No. 26-30203

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL; ROSALIE MARKEZICH,

Plaintiffs-Appellants / Cross-Appellees,

v.

U.S. FOOD & DRUG ADMINISTRATION; KYLE DIAMANTAS, Acting Commissioner, U.S. Food and Drug Administration; MICHAEL DAVIS, in his official capacity as Acting Director, Center for Drug Evaluation and Research, U.S. Food and Drug Administration; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., Secretary, U.S. Department of Health and Human Services,

Defendants-Appellees,

GENBIOPRO, INCORPORATED,

Intervenor-Appellee / Cross-Appellant,

v.

DANCO LABORATORIES, L.L.C.,

Intervenor-Appellee / Cross-Appellant.

On Appeal from the United States District Court
for the Western District of Louisiana (No. 6:25-cv-01491)
The Honorable David C. Joseph, U.S. District Judge

BRIEF OF LEGAL VOICE AND OTHER DOMESTIC VIOLENCE ORGANIZATIONS AND EXPERTS AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

/s/ Daniel W. Wolff
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National Network to End Domestic Violence
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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. A complete list of *amici* can be found in the Addendum to this brief.

INTRODUCTION

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 Supreme Court of the United States stayed this Court's May 1, 2026 order which stayed the FDA's

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici* or its counsel made a monetary contribution for preparation or submission of this brief. All parties have consented to the filing of this brief.

2023 Risk Evaluation and Mitigation Strategy ("REMS") decision to remove the in-person dispensing requirement for mifepristone. *See Danco Lab'ys, LLC v. Louisiana*, 146 S. Ct. 1192 (2026) (mem.); Mot. for § 705 Stay or Injunction Pending Appeal, ECF No. 12.

Reinstating the in-person dispensing requirement in the pre-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. This will directly affect—and significantly limit—IPV survivors' ability to access safe and effective, life-saving medication. IPV survivors must navigate nearly impossible situations; having a range of options available so they can identify which options are possible under their specific circumstances is critical to protecting their health and safety. *Amici* urge the Court to consider the immediate and irreparable harm that IPV survivors will face if access to mifepristone is restricted and to deny Plaintiffs-Appellants' ("Appellants") request to reverse the district court's denial of preliminary relief.

ARGUMENT

I. Survivors of intimate partner violence need access to reproductive healthcare, 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 having experienced sexual violence, physical violence, or stalking by an intimate partner during their

[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.

lifetimes.[4] No community is immune to IPV, but the 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 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 IPV as a pattern of behavior by an abuser to gain or maintain control over their victim through a variety of

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[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.

[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] *See* Leemis, *supra* note 4, at 14; Stockman, *supra* note 5.

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 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

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[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 July 17, 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).

[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*, 8 PSYCH. OF VIOLENCE 596, 596–604 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6291212/.

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 healthcare 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 domestic violence.[13] Making matters worse, many IPV

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

[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.

survivors lose their jobs as a direct consequence of the abuse they experienced.[14]

Survivors from marginalized communities also 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 LGBTQ+, disabled, or non-

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[14] Ellen Ridley et al., *Domestic Violence Survivors at Work: How Perpetrators Impact Employment*, ME. DEP'T OF LAB. & FAM. CRISISSERVS. 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., U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, P60-277, POVERTY IN THE UNITED STATES: 2021, at 29–30 (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.

citizens.[17] And women from these communities are more likely to experience IPV.[18]

Women living in rural areas, who experience higher rates of IPV and more severe physical abuse 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 healthcare 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 IPV 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

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[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.

[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.

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

[23] Elizabeth Tobin-Tyler et al., *How State Antiabortion Lawsuits and Increased Surveillance Empower Domestic Abusers*, 334 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 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*, 10 PLOS ONE e0118234 (2015), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118234.

have an abortion.[24] Reproductive coercion involves the systematic elimination of survivors' autonomy—their freedom to choose.[25] According to the American College of Obstetricians and Gynecologists, the most common forms of reproductive coercion include sabotage of contraceptive methods, pregnancy coercion, and pregnancy pressure.[26]

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,

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

[25] *See* A. Rachel Camp, *Coercing Pregnancy*, 21 WM. & MARY J. WOMEN & L. 275, 280 (2015).

[26] Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 554 (Feb. 2013), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.

> the pill by this point was ineffective, as I became pregnant as a result.[27]
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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.[28]
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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 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.[29]

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

[28] *Id.* at 17.

[29] *Id.* at 11.

> 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.[30]

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.[31] Survivors reported many forms of reproductive coercion, including prohibiting birth control use, hiding birth control, refusing to use condoms, and rape.[32] As a result, survivors of IPV are significantly

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[30] *Id.* at 17.

[31] *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).

