NOS. 25A1207 & 25A1208

IN THE

Supreme Court of the United States

DANCO LABORATORIES, L.L.C.,
Applicant,

v.

STATE OF LOUISIANA, ET AL.,
Respondents.

GENBIOPRO, INC.,
Applicant,

v.

STATE OF LOUISIANA, ET AL.,
Respondents.

On Applications to Stay or Vacate the Judgment of the United States Court of Appeals for the Fifth Circuit

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BRIEF OF LEGAL VOICE, THE NATIONAL DOMESTIC VIOLENCE HOTLINE, THE NATIONAL NETWORK TO END DOMESTIC VIOLENCE, UJIMA, THE NATIONAL CENTER ON VIOLENCE AGAINST WOMEN IN THE BLACK COMMUNITY, CENTER FOR SURVIVOR AGENCY & JUSTICE, AND EXPERT RESEARCHERS AS *AMICI CURIAE* IN SUPPORT OF APPLICANTS

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INTEREST OF *AMICI CURIAE*[1]

Amici are non-profit, non-partisan public interest organizations that advocate for survivors of intimate partner violence ("IPV") or are researchers with expertise in the intersection of reproductive healthcare and gender-based violence. As advocates for survivors of domestic violence, *amici* have a strong interest in ensuring that survivors can access reproductive healthcare, including medication abortion. These organizations and researchers have extensive knowledge of the barriers that domestic violence survivors face when seeking support, services, and healthcare. *Amici* are also knowledgeable about how access to medication abortion can be essential to IPV survivors' health, well-being, and safety.

Legal Voice is a public interest legal organization with a mission to advance gender justice. 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 healthcare, protect reproductive freedom, and end gender-based violence. Legal Voice has provided advocacy, trainings, and community education regarding numerous domestic violence issues, including tactics of coercive control, domestic violence in rural communities, and the intersection of reproductive health and survivor safety.

The National Domestic Violence Hotline ("The Hotline") serves domestic violence victims and survivors across the United States. It is the only 24/7/365 hotline

[1] No part of this brief was authored in whole or in part by counsel for any party, and no person or entity has made any monetary contribution to the preparation or submission of this brief other than amici curiae and their counsel.

dedicated to supporting victims and survivors of domestic violence. Highly trained advocates offer compassionate support and validation, personalized safety planning, and connections to local resources via call, chat and text. To date, The Hotline has answered nearly 8 million calls, chats and texts from people affected by relationship abuse in every state, U.S. territory, and U.S. military base around the world. The Hotline is a critical lifeline for millions of people seeking safety, support, and hope in moments of crisis. The Hotline provides support to survivors experiencing all forms of domestic violence, including reproductive coercion, and has unique insight into the circumstances of those who experience this type of domestic abuse.

The National Network to End Domestic Violence ("NNEDV") represents the 56 U.S. state and territorial coalitions against domestic violence. NNEDV is dedicated to creating a social, political, and economic environment in which domestic violence no longer exists.

Ujima, The National Center on Violence Against Women in the Black Community ("Ujima"), was founded in 2015 in the District of Columbia. Ujima works to inspire and support the Black community in responding to and preventing domestic and community violence and sexual assault. With a focus on collective responsibility and shared prosperity, Ujima strives to cultivate a world where Black women and girls thrive.

Center for Survivor Agency & Justice ("CSAJ") is a national organization that helps advocates, organizations, and systems respond to the self-defined economic needs of domestic violence survivors. CSAJ leverages the insights of advocates and

programs to influence equitable policies and systems, strengthens organizational capacity to address economic challenges in communities, and ensures that direct advocates and attorneys can meet survivors' economic needs.

Dr. Liz Tobin-Tyler, **Dr. Samuel Dickman, Dr. Karen Trister Grace, Dr. Maeve Wallace, and Julie Dahlstrom** are expert researchers, educators, and authors in the areas of reproductive health, reproductive coercion, inequity in access to healthcare, rights and justice, maternal health policy, maternal safety, gender-based violence, public health law, health justice, and/or social safety nets.

