No. 23-235, 23-236

In the Supreme Court of the United States

U.S. FOOD & DRUG ADMINISTRATION, ET AL.,
Petitioners,
v.
ALLIANCE FOR HIPPOCRATIC MEDICINE, ET AL.,
Respondents.

DANCO LABORATORIES, LLC,
Petitioner,
v.
ALLIANCE FOR HIPPOCRATIC MEDICINE, ET AL.,
Respondents.

BRIEF OF *AMICI CURIAE* LEGAL VOICE, THE NATIONAL DOMESTIC VIOLENCE HOTLINE ET AL. IN SUPPORT OF PETITIONERS

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STATEMENT OF AMICI INTEREST[1]

Amici Legal Voice, the National Domestic Violence Hotline, Sexual Violence Law Center, Washington Coalition Against Domestic Violence, Coalition Ending Gender Based Violence, the Asian Pacific Institute on Gender Based Violence, and Sanctuary for Families are non-profit, non-partisan public interest organizations that advocate for and serve survivors of intimate partner violence ("IPV")—abuse in intimate relationships. *Amici* serve IPV survivors through legal services, community education, coalition-building, and legal and policy advocacy. Each organization is familiar with the challenges that IPV survivors face in exercising their autonomy and understands the barriers that make it especially difficult for IPV survivors to access reproductive health care, including abortion care. *Amici* are also knowledgeable about how access to medication abortion can be essential to IPV survivors' health, well-being, and safety. As advocates for survivors of IPV, *amici* have a strong interest in ensuring that survivors can access reproductive health care, including medication abortion.

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[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.

SUMMARY OF ARGUMENT

The Fifth Circuit's decision altering the status quo and undermining the FDA's scientific decision-making jeopardizes the health and safety of IPV survivors by limiting that access. The Fifth Circuit upheld the stay of the Food and Drug Administration's ("FDA") 2016 and 2021 actions increasing accessibility of mifepristone despite plaintiffs' lack of standing, insufficient factual and scientific support for plaintiffs' claims, negligible legal precedent, and an incomplete administrative record. *See* Order, *Alliance for Hippocratic Medicine, et al. v. U.S. Food & Drug Administration et al.,* No. 23-10362 (5th Cir. Aug. 16, 2023), ECF No. 543. If the district court's decision goes into effect, it will immediately interfere with access to mifepristone and reinstate needlessly burdensome, medically unnecessary requirements for in-person dispensing of this safe and effective medication used by millions of American women. These wholly unwarranted changes undermine the FDA's expert assessment of mifepristone's safety and will have one clear and certain effect: reducing access to medication abortion across the United States.

Restricting access to mifepristone will cause particularly grave harm to the many Americans who face IPV and need abortion care to protect their own health and safety. Abusive partners often exert control over survivors of IPV and maintain power within the relationship by undermining survivors' autonomy to make reproductive decisions, limiting access to health care, and forcing pregnancy. Survivors of IPV who are forced to carry an unintended pregnancy to term because they cannot

access abortion care will be exposed to a higher likelihood of irreparable harms, including further violence, homicide, significant health risks, and a greater 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 even harder.

Affirming the lower courts' decisions regarding the 2016 and 2021 FDA actions would curtail access to medication abortion with grave consequences for the health and well-being of many survivors of IPV. The significant deficiencies and errors in the Fifth Circuit's reasoning and the serious risk of harm warrant reversal.

ARGUMENT

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

Intimate partner violence leads to increased risk of unintended pregnancy and results in adverse health outcomes for millions of survivors. Abusers use coercion to limit survivors' access to health care, generally, and reproductive health care, in particular. And some even force pregnancy to maintain control.

A. Intimate partner violence is widespread.

Nearly half of 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 physical aggression, sexual coercion, psychological abuse and controlling behaviours."[2] Almost *60 million* American women[3] report that they have experienced sexual violence, physical violence, and/or stalking by an intimate

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

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

partner during their lifetimes.[4] The numbers are even starker for women of color: More than half of all multi-racial, Native, and Black people in the United States report 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 to utilize the legal system, all layered on overall challenges of assimilation.[6]

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

Physical abuse is only one aspect of IPV. Abusers also exert "coercive control" by isolating survivors from family and friends and monitoring their whereabouts and relationships,[7] limiting their financial resources by sabotaging employment or

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

[5] *Id.* at 7.

[6] *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, 62 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302952/pdf/jwh.2014.4879.pdf.

