra* note 5.

[7] Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 SMU L. Rev. 2117, 2126–27 (1993), https://scholar.smu.edu/smulr/vol46/iss5/10/.

[8] *Id.* at 2121–22, 2131–32; *see also* Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012).

[9] Fischer et al., *supra* note 7, at 2122–23.

[10] Julie Goldscheid, *Gender Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 Colum. J. Gender & L. 61, 75–77 (2008), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1140246.

Poverty and lack of access to resources make it even more difficult for survivors to escape IPV. It takes money to flee an abusive relationship—for hotel rooms, gas, food, and childcare, among other things. Longer term costs include mental and physical health care needs, stable housing, legal representation, and finding flexible employers who will accommodate time off requests for court appearances and safety-related needs. Yet many IPV survivors do not have those resources. Indeed, women living in poverty (living on annual incomes of less than $25,000) are nearly twice as likely to experience domestic violence.[11] And making matters worse, many IPV survivors lose their jobs as a direct consequence of the abuse they experienced.[12]

Survivors from marginalized communities face systemic inequities that exacerbate the conditions for coercive control.[13] One in four Native Americans, nearly one in five Black Americans, and more than one in six Latinx Americans live in poverty, and people of color are even more likely to live in poverty if they also are

[11] Erika Sussman & Sara Wee, *Accounting for Survivors' Economic Security: An Atlas for Direct Service Providers, Mapbook 1*, Ctr. for Survivor Agency & Just. 1 (2016), https://csaj.org/wp-content/uploads/2021/10/Accounting-for-Survivors-Economic-Security-Atlas-Mapping-the-Terrain-.pdf.

[12] Ellen Ridley et al., *Domestic Violence Survivors at Work: How Perpetrators Impact Employment*, Me. Dep't Lab. & Fam. Crisis Services 1, 4 (Oct. 2005), https://www1.maine.gov/labor/labor_stats/publications/dvreports/survivorstudy.pdf.

[13] *See generally* Natalie J. Sokoloff & Ida Dupont, *Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities*, 11 Violence Against Women 38 (2005), https://pubmed.ncbi.nlm.nih.gov/16043540/.

LGTBQ+, disabled, or non-citizens.[14] And women from these communities are more likely to experience IPV.[15]

The COVID-19 pandemic only exacerbated existing economic inequities and coercive control experienced by IPV survivors. The effects were particularly pernicious on Black and Latinx survivors of IPV: A recent report found that they had barely one-sixth the savings of White women.[16] COVID-related economic hardship was particularly difficult for undocumented survivors, who were not eligible for most federal cash relief packages and who faced existing barriers to accessing health care and employment.[17] Abusers further limited survivors' access to resources by using lockdown policies to justify increased surveillance and coercive control of their partners.[18]

Women living in rural areas, who face more frequent and severe rates of IPV than women in urban areas, face additional challenges.[19] They have to drive, on average, more than 25 miles to access domestic violence intervention programs.[20] And

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[14] John Creamer et al., *Poverty in the United States: 2021*, U.S. Census Bureau Population Reports 29–30 (Sept. 2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf; Bianca Wilson et al., LGBT Poverty in the United States: Trends at the Onset of COVID-19, UCLA School of Law Williams Institute 3–4 (Feb. 2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf.

[15] See supra § I.A.

[16] Elena Ruiz et al., *Measuring the Economic Impact of COVID-19 on Survivors of Color*, Me Too & Free From 1, 9 (2020), https://metoomvmt.org/wp-content/uploads/2020/11/MeTooFreeFrom_CovidImpactReport2020.pdf.

[17] Bushra Sabri et al., *Effect of COVID-19 Pandemic on Women's Health and Safety: A Study of Immigrant Survivors of Intimate Partner Violence*, Health Care Women Int. (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7902436/.

[18] Minna Lyons & Gayle Brewer, *Experiences of Intimate Partner Violence during Lockdown and the COVID-19 Pandemic*, 37 J. of Fam. Violence 969 (Feb. 2021), https://link.springer.com/article/10.1007/s10896-021-00260-x.