SUMMARY OF ARGUMENT

IPV survivors are entitled to make their own reproductive choices, free from interference or coercion. Limiting access to mifepristone will reduce survivor safety and autonomy. The Fifth Circuit took the drastic step of staying the FDA's 2023 Risk Evaluation and Mitigation Strategy ("REMS") decision to remove the in-person dispensing requirement for mifepristone, which will cause immediate and serious harm to pregnant people and survivors by burdening their access to a safe and effective medication used in the most common and recommended protocol for medication abortion. Preserving survivors' ability to access abortion, including by telemedicine, is essential to the safety and autonomy of survivors.

The Fifth Circuit's stay of the 2023 REMS will upend the status quo that has existed for years and needlessly jeopardize the health and safety of IPV survivors by forcing them to travel in person to a health center to access medication, which will be dangerous or impossible for many survivors who must navigate surveillance or the impacts of coercive control by abusive partners. The stay will directly affect—and

significantly limit—IPV survivors' ability to access safe and effective, life-saving medication. *Amici* urge the Court to consider the immediate and irreparable harm that IPV survivors will face if access to mifepristone is restricted and to grant Applicants' requests to stay or vacate the Fifth Circuit's stay of the 2023 REMS.

ARGUMENT

I. Survivors of intimate partner violence need access to reproductive health care, including abortion care.

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 physical aggression, sexual coercion, psychological abuse and controlling behaviours."[2] Almost *60 million* women in the United States[3] report that they have experienced sexual violence, physical violence, or stalking by an intimate partner during their lifetimes.[4] No community is immune to intimate partner violence, but the numbers are even

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[2] *Violence Against Women*, WORLD HEALTH ORG. (Mar. 25, 2024), 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, WORLD HEALTH ORG. (2012), 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 W. Leemis et al., *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence* 1, 14, CTRS. FOR DISEASE CONTROL & PREVENTION (2022), https://www.cdc.gov/nisvs/documentation/NISVSReportonIPV_2022.pdf.

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 to utilize the legal system, all layered on top of the overall stress of assimilation.[6]

B. Abusers exert "coercive control" in many forms, and systemic inequities and barriers exacerbate the impacts of coercive control.

Researchers generally define intimate partner violence as a pattern of behavior by an abuser to gain or maintain control over their victim through a variety of tactics, not limited to physical violence.[7] Abusers also exert control by isolating survivors from family and friends, monitoring their whereabouts and relationships,[8] limiting their financial resources, tracking their use of transportation and time away from home, limiting access to birth control and reproductive healthcare,[9] and threatening

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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).

[6] *Id.*

[7] *See* Ashley Beeman, *The Need for More States to Adopt Specific Legislation Addressing Abusive Use of Litigation in Intimate Partner Violence*, 20 SEATTLE J. SOC. JUST. 825, 827-28 (2022); *What Is Domestic Abuse?*, UNITED NATIONS, https://www.un.org/en/coronavirus/what-is-domestic-abuse (last visited Apr. 27, 2026).

[8] 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).

[9] *Id.* at 2121–22, 2131–32; *see also* LEIGH GOODMARK, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 42 (2012).

to harm or kidnap children, among other tactics.[10] These intentional behaviors are called "coercive control": a repetitive pattern of acts that lessens the victim's independence and isolates them "from friends, family, or other support systems."[11] 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.

Access to mifepristone through telehealth, mail delivery, and pharmacy dispensing is even more important for survivors facing poverty or living in marginalized communities. Economic coercive control may include sabotaging employment or restricting access to money.[12] It takes money to flee an abusive relationship—for hotel rooms, gas, food, and childcare. 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 are nearly twice as likely to experience

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[10] Fischer et al., *supra* note 8, at 2122–23.

[11] Melissa E. Dichter et al., *Coercive Control in Intimate Partner Violence: Relationship with Women's Experience of Violence, Use of Violence, and Danger*, Psych. of Violence 8(5) Am. Psych. Ass'n 596–604 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6291212/.

