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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

STATE OF WASHINGTON ET AL., Plaintiffs, v. UNITED STATES FOOD AND DRUG ADMINISTRATION ET AL., Defendants.	No. 1:23-cv-03026 ASIAN PACIFIC INSTITUTE ON GENDER BASED VIOLENCE, THE FAMILY VIOLENCE APPELLATE PROJECT, IDAHO COALITION AGAINST SEXUAL AND DOMESTIC VIOLENCE, LEGAL VOICE, SEXUAL VIOLENCE LAW CENTER, AND THE WASHINGTON STATE COALITION AGAINST DOMESTIC VIOLENCE'S AMICUS CURIAE BRIEF

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I. INTRODUCTION[1]

The Food and Drug Administration's ("FDA") unnecessary and unfounded restrictions on mifepristone ignore the lived experience of survivors of intimate partner violence ("IPV"), who already face barriers to reproductive care and who are more likely to need medication abortion care. This is especially true for the many survivors of IPV who experience multiple forms of marginalization, including those who are also Black, Indigenous, and people of color; are part of the LGBTQ+ community; live in rural or underserved areas; or have immigration or socio-economic barriers to accessing care.

Access to safe abortion care is especially essential for survivors of IPV. Abusive partners exert control over survivors of IPV and maintain power within the relationship by undermining survivors' autonomy to make reproductive decisions, limiting access to health care, and forcing pregnancy. Federal courts have recognized the importance of access to care for survivors of IPV. The reality of intimate partner violence was central to the Supreme Court's decision to strike down the spousal notification requirement in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[2] The Court reasoned that "there are millions of women in this country who are the victims of regular physical and psychological abuse at the hands of their husbands. Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion."[3] The barriers and limitations survivors face when they need abortion care were significant in 1992, when *Casey* was decided, and they have not gone away in the

[1] Please see the statement of amici in the motion to appear as amicus.
[2] 505 U.S. 833, 888, 892–93 (1992).
[3] *Id.* at 893.

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intervening 31 years.

Survivors of IPV are more likely to be forced into unintended pregnancy, to need abortions, and to risk being trapped in violent relationships if they are unable to access abortion care. The consequences of such entrapment range from heightened abuse during pregnancy to death. As difficult as it is for all survivors of IPV to escape abusive relationships and exercise their reproductive autonomy, IPV survivors of color—who already experience disproportionately high rates of unintended pregnancy and increased health risks associated with unintended pregnancy—face systemic inequities that make doing so all the more difficult.

The FDA's unnecessary restrictions on mifepristone prevent IPV survivors from getting the healthcare that they need by making it more difficult for them to access abortion care. Mifepristone is a safe and effective drug that provides people with greater choice and flexibility in where and how they have an abortion. The restrictions at issue in this case, set out in the 2023 Risk Evaluation and Mitigation Strategy ("REMS"), reduce access.

The REMS reduce access to care in two significant ways. First, the Patient Agreement Form increases stigma around abortion and can increase fear for patients who seek to keep their abortion private. Second, the certification, documentation, and reporting rules for providers and pharmacies deter some providers and pharmacies from providing medication abortion, reducing access to care. For some survivors of IPV, the challenge of getting abortion medication will cause them to carry their pregnancies to term against their will, putting their health—and their lives—at risk. If the FDA's restrictions under the 2023 REMS remain in place, or the FDA takes new action to further reduce access to mifepristone, survivors of IPV

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will continue to face barriers accessing abortion when they need it.

II. ARGUMENT

A. Survivors of IPV are at a greater risk of unintended pregnancy, which creates significant risks for survivors' health and safety.

1. Many people in the United States, including in Plaintiff states, experience IPV.

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,"[4] affects nearly half of women[5] in the United States.[6] Almost *60 million* American women report that they have experienced sexual violence, physical violence, and/or stalking by an intimate partner during their lifetimes.[7] 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.[8] Rates of IPV are also disproportionately high for Asian and Latina immigrant women who face additional structural barriers including language difficulties, immigration status, and lack of faith in or resources about the legal

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

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

[6] Ctrs. for Disease Control & Prevention, The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence 3–4 (2022), https://www.cdc.gov/violenceprevention/pdf/nisvs/NISVSReportonIPV_2022.pdf.

[7] *Id.* at 1, 4.

