No. 26-1264

United States Court of Appeals
FOR THE FIRST CIRCUIT

A WOMAN'S CONCERN, INC. D/B/A YOUR OPTIONS MEDICAL CENTERS,
Plaintiff-Appellant,

v.

MAURA T. HEALEY, GOVERNOR OF MASSACHUSETTS, sued in the individual and official capacities; ROBERT GOLDSTEIN, COMMISSIONER OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, sued in the individual and official capacities; REPRODUCTIVE EQUITY NOW FOUNDATION, INC.; REBECCA HART HOLDER, EXECUTIVE DIRECTOR OF REPRODUCTIVE EQUITY NOW FOUNDATION, INC.,
Defendants-Appellees.

On Appeal from the United States District Court for the District of Massachusetts
Case No. 1:24-cv-12131-LTS

BRIEF OF HEALTH LAW, PUBLIC HEALTH, AND REPRODUCTIVE JUSTICE LEGAL SCHOLARS,
as *Amici Curiae* in support of Defendants – Appellees and Affirmance

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule 26.1, *Amici* represent, through their undersigned counsel, that they are individual law professors and not a corporation, association, joint venture, partnership, syndicate, or other similar entity and thus have no parent corporations, and no publicly held company has a 10% or greater ownership interest in them.

/s/ Caitlin Glass
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September 14, 2026

INTEREST OF *AMICI CURIAE*[1]

Amici, identified in the appendix, are legal scholars in health law, public health, and reproductive justice with expertise and scholarly interests in ensuring that government public education campaigns remain constitutionally protected, particularly when they address controversial health topics. *Amici* write to provide the Court with insights from a public health perspective and health law literature on the importance, necessity, and established practice of these campaigns, and to explain why allowing courts to question their content and structure in the way that Appellant asks would have significant consequences for public health beyond this case.

SUMMARY OF ARGUMENT

Government agencies have long conducted public education campaigns to ensure residents have accurate, timely health information. Such campaigns are a core feature of the state's responsibility to protect public health. The case for affirmative government communication is at its strongest when such a campaign concerns reproductive health care, where decisions are time-sensitive, options are irreversible, and misinformation causes concrete, documented harm to patients with limited

[1] Counsel for all parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), amicus curiae states that no party's counsel authored this brief either in whole or in part, and further, that no party or party's counsel, or person or entity other than amicus curiae, amicus curiae's members, and their counsel, contributed money intended to fund preparing or submitting this brief.

access to alternative sources of care. The Massachusetts anti-abortion center[2] campaign at issue reflects precisely this kind of responsible public health action that effective public health practice demands.

A ruling for the Appellant would expose public health agencies across the country to litigation risk whenever they choose to speak plainly about documented sources of misinformation and threats to patient welfare. The chilling effect of such a decision would also fall hardest on medically underserved communities with the fewest resources and the least access to care. As such, *Amici* respectfully urge this Court to affirm the District Court's judgment and preserve the government's capacity to perform this essential function.

ARGUMENT

I. Public-Health Education Is a Core Government Function and the Massachusetts Campaign Is a Straightforward Exercise of That Function.

A. The government's affirmative right to speak on matters of public health is well established and reflects a fundamental feature of effective public health governance.

[2] The facilities at issue in this case are referred to by various names in the legal, medical, and public health literature, including "crisis pregnancy centers," "fake pregnancy clinics," "unregulated pregnancy clinics," and "pregnancy resource centers." The Massachusetts public education campaign at issue uses the term "anti-abortion centers" to describe these facilities, which reflects their defining operational characteristics: they never provide abortion care, abortion referrals, or the full range of reproductive health services available at licensed medical facilities. For consistency with the campaign that is the subject of this litigation, and because that terminology most accurately describes the relevant category of facility for purposes of the arguments presented here, this brief uses "anti-abortion centers" or "AAC" throughout.

States have an inherent responsibility to protect public health.[3] States have protected the public's health, in part, through education campaigns. Such public education campaigns have never been treated as constitutionally suspect merely because they take a position.[4] The federal government's anti-tobacco campaigns are among the most visible examples of direct government speech on contested public health topics. The FDA's *The Real Cost* campaign communicates an unambiguously one-sided public health message through paid advertising, social media, and digital outreach.[5] The CDC has conducted parallel anti-smoking campaigns for decades.[6] Massachusetts has done the same with the *Get Outraged* campaign directed at youth vaping prevention.[7]

For decades, government agencies have conducted similar affirmative campaigns, withstanding legal challenges.[8] Moreover, the Supreme Court has long

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[3] *See Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) (affirming that "[t]he safety and the health of the people" is a matter "for that commonwealth to guard and protect."); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) ("States traditionally have had great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.").

[4] *See Rust v. Sullivan*, 500 U.S. 173, 193 (1991) ("The government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest."); *Pleasant Grove City v. Summum*, 555 U.S. 460, 467–68 (2009) (government speech is not subject to First Amendment viewpoint-neutrality requirements); *Walker v. Tex. Div., Sons of Confederate Veterans*, 576 U.S. 200, 208 (2015) ("When the government speaks it is entitled to promote a program, to espouse a policy, or to take a position."); *Shurtleff v. City of Boston*, 596 U.S. 243 (2022).