[19] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. Women's Health 1743, 1747 (Nov. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.

[20] *Id*. at 1748.

access to health care providers and hospitals is scarcer outside urban areas, often making it more difficult for rural survivors to receive needed care. Additionally, rural emergency departments have fewer resources in place to address IPV—meaning that even someone who has managed to find care may still be without the support needed to address the underlying problem.[21] These barriers further isolate a survivor from necessary resources and underline the importance of access to telehealth and medication abortion services.

C. Abusers coerce and force victims into unwanted pregnancies, putting those survivors at risk.

Along with other forms of coercive control, abusers frequently use "reproductive coercion" and rape to force victims into unwanted pregnancies to increase dependency and make it harder for the survivor to escape.[22] "Reproductive coercion" describes a spectrum of conduct used primarily to force pregnancy, ranging from rape to threats of physical harm to sabotaging a partner's birth control.[23] Abusers interfere with their partners' contraceptive use by discarding or damaging contraceptives, removing prophylactics during sex without consent, forcibly removing

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[21] Danielle M. Davidov et al., *Comparison of Intimate Partner Violence and Correlates at Urgent Care Clinics and an Emergency Department in a Rural Population*, Int'l J. Env't Res. & Pub. Health 1, 2 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10002050/.

[22] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896047/pdf/nihms164544.pdf; *see also* Anne M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737 (2010); Sanctuary for Families, *Access to Abortion – A Lifeline for Survivors of Domestic Violence* (June 24, 2022), https://sanctuaryforfamilies.org/abortion-domestic-violence/.

[23] Miller et al., *supra* note 22, at 316–17; Moore et al., *supra* note 22, at 1738; *see also ACOG Committee Opinion No. 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411, 411–15 (2013 *reaffirmed* 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.pdf.

internal use contraceptives, or retaliating against or threatening harm for contraceptive use.[24] When the National Domestic Violence Hotline surveyed over 3,000 women seeking help, more than 25 percent reported that their abusive partner sabotaged birth control and tried to coerce pregnancy.[25] Survivors of IPV "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning . . . ."[26] As a result, survivors of IPV are significantly less likely to be able to use contraceptives than their non-victimized counterparts.[27]

It is hardly surprising, therefore, that reproductive coercion in abusive relationships dramatically increases the risk of unintended pregnancy.[28] Again, systemic inequities further compound the risks associated with reproductive coercion. Marginalized communities generally already experience disproportionately high rates of unintended pregnancy,[29] largely due to a lack of access to sexual health

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[24] Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 Trauma, Violence, & Abuse 149, 151–53 (2007); *see also* Miller et al., *supra* note 22, at 319; Lauren Maxwell et al., *Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis*, 10 PLoS One 1 (2015), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0118234&type=printable.

[25] *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion*, Nat'l Domestic Violence Hotline (Feb. 15, 2011), https://www.thehotline.org/news/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/; *see also* Heike Thiel de Bocanegra et al., *Birth Control Sabotage and Forced Sex: Experiences Reported by Women in Domestic Violence Shelters*, 16 Violence Against Women 601 (2010).

[26] Miller et al., *supra* note 22, at 316–17; *see also* Coker, *supra* note 24, at 151–53.

[27] Megan Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systemic Review and Meta-Analysis*, 11 PLoS Med. 1, 2 (2014), https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001581&type=printable; *see also* Maxwell et al., *supra* note 24.

[28] Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 Contraception 457, 457 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872678/pdf/nihms185106.pdf.