[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, 2132 (1993), https://scholar.smu.edu/cgi/viewcontent.cgi?article=2322&context=smulr.

restricting access to money,[8] restricting their use of transportation and time away from home,[9] and threatening to harm or kidnap children, among other tactics.[10] This coercion limits survivors' access to resources needed to escape the abusive relationship and positions the abuser to use violence with relative impunity because the survivors' support system, economic security, and opportunities to seek safety from abuse are compromised.

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. But many IPV survivors do not have those resources. Indeed, women living in poverty are nearly twice as likely to experience domestic violence.[11] And making matters worse, many IPV

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[8] *See id.* at 2121–22; Julie Goldscheid, *Gendered Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 Colum. J. Gender & L. 61, 75–77 (2008), https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1162&context=cl_pubs; Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012).

[9] *See* Goldscheid, *supra* note 8, at 75; Goodmark, *supra* note 8, at 42.

[10] Fischer et al., *supra* note 7, at 2121–22, 2131–32.

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

survivors lose their jobs as a direct consequence of the abuse they experience.[12]

Survivors from marginalized communities face systemic inequities that exacerbate the conditions for coercive control.[13] One in four Native Americans,[14] nearly one in five Black Americans,[15] and more than one in six Hispanic Americans,[16] live in poverty. People of color are even more likely to live in poverty if they also are LGTBQ+, disabled, or non-citizens.[17] And women from these communities are more likely to experience IPV.[18]

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

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[12] Ellen Ridley et al., Me. Dep't Lab. & Fam. Crisis Servs., *Domestic Violence Survivors at Work: How Perpetrators Impact Employment* 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/.

[14] John Creamer et al., U.S. Census Bureau, *Poverty in the United States: 2021* 31 (2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf.

[15] *Id.* at 29.

[16] *Id.* at 33.

[17] Bianca D.M. Wilson et al., UCLA Williams Inst., *LGBT Poverty in the United States: Trends at the Onset of COVID-19*, 3–4 (2023), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf.

[18] *See supra* § I.A.

of IPV: A recent report found that they had barely one-sixth the savings of White women.[19] 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.[20] Abusers further limited survivors' access to resources by leveraging lockdown policies to justify increased surveillance and coercive control of their partners.[21]

Women living in rural areas experience more frequent and severe rates of IPV than women in urban areas and face additional challenges.[22] On average, they have to drive more than 25 miles to access domestic violence intervention programs.[23] And access to health care providers and hospitals is scarcer outside urban areas, often making it more

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

[20] Bushra Sabri et al., *Effect of COVID-19 Pandemic on Women's Health and Safety: A Study of Immigrant Survivors of Intimate Partner Violence*, 41 Health Care Women Int. 1294, 1299, 1308 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7902436/.

[21] Minna Lyons & Gayle Brewer, *Experiences of Intimate Partner Violence during Lockdown and the COVID-19 Pandemic*, 37 J. Fam. Violence 969, 972–73 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7908951/pdf/10896_2021_Article_260.pdf.

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

[23] *Id*. at 1748.

difficult for rural survivors to receive needed care. Additionally, rural emergency departments have fewer resources in place to address IPV, so even someone who has managed to find care may still be without the support needed to address the underlying problem.[24] These barriers further isolate survivors from necessary resources and highlight the importance of measures, like direct-to-patient telehealth, that reduce barriers to accessing reproductive health care, including medication abortion care.

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.[25] Reproductive coercion describes

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[24] Danielle M. Davidov et al., *Comparison of Intimate Partner Violence and Correlates at Urgent Care Clinics and an Emergency Department in a Rural Population*, 20 Int'l J. Env't Res. & Pub. Health 4554, at 2 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10002050/.

[25] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316, 320 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896047/pdf/nihms164544.pdf; *see also* Ann M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737, 1737–38 (2010), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/socscimed201002009.pdf; Sanctuary for Fams., *Access to Abortion – A Lifeline for Survivors of Domestic Violence* (June 24,

a spectrum of conduct used primarily to force pregnancy, ranging from rape to threats of physical harm to sabotaging a partner's birth control.[26] Abusers interfere with their partners' contraceptive use by discarding or damaging contraceptives, removing prophylactics during sex without consent, forcibly removing internal use contraceptives, or retaliating against their partners or threatening harm for contraceptive use.[27]

Reproductive coercion is widespread: The Centers for Disease Control and Prevention ("CDC") reports that 10.3 million—8.6 percent of—American women have had a partner who tried to get them pregnant against their will or refused to wear a condom.[28] And it's particularly common among people who have experienced IPV. When Amicus National Domestic Violence Hotline surveyed over 3,000

2022), https://sanctuaryforfamilies.org/abortion-domestic-violence/.

