45 Women's Rts. L. Rep. 151

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Prof. Dr. Melanie Levy[a1]

“THE WALK OF SHAME”: NORMATIVE MISALIGNMENTS HINDERING ACCESS TO EMERGENCY CONTRACEPTION

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Keywords

Emergency contraception; pharmacy; equality; control; discipline; gatekeeping; women's bodies; power; gender; right to health; sexual and reproductive rights; responsibility; choice; autonomy; self-determination; agency; intersectionality; shame; insurance; conscientious objection; politics of sexuality; pharma law; pharmaceutical regulation; exceptionalism

*152 Abstract

Women's health-related human rights are contested. Beyond the recent pushbacks on abortion rights, more subtle developments are discernable. This paper dissects one case study illustrating how professional self-regulation in pharmaceutical law can undermine equal access to emergency

contraception (EC). In Switzerland, around 100,000 “morning after” pills are sold through pharmacies per year. Empirical evidence demonstrates how traumatic or shameful the experience can be for women. Because if regulation was liberalized in 2002 and EC has since been available without a doctor's prescription, access remains subject to strict professional gatekeeping. Women must undergo a compulsory interview with a pharmacist in a pharmacy backroom. They must indicate their contact details, answer an intrusive questionnaire archived for twenty years, receive information about sexually transmitted diseases, and bear the costs. Prices for EC vary and peak in the evening and on weekends. The exceptionalism of access to EC, despite formal legal liberalization, highlights gender bias and perpetuates shame and stigma surrounding women's sexually active behavior. Switzerland's normative position on access to contraception is based on individual responsibility and formal equality. Every woman is responsible for avoiding unwanted pregnancy, and access to EC is guaranteed since it is available in all pharmacies. In reality, access obstacles created by EC dispensing mechanisms result in intersectional inequalities, depending on women's age, socio-economic background, and migration status. This paper critically deconstructs the intricate intertwining of a liberal focus on individual responsibility and the disciplining power mechanisms of professional gatekeepers affecting female bodies and choices. Going beyond the personal and the political, it demonstrates how backsliding on sexual and reproductive rights can happen through the backdoor of professional self-regulation. Finally, this paper focuses on a substantive concept of equality for realizing women's health-related human rights.

*154 Introduction

Liberalization in the context of women's sexual and reproductive health over the last decades has been based on health rights, sexual and reproductive rights, and equality rights.[1] Access to sexual and reproductive health services, including determining if and when to give birth, is essential for individuals to achieve full and equal participation in society.[2] However, these rights are contested. Despite the considerable normative and political achievements for women's health-related human

rights at the international ***155** and domestic levels, current developments suggest a backsliding.[3] While technology is constantly moving forward, pushing the viability limits of newborns and allowing for digital surveillance of women's fertility windows, norms and rights appear to be on a rescinding trajectory lately. As former US Supreme Court Justice Ruth Bader Ginsburg famously observed, the pendulum seems to be swinging backward.[4]

This phenomenon is visible through the recent pushbacks regarding abortion rights in domestic law, either through outright outlawing abortion or indirectly through professional requirements and practical obstacles. Examples from both the USA and Eastern Europe illustrate such tendencies.[5] However, ***156** more subtle developments impacting women's sexual and reproductive rights are also discernible. One example is access to contraception and emergency contraception (hereafter: EC) in particular.[6]

This paper illustrates a backlash on women's sexual and reproductive rights in the aftermath of regulatory liberalization through the case study of access to EC in Switzerland. EC is defined as a drug or medical device used to prevent pregnancy after intercourse in which a contraceptive was not used or in case of contraceptive failure.[7] Available methods include hormone-based pills, which this paper focuses on, and a copper intrauterine device.[8]