[32] *See* Nat'l Domestic Violence Hotline, *supra* note 27, at 8–9; *see also* Am. Coll. of Obstetricians & Gynecologists, *supra* note 26, at 2 ("Among adolescent mothers on public assistance who experienced recent intimate partner violence (IPV), 66% experienced birth control sabotage by a dating partner.").

less likely to be able to use contraceptives than their non-victimized counterparts.[33]

It is hardly surprising, therefore, that reproductive coercion in abusive relationships dramatically increases the risk of unintended pregnancy.[34] Again, systemic inequities further compound the risks associated with reproductive coercion. Marginalized communities already experience disproportionately high rates of unintended pregnancy,[35] largely due to a lack of access to sexual health information,[36]

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[33] 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.

[34] Elizabeth Miller et al., *Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy*, 81 CONTRACEPTION 457, 457 (2010); Am. Coll. of Obstetricians & Gynecologists, *supra* note 26, at 2.

[35] 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).

[36] 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,[37] and affordable contraceptives,[38] as well as a history of coercion by and mistrust of state and medical institutions.[39] Because reproductive coercion works by restricting options, the antidote is restoring those options and ensuring survivors can access them. Laws like the in-person dispensing requirement that further restrict those options compound—rather than relieve—the harm survivors face.

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, while important to all women, is particularly critical for IPV survivors, and especially those whose unintended pregnancies resulted from reproductive coercion. An

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[37] Latoya Hill et al., *Health Coverage by Race and Ethnicity, 2010-2024*, KAISER FAM. FOUND. (May 4, 2026), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

[38] 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/.

[39] 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.

estimated one in twenty women in the United States experienced a pregnancy from rape, sexual coercion, or both during their lifetimes.[40]

Experiencing IPV can cause a survivor to decide abortion is her safest option.[41] A survivor may choose to terminate a pregnancy that results from reproductive coercion,[42] that results from rape,[43] or out of fear of increased violence or being trapped in an abusive relationship if the pregnancy continues.[44] 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. Abusers may threaten to

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

[41] *See* Hall et al., *supra* note 33 (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).

[42] Hall et al., *supra* note 33, at 6–7.

[43] 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).

[44] 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/.

take away a survivor's children in a custody case, which often inhibits a survivor's decision to leave an abusive relationship. Having more children increases economic and logistical challenges that can limit survivors' options.[45] Having an abortion does not guarantee that a survivor will leave an abusive relationship. For many survivors, however, abortion can help reduce violence.[46] Not all survivors will choose abortion—but that does not mean it should not be an option.[47] Survivors

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[45] *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, NAT'L CTR. ON FAM. HOMELESSNESS (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).

[46] Roberts et al., *supra* note 44, at 5 ("Among women seeking abortion, having an abortion was associated with a reduction over time in physical violence . . . while having a baby from an unwanted pregnancy appears to result in sustained physical violence over time.").

[47] *See* Camp, *supra* note 25, at 311 ("Women may not universally desire abortion. Even if a woman doesn't want to be pregnant, she may also not want to have an abortion. . . . Abortion may offer a solution for some women experiencing a coerced pregnancy, but for others, it may simply be no solution at all.").

need access to the full range of options so they can make the decisions that are right for their own safety and circumstances.[48]

Abortion care, including access to mifepristone through telehealth and mail or pharmacy delivery, is lifesaving medical care for many survivors. It is common for abusers to prevent survivors from making or keeping in-person medical appointments, from accessing transportation, or from having private in-person conversations with healthcare providers.[49] Abusers also use financial exploitation to control a survivor's medical care—by refusing to make co-payments or provide insurance.[50] Even when survivors are able to travel for in-person appointments, abusive partners can reframe the survivor's injuries when speaking to healthcare professionals.[51] As a result, IPV survivors are less likely to

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[48] *See* JUDITH HERMAN, TRAUMA AND RECOVERY 133 (1997) ("No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.").

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

[50] *Id.*

[51] *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." (alteration in original)).

receive prenatal care and more likely to miss important doctors' appointments than pregnant people in non-violent relationships.[52]

Survivors of color are further burdened by the negative health effects of transgenerational racism and poverty, making them especially vulnerable to pregnancy-related complications.[53] While the United States as a whole has a maternal mortality rate over three times that of other developed nations,[54] the rates for women of color are strikingly higher: Black women die three times as often as white women during pregnancy, and American Indian and Alaskan Native women die twice as often.[55] Moreover, Black, American Indian, Alaskan Native, Native

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[52] Gunnar Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 32 J. FAM. VIOLENCE 79, 79–87 (2017).

[53] 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.

[54] 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.