[5] U.S. Food & Drug Admin., *The Real Cost Campaign*, (June 24, 2026), https://www.fda.gov/tobacco-products/public-health-education-campaigns/real-cost-campaign (explaining that, begun in 2014, *The Real Cost* is a direct government public education focused on educating youth about the negative health effects and risks of vaping and smoking).

[6] Ctrs. for Disease Control & Prevention, *Tips From Former Smokers: About the Campaign*, https://www.cdc.gov/tobacco/campaign/tips/about/index.html (last visited July 23, 2026).

[7] Mass. Dep't of Pub. Health, *Get Outraged: Adult and Youth Campaigns for Vaping Education and Prevention*, https://www.mass.gov/get-outraged (last visited Aug. 5, 2026).

[8] *See R.J. Reynolds Tobacco Co. v. Bonta*, 272 F. Supp. 2d 1085, 1106 (E.D. Cal. 2003) (upholding California's anti-tobacco education campaign against legal challenge and finding the state's "decision to combat the problem through

held that states can engage in such public health campaigns, including education about vaccinations,[9] federally funded HIV/AIDS public education efforts,[10] and highway safety public awareness programs.[11]

In none of these contexts has the government's choice to provide substantive public information rendered an education campaign constitutionally infirm. When the government speaks in its own voice, it is not subject to the First Amendment.[12] As such, the state may communicate a particular public health message without being constitutionally required to promote competing viewpoints.[13] Conversely, requiring the government to balance every public health message with a competing viewpoint would be burdensome and, more importantly, constitutionally anomalous.[14]

The government's role as a public educator is categorically distinct from its role as a regulator or enforcement authority. Public awareness campaigns and

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a strategy of education and counter-advertising … is, under present doctrine, a political and practical judgment that the state is free to make.").

[9] *Zucht v. King*, 260 U.S. 174, 176–77 (1922) ("that broad discretion [is] required for the protection of the public health.").

[10] *See* Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (authorizing federal funding for HIV/AIDS public education, community outreach, and direct services to vulnerable populations).

[11] 23 U.S.C. § 402.

[12] *See* 555 U.S. 460, 467 (2009) ("The Free Speech Clause restricts government regulation of private speech; it does not regulate government speech."); *Matal v. Tam*, 582 U.S. 218, 234 (2017) ("When a government entity embarks on a course of action, it necessarily takes a particular viewpoint and rejects others."); *Nat'l Rifle Ass'n of Am. v. Vullo*, 602 U.S. 175, 187 (2024).

[13] 500 U.S. 173 (1991) (holding that "[t]he government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program.")

[14] *See* 576 U.S. 200, 207 (2015) (questioning "how government could function" if the First Amendment required viewpoint neutrality in government communications).

licensing actions are fundamentally different exercises of state power, and the constitutional frameworks that govern them are correspondingly distinct.[15] The Massachusetts messaging at issue involves a public health campaign that was developed and shared by the government.[16] The government retained control over the message and delivered the message such that a reasonable observer of the campaign would attribute the message to the Commonwealth.[17]

Limiting the government's ability to speak on contested health topics by treating such speech as inherently coercive would impair state public health agencies' ability to fulfill their statutory and constitutional mandates.[18] Indeed, as the U.S. Supreme Court has stated, "a government entity has the right to 'speak for itself' … and '[t]o make judgments about what [it] does and does not support."[19]

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[15] *See Linmark Associates v. Willingboro*, 431 U.S. 85, 97 (1977) (finding that although a city could not regulate the presence of "For Sale" signs, it could educate against white flight through widespread publicity); *Sorrell v. IMS Health*, 564 U.S. 552, 578 (2011) (state could not ban certain uses of prescriber-identifying information, but it could express its view through its own speech).

[16] Governor Healey launched the campaign "highlighting the dangers and potential harm of AACs," building on the states previous efforts advising the public about the threat. Mass. Exec. Off. of Health and Human Servs., *Healey-Driscoll Administration Launches First-in-the-Nation Public Education Campaign on the Dangers of Anti-Abortion Centers,* (June 10, 2024), https://www.mass.gov/news/healey-driscoll-administration-launches-first-in-the-nation-public-education-campaign-on-the-dangers-of-anti-abortion-centers; *see also* Mass. Office of Att'y Gen., *Anti-Abortion Centers (AACs)*, https://www.mass.gov/info-details/anti-abortion-centers-aacs (last visited Aug. 25, 2026); Mass. Dep't of Pub. Health, *Maintaining Integrity, Accessibility, and Transparency in Reproductive Care* (Jan. 3, 2024), https://www.mass.gov/news/maintaining-integrity-accessibility-and-transparency-in-reproductive-care.

[16] 596 U.S. 243, 252–53 (2022) (identifying government control over the message — including editorial control, final approval authority, and attribution to the government — as the defining markers of government speech and finding that Boston's flag program lacked those markers).