EC is a time-sensitive medication. Ideally, it is taken shortly after unprotected sexual intercourse, as its efficacy decreases with an increasing timespan. The timeline for taking EC lies between three to five days after unprotected sexual intercourse, after which the drug is not efficient anymore in preventing an unwanted pregnancy. EC is not a method of abortion.[9] It does not prevent pregnancy by hindering implantation but by inhibiting or blocking ovulation.[10] However, there is still widespread public misunderstanding over the mechanism of EC, as the idea that contraception may occur after intercourse is counterintuitive.[11] Furthermore, false information is spread, on social media in particular, to imply that EC might act after fertilization, to place it in the category of ***157** abortion rather than contraception mechanisms.[12] As a form of medication, EC is very safe.[13] EC side effects are uncommon, with no threat to future fertility. The WHO has placed no restrictions on the medical eligibility of those women who can use EC.[14]

In Switzerland, around 100,000 “morning after” pills are sold through pharmacies per year.[15] Empirical evidence and media reporting demonstrate how traumatic or shameful the experience can be for women.[16] Because if ***158** EC regulation was liberalized in 2002 and the drug has since been available without a doctor's prescription, access remains subject to strict professional gatekeeping. Women must undergo a compulsory interview with a pharmacist in a pharmacy backroom to obtain the medication. They must indicate their contact details, answer an intrusive

written questionnaire archived for twenty years, and the drug has to be taken on pharmacy premises. After passing the stringent dispensing requirements, women must bear the costs of EC themselves. Without a price-setting mechanism, prices for EC vary, generally peaking in evening hours and weekends. No other medication in the same dispensing category as EC is subject to such stringent requirements, which, in addition, are not provided for by law. The unique character of these requirements in the general landscape of pharmaceutical regulation in Switzerland highlights gender bias, particularly considering that EC does not pose any particular risk to patient safety. A revealing comparison is Viagra, which has followed the same liberalization pathway as EC, having moved from a prescription drug to a behind-the-counter drug but without all the additional dispensing requirements.[17]

The purpose of liberalizing EC and making it available as a prescription-free drug in pharmacies was to facilitate access, thus guaranteeing women's health-related human rights and contributing to the public health objective of preventing unwanted pregnancies. However, this formal legal liberalization has not led to deregulation and women's increased self-determination, agency, and empowerment. It has introduced new barriers and inequalities regarding access to EC through the backdoor of professional self-regulation. Practical obstacles and professional gatekeeping strongly impact access to EC, depending on women's age, socio-economic background, and migration status. These mechanisms also perpetuate shame and stigma surrounding women's sexual and reproductive health.[18]

***159** The paper critically dissects this regulatory context in which the law guarantees formal equality, which is then undermined through professional gatekeeping mechanisms, such as procedural obstacles, shame, and financial barriers, resulting in unequal access to EC.[19] The analytical lens of this paper is thus based on the idea that contested equalities are not only a result of the established legal framework, as reflected through governmental, legislative, and judicial actors, but appear through healthcare professionals, such as pharmacists, who stand between women and their access to sexual and reproductive health products. Furthermore, the paper shows that even allegedly technical areas of law, such as pharmaceutical law, are not neutral, as they reflect gender norms and can have gendered or gender-biased consequences.[20]

The paper adds to the existing literature by exploring the continued control over women's sexual and reproductive rights and choices, even in the presence of liberalization efforts in the law, through professional gatekeeping mechanisms such as pharmacy dispensing procedures. The Swiss case study offers a unique setting in this context. While legal scholarship usually addresses access to contraception through the lens of sexual and reproductive rights, it rarely focuses on the issue of professional gatekeeping.[21] The existing literature discusses, however, other access obstacles, such as low awareness about EC, myths about its mechanisms of action, and widespread misinformation.[22] These elements go beyond the scope of this paper.

For its case study, the paper builds on a methodology of document analysis methodology, which includes empirical, legislative, policy, judicial, and professional documents regarding access to EC in Switzerland. A non-exhaustive literature review of empirical data on access to EC in other states complements this document analysis. For its conceptual framework and ***160** critical analysis, the paper draws on literature in feminist studies in the areas of law, political science, and sociology.