[26] Miller et al., *supra* note 25, at 316–17; Moore et al., *supra* note 25, at 1738; *see also* Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411, 1–2 (2013, reaffirmed 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.pdf.

[27] 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 25, at 316–17; 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.

[28] M.C. Black et al., Ctr. for Disease Control & Prevention, *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 48 (2011).

women seeking help, more than 25 percent reported that their abusive partner sabotaged birth control and tried to coerce pregnancy.[29] Women who have experienced IPV are almost three times more likely to report that their partner made it difficult for them to use birth control and are 2.3 times more likely to report that their partner wanted them to get pregnant or did not want them to use contraception at all.[30] Survivors of IPV "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning . . . ."[31] As a result, they are significantly less likely to be able to use contraceptives than their non-victimized peers.[32]

It is thus hardly surprising that reproductive coercion in abusive relationships dramatically

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[29] Nat'l Domestic Violence Hotline, *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion* (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, 605–06 (2010).

[30] Elizabeth Miller & Jay G. Silverman, *Reproductive Coercion and Partner Violence: Implications for Clinical Assessment of Unintended Pregnancy*, 5 Expert Rev. Obstetrics & Gynecology 511 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3282154/pdf/nihms250246.pdf.

[31] Miller et al., *supra* note 25, at 316–17; *see also* Coker, *supra* note 27, at 151.

[32] *See* Megan Hall et al., *Associations between Intimate Partner Violence and Termination of Pregnancy: A Systemic Review and Meta-Analysis*, 11 PLoS Med. 1, 10 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3883805/pdf/pmed.1001581.pdf; *see also* Maxwell et al., *supra* note 27.

increases the risk of unintended pregnancy.[33] Again, systemic inequities further compound the risks. Marginalized communities already experience disproportionately high rates of unintended pregnancy,[34] largely due to a lack of access to sexual health information,[35] health insurance,[36] and affordable contraceptives,[37] as well as a history of coercion by and mistrust of state and medical institutions.[38]

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[33] 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.

[34] 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/.

[35] Amaranta D. Craig et al., *Exploring Young Adults' Contraceptive Knowledge and Attitudes: Disparities by Race/Ethnicity and Age*, 24 Women's Health Issues 281, 285–87 (2014), https://www.teachtraining.org/wp-content/uploads/2013/10/Exploring-young-adults-contraceptive-knowledge-and-attitudes.pdf.

[36] Latoya Hill et al., Kaiser Fam. Found., *Health Coverage by Race and Ethnicity, 2010–2022* (Jan. 11, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

[37] Usha Ranji et al., Kaiser Fam. Found., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities* (Nov. 14, 2019), https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

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

II. Intimate partner violence survivors need meaningful access to abortion care but face heightened barriers to access.

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 or rape. Because pregnancy termination undermines abusers' control, survivors face increased barriers to obtaining abortion care.

A. Abortion care is particularly important health care for intimate partner violence survivors.

Dozens of studies have found a strong association between IPV and the decision to terminate a pregnancy.[39] And one study found that 10.8 percent of women seeking abortions reported IPV within the past year.[40] A survivor may choose to

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[39] *See* Hall et al., *supra* note 32 (meta-analysis of 74 studies from the United States and around the world that found an association between IPV and abortion); *see also* Dominque Bourassa & Jocelyn Bérubé, *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.

[40] *See* Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population*, 100 Am. J. Pub. Health 1412, 1413 (2010), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.178947; *see also* Gigi Evins et al., *Prevalence of Domestic Violence Among Women Seeking Abortion Services*, 6 Women's Health Issues 204 (1996) (stating that, of the 51 women who sought an abortion at the University of North Carolina's abortion clinic during a two-month period in 1994, 31.4 percent had experienced

terminate a pregnancy that results from reproductive coercion[41] or rape,[42] or out of fear of increased violence or being trapped in the relationship if the pregnancy continues.[43] A survivor of IPV also may terminate a pregnancy to avoid exposing a child to violence.[44] Indeed, many survivors have children whom they already struggle to protect.[45] Among other risks, having a child, or another child, with an abusive partner exacerbates challenges survivors face in finding housing upon leaving the abuser, as they would be limited to shelters which permit children.[46]

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physical or sexual abuse their entire lives; 21.6 percent had been abused in the previous year, and 7.8 percent been abused during their current pregnancy).