[17] *Id.*

[18] *See* 576 U.S. 200, 207–08 (2015) ("Were the Free Speech Clause interpreted otherwise, government would not work. … How could a state government effectively develop programs designed to encourage and provide vaccinations, if officials also had to voice the perspective of those who oppose this type of immunization?").

[19] 555 U.S. 460, 468 (2009).

B. The Massachusetts campaign is the government's own speech, not suppression of, or retaliation against, Appellant's speech.

The First Amendment protects the government's ability to communicate its own views to its constituents. Where the government has neither compelled a private party to carry a government message nor threatened sanctions for refusing to do so, no cognizable First Amendment injury occurs.[20] Furthermore, when the government speaks in its own name through funding, producing, or disseminating a public health message, it is engaged in government speech, which is firmly outside the First Amendment.[21] The government must convey meaningful messages on matters of public health, whether to advocate for particular behaviors, share resources, criticize practices it regards as harmful, or simply to educate the public. Never, when government has engaged in such basic public health prerogatives, has it been constitutionally required to present an opposing view when speaking for itself.[22]

That is precisely what Massachusetts has done here and what courts have sustained in every analogous public health context.[23] The Massachusetts campaign represents a public education effort that identifies well-documented concerns around anti-abortion centers ("AAC").[24] Regardless of the public education campaign, Appellant can communicate its own message, operate its centers, and provide its

[20] *See Nat'l Inst. of Fam. and Life Advocates v. Becerra*, 585 U.S. 755, 766 (2018); *Wooley v. Maynard*, 430 U.S. 705, 714 (1977).
[21] *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 559 (2005); 555 U.S. 460, 467–68 (2009).
[22] 500 U.S. 173, 193 (1991).
[23] *See* 423 F.3d 906, 916–17 (9th Cir. 2005).
[24] *Supra* note 16.

services. No state action has compelled Appellant to alter its speech, close its doors, or face legal sanctions for continuing to speak. Appellant also remains free to publish its own counter-messaging and advocate for AACs.[25]

Although the Massachusetts campaign is critical of AACs, criticism alone is not coercion. Public officials may criticize private parties, publicly identify what they regard as harmful conduct, and urge citizens to make different choices so long as there is no actual or threatened imposition of government power or sanction.[26] The Massachusetts campaign does not constitute an ultimatum. The language of the campaign uses objectively true, general terms and makes no particularized accusations against Appellant or any other specific entity. While the campaign employed phrases such as "deceptive advertising" and "public health threat," such terminology accurately reflects the dangers to the public and is common in public health communications.[27]

For instance, the FDA developed the *Bad Ad Program*, an outreach initiative designed to help health care providers recognize "potentially false or misleading

[25] 585 U.S. 755, 766 (2018) (states may engage in public-information campaigns).
[26] *Kennedy v. Warren*, 66 F.4th 1199, 1207–09 (9th Cir. 2023) (A First Amendment problem arises only where an official intimates they will deploy the government's coercive apparatus against the target if it does not change); 602 U.S. 175 (2024).
[27] *See* Andrea Swartzendruber et al., *Crisis Pregnancy Centers in the U.S.: Lack of Adherence to Medical and Ethical Practice Standards*, 65 J. Adolescent Health 821 (2019) (joint position statement of the Society for Adolescent Health and Medicine and the North American Society for Pediatric and Adolescent Gynecology); *see generally* Kush S. Desai et al., *Characterizing Services Advertised on Crisis Pregnancy Center Websites*, 185 JAMA Internal Med. 238 (2025) (collectively documenting that CPC advertising practices depart from evidence-based medical standards and misrepresent available services); *see also* Fed. Trade Comm'n, *FTC Policy Statement on Deception* (Oct. 14, 1983), https://www.ftc.gov/system/files/documents/public_statements/410531/831014deceptionstmt.pdf (establishing "deceptive advertising" as standard regulatory vocabulary for health-related consumer misrepresentation).

prescription drug promotion."[28] Massachusetts itself has used similar language in its anti-vaping campaign over the years, highlighting the dangers of vaping for young people.[29] The federal government has also routinely utilized "public health threat" language in a variety of public education campaigns.[30] As demonstrated, such terms are descriptive, not coercive, and are being used to educate about matters that represent a public health threat.

Although Appellant relies heavily on *NIFLA v. Becerra* in its argument, that reliance is misplaced. *NIFLA* was a compelled speech case concerning California's attempt to require AACs to deliver a government-written message.[31] The Court struck down the California law because the government insisted private speakers deliver a message that the state wanted to convey.[32] *NIFLA*, in other words, involved compelled speech, but that doctrine has no application here, where Massachusetts spoke for itself, through its own campaign, in its own name, without requiring AACs to deliver any message whatsoever.

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[28] U.S. Food & Drug Admin., *The Bad Ad Program*, https://www.fda.gov/drugs/prescription-drug-advertising-and-promotional-labeling/bad-ad-program (last visited July 23, 2026).
[29] *Supra* note 7.
[30] U.S. Dep't of Health & Human Servs., *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021–2025* (2020), https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf (last visited July 23, 2026) ("a public health threat [that] requires action from all parts of society"); *see also* Ctrs. for Disease Control & Prevention, *Environmental Public Health Threats in the 21st Century –A Primer for Clinicians* (Sep. 18, 2024), https://www.cdc.gov/eh-nexus/media/environmental-public-health-threats-21st-century.html
[31] 585 U.S. 755 (2018).
[32] *Id.* at 766–68.