[12] Julie Goldscheid, *Gender Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 COLUM. J. GENDER & L. 61, 75–77 (2008).

domestic violence.[13] Making matters worse, many IPV survivors lose their jobs as a direct consequence of the abuse they experienced.[14]

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

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[13] Erika A. Sussman & Sara Wee, *Accounting for Survivors' Economic Security: An Atlas for Direct Service Providers, Map Book One*, 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.

[14] Ellen Ridley et al., *Domestic Violence Survivors at Work: How Perpetrators Impact Employment*, ME. DEP'T OF LAB. & FAM. CRISIS SERVS. 1, 4 (Oct. 2005), https://www1.maine.gov/labor/labor_stats/publications/dvreports/survivorstudy.pdf.

[15] *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).

[16] John Creamer et al., *Poverty in the United States: 2021*, at 29–30, U.S. CENSUS BUREAU POPULATION REPORTS (Sept. 2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf; Victoria Tran, *Asian Americans Are Falling Through the Cracks in Data Representation and Social Services*, URB. INST. (June 19, 2018), https://www.urban.org/urban-wire/asian-americans-are-falling-through-cracks-data-representation-and-social-services.

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

[18] *See supra* Section I.A.

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] Access to health care providers and hospitals is scarcer outside urban areas, often making it more difficult for rural survivors to receive needed care. Rural communities generally have access to fewer resources, and those limited resources must be spread out in a larger geographic area.[21] These barriers further isolate a survivor from necessary resources.[22] Under these circumstances, the importance of access to critical medications through mail and pharmacy dispensing is even greater.

C. Abusers interfere with survivors' reproductive choices, including coercing and forcing victims into unwanted pregnancies, putting those survivors at risk.

Along with other forms of coercive control, abusers may use "reproductive coercion" to control their partners. 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.[23]

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[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).

[20] *Id.* at 1747–48.

[21] *Id.* at 1743.

[22] *See id.* at 1748.

[23] Elizabeth Tobin-Tyler et al., *How State Antiabortion Lawsuits and Increased Surveillance Empower Domestic Abusers*, 334(4) JAMA 297 (2025); Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 TRAUMA, VIOLENCE, & ABUSE 149, 151–53 (2007); Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81(4)

Reproductive coercion can also include coercing a partner to have an abortion or not to have an abortion.[24]

The stories of the survivors who have faced reproductive coercion are harrowing and can best be understood through their own words, collected by the National Domestic Violence Hotline.

> My partner knowingly and forcefully kept having sex after [my] consent was withdrawn. I became pregnant as a result of rape. I was raped again once I discovered I was pregnant while I was in an incredibly vulnerable state. After the first rape, I wanted to go to the pharmacy as soon as possible to get the morning-after pill. However, I had no way of getting there and feared trying to go on my own, of what he would have tried to do if I left. I had to wait until he took me, which was well over the amount of time I wanted to go, and obviously, the pill by this point was ineffective, as I became pregnant as a result.[25]
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>
> My husband has taken my birth control because he told me it was making me gain weight. He has come with me to ob-gyn appointments expecting to talk to the doctor about my birth control. He has cheated multiple times and forced me to continue to have unprotected sex.[26]
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>
> My former partner refused to allow me the recommended six-week post-partum recovery period of no penetration after the birth of our first child. He warned me when I got out of the

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CONTRACEPTION 316, 316–17 (2010), https://pmc.ncbi.nlm.nih.gov/articles/PMC2896047/pdf/nihms164544.pdf; Lauren Maxwell et al., *Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis*, PLOS ONE 10(2): e0118234 (2015), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118234.

[24] Karen Trister Grace & Jocelyn C. Anderson, *Reproductive Coercion: A Systematic Review*, 19 TRAUMA, VIOLENCE, & ABUSE 371–90 (2018).

[25] Nat'l Domestic Violence Hotline, *Reproductive Coercion and Abuse Report* 8, https://www.thehotline.org/wp-content/uploads/media/2025/04/ReproductiveCoercionAndAbuseReport.pdf.

[26] *Id.* at 17.