[41] 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).

[42] Hall et al., *supra* note 32, at 15.

[43] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 144, 5 (2014), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z.

[44] Karuna S. Chibber et al., *The Role of Intimate Partners in Women's Reasons for Seeking Abortion*, 24 Women's Health Issues 131, 134 (2014).

[45] *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).

[46] Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 Vand. L. Rev. 1041, 1051 (1991),

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 with a reduction over time in physical violence . . . ."[47] Indeed, abortion care is lifesaving health care for many survivors. Every pregnancy carries some level of risk, and unintended pregnancies have significantly greater risks of complications and poor birth outcomes.[48] These problems are compounded for survivors of IPV because coercive control often extends to prenatal care. It is common for abusers to prevent survivors from making or keeping medical appointments or from having private conversations with health care providers.[49] As a result, IPV survivors are less likely to receive prenatal care and more likely to miss medical appointments than pregnant people in non-violent relationships, which increases the risks of further harm to them.[50] Pregnant people experiencing

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https://heinonline.org/HOL/Page?collection=journals&handle=hein.journals/vanlr44&id=1057&men_tab=srchresults; *see* James Carroll, *Healthy Communities: Housing and Women Victims of Domestic Violence (WVODV)*, 1 The Opine 3 (2023), https://www.asterhill.com/The%20Opine_WVODV%20February%202023.pdf (indicating that in some counties there are fewer family-beds than adult-only beds).

[47] Roberts et al., *supra*, note 43, at 5.

[48] Judith McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 Trauma, Violence, & Abuse 127, 130 (2007).

[49] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2013).

[50] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 32 J. Fam. Violence 79, 85 (2017),

IPV are also at high risk of depression and post-traumatic stress disorder and at increased risk of having babies preterm and babies with low birth weight.[51]

Survivors of color are further burdened by transgenerational racism and poverty, making them especially vulnerable to pregnancy-related complications.[52] While the United States as a whole has a maternal mortality rate over three times that of other developed nations,[53] women of color are disproportionately affected: pregnancy-related death rates are three times higher for Black women and twice as high among American Indian and Alaskan Native women.[54] Moreover, Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5397110/pdf/nihms-818726.pdf.

[51] Jeanne L. Alhusen, *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24 J. Women's Health 100, 101 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4361157/pdf/jwh.2014.4872.pdf.

[52] 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.

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

[54] Latoya Hill et al., Kaiser Fam. Found., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them* (Nov. 1, 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/.

Islander women are more likely to have preterm births and babies with low birth weights.[55] Asian American and Pacific Islander women are at greater risk of severe maternal morbidities and maternal mortality compared to White women.[56] Immigrant 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.[57]

Not only do pregnant people in abusive relationships face increased health risks associated with pregnancy, IPV is common during pregnancy: Approximately 324,000 pregnant women are abused in the United States each year.[58] The abuse may worsen during pregnancy.[59] And it can and does escalate to homicide.[60] In fact, homicide is the leading

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[55] *Id.*

[56] Maryam Siddiqui et al., *Increased Perinatal Morbidity and Mortality Among Asian American and Pacific Islander Women in the United States*, 124 Anesthesia & Analgesia 879, 881 (2017).

[57] Sheela Maru et al., *Utilization of Maternal Health Care Among Immigrant Mothers in New York City, 2016–2018*, 98 J. Urban Health 711, 721–723 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8688674/pdf/11524_2021_Article_584.pdf.

[58] Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 518: Intimate Partner Violence*, 119 Obstetrics & Gynecology 1, 2 (2012, reaffirmed 2022), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence.

[59] *Id.*

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

cause of maternal death in the United States,[61] and women who are pregnant or post-partum are more than twice as likely to die by homicide in the United States than by any other cause of maternal mortality.[62] In 2020, the homicide rate for pregnant and post-partum women was 35 percent higher than that for other women of reproductive age.[63] 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.[64]

Meaningful access to abortion care is also 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 may become increasingly difficult for the survivor to escape that abusive relationship.[65] The survivor must navigate the legal system to obtain custody and

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[61] Maeve Wallace et al., *Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019*, 138 Obstetrics & Gynecology 762, 762 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9134264/pdf/nihms-1804550.pdf.

[62] *Id.* at 764.