As such, instead of advancing Appellant's case, *NIFLA* undermines it while affirmatively supporting Massachusetts' position. Having invalidated California's compelled-disclosure requirement, the *NIFLA* Court specifically observed that California could instead "inform[] women" through a "public-information campaign," or "post[] information … on public property near" the centers.[33] Massachusetts delivered its own message through this campaign, in line with the approach the Court endorsed in *NIFLA* as a constitutionally permissible path for the government when wanting to educate the public.

C. The campaign's content reflects the state's legitimate interest in patient self-determination and consumer protection in health care and does not constitute viewpoint suppression.

Patients have a right to appropriate information about their medical condition and care options, the nature of risks involved in the condition, the likely outcome of choosing no treatment, and available alternatives.[34] Consumer protection statutes apply to the entrepreneurial and business aspects of providing medical services, including advertising and billing.[35] Massachusetts courts have upheld the removal of a physician's license for misrepresenting board certification specifically because that conduct deprived patients of the opportunity to make informed choices.[36]

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[33] *Id.* at 775.
[34] *See Harnish v. Child.'s Hosp. Med. Ctr.*, 387 Mass. 152, 156 (1982).
[35] *See Daviris v. Petros*, 442 Mass. 274, 279 (2004).
[36] *See Welter v. Bd. of Registration in Med.*, 490 Mass. 718, 731 (2022).

The Commonwealth's identification of AAC information practices as a concern for patients navigating reproductive health care is an exercise of that longstanding state interest.[37] When addressing the opioid crisis, for example, the government simultaneously pursued litigation and issued public education campaigns, alerting the public to the dangers of using opioids.[38] Framing a public health concern in direct, accessible terms is a common feature of public health communication, not evidence of animus.[39] Likewise, anti-tobacco advertisements have consistently employed forceful language, including accusing tobacco companies of exploiting low-income populations, lying about health effects, and targeting teenagers, which courts have sustained as permissible government speech without requiring the government to balance its message with a competing viewpoint.[40]

The Massachusetts campaign is similarly unremarkable when situated within the government's long history of educating the public on matters of sexual and reproductive health. For decades, the federal government and Massachusetts have issued affirmative, one-sided public health campaigns in this area. The CDC's

[37] *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992).
[38] Mass. Dep't of Pub. Health, *DPH public information campaigns about opioids*, https://www.mass.gov/info-details/dph-public-information-campaigns-about-opioids (last visited July 23, 2026).
[39] *See* 272 F. Supp. 2d 1085, 1104–05 (E.D. Cal. 2003).
[40] *See id.* at 1106 (upholding California's anti-tobacco counter-advertising campaign as "a political and practical judgment that the state is free to make"); *see generally Discount Tobacco City & Lottery v. United States*, 674 F.3d 509 (6th Cir. 2012) (sustaining federal anti-tobacco graphic warning requirements as a permissible exercise of the government's public health communication authority).

campaign encouraging HPV vaccination for adolescents unambiguously advocates for vaccination as a means of preventing cervical cancer, expressing a clear public health position.[41] The federal government's *America Responds to AIDS* campaign communicated explicitly about sexual transmission and risk reduction at a time when such topics were socially contested.[42] The CDC's *Hear Her* campaign expressly targets Black women and other women of color to encourage them to seek prompt maternal care.[43]

Massachusetts itself has conducted parallel work in the maternal health space and issued public-facing guidance directing patients – particularly Black and Brown women facing disproportionate maternal morbidity and mortality risk – towards timely health care options.[44] Thus, the current campaign is not novel, but a continuation of the Commonwealth's tradition of ensuring the public remains educated and aware of sexual and reproductive health care options.

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[41] Ctrs. for Disease Control & Prevention, *Clinical Overview of HPV*, https://www.cdc.gov/hpv/hcp/clinical-overview/index.html (last visited July 23, 2026).
[42] *See* Ctrs. for Disease Control & Prevention, *HIV and AIDS – United States, 1981-2000,* 50 Morbidity & Mortality Wkly. Rep. 430 (June 1, 2001); Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576).
[43] Ctrs. for Disease Control & Prevention, *Hear Her: Urgent Maternal Warning Signs*, https://www.cdc.gov/hearher (last visited July 23, 2026).
[44] Mass. Dep't of Pub. Health, *Maternal Mortality and Morbidity Review Initiative*, https://www.mass.gov/orgs/maternal-mortality-and-morbidity-review-initiative (last visited July 23, 2026).

II. Utilizing Public Education Campaigns to Ensure the Public has Accurate and Comprehensive Information about Pregnancy Options Serves a Compelling Public Interest, Particularly for Medically Underserved Populations.

A. Reproductive health decisions are uniquely time-sensitive, and the consequences of misinformation are both immediate and irreversible.