[8] *Id.* at 7; *see also* Jamila K. Stockman et al., *Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups*, 24 J. Women's Health 62, 62 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302952/.

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system, all coupled with the overall stress of assimilation.[9]

Many individuals in Plaintiff states are harmed by IPV. In fact, women in Washington and Oregon suffer IPV at rates even higher than the national average.[10]

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

Physical abuse is only one aspect of IPV. Abusers also exert control by isolating survivors from family and friends and monitoring their whereabouts and relationships,[11] limiting their financial resources, tracking their use of transportation and time away from home,[12] and threatening to harm or kidnap children, among other tactics.[13] This "coercive control" limits survivors' access to the resources necessary to escape the abusive relationship. Economic control is another aspect of "coercive control" and may include sabotaging employment or restricting access to money.[14] 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.

Poverty and lack of access to resources make it even more difficult for survivors to escape IPV. It takes money to flee an abusive relationship—for hotel rooms, gas, food, and childcare, for example. Longer term costs include finding

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[9] Stockman, *supra* note 5, at 62.
[10] Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Injury Prevention & Control, *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report 128–29* (2017), https://www.cdc.gov/violenceprevention/pdf/nisvs-statereportbook.pdf.
[11] Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 SMU L. Rev. 2117, 2131–32 (1993).
[12] *Id.* at 2121–22, 2131–32; *see also* Leigh Goodmark, *A Troubled Marriage: Domestic Violence and the Legal System* 42 (2012).
[13] Fischer et al., *supra* note 8, at 2122–23.
[14] Julie Goldscheid, *Gender Violence and Work: Reckoning with the Boundaries of Sex Discrimination Law*, 18 Colum. J. Gender & L. 61, 75–77 (2008).

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flexible employers, mental and physical health care needs, stable housing, and legal representation. Yet many IPV survivors do not have those resources. Indeed, women living in poverty (living on annual incomes of less than $25,000) are nearly twice as likely to experience domestic violence.[15] And making matters worse, many IPV survivors lose their jobs as a direct consequence of the abuse they experienced.[16]

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

The COVID-19 pandemic only exacerbated existing economic inequities and coercive control of IPV survivors. The effects were particularly pernicious on Black and Latinx survivors of IPV: A recent report found that the Black and Latinx survivors had barely one-sixth the savings of White women.[19] COVID-related

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

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

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

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

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

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economic hardship was particularly difficult for undocumented survivors, who were not eligible for most federal cash relief packages and who faced existing barriers to accessing health care and employment.[20] Abusers further limited survivors' access to resources by using lockdown policies to justify increased surveillance and coercive control of their partners.[21]

Women living in rural areas, who face more frequent and severe rates of IPV than women in urban areas, face additional challenges.[22] Women in rural areas have to drive, on average, more than 25 miles to access domestic violence intervention programs.[23] Access to healthcare providers and hospitals is scarcer outside urban areas, often making it more difficult for rural survivors to receive needed care. Additionally, rural emergency departments have fewer resources in place to address IPV—meaning that even someone who has managed to find care may still be without the support needed to address the underlying problem.[24] These barriers further isolate a survivor from necessary physical resources and underline the importance of access to telehealth and medication abortion services.

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

Abusers frequently use "reproductive coercion" and rape to force victims into

[20] Bushra Sabri et al., *Effect of COVID-19 Pandemic on Women's Health and Safety: A Study of Immigrant Survivors of Intimate Partner Violence*, Health Care Women Int. 4–5 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7902436/.
[21] Minna Lyons & Gayle Brewer, *Experiences of Intimate Partner Violence during Lockdown and the COVID-19 Pandemic*, 37 J. Fam. Violence 969, 969–70 (2021), https://link.springer.com/article/10.1007/s10896-021-00260-x.
[22] Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 J. Women's Health 1743, 1747 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064/.
[23] *Id.* at 1748.
[24] Danielle M. Davidov et al., *Comparison of Intimate Partner Violence and Correlates at Urgent Care Clinics and an Emergency Department in a Rural Population*, 20 Int'l J. Env't. Res. & Pub. Health 1, 2 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10002050/.