[29] Theresa Y. Kim et al., *Racial/Ethnic Differences in Unintended Pregnancy: Evidence from a National Sample of U.S. Women*, 50 Am. J. Preventative Med. 427, 427 (2016), https://pubmed.ncbi.nlm.nih.gov/26616306/.

information,[30] health insurance,[31] and affordable contraceptives,[32] as well as a history of coercion by and mistrust of state and medical institutions.[33]

II. Intimate partner violence survivors need meaningful access to abortion care.

Meaningful access to abortion care, while important to all women, is particularly critical for IPV survivors, and especially those whose unintended pregnancies resulted from reproductive coercion. Dozens of studies have found a strong association between IPV and pregnancy termination, for many reasons.[34] A survivor may choose to terminate a pregnancy that results from rape or coercion[35] or out of fear of increased violence and/or being trapped in the relationship if the pregnancy continues.[36] A survivor of IPV also may terminate a pregnancy to avoid

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[30] Amaranta D. Craig et al., *Exploring Young Adults' Contraceptive Knowledge and Attitudes: Disparities by Race/Ethnicity and Age*, 24 Women's Health Issues e281, e287 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4119871/pdf/nihms584501.pdf.

[31] Samantha Artiga et al., *Health Coverage by Race and Ethnicity 2010-2021*, Kaiser Family Foundation (Dec. 20, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

[32] Usha Ranji et al., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities*, Kaiser Family Foundation (2019), https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

[33] Marcela Howell et al., *Contraceptive Equity for Black Women*, In Our Own Voice: Nat'l Black Women's Reprod. Just. Agenda 1, 2–3 (2020), http://blackrj.org/wp-content/uploads/2020/04/6217-IOOV_ContraceptiveEquity.pdf.

[34] *See* Hall et al., *supra* note 27 (identifying 74 studies from the United States and around the world that demonstrated a correlation between IPV and abortion); *see also* Dominque Bourassa & Jocelyn Berube, *The Prevalence of Intimate Partner Violence among Women and Teenagers Seeking Abortion Compared with Those Continuing Pregnancy*, 29 J. Obstetrics & Gynaecology Can. 415 (2007), https://www.jogc.com/article/S1701-2163(16)35493-7/pdf.

[35] Melisa M. Holmes et al., *Rape-Related Pregnancy: Estimates and Descriptive Characteristics from a National Sample of Women*, 175 Am. J. Obstetrics & Gynecology 320, 322 (1996) (50 percent of women pregnant through rape had abortions).

[36] Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1, 5 (2014), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z.

exposing a child to violence.[37] And many survivors have children whom they already struggle to protect.[38] Having a child, or another child, with an abusive partner can exacerbate challenges survivors face in finding housing upon leaving the abuser, increasing the risk of homelessness.[39] Notably, pregnancy termination can improve survivors' circumstances: While research shows that having a baby with the abuser is likely to result in increased violence, "having an abortion was associated in a reduction over time in physical violence . . . ."[40]

Indeed, abortion care is lifesaving medical care for many survivors. Every pregnancy carries some level of risk. But unintended pregnancies have significantly greater risks of pregnancy complications and poor birth outcomes,[41] including miscarriage or stillbirth.[42] These problems are compounded for survivors of IPV. It is common for abusers to prevent survivors from making or keeping medical appointments or from having private conversations with health care providers.[43] As

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[37] Karuna S. Chibber et al., *The Role of Intimate Partners in Women's Reasons for Seeking Abortion*, 24 Women's Health Issues e131, e134 (2014).

[38] *See, e.g.*, Joan S. Meier, *Domestic Violence, Child Custody, and Child Protection: Understanding Judicial Resistance and Imagining the Solutions*, 11 Am. U. J. Gender Soc. Pol'y & L. 657 (2003), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1768029 (discussing difficulties parent survivors face in protecting children from physical harm and navigating courts for custody and protective orders).

[39] *See* Carmela DeCandia et al., *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness*, The National Center on Family Homelessness 4 (2013), https://www.air.org/sites/default/files/2021-06/Closing%20the%20Gap_Homelessness%20and%20Domestic%20Violence%20toolkit.pdf.

[40] *Id*. at 5.