It is undisputed that AACs do not provide pregnant people with accurate and comprehensive information about the full spectrum of care options.[45] Pregnant people can therefore be delayed in accessing care when they end up at an AAC.[46] Unlike most health care decisions, reproductive decisions – especially those about continuing or ending a pregnancy – are subject to strict gestational timelines. Medication abortion with mifepristone and misoprostol is FDA-approved only through ten weeks' gestation.[47] This timeline makes delay in care outcome-determinative in a way that distinguishes reproductive health misinformation from most other contexts. The risk of a major complication increases from approximately 2 per 1,000 procedures at 8 weeks' gestation to approximately 15 per 1,000 procedures at 20 weeks' gestation.[48] If a patient is continuing a pregnancy, then

[45] Swartzendruber et al., *supra* note 27 at 821 "The [crisis pregnancy] centers do not provide or refer for abortion or contraception but often advertise in ways that give the appearance that they do provide these services without disclosing the biased nature and marked limitations of their services.").
[46] *Id.* at 823.
[47] U.S. Food & Drug Admin., *Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last visited July 6, 2026); *see also* Am. Coll. of Obstetricians & Gynecologists, *Medication Abortion Up to 70 Days of Gestation*, Practice Bulletin No. 225 (Oct. 2020), https://doi.org/10.1097/AOG.0000000000004082.
[48] Sandra Kumwong, Meera Sunder & Rotimi Akinbinu, *Abortion*, StatPearls (Apr. 12, 2025), https://www.ncbi.nlm.nih.gov/books/NBK518961/ (last visited July 6, 2026)

evidence-based maternity care also requires timely attention for the health of the patient and the developing fetus.

The American College of Obstetricians and Gynecologists notes that gestational age is the most important risk factor for abortion complications; and as gestational age increases, the number of trained health care professionals available to provide abortion care decreases, making delay especially harmful for patients with transportation barriers.[49] A 2015 mortality analysis found 0.3 deaths per 100,000 abortions at eight weeks or fewer, rising to 6.7 per 100,000 at eighteen weeks or more, with hemorrhage and infection identified as the most common causes of death after second-trimester abortion.[50] These statistics quantify the cost of the kind of gestational-age-related delay an AAC misrepresentation regularly causes, even in a state that protects abortion access like Massachusetts.[51]

Furthermore, research examining statutory barriers to abortion care found that travel time for abortion seekers in states that implemented bans increased from 2.8 to 11.3 hours, and overnight stays increased from 5% to 58%.[52] The study also found

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[49] Am. Coll. of Obstetricians & Gynecologists, *Increasing Access to Abortion: ACOG Committee Statement No. 16* (Feb. 2025), https://doi.org/10.1097/AOG.0000000000005804.

[50] Matthew B. Barry, Cong. Rsch. Serv., R45161, *Abortion At or Over 20 Weeks' Gestation: Frequently Asked Questions* (2018), https://www.congress.gov/crs-product/R45161.

[51] *See* Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (2014).

[52] Nancy F. Berglas et al., *Changes in Abortion Access, Travel, and Costs Since the Implementation of State Abortion Bans, 2022-2024*, 115 Am. J. Pub. Health 1713, 1716 (2025), https://doi.org/10.2105/AJPH.2025.308191 (last visited Aug. 19. 2026); *see also* Fiona de Londras et al., *The Impact of Gestational Age Limits on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence*, 3 BMC Glob. Pub. Health 7 (2025), https://doi.org/10.1186/s44263-025-00124-2.

that pregnancy duration at the time of abortion increased, with the proportion of abortions occurring at 13 weeks or later increasing from 8% to 17%.[53] This research confirms that structural access barriers and delays in obtaining accurate information represent a public health threat.[54]

B. AACs' information practices are a documented subject of public health concern, which government education campaigns help to address.

Independent scholarly research and government investigation have long documented concerns around AACs. In the 2006 Waxman Report, investigators posed as pregnant teens and contacted 23 federally funded AACs across 15 states and found that 87% of the centers provided false or misleading information.[55] Despite medical evidence to the contrary, eight centers said that abortion would increase the risk of breast cancer, seven said it would hurt future fertility, and thirteen said it would yield severe and common psychological effects.[56]

Additional peer-reviewed literature over the last decade documents misleading AAC practices in their tactics and messaging. From communicating inaccurately with patients about gestational age, to misrepresenting the safety of

[53] Berglas et al., *supra* note 52.
[54] *See* Am. Coll. of Obstetricians & Gynecologists, *Opposition to "Abortion Reversal" Regimens and Disinformation by Crisis Pregnancy Centers: ACOG Committee Statement No.* (2024) (stating that AAC tactics including intentional gestational-age overstatement "create[] delays that leave people unable to access abortion care in their communities").
[55] H. Comm. on Gov't Reform, Minority Staff Special Investigations Div., 109th Cong. *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers* (Comm. Print 2006), https://motherjones.com/wp-content/uploads/waxman2.pdf.
[56] *Id.*

abortion procedures, to delaying referrals and failing to provide complete information about available options, AACs consistently threaten public and individual health.[57] These practices produce measurable delays in care. Research has found that patients who visited an AAC prior to obtaining abortion care experienced delays in accessing services.[58] Those delays carry direct clinical significance because the safety profile, available methods, and cost of care all change as gestational age advances.[59]As such, several states Attorneys General have investigated AACs and issued consumer protection advisories for the public.[60]