> hospital that he would not hold off on having sex for six weeks, so I needed to get that notion out of my head. Two weeks after giving birth, he initiated penetration with no discussion or permission while we were in bed for the night. Since my pregnancy and onward, he had become more violent and refusing sex was not an option for me. I did not begin birth control immediately after birthing my first child. I was in survival mode and looking for the first opportunity to escape from my abusive partner, hopefully with my baby. I did not know how he would respond to me being on birth control. After a couple of months of unprotected sex, I did not know if I was pregnant again and was afraid to start birth control if I was.[27]
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>
> During those two years, I couldn't take birth control. My ex-husband would have sex with me when I was sleeping. I confided in my ex-mother-in-law, who told me that a husband can't rape his wife. He just wanted me to keep having babies until I had a boy. Yet, he'd punish [me] for the expense of having children to take care of or [for] the time it took away from him. The whole thing was a nightmare. After my third and last child, I covertly went on birth control using a patch. My ex-husband thought it was a bandage.[28]

When the National Domestic Violence Hotline surveyed over 3,000 women seeking help, 23 percent reported that their abusive partner pressured them into becoming pregnant when they did not want to and 20 percent reported that their partner prevented them from using birth control.[29] Survivors reported many forms of reproductive coercion, including prohibiting birth control use, hiding birth control,

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[27] *Id.* at 11.

[28] *Id.* at 17.

[29] *Id.* at 11; *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).

refusing to use condoms, and rape.[30] As a result, survivors of IPV are significantly less likely to be able to use contraceptives than their non-victimized counterparts.[31]

It is hardly surprising, therefore, that reproductive coercion in abusive relationships dramatically increases the risk of unintended pregnancy.[32] Again, systemic inequities further compound the risks associated with reproductive coercion. Marginalized communities already experience disproportionately high rates of unintended pregnancy,[33] largely due to a lack of access to sexual health information,[34]

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[30] *See supra* note 25, at 8–9.

[31] 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); *see also* Maxwell et al., *supra* note 23.

[32] Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 CONTRACEPTION 457, 457 (2010).

[33] 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).

[34] 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).

health insurance,[35] and affordable contraceptives,[36] as well as a history of coercion by and mistrust of state and medical institutions.[37]

D. After experiencing pregnancy coercion and birth control sabotage, survivors may seek abortion care, which can be essential to escaping further abuse.

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. An estimated one in twenty women in the United States experienced a pregnancy from rape, sexual coercion, or both during their lifetimes.[38]

Dozens of studies have found a strong association between IPV and the decision to terminate pregnancy.[39] A survivor may choose to terminate a pregnancy

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[35] Latoya Hill et al., *Health Coverage by Race and Ethnicity 2010-2023*, KAISER FAM. FOUND. (Feb. 13, 2025), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

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

[37] 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.

[38] Denise D'Angelo et al., *Rape and Sexual Coercion Related Pregnancy in the United States*, 66(3) AM. J. PREVENTIVE MED. 389–98 (2024).

[39] *See* Hall et al., *supra* note 31 (identifying 74 studies from the United States and around the world that demonstrated a correlation between IPV and abortion); *see also* Dominique Bourassa & Jocelyn Berube, *The Prevalence of Intimate Partner Violence Among Women and Teenagers Seeking Abortion Compared with Those Continuing Pregnancy*, 29 J. OBSTETRICS & GYNECOLOGY CAN. 415 (2007).

that results from reproductive coercion,[40] that results from rape,[41] or out of fear of increased violence or being trapped in an abusive relationship if the pregnancy continues.[42] 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 leave that abusive relationship.[43]

Abortion care is lifesaving medical care for many survivors. It is common for abusers to prevent survivors from making or keeping in-person medical appointments, restricting access to transportation, or from having private in-person conversations with health care providers.[44] Abusers also use financial exploitation to control a survivor's medical care—by refusing to make co-payments or provide insurance.[45] Even when survivors are able to travel for in-person appointments,

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[40] Hall et al., *supra* note 31, at 6–7.

[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] 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://pubmed.ncbi.nlm.nih.gov/25262880/.

[43] *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) (use of legal system and child custody to continue coercive control); Carmela DeCandia et al., *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness* 4, THE NAT'L CTR. ON FAM. HOMELESSNESS 4 (2013), https://www.air.org/sites/default/files/2021-06/Closing%20the%20Gap_Homelessness%20and%20Domestic%20Violence%20toolkit.pdf (barriers to finding housing for families fleeing abuse).