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

Hawaiian, and Pacific Islander women are generally more likely to have preterm births and babies with low birthweights.[56] Asian American and Pacific Islander women are at greater risk of severe maternal morbidities and maternal mortality compared to white women.[57]

Not only do pregnant people in abusive relationships face increased health risks associated with pregnancy; they are also likely to suffer more, and more intense, violence during pregnancy.[58] IPV is common in pregnancy: IPV affects as many as 324,000 pregnant women each year.[59] And IPV can and does escalate to homicide.[60] Homicide is one of the

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(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/.

[56] *Id.*

[57] 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).

[58] 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).

[59] 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/.

[60] 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 (Continued…)

leading causes of maternal death across the United States,[61] and the second-leading cause of pregnancy-associated death in Louisiana.[62] Most cases of pregnancy-associated homicide involve domestic violence.[63] Homicide is highest among Black women and women under 25 years of age.[64] 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.[65]

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).

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

[62] La. Dep't of Health, *Louisiana Pregnancy-Associated Mortality Review: Maternal Mortality in Louisiana 2020 Report* 13–14 (2024), https://ldh.la.gov/assets/oph/Center-PHCH/FamilyHealth/2020_PAMR_Report_April2024.pdf (also reporting that homicide was a top cause of pregnancy-associated deaths for Black women).

[63] *See* Wallace, *supra* note 61.

[64] *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).

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

Notably, losing access to abortion, including access to mifepristone through telehealth and mail or pharmacy delivery, can worsen survivors' circumstances. Research shows that "having a baby from an unwanted pregnancy appears to result in sustained physical violence over time."[66] In contrast, "having an abortion was associated in a reduction over time in physical violence" from the abuser.[67] Survivors should have access to all available options, including abortion and medication abortion using mifepristone, when making choices about their health and safety.

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

Reinstating the in-person dispensing requirement would increase barriers to abortion care for survivors of IPV across the United States, threatening their health and well-being. Preliminary relief 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 would follow from reversing the district court's denial of preliminary relief will do the opposite, indiscriminately taking away

[66] Roberts et al., *supra* note 44, at 5.

[67] *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.

Removing the ability to access mifepristone via telemedicine would be harmful to survivors nationwide. Research has shown a significant increase in IPV rates in areas with limited access to abortion, including Louisiana. [68] Having already banned abortion within its borders, Louisiana now seeks to force burdensome and unnecessary restrictions on the rest of the country. Where permitted, the ability to receive care via telehealth and to fill prescriptions at local pharmacies, or the ability to receive medication by mail, are essential to survivors of IPV. 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

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

survivor's only option for abortion care because the survivor must obtain care without the abuser finding out.[69] Having a variety of options for accessing a telehealth appointment—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.

Moreover, when a survivor chooses one of these options, she receives evidence-based medical care, just as at an in-person appointment. Contrary to what other *amici* have suggested to this Court, telehealth providers can and do screen effectively for IPV and provide education, resources, and referrals via telehealth.[70] Telehealth allows for "real-time and/or asynchronous modes" of consultation that increase

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

[70] *See* Katherine Obenschain, *How Telehealth Impacts Screening for Intimate Partner Violence*, CHILDREN'S HOSP. OF PHIL. (Oct. 12, 2021), https://injury.research.chop.edu/blog/posts/how-telehealth-impacts-screening-intimate-partner-violence; APA, RESOURCE DOCUMENT ON TELEHEALTH SERVICES IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE (IPV) ADDRESSING POTENTIAL RISKS TO SAFETY AND SECURITY (Aug. 2022), https://www.psychiatry.org/getattachment/b5bee1e6-75be-41e5-93af-0e6afc3d1bb6/Resource-Document-Telehealth-and-Intimate-Partner-Violence.pdf.

accessibility of services.[71] Because survivors can access telehealth privately and from a variety of locations, telehealth is "critical to ensuring that people who experience [IPV] have access to needed mental health and substance use care"[72] especially in "health provider shortage areas, where victimization may intersect with other determinants of violence."[73] In short, a telehealth visit that actually takes place is far

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[71] Mysore Narasimha Vranda & Vasanthra Radhakrishnan Civil, *Tele-Consultation for the Survivors of Intimate Partner Violence: Guidelines for Mental Health Professionals*, 44 INDIAN J. PSYCHOL. MED. 349, 349 (2022); *see also* Tamar Krishnamurti et al., *Mobile Remote Monitoring of Intimate Partner Violence Among Pregnant Patients During the COVID-19 Shelter-In-Place Order: Quality Improvement Pilot Study*, 23 J. MED. INTERNET RES. e22790 (2021), https://doi.org/10.2196/22790 (examining cases of IPV that were reported on a prenatal care app and finding "app-based screening may capture a different set of patients who are at risk of IPV, which means that an app-based approach can be used to complement in-person assessments. An app-based approach also provides patients (ie, those who feel that they may be at risk of IPV) with the freedom to engage with screening tools when they feel safe and comfortable.").