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[57] *See* Melissa N. Montoya et al., *The Problems with Crisis Pregnancy Centers Reviewing the Literature and Identifying New Directions for Future Research*, 14 Int'l J. Women's Health 757 (2022), https://doi.org/10.2147/IJWH.S288861 (finding that AACs present themselves as health care clinics while providing counseling explicitly intended to discourage and limit access to abortion); Amy G. Bryant & Erika E. Levi, *Abortion Misinformation from Crisis Pregnancy Centers in North Carolina*, 86 Contraception 752, 752-56 (2012), https://doi.org/10.1016/j.contraception.2012.06.001 (North Carolina study finding that 17 of the 32 centers contacted provided at least one misleading or inaccurate piece of information and 14 of 32 centers offered unsolicited counseling on abortion and its risks despite claiming not to provide or refer for abortion); Christina Frasik et al., *A Mystery Client Study of Crisis Pregnancy Center Practices in New York State*, 117 Contraception 36, 36-38 (2023), https://doi.org/10.1016/j.contraception.2022.08.004 (finding that of the 86 centers reached, only 12 spontaneously disclosed their non-medical status, 33 conveyed clinically inaccurate information, and 49 shared inflammatory statements about abortion care.).

[58] Montoya et al., *supra* note 57 at 758 ("Evidence suggests that CPCs have a negative individual and public health impact through dissemination of medically inaccurate information and delaying access to legitimate medical care"); *see also* Am. Coll. of Obstetricians & Gynecologists, *Issue Brief: Crisis Pregnancy Centers*, (Oct. 2022), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/crisis-pregnancy-centers.pdf?rev=57762c9dbc624161b1b21018417e2011&hash=25CDF1171054215CCD197C06A6D0940A.

[59] Swartzendruber et al., *supra* note 27 at 823 ("[M]any centers inform clients that they 'have plenty of time' to make pregnancy decisions [], which could endanger people who ultimately decide to terminate their pregnancies by exposing them to slightly riskier procedures later in pregnancy and obstruct their opportunity to obtain an abortion due to state-imposed gestational age limits, increased costs, and limited access to later-term abortion services. Such advice may also risk maternal and infant health through delayed prenatal care."); Montoya et al., *supra* note 57 at 758. ("Individuals seeking pregnancy confirmation at CPCs not only experience delays in accessing abortion care when desired [] but in the case of desired pregnancies, may also experience delayed entry into prenatal care or delayed recognition of pregnancy complications or medical conditions as a result of visiting a non-licensed clinic … This tactic forces an increase in second-trimester abortions, which are harder to obtain, more expensive, and less safe than abortions in the first trimester.").

[60] Office of Cal. Att'y Gen., Open Letter from Attorneys General Regarding CPC Misinformation and Harm (Oct. 23, 2023), https://oag.ca.gov/system/files/attachments/press-docs/Open%20Letter%20re%20Crisis%20Pregnancy%20Centers%20FINAL.pdf (joint open letter led by California Attorney General Bonta and signed by sixteen state Attorneys General documenting concrete real-world harm caused by AACs).

The clinical stakes of delay are illustrated most sharply by cases involving undetected pregnancy complications. In Massachusetts, staff at an AAC mistakenly told a woman with an ectopic pregnancy that she had a viable intrauterine pregnancy, resulting in a ruptured fallopian tube and emergency surgery.[61] Indeed, research has found that AAC staff "are often explicitly instructed not to diagnose, not to follow up, and above all, not to assume responsibility" when they suspect a patient has an ectopic pregnancy, adding another layer of deception.[62] This structural concern is compounded by the clinical infrastructure findings that pregnancy complications can emerge rapidly and, in some obstetric emergencies, minutes can meaningfully affect clinical outcomes.[63] Yet, 77% of identified AAC medical directors appear to maintain primary employment outside the AAC they oversee, raising legitimate questions about the supervisory capacity available when time-sensitive complications arise.[64]

This record about the risks that AACs pose to health care illustrates the decades-long, multi-jurisdictional, peer-reviewed evidentiary basis that government

[61] *Doe v. Clearway Clinic, Inc.*, No. 23-cv-708 (Super. Ct. Jan. 24, 2024); *see also,* Carrie Baker, *Class-Action Lawsuit Against Crisis Pregnancy Center and Groundbreaking Massachusetts Law Regulating Ultrasounds: 'A Chink in the Armor'*, Ms. Magazine (Apr. 15, 2025), https://msmagazine.com/2025/04/15/massachusetts-crisis-pregnancy-center-lawsuit-ultrasound-regulation/.