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unwanted pregnancies to increase dependency and make it harder for the survivor to escape.[25] "Reproductive coercion" describes a spectrum of conduct, ranging from rape to threats of physical harm to sabotaging a partner's birth control, used primarily to force pregnancy.[26] Abusers may 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 or threatening harm for contraceptive use.[27] As a result, survivors of IPV "face compromised decision-making regarding, or limited ability to enact, contraceptive use and family planning. . . ."[28] So, survivors of IPV are significantly less likely to be able to use contraceptives as compared to their non-victimized counterparts.[29]

It is hardly surprising, therefore, that the presence of reproductive coercion in abusive relationships dramatically increases the risk of unintended pregnancy.[30]

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[25] Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316, 316–17 (2010); *see also* Anne M. Moore et al., *Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States*, 70 Soc. Sci. & Med. 1737, 1737 (2010); *Access to Abortion – A Lifeline for Survivors of Domestic Violence*, Sanctuary for Families (June 24, 2022), https://sanctuaryforfamilies.org/abortion-domestic-violence/.

[26] Miller et al., *supra* note 25, at 316–17; Moore et al., *supra* note 25, at 1738; *see also ACOG Committee Opinion No. 554: Reproductive and Sexual Coercion*, 121 Obstetrics & Gynecology 411, 411–15 (Feb. 2013 *reaffirmed* 2022), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion.pdf.

[27] Ann L. Coker, *Does Physical Intimate Partner Violence Affect Sexual Health? A Systematic Review*, 8 Trauma, Violence, & Abuse 149, 151–53 (2007); *see also* Miller et al., *supra* note 25, at 319; Lauren Maxwell et al., *Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis*, 10 PLoS One 1, 2 (2015), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0118234&type=printable.

[28] Miller et al., *supra* note 25, at 316–17; *see also* Coker, *supra* note 27, at 151–53.

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

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

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When the National Domestic Violence Hotline surveyed over 3,000 women seeking help, more than 25 percent reported that their abusive partner sabotaged birth control and tried to coerce pregnancy.[31] Again, systemic inequities further compound the risks associated with reproductive coercion. Marginalized communities generally already experience disproportionately high rates of unintended pregnancy,[32] largely due to a lack of access to sexual health information,[33] health insurance,[34] and affordable contraceptives,[35] as well as a history of coercion by and mistrust of state and medical institutions.[36]

B. Survivors need meaningful access to abortion care.

Dozens of studies have found a strong association between IPV and pregnancy termination, for many reasons.[37] A survivor may choose to terminate a pregnancy

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[31] *1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion*, Nat'l Domestic Violence Hotline (Feb. 15, 2011), https://www.thehotline.org/news/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/; *see also* Heike Thiel de Bocanegra et al., *Birth Control Sabotage and Forced Sex: Experiences Reported by Women in Domestic Violence Shelters*, 16 Violence Against Women 601 (2010).

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

[33] 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).

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

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

[36] 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.

[37] *See* Hall et al., *supra* note 29, at 1 (identifying 74 studies from the United States and around the world that demonstrated a correlation between IPV and abortion); *see also, e.g.*, Dominique Bourassa & Jocelyn Bérubé, *The Prevalence of Intimate Partner Violence Among Women and Teenagers Seeking Abortion Compared with Those Continuing Pregnancy*, 29 J. Obstet Gynaecology Can. 415 (2007).

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that results from rape or coercion,[38] or out of fear of increased violence and/or being trapped in the relationship if the pregnancy continues.[39] A survivor of IPV also may terminate a pregnancy to avoid exposing a child to violence.[40] And many survivors have children whom they already struggle to protect.[41] Having a child, or another child, with an abusive partner can exacerbate challenges survivors face in finding housing upon leaving the abuser, leading to homelessness.[42] Notably, pregnancy termination can improve survivors' circumstances: while research shows that having a baby with the abuser is likely to result in increased violence, "having an abortion was associated in a reduction over time in physical violence . . . ."[43]

Indeed, abortion care is lifesaving medical care for many survivors. Every pregnancy carries some level of risk. But unintended pregnancies have significantly greater risks of pregnancy complications and poor birth outcomes,[44] including miscarriage or stillbirth.[45] These problems are compounded for survivors of IPV. It