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

[45] *Id.*

abusive partners can reframe the survivor's injuries when speaking to healthcare professionals.[46] As a result, IPV survivors are less likely to receive prenatal care and more likely to miss important doctors' appointments than pregnant people in non-violent relationships.[47]

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.[48] While the United States as a whole has a maternal mortality rate over three times that of other developed nations,[49] 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.[50] Moreover, Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander women are

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[46] *Id.* at 633–34 (one survivor reporting: "my [abusive] husband, who is a doctor, would always make sure he was with me at my doctor appointments and would never leave me alone with any doctor.").

[47] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. FAM. VIOLENCE 79, 79–87 (2017).

[48] 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.

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

[50] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KAISER FAM. FOUND. (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/.

generally more likely to have preterm births and babies with low birthweights.[51] Asian American and Pacific Islander women are at greater risk of severe maternal morbidities and maternal mortality compared to white women.[52]

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.[53] IPV is common in pregnancy: Intimate partner violence affects as many as 324,000 pregnant women each year.[54] And IPV can and does escalate to homicide.[55] Homicide is one of the leading causes of maternal death across the United States,[56] and the second-leading cause of pregnancy-associated death in Louisiana.[57] Most cases of pregnancy-associated homicide involve domestic

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[51] *Id.*

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

[53] Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 INT'L J. WOMEN'S HEALTH 183 (2010); *see also* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).

[54] Shaina Goodman, *Intimate Partner Violence Endangers Pregnant People and Their Infants*, NAT'L P'SHIP FOR WOMEN & FAMS. (May 2021), https://nationalpartnership.org/report/intimate-partner-violence/.

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

[56] Maeve Wallace, *Trends in Pregnancy Associated Homicide, United States 2020*, 112 AM. J. PUB. HEALTH 1333–36 (2022).

[57] La. Dep't of Health, *Louisiana Pregnancy-Associated Mortality Review: Maternal Morality in Louisiana 2020 Report* 13–14 (2024), https://ldh.la.gov/assets/oph/Center-

violence.[58] Homicide is highest among Black women and women under 25 years of age.[59] Access to abortion is a matter of life or death: Researchers have found an association between increased state-based limits on abortion access and increased rates of IPV-related homicide.[60]

Notably, losing access to abortion can worsen survivors' circumstances. Research shows that "having a baby from an unwanted pregnancy appears to result in sustained physical violence over time."[61] In contrast, "having an abortion was associated in a reduction over time in physical violence" from the abuser.[62]

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

As the Fifth Circuit acknowledged, its decision to stay the 2023 REMS will have a nationwide effect. Dkt. 119-1, at 18. Preliminary relief, however, is intended to preserve the status quo and prevent irreparable harm. *See City of Dallas v. Delta Air Lines, Inc.*, 847 F.3d 279, 285 (5th Cir. 2017). The nationwide restrictions that follow from staying the 2023 REMS will do the opposite, indiscriminately taking away

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PHCH/FamilyHealth/2020_PAMR_Report_April2024.pdf (also reporting that homicide was a top cause of pregnancy-associated deaths for Black women).

[58] *See* Wallace, *infra* note 62.

[59] *Id.* at 1334; 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 WKLY. REP. 741 (July 21, 2017).

[60] Maeve Wallace et al., *States' Abortion Laws Associated with Intimate Partner Violence-Related Homicide of Women and Girls in the US, 2014-20*, 43(5) HEALTH AFF. 682 (2024).

[61] Roberts et al., *supra* note 42, at 5.

[62] *Id.*

pregnant IPV survivors' ability to make choices about their own bodies and protect their own health and safety. As explained above, being forced to carry a 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.

Reinstating the in-person dispensing requirement would increase barriers to abortion care for survivors of IPV across the United States, with grave consequences for their health and well-being.