[62] Reproductive Health & Freedom Watch, *The Unregulated Pregnancy Clinic Industry and Ectopic Pregnancy* (July 1, 2025), https://reproductivehealthfreedom.us/wp-content/uploads/2025/07/UPCs-and-ectopic-pregnancy-July-1-2025.pdf

[63] Reproductive Health & Freedom Watch, *Is There a Doctor in the House? A National Analysis of Medical Service Oversight at Unregulated Pregnancy Clinics* (June 25, 2026), https://reproductivehealthfreedom.us/wp-content/uploads/2026/06/The-Clinical-Infrastructure-of-Unregulated-Pregnancy-Clinics.pdf

[64] *Id.*

agencies routinely act upon when designing public health education efforts. The risks described in these studies are well-documented, and the word choice in the Massachusetts campaign did not target specific centers or overstate their actions or inactions. Framing the Commonwealth's response to this record as viewpoint discrimination mischaracterizes both the nature of the government's interest and the depth of the evidence underlying the state's campaign.

C. Medically underserved populations are disproportionately reliant on AACs and have the fewest alternative sources of accurate information.

The public health stakes of the Massachusetts campaign are felt most acutely by patients in communities with the fewest alternatives for health care resources and information. These communities are also disproportionately exposed to AACs. A pre-*Dobbs* national study found an AAC-to-abortion facility ratio of 3.4:1, with approximately 19.7 million reproductive-aged women living in an AAC-only zone.[65] AAC-only exposure is roughly 33 times more common than abortion-facility-only exposure.[66]

[65] Andrea Swartzendruber et al., *Spatial Analyses of Crisis Pregnancy Centers and Abortion Facilities in the United States, 2021 (Pre-Dobbs): Cross-Sectional Study*, 10 J. Med. Internet Rsch. Pub. Health & Surveillance e60001 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11579622/ (defining AAC zones as within 15 miles of an AAC but not an abortion facility. Only 0.8% were living in an abortion facility only zone).

[66] *Id.*; *see also New Study Conducts Spatial Analysis of CPCs*, Univ. of Ga. Coll. of Pub. Health (Nov. 25, 2024), https://publichealth.uga.edu/new-study-conducts-spatial-analysis-of-cpcs/ (For 86% of women before *Dobbs*, "there was the possibility that the website or online advertising they were coming across for nearby locations had the potential to be a[n AAC], which could create confusion about which places provide abortion and prenatal care services and which do not.").

Over one-third of U.S. counties are currently classified as "maternity care deserts," affecting more than 2.3 million reproductive-aged women and roughly 150,000 births annually, with nearly two-thirds of those deserts located in rural areas.[67] In Massachusetts, the ratio of OB/GYNs per 10,000 births in rural counties fell from nearly 162 in 2010 to 87 in 2021 — a decline of roughly 46% — and eleven Massachusetts hospitals have closed or filed to close their maternity units since 2014.[68] A study analyzing all live births in the U.S. in 2020 found that one-third of counties constituted comprehensive reproductive health care deserts that lacked both nearby abortion access and in-county maternity care access.[69] Ninety percent of those deserts were rural, and they had worse socioeconomic conditions on average than counties with greater access to care.[70] The study specifically identified misinformation at AACs as one of the constraints that can compound geographic barriers to abortion care.[71]

AACs invest heavily in ensuring they are the primary source of information for many of these communities. Over a two-year period, AACs spent an estimated

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[67] Ashley Stoneburner et al., *Nowhere to Go: Maternity Care Deserts Across the US (2024 Report)*, MARCH OF DIMES (2024), https://www.marchofdimes.org/peristats/assets/s3/reports/2024-Maternity-Care-Report.pdf (defining maternal care deserts as counties without a single birthing facility or obstetric clinician); *see also* Am. Coll. of Obstetricians & Gynecologists, *ACOG Workforce Data*, https://www.acog.org/about/acog-departments/government-affairs-and-outreach/acog-workforce-data (last visited July 23, 2026).

[68] Hallie Claflin, *Two Years After the Closure of Leominster's Maternity Unit, a Region Is Struggling*, COMMONWEALTH BEACON (Mar. 2026), https://commonwealthbeacon.org/health-care/two-years-after-the-closure-of-leominsters-maternity-unit-a-region-is-struggling.

[69] Maeve E. Wallace et al., *Health Care Use and Health Consequences of Geographic Lack of Access to Abortion and Maternity Care*, 51 Birth: Issues in Perinatal Care 363, 366 (2024), https://doi.org/10.1111/birt.12792.

[70] *Id.*

[71] *Id.*

$10.2 million on Google Search ads to intercept patients searching for terms like "abortion clinic near me" before they reached accurate sources.[72] Additional research found that nearly 40% of people who said they visited an AAC provided the name of an abortion provider or other medical provider when asked to name the AAC, suggesting widespread confusion about what distinguishes AACs from health care providers.[73]

Taken together, these statistics expose structural steps taken by AACs to reach and confuse vulnerable patients seeking care and the real clinical costs that follow when such care is delayed or denied. For these communities, government public health education campaigns are often the primary mechanism for accurate information.[74] The Supreme Court has long recognized this dynamic.[75] Public education campaigns are a critical mechanism to fill the information gap. Chilling

[72] CTR. FOR COUNTERING DIGITAL HATE, PROFITING FROM DECEIT: HOW GOOGLE PROFITS FROM ANTI-CHOICE ADS DISTORTING SEARCHES FOR REPRODUCTIVE HEALTHCARE 4 (2023), https://counterhate.com/wp-content/uploads/2023/06/Profiting-from-Deceit-CCDH-FINAL.pdf; Kush S. Desai et al., *supra* note 27.