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[38] 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).
[39] Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1, 5 (2014), https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z.
[40] Karuna S. Chibber et al., *The Role of Intimate Partners in Women's Reasons for Seeking Abortion*, 24 Women's Health Issues e131, e134 (2014).
[41] *See generally*, Joan S. Meier, *Domestic Violence, Child Custody, and Child Protection: Understanding Judicial Resistance and Imagining the Solutions*, 11 Am. U. J. Gender Soc. Pol'y & L. 657 (2003) (discussing difficulties parent survivors face in protecting children from physical harm and navigating courts for custody and protective orders).
[42] *See* Carmela DeCandia et al., Nat'l Ctr. on Fam. Homelessness, *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness* 4 (2013), https://www.air.org/sites/default/files/2021-06/Closing%20the%20Gap_Homelessness%20and%20Domestic%20Violence%20toolkit.pdf.
[43] Roberts et al., *supra* note 39, at 5.
[44] Judith McFarlane, *Pregnancy Following Partner Rape: What We Know and What We Need to Know*, 8 Trauma, Violence, & Abuse 127, 130 (2007); *see also Public Health Impact: Unintended Pregnancy*, America's Health Rankings: United Health Foundation, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/unintended_pregnancy/state/U.S (last accessed Mar. 16, 2023).
[45] McFarlane, *supra* note 44, at 130.

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is common for abusers to prevent survivors from making or keeping medical appointments or from having private conversations with health care providers.[46] As a result, IPV survivors are less likely to receive prenatal care and more likely to miss doctors' appointments than pregnant people in non-violent relationships, all of which increases the risks to them.[47] Pregnant people experiencing IPV are at high risk of depression and PTSD and at increased risk of having babies preterm and babies with low birth weight.[48]

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.[49] While the United States as a whole has a maternal mortality rate over three times that of other developed nations,[50] 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.[51] Moreover, Black, American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander women are more likely to have preterm births and babies with low birthweights.[52] Immigrant

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[46] Nat Stern et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2013).
[47] Gunnur Karakurt et al., *Mining Electronic Health Records Data: Domestic Violence and Adverse Health Effects*, 3 J. Fam. Violence 79–87 (2017).
[48] Jeanne Alhusen, *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24(1) J. Womens Health (Larchmt) 100–06 (2015).
[49] 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).
[50] 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.
[51] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, Kaiser Family Found. (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.
[52] *Id.*

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women are at higher risk in part because they tend to receive less prenatal care than non-immigrant women, in part due to exclusionary health insurance laws and policies.[53]

Not only do pregnant people in abusive relationships face increased health risks associated with pregnancy itself, but they are also likely to suffer more, and more intense, violence during pregnancy.[54] IPV is common in pregnancy: "Nearly one in six pregnant women in the United States [has] been abused by a partner."[55] Intimate partner violence can and does escalate to homicide.[56] In fact, homicide is the leading cause of maternal death in the U.S.[57] Risks are even greater for people of color. Pregnancy-associated homicide is highest among Black women and young women under 25 years of age.[58]

If a survivor who is coerced into pregnancy goes on to have a child with the abuser, it becomes even more difficult to sever that abusive relationship.[59] The abused parent must navigate the legal system to obtain custody and ensure protective

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[53] Sheela Maru et al., *Utilization of Maternal Health Care Among Immigrant Mothers in New York City, 2016–2018*, 98 J. Urb. Health 711, 712 (2021).
[54] Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183, 183–86 (2010); *see also* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JAMA 1915, 1918 (1996).
[55] *Intimate Partner Violence Screening Fact Sheet and Resources*, Agency for Healthcare Rsch. & Quality, Nat'l Ctr. for Excellence in Primary Care Rsch., https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html (last visited Mar. 16, 2023).
[56] Alexia Cooper & Erica L. Smith, U.S. Dep't Just., Bureau Just. Stats., *Homicide Trends in the United States, 1980-2008, Annual Rates for 2009 and 2010* at 10 (2011), http://bjs.gov/content/pub/pdf/htus8008.pdf (between 1980 and 2008, 40% of homicides of women were committed by intimate partners).
[57] Maeve Wallace et al., *Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019*, 138(5) Obstetrics & Gynecology 762, 763 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9134264/.
[58] *Id.*; Emiko Petrosky et al., *Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence — United States, 2003–2014*, 66 Morbidity and Mortality Weekly Rep. 741, 743 (2017).
[59] *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).