[63] Maeve Wallace, *Trends in Pregnancy-Associated Homicide, United States*, 2020, 112 Am. J. Pub. Health 1333, 1334 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9382166/pdf/AJPH.2022.306937.pdf.

[64] *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 & Mortality Weekly Rep. 741, 743 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657947/pdf/mm6628a1.pdf.

[65] *See, e.g.*, Rebecca L. Heron et al., *Why Do Domestic Violence Victims Remain in or Leave Abusive Relationships? A Qualitative Study*, 31 J. Aggression, Maltreatment & Trauma 677, 679, 683–84 (2022).

ensure protective parenting arrangements, commonly without legal advice or representation.[66] Many abusers have learned to use this system to their advantage to continue the abuse.[67] Nationwide, abusive partners are more likely to seek child custody than non-abusive partners, and they succeed more than 70 percent of the time.[68] 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.

B. Mifepristone affords intimate partner violence survivors with discreet, accessible abortion care.

Despite the increased importance of abortion care for survivors of intimate partner violence, meaningful access to such health care is particularly challenging for IPV survivors because they are subject to coercive control and, often, reproductive coercive control. Traveling for abortion care may not be an option, and having options for discreetly

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[66] *See, e.g.*, Off. Of Civ. Legal Aid, *2015 Washington State Civil Legal Needs Study Update* 15 (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.

[67] Ellen R. Gutowski & Lisa A. Goodman, *Coercive Control in the Courtroom: The Legal Abuse Scale (LAS)*, 38 J. Fam. Violence 527, 527 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9119570/pdf/10896_2022_Article_408.pdf.

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

accessing abortion care helps survivors maintain safety and privacy.

Direct-to-patient 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 abusers. In-home medication abortion is often a survivor's only option for abortion care because they must obtain care without the abuser finding out.[69] Indeed, IPV survivors are nearly three times as likely to conceal their abortion from their partner.[70]

Moreover, even if they were otherwise able to travel for care, travel is costly, both financially and in time spent away from work and care-giving responsibilities.[71] 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, and leaving children alone with an abuser may not be an option. 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

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[69] 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.

[70] Hall et al., *supra* note 32, at 10.

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

disproportionately face economic hardship and financial control by their partners.[72]

For survivors of color and immigrant survivors, discrimination and structural oppression exacerbate the barriers to abortion when mifepristone is more difficult to access. Black, Native American, and immigrant households are all less likely to have access to a car compared to White and non-immigrant households.[73] And Black and Latinx women tend to have significantly lower wages than White women and men.[74] 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 Native Hawaiian, Pacific Islander, and Black people.[75] Depending on their status, immigrants may be excluded from medical assistance programs and health marketplace coverage.[76] Accessible medication abortion is particularly important for communities of color who experience rape at high rates, including American Indian and Alaskan Native, Black, and multiracial

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[72] Sussman et al., *supra* note 11, at 1, 34.

[73] Nat'l Equity Atlas, *Car Access: Everyone Needs Reliable Transportation Access and In Most American Communities that Means a Car*, https://nationalequityatlas.org/indicators/Car_access.

[74] Ariane Hegewisch & Lucie Prewitt, Inst. For Women's Pol'y Rsch., *Fact Sheet: Gender and Racial Wage Gaps Persist as the Economy Recovers* 2 (2022), https://iwpr.org/wp-content/uploads/2022/10/Annual-Gender-Wage-Gap-by-Race-and-Ethnicity-2022.pdf.

[75] Hill et al., *supra* note 36.

[76] *Id.*

women,[77] and who may seek to terminate a rape-related pregnancy.[78]

Physical injuries and other trauma from past sexual assault can also interfere with future medical care to limit options for abortion care. For example, *Amici* have worked with survivors who experienced significant internal scarring and medical complications due to rape, which limited surgical interventions for medical needs, including abortion. Obstetric and gynecological care, particularly medical procedures that require instruments such as non-medication abortions, can be psychologically and emotionally difficult due to sexual assault trauma.[79] Meeting the reproductive health needs of rape and sexual assault survivors requires specialized and trauma-informed medical options, including medication abortion.

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[77] *See* Nat'l All. to End Sexual Violence, *Where We Stand: Racism and Rape*, https://endsexualviolence.org/where_we_stand/racism-and-rape/.

[78] *See* Rachel Perry et al., *Prevalence of Rape-related Pregnancy as an Indication for Abortion at Two Urban Family Planning Clinics*, 91 Contraception 393 (2015).