Reducing abortion access harms survivors. Research has shown a significant increase in IPV rates in areas with limited access to abortion, including Louisiana.[63] Having already banned abortion within its borders, Louisiana now seeks to force burdensome and unnecessary restrictions on the rest of the country. Removing the ability to access mifepristone via telemedicine is especially harmful to survivors nationwide. The availability of telehealth, the ability to fill prescriptions at local pharmacies, and the ability to receive medication by mail after receiving care through telemedicine are essential to survivors of IPV because these options reduce both the cost of abortion care and the barriers of having to pay for and arrange transportation, childcare, and time off work outside the surveillance of an abuser, even in states that protect access. *See supra* Section I.B. Indeed, in-home medication abortion is often a survivor's only option for abortion care because the survivor must obtain care without

[63] Dhaval Dave et al., *Abortion Restrictions and Intimate Partner Violence in the Dobbs Era*, 104 J. HEALTH ECON. 103074 (2025).

the abuser finding out.[64] Having a variety of options for accessing that care—in one's home, at work, in the car, or in another safe location of choosing, with the medication then mailed to a safe location or picked up—helps survivors maintain safety and privacy.

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.[65] If rural survivors of IPV cannot access mifepristone by mail, many will have to travel long distances to get the medication they need, increasing the risk that their abuser will find out—with potentially deadly consequences. Indeed, reinstating the in-person dispensing requirement would jeopardize not only their ability to end their pregnancy but also their lives.

Requiring in-person dispensing of mifepristone by providers—which means that clinicians who wish to prescribe this medication to their patients can do so only if they also have the ability to stock and dispense it onsite—will also reduce the number of providers that IPV survivors can turn to, as the FDA found in its determination to modify the REMS.[66] Family physicians who might otherwise provide

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[64] Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and at-Home Reproductive Care*, 32 CONST. COMMENT. 341, 373 (2017).

[65] 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).

[66] U.S. Food and Drug Administration, Medical Review of Mifepristone (Application No. NDA 020687), Center for Drug Evaluation and Research, Dkt. 1, Exh. 51, 17–18 (Dec. 16, 2021) (finding a "potential for doubling of the number of

mifepristone-based abortions as one of their services have described the in-person dispensing requirement as a barrier to providing mifepristone because it necessitated that the provider stock, dispense, and bill for the medication onsite at their facility, requiring extra administrative steps and involvement of clinic administration.[67] When there are fewer providers available and telehealth is not an option, people who want to use mifepristone will be forced to travel long distances and wait longer for appointments to get the care they need.

Survivors who must travel longer distances for abortion care will face greater difficulty hiding their abortion from an abusive partner. Compared to people in non-violent relationships, IPV survivors are three times as likely to conceal their abortion from their partner.[68] For the many survivors who are subject to reproductive coercion by their partners, traveling to a clinic or hospital may not be an option. Travel is costly, both financially—such as hotel costs, gas, or flights—and in time spent away from work and care-giving responsibilities.[69] Many IPV survivors have children and need to arrange childcare to go to medical appointments. Childcare options are

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prescribers of mifepristone if the in-person dispensing requirement in ETASU C is removed from the Mifepristone REMS Program.").

[67] 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); Silpa Srinivasulu, et al., *US Clinicians' Perspectives on How Mifepristone Regulations Affect Access to Medication Abortion and Early Pregnancy Loss in Primary Care*, 104 CONTRACEPTION 92, 94–95 (2021).

[68] Hall et al., *supra* note 31, at 25.

[69] Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 104(1) CONTRACEPTION 16, 17 (2021).

limited for people who lack funds, want to keep their need for an abortion private, or are isolated from friends and family. These costs will be prohibitive for many survivors of IPV, who disproportionately face economic hardship and financial control by their partners.[70] In contrast, telehealth appointments can be completed from a strategically safe place and mifepristone can be mailed to a local address or picked up at a local pharmacy.

For survivors of color, discrimination and structural oppression exacerbate the barriers to abortion when telemedicine is unavailable. Transportation is a major barrier.[71] Missing work and traveling are costly, and Black and Latinx women tend to have significantly lower wages than white women and men.[72] 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.[73] Reinstating the in-person dispensing requirement for mifepristone would compound the many barriers to care that survivors of IPV already face. As a result, some simply will not be able to access abortion care at all.