The paper unfolds as follows. It first presents the evolution of access to EC in Switzerland. Deconstructing the role of pharmacists as gatekeepers, the paper analyzes the various elements of power and discipline over female bodies and choices present in the process of providing access to EC. The paper then develops a conceptual framework going beyond the personal and the political discussed in feminist literature to include “the professional” (*i.e.*, professional gatekeeping) as an equality issue. Based on this framework, the paper proceeds with a critical analysis focusing on control and dependency, misuse of patient safety and informed consent, and a contradiction with the liberal paradigm of individual responsibility. Finally, the paper concludes with a call for a substantive concept of equality for realizing women's health-related human rights.

Evolution of access to emergency contraception in Switzerland

Regulatory changes over time

EC has been available in Switzerland for more than thirty years. Today, two oral hormonal emergency contraceptives are marketed: levonorgestrel 1.5 mg and ulipristal acetate 30mg.[23] Both forms are part of the WHO's core list of essential medicines.[24]

In the years after its introduction on the Swiss market in the 1980s, access to EC was only available with a medical prescription, necessitating a doctor's appointment and then a visit to a pharmacy to buy the drug.[25] In 2002, ***161** access to EC was facilitated as Swissmedic,[26] the Swiss Federal Drug Agency, changed the market authorization for EC.[27] Liberalizing access, Swissmedic moved EC from the category of prescription drugs (A or B) to the drug category C (behind-the-counter, sold in pharmacies without a medical prescription, after pharmacists' advice).[28] This change was realized based on the idea that pharmacies offer better accessibility through shorter waiting times and extended opening hours, contributing to treatment efficacy (since the earlier the pill is taken, the better it works).[29] EC with levonorgestrel (since 2002) and ulipristal acetate (since 2016) can now be obtained in pharmacies without a prescription.[30]

More recently, as part of a 2019 reform of the Federal Therapeutic Products Act, the legislator decided to abolish drug category C and facilitate dispensing medicines without jeopardizing patient safety. Swissmedic had to evaluate and reassign all drugs in dispensing category C as

part of this law reform. Most category C medicines (85%) met the criteria for moving them to category D (over-the-counter dispensation in drugstores and pharmacies, after specialist advice). EC, however, was reclassified from C to B, which, in principle, only includes prescription drugs. To avoid unnecessary burdens through this re-classification, the legislator decided that in the event of reassignment of a drug from category C to B, these drugs may continue to be dispensed by pharmacists without a medical prescription on the condition ***162** that they provide advice to patients who must be physically present in the pharmacy. Pharmacists must also document the dispensing, as is required for any medication subject to medical prescription.[31]

Pharmaceutical companies have appealed against this re-classification in two recent cases, arguing that EC belongs in drug category D and not B, which would allow for facilitated access beyond pharmacies, particularly in drug stores. In addition, advertisement is allowed for category D drugs, while it is prohibited for category B drugs.[32] Two 2022 Swiss Federal Administrative Tribunal decisions have confirmed the re-classification of EC in dispensing category B after the discontinuation of category C.[33]

The law in the books puts the power to dispense and sell EC into the hands of pharmacists, accompanied by dispensing requirements. Before analyzing how access to EC in pharmacies is realized in practical terms, two other elements are critical for setting the stage and understanding the context of access to EC.

Discourse of fear about sexual promiscuity and sexual risk behavior

Fears of intensified sexual promiscuity and sexual risk behavior have accompanied the regulatory steps towards liberalization through pharmacy access to EC. Media outlets in Switzerland have repeatedly conveyed this characterization of (young) women as sexual risk-takers, facilitated by EC, through the text of published articles and the choice of images accompanying them.[34]