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parenting arrangements, commonly without legal advice or representation.[60] Violent partners have learned to use this system to their advantage to continue the abuse[61] Nationwide, abusive fathers are more likely to seek child custody than non-abusive fathers, and they succeed more than 70 percent of the time.[62]

At the same time, the child welfare system wrongly punishes survivors—especially survivors of color—for failure to protect their children from IPV.[63] This "damned if you do, damned if you don't" response undermines the rights of survivors and provides abusive partners with another weapon of control.[64] Again, marginalized communities experience these injustices even more often. Children of Black survivors are overrepresented in the child welfare system,[65] and American Indian and Alaskan Native children are in foster care at twice the rates of their White counterparts.[66]

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[60] *See, e.g.*, Civ. Legal Needs Study Update Comm., Wash. State Sup. Ct., *2015 Washington State Civil Legal Needs Study Update* 15 (2015), https://ocla.wa.gov/wp-content/uploads/2015/10/CivilLegalNeedsStudy_October2015_V21_Final10_14_15.pdf; Montana Access to Just. Comm'n, *The Justice Gap in Montana: As Vast as Big Sky Country* 24 (2014), https://courts.mt.gov/External/supreme/boards/a2j/docs/justicegap-mt.pdf.

[61] Ellen R. Gutowski & Lisa A. Goodman, *Coercive Control in the Courtroom: the Legal Abuse Scale (LAS)*, 28 J. Fam. Violence 527, 527–28 (2022).

[62] *10 Custody Myths and How to Counter Them*, 4 ABA Comm'n on Domestic Violence Q. E-Newsletter 3 (July 2006), https://xyonline.net/sites/xyonline.net/files/ABACustodymyths.pdf.

[63] Leigh Goodmark, *Law is the Answer? Do We Know That for Sure?: Questioning the Efficacy of Legal Interventions for Battered Women*, 23 St. Louis Univ. Pub. L. Rev. 7, 23 (2004).

[64] *Id.* at 26; *see generally* Heather Douglas & Emma Fell, *Malicious Reports of Child Maltreatment as Coercive Control: Mothers and Domestic and Family Violence*, 35 J. Fam. Violence 827 (2020) (discussing "the phenomenon of abusive partners or ex-partners making malicious false reports of child maltreatment to child protective services as an aspect of coercive control and systems abuse.").

[65] *Disproportionality & Race Equity in Child Welfare*, Nat'l Conf. State Legs. (2021), https://www.ncsl.org/human-services/disproportionality-and-race-equity-in-child-welfare.aspx.

[66] Jason R. Williams et al., Casey Fam. Programs, *A Research and Practice Brief: Measuring Compliance with the Indian Child Welfare Act* (2015), https://www.casey.org/media/measuring-compliance-icwa.pdf.

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C. The unnecessary REMS restrictions have grave consequences for the lives and health of IPV survivors, especially the most marginalized.

Combined with the barriers that survivors of IPV already face in accessing abortion care, the 2023 REMS restrictions further reduce access to care and prevent some survivors from obtaining care altogether. Being forced to carry an unintended pregnancy to term exposes survivors of IPV to a higher likelihood of further violence, including homicide, and poses significant health risks. Indeed, it could cost some pregnant people their lives.

In particular, the REMS requirement that patients sign a special Patient Agreement Form certifying that they have decided to take mifepristone to end their pregnancy is stigmatizing and can trigger fear in a patient that their personal decision to have an abortion will be discovered or disclosed. These fears are especially acute for survivors of IPV, who are more likely to want to hide their abortion from their abuser or family members. Indeed, "consistent evidence [finds] that women in violent relationships were more likely not to tell their partner about their decision to terminate."[67]

The Patient Agreement Form requires patients to sign a document that states: "I have decided to take mifepristone and misoprostol to end my pregnancy."[68] Although privacy protections *should* keep their Patient Agreement Form confidential, patients may have significant concerns that their medical information will be shared with family members inappropriately. Further, many patients travel

[67] Hall et al., *supra* note 29; *see also* Cynthia K. Sanders, *Economic Abuse in the Lives of Women Abused by an Intimate Partner: A Qualitative Study*, 21 Violence Against Women 3 (2015).
[68] Patient Agreement Form for Mifepristone Tablets, 200 mg, Reference ID: 5103833, https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_Patient_Agreement_Form.pdf (last accessed Mar. 21, 2023).

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to access abortion from states that have established criminal and civil penalties targeting providers of abortions and people who help patients access care.[69] For people traveling from these states, the fear of a paper trail is even more significant, as their records could be subject to a warrant or a subpoena, and the legal consequences could be significant.