[41] Judith McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 Trauma, Violence, & Abuse 127, 130 (2007); *see also Public Health Impact: Unintended Pregnancy*, America's Health Rankings: United Health Foundation, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/U.S.

[42] McFarlane, *supra* note 41, at 130.

[43] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014).

a result, IPV survivors are less likely to receive prenatal care and more likely to miss doctors' appointments than pregnant people in non-violent relationships, all of which increases the risks of further harm to them.[44] Pregnant people experiencing IPV are also at high risk of depression and PTSD and at increased risk of having babies preterm and babies with low birth weight.[45]

Survivors of color are further burdened by the effects of transgenerational racism and poverty on their health, making them especially vulnerable to pregnancy-related complications.[46] While the United States as a whole has a maternal mortality rate over three times that of other developed nations,[47] the rates for women of color are strikingly higher: Black women die three times as often as White women, and American Indian and Alaskan Native women die twice as often.[48] Moreover, Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander women are more likely to have preterm births and babies with low birthweights.[49] Immigrant

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[44] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. of Fam. Violence 79, 79–87 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5397110/pdf/nihms-818726.pdf.

[45] Jeanne Alhusen, *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24 J. Womens Health (Larchmt) 100, 100–106 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157/pdf/jwh.2014.4872.pdf.

[46] Cynthia Prather et al., *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2 Health Equity 249, 253 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6167003/pdf/heq.2017.0045.pdf.

[47] Munira Z. Gunja et al., *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison,* The Commonwealth Fund (Dec. 1, 2022), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison.

[48] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, Kaiser Family Foundation (2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.

[49] *Id.*

women are at higher risk because they tend to receive less prenatal care than non-immigrant women, in part due to exclusionary health insurance laws and policies.[50]

Not only do pregnant people in abusive relationships face increased health risks associated with pregnancy, they are likely to suffer more, and more intense, violence during pregnancy.[51] IPV is common in pregnancy: "Nearly one in six pregnant women in the United States [has] been abused by a partner."[52] And IPV can and does escalate to homicide.[53] In fact, homicide is the leading cause of maternal death in the United States.[54] Risks are even greater for people of color and young women: Pregnancy-associated homicide is highest among Black women and women under 25 years of age.[55]

Meaningful access to abortion care is critical to IPV survivors' ability to escape abusive relationships. If a survivor who is coerced into pregnancy goes on to have a child with the abuser, it becomes even more difficult for the survivor to sever that

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[50] Sheela Maru et al., *Utilization of Maternal Health Care Among Immigrant Mothers in New York City, 2016–2018*, 98 J. Urban Health 711, 711–726 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8688674/pdf/11524_2021_Article_584.pdf.

[51] Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2971723/pdf/ijwh-2-183.pdf; *see also* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).

[52] *Intimate Partner Violence Screening Fact Sheet and Resources*, National Center for Excellence in Primary Care Research, Agency for Healthcare Research and Quality, https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html.

[53] Alexia Cooper & Erica L. Smith, *Homicide Trends in the United States, 1980–2008, Annual Rates for 2009 and 2010* at 10 (2011), U.S. Dep't Just., Bureau of Just. Stats., http://bjs.gov/content/pub/pdf/htus8008.pdf (between 1980 and 2008 40% of homicides of women were committed by intimate partners).

[54] Maeve Wallace et al., *Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019*, 138 Obstetrics & Gynecology 762, 763 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9134264/.

[55] *Id.*; Emiko Petrosky et al., *Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence — United States, 2003–2014*, 66 Morbidity and Mortality Weekly Rep. 741 (July 21, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657947/pdf/mm6628a1.pdf.

abusive relationship.[56] The survivor must navigate the legal system to obtain custody and ensure protective parenting arrangements, commonly without legal advice or representation.[57] Violent partners have learned to use this system to their advantage to continue the abuse.[58] Nationwide, abusive fathers are more likely to seek child custody than non-abusive fathers, and they succeed more than 70 percent of the time.[59] When the legal system forces an ongoing relationship with an abuser, IPV survivors have less trust in systems and may become more isolated from support.