[72] *See* APA, *supra* note 70.; *see also* Maka Lortkipanidze, et al., *Mental health of intimate partner violence victims: depression, anxiety, and life satisfaction*, 16 FRONT PYSCHOL. 1531783 (Aug. 11, 2025), doi: 10.3389/fpsyg.2025.1531783 (study showing that IPV survivors suffer from various and distinct mental health outcomes requiring targeted intervention).

[73] Chuka Emezue, *Digital or Digitally Delivered Responses to Domestic and Intimate Partner Violence During COVID-19*, 6 JMIR PUB. HEALTH & SURVEILLANCE e19831 (July 30, 2020), https://doi.org/10.2196/19831.

more protective than an in-person visit that a survivor cannot safely attend because her abuser controls her transportation, monitors her whereabouts, or accompanies her to appointments.

The need for telehealth-based abortion care is especially acute for survivors who live in rural areas. Survivors in rural America are more likely to face chronic and severe IPV and have worse psychosocial and physical health outcomes.[74] If rural survivors 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

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[74] Katie M. 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).

the REMS. [75] 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 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. [76] 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.

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

[76] 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).

Compared to people in non-violent relationships, IPV survivors are three times as likely to conceal their abortion from their partner.[77] Both quantitative and qualitative studies have documented men pressuring women not to end their pregnancy, including through threats of violence and even homicide, excessive badgering, making a woman eat on the day of her abortion so that she cannot get the procedure, being disruptive at abortion clinics to force a partner to leave, and refusing to provide money or transportation so that a woman can get an abortion.[78]

For the many survivors who are subject to reproductive coercion or other forms of violence and coercive control 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.[79] 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.

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[77] Hall et al., *supra* note 33, at 25.

[78] Grace & Anderson, *supra* note 24.

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

These costs will be prohibitive for many survivors of IPV, who disproportionately face economic hardship and financial control by their partners.[80] 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 provision is unavailable. Transportation is a major barrier.[81] Missing work and traveling are costly, and Black and Latinx women tend to have significantly lower wages than white women and men.[82] 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.[83]

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

[81] *Car Access: Everyone Needs Reliable Transportation Access and in Most American Communities That Means a Car*, NAT'L EQUITY ATLAS, https://nationalequityatlas.org/indicators/Car_access (last visited July 17, 2026).

[82] *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.

[83] Hill et al., *supra* note 37.

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.

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.[84] 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.[85] These are prime examples of the support that

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

[85] Phyllis Holditch Niolon et 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; *see* (Continued…)

enables survivors to weigh their range of options and make decisions tailored to their health and wellbeing. 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 all incidents of reproductive coercion seriously *and* recognize that broadly ending patients' ability to obtain mifepristone by mail and at pharmacies is neither a proportionate nor effective response to IPV and will reduce healthcare options and autonomy for survivors nationwide. Reducing healthcare options for survivors who would benefit from accessing mifepristone will not reduce the risk of abortion coercion.[86]

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also Krishnamurti et al., *supra* note 71 (discussing the importance of various mediums for patients at risk of IPV to report incidents of IPV).

[86] *See* Grace & Anderson, *supra* note 24.

Drastically reducing access to mifepristone for countless survivors is not the solution to reproductive coercion. 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.[87] 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 and mail delivery is no longer available.[88] Making healthcare harder to access in the name of protecting survivors is misguided and counterproductive. Reinstating the in-person

[87] 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 battery); *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).

[88] Nat'l Domestic Violence Hotline, *supra* note 27, at 13 (9% of survey respondents reported current or former partner threatened violence if termination of pregnancy was under consideration).

dispensing requirement for mifepristone 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.

Reinstating the in-person dispensing requirement in the pre-2023 REMS 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 urges the Court to deny Appellants' request for reversal and affirm the district court's denial of a preliminary injunction.

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CERTIFICATE OF SERVICE

I hereby certify that, on July 22, 2026, I electronically filed the foregoing brief with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Daniel W. Wolff
Daniel W. Wolff

CERTIFICATE OF COMPLIANCE

The undersigned counsel certifies that this brief:

(i) complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 6,492 words including footnotes and excluding the parts of the brief exempted by Rule 32(f);

(ii) complies with the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14 point Century Schoolbook;

(iii) all required privacy redactions have been made;

(iv) the hardcopies submitted to the Clerk are exact copies of the ECF submission; and

(v) the digital submission has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses.

Dated: July 22, 2026

/s/ Daniel W. Wolff
Daniel W. Wolff

ADDENDUM

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LIST OF AMICI CURIAE

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 health care, 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 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 founded in 2007 that advances economic security for survivors of domestic and sexual violence. CSAJ's work is grounded in one core truth: There is no safety without economic security. CSAJ

enhances individual advocacy, strengthens organizational responses, and fuels systems and policy change**.**

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