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[70] Sussman & Wee, *supra* note 13, at 1, 4.

[71] *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 (last visited Apr. 27, 2026).

[72] *Fact Sheet: Gender and Racial Wage Gaps Persist as the Economy Recovers* 2, INST. WOMEN'S POL'Y RSCH. (Sept. 2022), https://iwpr.org/wp-content/uploads/2022/10/Annual-Gender-Wage-Gap-by-Race-and-Ethnicity-2022.pdf.

[73] Hill et al., *supra* note 35.

III. Reinstating the in-person dispensing requirement will not prevent reproductive coercion but will harm IPV survivors.

Reproductive coercion takes many forms. Preventing reproductive coercion requires a wide range of interventions to reduce IPV and give survivors the tools, resources, and support that they need to escape abuse. Interventions that have been effective at reducing IPV include individual support, counseling, economic empowerment, community mobilization, and IPV screening and referrals.[74] Response systems must also be ready to provide immediate assistance to survivors who are in or are leaving dangerous situations. This includes investment in survivor-centered services, safe housing programs, civil legal protections, and responsive healthcare.[75] Effective support must ensure that survivors can safely discern and access their reproductive choices without fear of harm.

No one should ever be forced to have, continue, or end a pregnancy against their will. Just as stories of pregnant people having their birth control sabotaged, being raped, or being blocked from accessing abortion care are horrific, so too are stories of pregnant people being forced or tricked into taking mifepristone. We must take these incidents seriously *and* recognize that broadly ending patients' ability to obtain mifepristone by mail and at pharmacies is neither a proportionate nor effective

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[74] Ema Alsina et al., *Interventions to Prevent Intimate Partner Violence: A Systematic Review and Meta-Analysis*, 30(3-4) VIOLENCE AGAINST WOMEN 953–80 (2024), https://pubmed.ncbi.nlm.nih.gov/37475456/.

[75] Phyllis Holditch Niolonet al., *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices*, NAT'L CTR. FOR INJURY PREVENTION & CONTROL, DIV. OF VIOLENCE PREVENTION (2017), https://stacks.cdc.gov/view/cdc/45820.

response to intimate partner violence and will reduce health care options and autonomy for survivors nationwide. An abusive partner in Louisiana can already be prosecuted for offenses such as domestic or dating partner battery, aggravated assault of a partner, and drug-facilitated harm.[76] Abusers who are willing to deceive medical providers to get mifepristone and then drug their partners in violation of criminal and civil laws will find other ways to interfere with their partners' pregnancies if telemedicine is no longer available.[77] Making health care harder to access in the name of protecting survivors is misguided and counterproductive: The Fifth Circuit's stay will harm survivors who need abortion care for their health and safety.

This Court should 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.

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[76] LA Rev. Stat. § 14:38.1 (mingling harmful substances); *id.* § 40:969D (unlawful administration or dispensing of controlled dangerous substances); *id.* § 14:35.3 (domestic abuse); *id.* § 14:34.9 (battery of a dating partner); *id.* § 14.37.7 (domestic abuse aggravated assault). Louisiana has also adopted coercive control principles in its response to domestic violence, calling the harm "power-based violence." *Id.* § 17:3399.13 (mandatory reporting of power-based violence in the education system); Univ. of La. Monroe Police Dep't, Power-Based Violence Crime Statistics Report (2024), https://www.ulm.edu/police/power-based_violence_crime_report_october_1_2024.pdf (defining domestic violence, dating violence, aggravated assault, and family violence as power-based crimes).

[77] Nat'l Domestic Violence Hotline, *supra* note 25, at 13 (9% of survey respondents reported current or former partner threatened violence if termination of pregnancy was under consideration).

There is no evidence-based reason for staying the 2023 REMS and reinstating the in-person dispensing requirement. The Fifth Circuit's stay will have sweeping effects across the nation, upending how abortion care is delivered and causing serious harm to the public—especially survivors of violence and abuse.

CONCLUSION

Amici respectfully urge the Court to grant Applicants' requested relief and stay or vacate the Fifth Circuit's stay.

Dated: May 7, 2026

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