III. Reducing access to mifepristone will have grave consequences for the lives and health of intimate partner violence survivors.

The Fifth Circuit erred in declining to stay the Order in full, and if not stayed, the district court's undoing of the 2016 REMS modification, the 2019 approval, and the suspension of the in-person dispensing requirement will make medication abortion extremely difficult to access for many survivors of IPV, with grave consequences for their health and well-being. It will cause irreparable harm to IPV survivors because many will be unable to access abortions due to the disruption of the distribution of mifepristone and reinstatement of medically unnecessary,

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[56] *See, e.g.*, Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 Vand. L. Rev. 1041, 1051 (1991), https://scholarship.law.vanderbilt.edu/vlr/vol44/iss4/8/.

[57] *See, e.g.*, 2015 Washington State Civil Legal Needs Study Update, Civil Legal Needs Study Update Committee, Washington State Supreme Court 15 (Oct. 2015), https://ocla.wa.gov/wp-content/uploads/2015/10/CivilLegalNeedsStudy_October2015_V21_Final10_14_15.pdf; Carmody and Assocs., *The Justice Gap in Montana: As Vast as Big Sky Country* 24 (2014), https://courts.mt.gov/External/supreme/boards/a2j/docs/justicegap-mt.pdf.

[58] Ellen Gutowski & Lisa Goodman, *Coercive Control in the Courtroom: the Legal Abuse Scale (LAS)*, 28 J. of Family Violence 527 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9119570/pdf/10896_2022_Article_408.pdf.

[59] Am. Bar Ass'n Comm'n on Domestic Violence, *10 Custody Myths and How to Counter Them*, 4 ABA Comm'n on Domestic Violence Quarterly E-Newsletter 3 (July 2006), https://xyonline.net/sites/xyonline.net/files/ABACustodymyths.pdf.

burdensome restrictions on the dispensing of mifepristone that will result if the Order is not stayed in full. Being forced to carry an unintended pregnancy to term exposes survivors of IPV to a higher likelihood of further violence, including homicide, and poses significant health risks. Indeed, it could cost some pregnant people their lives.

The Order's sweeping invalidation of the FDA's recent decisions regarding mifepristone will have the immediate effect of limiting the availability of mifepristone across the country. The distribution of branded mifepristone will be severely limited, and generic mifepristone could be taken off the market altogether. *See* U.S. Food and Drug Administration's Application to Stay the Order, No. 22A902 (U.S. Apr. 14, 2023). Survivors of IPV who need a medication abortion instead of a surgical abortion, due to medical conditions, cost, and travel limitations, or the need to hide the abortion from an abuser, will be forced to forgo the abortion.

The Order's stay of the FDA decision removing the in-person dispensing requirement may effectively prohibit telehealth services for mifepristone, removing a critical option for IPV survivors. The availability of telehealth, the ability to fill prescriptions at local pharmacies, and the ability to receive medication by mail are essential to survivors of IPV because these options reduce travel and cost barriers and protect survivors from coercion and violence by their abuser. Indeed, in-home medication abortion is often a survivor's only option for abortion care because they must obtain care without the abuser finding out.[60] Having a variety of options for

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[60] Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and at-Home Reproductive Care*, 32 Const. Comment 341, 373 (2017), https://www.law.berkeley.edu/wp-content/uploads/2017/10/4-Lindgren.pdf.

accessing that care—in one's home via telehealth or from a local physician—helps survivors maintain safety and privacy.