[79] *See* Erica Sharkansky, U.S. Dep't of Veterans Affs., *Sexual Trauma: Information for Women's Medical Providers* (2014), https://www.ptsd.va.gov/professional/treat/type/sexual_trauma_women.asp; Carol K. Bates et al., *The Challenging Pelvic Examination*, 26 J. Gen. Internal Med. 651, 654–55 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101979/pdf/11606_2010_Article_1610.pdf; Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 825: Caring for Patients Who Have Experienced Trauma*, Obstetrics & Gynecology 94, 96 (2021); *cf.* Sobel et al., *Pregnancy and Childbirth After Sexual Trauma: Patient Perspectives and Care Preferences*, 132 Obstetrics & Gynecology 1461, 1463 (2018).

The need for direct-to-patient telehealth-based abortion care is especially acute for survivors in rural areas. Survivors in rural America are more likely to face chronic and severe IPV and have worse psychosocial and physical health outcomes.[80] But they are less likely to have access to abortion care because rural areas have significantly fewer primary care physicians and fewer hospitals with obstetric care.[81] As a result, rural survivors of IPV will be especially harmed by the Fifth Circuit's decision.

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

Affirming the lower courts' decisions regarding the 2016 and 2021 FDA actions would curtail access to medication abortion with grave consequences for the health and well-being of many survivors of IPV. Disrupting the distribution of mifepristone and reinstating medically unnecessary, burdensome restrictions on its dispensing would irreparably harm IPV survivors by rendering abortion care inaccessible to many and consequently exposing them to a higher likelihood of further violence, including homicide, and significant health risks. Indeed, it could cost some pregnant people their lives. Limiting the availability

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[80] 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, 359 (2015).

[81] Ctr. for Medicare & Medicaid Servs., *Issue Brief: Improving Access to Maternal Health Care in Rural Communities* 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.

of mifepristone would decrease abortion options in a way that is particularly difficult for IPV survivors. Medication abortion makes up more than half of abortions in the United States and, because they are subject to coercive control, it is a particularly important option for survivors of IPV.

Staying the FDA's decision to remove the in-person dispensing requirement may effectively prohibit direct-to-patient telehealth services for mifepristone, removing a critical option for IPV survivors. And requiring in-person dispensing of mifepristone by providers would reduce the number of providers that IPV survivors can turn to for medication abortion. Indeed, providers 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 extra administrative steps and involvement of clinic administration.[82]

When there are fewer providers available and direct-to-patient telehealth is not an option, people who want a medication abortion will be forced to travel long distances for care, and others will need to travel farther to reach a clinic that offers procedural abortions and that has available appointments—if

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[82] 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.

they can.[83] But even if they have the resources to travel for care—many may not—survivors will face greater difficulty hiding their abortion from an abusive partner if they must travel longer distances. Rural survivors of IPV who cannot access mifepristone by mail may have to travel particularly long distances to receive abortion care. For survivors of color and immigrant survivors, discrimination and structural oppression exacerbate the barriers to abortion when mifepristone is more difficult to access. Between the 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, traveling for any abortion care may not be an option, particularly for those who are subject to reproductive coercion. Moreover, some IPV survivors will forgo desired abortion care if medication abortion is unavailable because a procedural abortion feels unsafe due to trauma from sexual violence.

As a result, if the Fifth Circuit's decision stands, many survivors simply will not be able to access abortion care at all and will be forced to bear the burden of higher risks of negative health outcomes and further reproductive control.

For similar reasons, IPV survivors who experience miscarriage may also strongly prefer to treat their miscarriage with medication. Mifepristone is commonly used as part of a safe and effective regimen for miscarriage management.[84] In this way,

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[83] *See* Caitlin Myers et al., *What If Medication Abortion Were Banned?* (Apr. 7, 2023), https://storymaps.arcgis.com/stories/5c7256ea935e4b3f89be2e5f2ce499bd.

[84] Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin No. 200, Early Pregnancy Loss*, 132 Obstetrics & Gynecology

too, the Fifth Circuit's decision jeopardizes the safety and emotional well-being of IPV survivors experiencing a miscarriage.

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). The Court should likewise recognize that, for many survivors of IPV, accessing mifepristone 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 risks to their health, well-being, and safety.

197, 200 (2018, reaffirmed 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.

CONCLUSION

The Court should reverse the Fifth Circuit's decision as to the FDA's 2016 and 2021 actions.

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