Requiring an extra patient attestation for mifepristone, far beyond what is required for most other prescription medication, unnecessarily adds stigma to a sensitive medical interaction. Abortion is already highly stigmatized in the United States, and abortion stigma is linked to uncertainty and delay in seeking abortion care and can bring up difficult negative feelings when a patient has an abortion.[70] Survivors of IPV already face stigma for being victims of domestic violence, including from health care providers.[71] When survivors need life-saving healthcare in the form of abortion medication, providers and systems should do all that they can to reduce stigma. But the Patient Agreement Form does the opposite.

The REMS requirement that providers complete special certifications to prescribe mifepristone also makes it more difficult for people to access abortion medication. Mifepristone has the potential to make it easier for survivors to access abortions by increasing the number of providers who provide abortion services, since administering a medication abortion is simpler than carrying out a clinical procedure.

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[69] *See, e.g.*, Idaho Code § 18-8801 *et seq.* (criminal and civil liability for healthcare providers who conduct abortions); Tex. Code § 171.208 (civil liability for healthcare providers who conduct abortions and individuals who help a patient access abortion).

[70] *See, e.g.*, Amanda Gelman et al., *Abortion Stigma Among Low-Income Women Obtaining Abortions in Western Pennsylvania: A Qualitative Assessment*, 49 Perspect. Sex Reprod. Health 29 (2017).

[71] Allison Crowe & Christine Murray, *Stigma from Professional Helpers toward Survivors of Intimate Partner Violence*, 6 Partner Abuse 157, 170 (2015), https://libres.uncg.edu/ir/uncg/f/C_Murray_Stigma_From_2015.pdf.

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But this promise of expanded abortion access has yet to be achieved: "More than twenty years [after FDA approval of mifepristone] most abortions still take place in specialized abortion clinics, with only 1% of abortions taking place in a physician's office."[72] Family physicians who might provide medication abortion as one of their services have described REMS requirements as a barrier to providing medication abortion, since extra administrative steps require involvement of clinic administration and the complexity of navigating REMS is not seen as worth the effort.[73] Typically a providers' medical license is sufficient evidence of training to allow them to prescribe medication, but the REMS singles out medication abortion for extraordinary additional measures, thus reducing the number of providers offering the services, which results in less patient access.

The REMS requirements for pharmacies similarly create administrative hurdles, add to the stigma around abortion medication, and may limit the number of pharmacies willing to dispense the mifepristone. To dispense mifepristone for use in medication abortion, pharmacies must overcome multiple administrative hurdles, including executing a Pharmacy Agreement Form for each location, agreeing to ship mifepristone only with a shipping tracking service, verifying that each prescriber has completed a Prescriber Agreement Form, confirming with the prescriber if a patient will receive the drug more than four days after the prescription is first received,

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[72] 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 (2022), https://www.contraceptionjournal.org/article/S0010-7824(22)00027-0/fulltext.

[73] *Id.* at 21, 23. Interviewees in the study discussed challenges under an older version of the REMS, which included a requirement for in-person dispensing by providers. While the in-person dispensing requirement is no longer part of the REMS, many of the concerns physicians raised in the study still apply to the current REMS, including certification requirements, administrative burdens, and the need to work with clinical administrators to meet REMS requirements.

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recording patient information and corresponding lot number, maintaining records of all processes and procedures, training staff on the Mifepristone REMS, complying with audits, and more.[74] One of the largest pharmacy chains in the United States has already announced that they will not be stocking mifepristone in much of the country.[75] The reduced number of pharmacies stocking mifepristone is exacerbated by the long history and pattern of patients being turned away at pharmacies when seeking various forms of reproductive care.[76] Such discrimination by pharmacists will continue to pose a challenge to people trying to fill prescriptions for mifepristone.

Access to medication abortion is essential to survivors of IPV. In-home medical abortion is often a survivor's only option because they must obtain care without the abuser finding out. "[I]ntimate partner violence may drive some pregnant people to medication abortion at home to avoid detection by abusive partners for ending a pregnancy."[77] Having a variety of options for accessing that care—in one's home via telemedicine and mail, from a local physician, or from a nearby town where friends or family live—helps survivors maintain safety and privacy.