Requiring in-person dispensing of mifepristone by providers will also reduce the number of providers that IPV survivors can turn to for medication abortion. Family physicians who might otherwise provide mifepristone-based abortions as one of their services have described the in-person dispensing requirement as a barrier to providing medication abortion because the provider must stock and dispense the medication, requiring the extra administrative steps and involvement of clinic administration.[61]

When there are fewer providers available and telehealth is not an option, people who want a medication abortion will be forced to travel long distances to get the care they need. Travel is costly, both financially and in time spent away from work and care-giving responsibilities.[62] Many IPV survivors have children and need to arrange childcare to go to medical appointments. Childcare options are limited for people who lack funds, want to keep their need for an abortion private, or are isolated from friends and family. Further, the cost of travel, including gas—assuming a survivor has access to a car—and lodging, is a significant barrier. These costs will be prohibitive for many survivors of IPV, who disproportionately face economic hardship and financial control by their partners.[63]

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[61] Na'amah Razon et al., *Exploring the Impact of Mifepristone's Risk Evaluation and Mitigation Strategy (REMS) on the Integration of Medication Abortion into US Family Medicine Primary Care Clinics*, 109 Contraception 19, 20–21 (2022), https://www.contraceptionjournal.org/article/S0010-7824(22)00027-0/fulltext.

[62] Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 104 Contraception 16, 17 (2021).

[63] Sussman et al., *supra* note 11, at 1, 4.

The need for telehealth-based abortion care is especially acute for survivors who live in rural areas. Survivors in rural America need access to abortion: They are more likely to face chronic and severe IPV and have worse psychosocial and physical health outcomes.[64] But rural areas have significantly fewer primary care physicians and fewer hospitals with obstetric care.[65] If rural survivors of IPV cannot access mifepristone by mail, many will have to travel long distances to get an abortion, resulting in higher risk that their abuser will find out.

For survivors of color and immigrant survivors, discrimination and structural oppression exacerbate the barriers to abortion when mifepristone is more difficult to access. Transportation is a major barrier—female-led, Black, Native American, and immigrant households are all less likely to have access to a car compared to White and non-immigrant households.[66] Missing work and traveling are costly, and Black and Latinx women tend to have significantly lower wages than White women and men.[67] Lack of health insurance can also limit access to abortion care. American Indian, Alaskan Native, and Latinx people are the most likely to be uninsured, followed by Black, Native Hawaiian, and Pacific Islander people.[68] Depending on

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[64] Katie Edwards et al., *Intimate Partner Violence and the Rural-Urban-Suburban Divide: Myth or Reality? A Critical Review of the Literature*, 16 Trauma, Violence, & Abuse 359 (2015).

[65] Issue Brief: Improving Access to Maternal Health Care in Rural Communities, Center for Medicare & Medicaid Services 3, 8, 10 (2019), https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf.

[66] Car Access: Everyone Needs Reliable Transportation Access and In Most American Communities that Means a Car, National Equity Atlas, https://nationalequityatlas.org/indicators/Car_access.

[67] *Fact Sheet: Gender and Racial Wage Gaps Persist as the Economy Recovers*, Institute for Women's Policy Research 2 (Sept. 2022), https://iwpr.org/wp-content/uploads/2022/10/Annual-Gender-Wage-Gap-by-Race-and-Ethnicity-2022.pdf.

[68] Artiga et al., *supra* note 31.

their status, immigrants may be excluded from medical assistance programs and health marketplace coverage.[69] Between the drastic reduction in abortion availability if the FDA's recent regulatory decisions are stayed, and the many barriers to access to care that survivors of IPV already face, some simply will not be able to access abortion care at all.

Federal courts have recognized the importance of access to abortion care for survivors of IPV. *See, e.g.*, *Robinson v. Attorney General*, 957 F.3d 1171, 1180–81 (11th Cir. 2020) (summarizing the unchallenged district court factual finding of undue burden based, in part, on expert testimony about abortion delays leading to increased IPV and mental toll on patients). This Court should likewise recognize that for many survivors of IPV accessing abortion care is critical to their health and safety because being forced to carry an unintended pregnancy to term increases survivors' risks of suffering further violence, including homicide, and poses significant health risks. Failure to grant the requested stay of the Order will cause irreparable harm.

CONCLUSION

The Court should grant the application for stay pending appeal.

[69] *Id.*

April 14, 2023

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