[73] Alice F. Cartwright, Katherine Tumlinson & Ushma D. Upadhyay, *Pregnancy Outcomes After Exposure to Crisis Pregnancy Centers Among an Abortion-Seeking Sample Recruited Online*, 16 PLOS One e0255152 (2021), https://doi.org/10.1371/journal.pone.0255152

[74] INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 96–97 (2002) (identifying government public health agencies as the primary institutional mechanism for delivering accurate health information to underserved populations); *see also* U.S. Dep't of Health & Human Servs., *Healthy People 2030: Health Communication*, https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication (last visited July 23, 2026).

[75] *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976) (holding that suppression of prescription-drug price information hit hardest the poor, the sick, and particularly the aged, because they were least able to shop from pharmacy to pharmacy); *Nat'l Inst. of Fam and Life Advocates v. Becerra*, 585 U.S. 755 (2018); *Nat'l Rifle Ass'n of Am. v. Vullo*, 602 U.S. 175 (2024).

government public education would most harm people who lack the resources to independently identify accurate providers or correct misinformation.[76]

D. Chilling government speech in this context would have far-reaching, unintended consequences.

A ruling that treats the Massachusetts campaign as constitutionally suspect would send an unmistakable signal to all public health agencies that directing public attention to documented health information gaps invites litigation. The practical consequence would be a retreat from proactive public health education precisely in the contexts where it is most needed.

Massachusetts's public health campaign falls squarely within government speech and is categorically outside the First Amendment.[77] Government speech doctrine recognizes that the state, as an institutional actor with its own legitimate voice, must be free to communicate the conclusions it reaches through its own deliberative and scientific processes, without being required to subsidize, amplify, or remain silent in deference to competing private viewpoints.[78] When the government speaks in its own voice, the constitutional check on that speech is democratic accountability at the ballot box, not a judicial requirement of viewpoint

[76] *See Bates v. State Bar of Arizona*, 433 U.S. 350 (1977) (assessing benefits of public outreach on cost-constrained consumers).
[77] 602 U.S. 175, 187 (2024); *Pleasant Grove City v. Summum*, 555 U.S. 460, 467–68 (2009); *Rust v. Sullivan*, 500 U.S. 173, 193 (1991).
[78] *See* 576 U.S. 200, 207 (2015).

neutrality that would effectively silence the government on any topic that generates private disagreement.[79]

The Massachusetts campaign is simply government speech. The Commonwealth has not compelled AACs to speak or suppressed their speech, nor has Massachusetts initiated enforcement against AACs' protected expression. Instead, the Commonwealth spoke for itself, which is precisely what the government may do and what the District Court correctly upheld.

Ruling otherwise would rewrite the rules regarding the government's expressive authority in the public health context, stripping agencies of the ability to speak plainly about documented health risks without assuming litigation exposure. The communities that would bear the cost of that outcome are patients, disproportionately low-income and underserved, for whom a government public health campaign is often the only reliable corrective.[80] The First Amendment has never required that result, and this Court should decline to read it that way.[81]

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[79] 596 U.S. 243, 251 (2022) ("The government's own speech . . . is not subject to the Free Speech Clause's usual prohibition on viewpoint discrimination . . . Instead, the people hold the government accountable for its speech through the ballot box."); *see also* Helen Norton, *The Government's Speech and the Constitution* 8–9 (2019) ("Citizens who dislike the government's message may vote out the officials responsible for it; they may not invoke the Constitution to silence it.").

[80] KFF, *Women's Health Insurance Coverage* (Oct. 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/ (finding that low-income women of reproductive age are significantly more likely to rely on publicly-funded health programs and government outreach as their primary source of health information); U.S. Dep't of Health & Human Servs., Office of Minority Health, *National Partnership for Action to End Health Disparities: The National Plan for Action* 47–49 (2011) https://aspe.hhs.gov/sites/default/files/private/pdf/206166/DisparitiesActionPlan.pdf.

[81] 425 U.S. 748 (1976).

CONCLUSION

Government public health education campaigns are a core feature of the state's public health function. They serve compelling interests, are grounded in a substantial and long-standing evidentiary record, and are the primary mechanism through which accurate health information reaches the patients who need accurate information the most. A ruling that treats the Massachusetts AAC campaign as constitutionally suspect would severely undermine the government's ability to protect public health and would inflict its greatest harm on those patients least equipped to protect themselves. This court should affirm the District Court's judgment.

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CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 32(a)(7) and Fed. R. App. P. 29(a)(5) because, excluding the parts of the brief exempted by Fed. R. App. P. 32(f), this document contains 6,150 words.
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