Survivors who live in rural areas are especially affected by the lack of providers able to prescribe and pharmacies willing to dispense mifepristone. Rural

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[74] Pharmacy Agreement Form for Mifepristone Tablets, 200 mg, Reference ID: 5103833, GenBioPro, https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_01_03_Pharmacy_Agreement_Form_GenBioPro_Inc.pdf (last accessed Mar. 16, 2023).

[75] Kaitlyn Radde & Sarah McCammon, *Walgreens Won't Sell Abortion Pills in Red States that Threatened Legal Action*, Nat'l Pub. Radio (Mar. 4, 2023), https://www.npr.org/2023/03/04/1161143595/walgreens-abortion-pill-mifepristone-republican-threat-legal-action.

[76] *Pharmacy Refusals 101*, Nat'l Women's Law Ctr. (Dec. 28, 2017), https://nwlc.org/resource/pharmacy-refusals-101/.

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

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areas have significantly fewer primary care physicians and obstetrics/gynecology specialists and less access to acute care hospitals.[78] Data from the 2010 census indicates that 16% of Washingtonians live in rural areas and a recent survey showed that 450,000 adults live in "pharmacy deserts"—towns located more than 10 miles from the nearest pharmacy.[79] If people need to get care at an abortion clinic, they often have to travel very far to do so. For example, 78% of Oregon counties had no clinics that provide abortions,[80] while 20% of women in Alaska and Montana would need to travel over 120 miles to reach an abortion clinic.[81] If healthcare is already far away and the nearest providers do not provide abortion medication, rural survivors of IPV must travel even farther, increasing the barriers to access, especially for the many survivors who struggle with lack of transportation, funds, and time, and further risking discovery by the abuser.

For survivors of color and immigrant survivors, discrimination and structural oppression exacerbate the barriers to abortion when few providers and pharmacies will provide mifepristone. Transportation is a major barrier—female-led households, Black households, Native American households, and immigrant households are all less likely to have access to a car compared to White and non-

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[78] Corinne Peek-Asa, *supra* note 22 at 1747.

[79] Wash. Dept. Health, Off. Cmty. Health Sys. Series on Rural-Urban Disparities, *Percent Change of Population Distribution for Washington State and Its Counties by Percent Population Rural*, (Feb. 2017), https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/346090.pdf?uid=641399247359d; James Hanlon, *WSU Program Aims to Address Shortage of Rural Pharmacists, 'the Most Accessible Health Care Providers in America,'* Spokesman Rev. (Jan. 31, 2023), https://www.spokesman.com/stories/2023/jan/31/wsu-program-aims-to-address-shortage-of-rural-phar/.

[80] *State Facts About Abortion: Oregon*, Guttmacher Inst. (June 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-oregon.

[81] Jonathan Bearak et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: a Spatial Analysis*, 2 Lancet Pub. Health e493, e495 (2017).

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immigrant households.[82] Missing work and traveling are costly. Black and Latinx women tend to have significantly lower wages than White women and men.[83] 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.[84] Depending on their status, immigrants may be excluded from medical assistance programs and health marketplace coverage.[85] Between the limited number of providers offering medication abortion and the many barriers to access to care that survivors of IPV already face, some simply will not be able to access care at all.

III. CONCLUSION

The right to abortion care is vital to the ability to participate equally in "the economic and social life of the Nation" for all persons. *Casey*, 505 U.S. at 856. For survivors of IPV, the stakes are even higher, and this right is even more critical. IPV survivors already face systemic inequities and barriers to reproductive care in general. The FDA's unnecessary restrictions on the availability of mifepristone and medication abortions further endangers this community, putting them at higher risk of violence. We ask this Court to support the efforts of survivors of IPV to maintain control over their reproductive health care decisions and void the restrictions under the 2023 REMS.

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[82] *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 accessed Mar. 16, 2023).
[83] Inst. for Women's Pol'y Rsch., *Fact Sheet: Gender and Racial Wage Gaps Persist as the Economy Recovers* 2 (2022) https://iwpr.org/wp-content/uploads/2022/10/Annual-Gender-Wage-Gap-by-Race-and-Ethnicity-2022.pdf.
[84] Artiga et al., *supra* note 34.
[85] *Id.*

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CERTIFICATE OF SERVICE

I hereby certify that on March 22, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically generated a Notice of Electronic Filing (NEF) to all parties in the case who are registered users of the CM/ECF system. The NEF for the foregoing specifically identifies recipients of electronic notice.

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