Preventing unwanted pregnancies and sexually transmitted diseases (STDs) are critical public health concerns.[35] However, in the context of EC, ***163** the media rhetoric of prevention and risk behavior deviates into gender-pejorative reporting about "easy" women (the adjective "leichtsinnig" is used in German) and "good" women.[36] Such a narrative denigrates women's sexuality and feeds and reinforces harmful gender stereotypes. It constitutes an example of a genderized public health discourse purported in news media. In addition, the concerns voiced are contradicted by empirical evidence about liberalized access to EC. As Arnet and others note when comparing the EC user profile before and three years after the deregulation in Switzerland, the "... *observed changes in user profiles do not support the concern regarding enhanced sexually risky behaviour ....*"[37]

Similar fears appeared when a company manufacturing the EC drug ellaOne® started an advertisement campaign in nightclubs and bars in Switzerland.[38] Here again, harsh reactions voicing a discourse of increased sexual promiscuity and sexual risk behavior, particularly in nightlife, were expressed.[39]

Another recurring phenomenon is media reporting insisting that EC sales increase or "explode" over the weekend and in the aftermath of events. The latest example is the 2022 StreetParade in Zurich, a yearly techno music festival attracting thousands of partygoers.[40] Such moralizing media reporting ***164** insisting on the link between the party context and the need for EC is irrelevant and leads to stigmatizing and shaming sexually active behavior. Stigma and shame create significant practical obstacles for access to EC, as discussed below.

In comparison, Viagra, having followed the same liberalizing pathway in pharmaceutical law as EC, is pictured very differently in media coverage. This medication is sold in principle to treat erectile dysfunction. However, newspaper articles have celebrated the drug as a "masculinity enhancer."[41] They have also described the phenomenon of young men buying Viagra as a lifestyle drug without using language associated with stigma, shame, or sexual risk behavior.[42]

Emergency or replacement for regular contraception?

Looking at the empirical evidence of EC sales over the years is critical. The numbers show that EC pharmacy sales in pharmacies have steadily increased since the regulatory liberalization in 2002.[43] Numbers went up from 8,000 units sold in pharmacies in 2002 to 93,500 in 2008.[44] The numbers have doubled over the last four years (2017 to 2021), the numbers have doubled, from 52,000 to 105,.000[45] Other states present similar trajectories. For example, a long-term European comparative study shows that switching EC to non-prescription status increases EC use and may contribute to reducing unwanted pregnancy.[46]

The terminology used, EC, or the morning-after pill, implies that this contraception is reserved for emergencies only (*e.g.*, the regular pill has not been taken correctly; the condom was torn).[47] Two studies conducted in ***165** Switzerland in the early years after regulatory liberalization have demonstrated that facilitated access through pharmacies had no impact on using other means of contraception.[48] EC was still mainly used as an emergency method, not as a substitute.[49]

However, a different phenomenon has been gaining traction more recently, illustrated by a new type of patronizing discourse in media reporting. Pharmacists seem to observe that younger generations of women are less willing to take hormonal contraception regularly, as they prefer

natural contraception.[50] Resorting to natural methods (measuring temperature, tracking fertility through health apps, etc.) that are less reliable, these women want to access EC if necessary. Doctors have also been noticing “pill fatigue”, describing the phenomenon of young women, in particular, who prefer natural contraception instead of regular hormonal contraception.[51]

The “explosion” of sales numbers for EC in Switzerland (numbers have doubled in four years, from 2017 to 2021, from 52,000 to 105,000) is advanced as empirical evidence for this type of patronizing discourse. Such reporting is accompanied by a discourse on irresponsible behavior, *i.e.*, not wanting to take the pill regularly and preferring hormone-free means of contraception, which is considered reckless or negligent behavior on the part of the women.[52] So again, women's individual responsibility is at stake, but the scope and content of what it means to be responsible seems to be shifting.[53]

Beyond the rhetoric of individual responsibility versus negligence, the increasing use of EC and possible replacement of regular hormonal contraception based on facilitated access is also framed as potential drug misuse or abuse.[54] It is revealing that even the Swiss Federal Administrative Tribunal, in its two 2022 decisions on the re-categorization of EC from drug category C to B, refers to women's potential abuse and replacement of regular contraception through EC, should access to it be facilitated:

“In this context, it should be borne in mind that making the morning-after pill much easier to access than the normal pill is certainly apt to increase the potential for abuse of the morning-after pill (i.e., use not only in emergencies but instead of regular contraception)”;[55] “Especially since easier access ***166** compared to the normal pill brings with it a certain potential for abuse of the morning-after pill”.[56]

This lens of potential EC misuse or abuse reveals the general context in which access to EC is framed: detached from reality. Studies accompanying the liberalization of access in various countries contradict the alleged risk of abuse.[57] In addition, there is a considerable price tag attached to EC in Switzerland.[58] Replacing a regular contraceptive method with EC is too expensive for most women.[59] Finally, the discussion about potential misuse or abuse is gender-biased. Regarding the regulatory liberalization of Viagra, no such debate about the risk of misuse or abuse took place; quite the opposite, as Viagra was sometimes portrayed as a lifestyle drug (despite the health risks).[60]

Pharmacists as gatekeepers: elements of power over female bodies and choices

Access to EC is thus embedded in a normative framework that displays friction between regulatory liberalization, pursued in the name of facilitated access to a product critical to women's sexual and reproductive health, and the gender-biased consideration of women's choices and sexually active behavior. Professional self-regulation - the centerpiece of this paper - adds another element of normative misalignment to the detriment of women's health-related human rights.

Providing an essential service

Pharmacists are embedded in sexual and reproductive healthcare in Switzerland. While access to regular hormonal contraception requires a prescription from a physician, Swiss law allows pharmacists to dispense prescription-only medications in justified exceptional cases without a prescription.[61] Pharmacists also provide preventive health services, such as immunization ***167** or screening for STDs.[62] Regarding access to EC, available without a prescription, pharmacists assume a quasi-monopoly position, particularly during weekends and evenings. While EC is also available in family planning centers and hospital emergency rooms, access is less straightforward due to a lack of information, limited opening hours, and geographical locations (family planning centers) or waiting times and costs (hospitals).[63]

Most pharmacies are privately owned by individual pharmacists or companies. However, the exercise of the pharmacist profession of pharmacists is publicly regulated. Pharmacists need public authorization (*i.e.*, a license) from the relevant cantonal office to exercise their profession.[64] In addition, pharmacies need public authorization (*i.e.*, a license) from the relevant cantonal office to operate their business.[65] Pharmacists and pharmacies are thus licensed by a state authority and granted a monopoly to dispense medications that require prescriptions (drug categories A and B). They are subject to regulations in how they dispense medications. As a result, pharmacists do not only act as private economic actors selling a consumer good; they also provide the essential service of granting access to medications.

Procedural steps as access obstacles

With the regulatory liberalization of 2002, a critical power shift from doctors to pharmacists occurred, as women can since access EC in pharmacies without a medical prescription if specific dispensing requirements are met. According to the Federal Therapeutic Products Act (LPTh) and its executive order (OMéd), pharmacists must deliver category A and B (and C) drugs **only in person**. Women seeking access to EC thus have to be physically present in the pharmacy.[66]

LPTh and OMéd also impose a **documentation requirement** for category A and B (and C) drugs.[67] The following pieces of information have to be recorded in the pharmacy, either in writing

or electronically: surname, first name, date of birth, and sex of the patient; designation of the point of delivery and of the person who made the delivery; drug name, dosage, and pack size; date; information supporting the dispensing decision. Anonymous EC dispensing in pharmacies is thus not possible.

***168** Furthermore, a **mandatory counseling requirement** is imposed by law for category A and B (and C) drugs.[68] Swissmedic's market authorization decision for EC also specifies a counseling requirement. The same requirement is part of the information notice for medical professionals accompanying the market authorization decision.[69] The EC counseling requirement thus appears in three different normative sources: LPTh and OMéd; Swissmedic's decision granting EC market access; and the public database publishing professional information notices for all drugs having access to the Swiss market. Pharmacists are bound by professional secrecy.[70] The mandatory counseling before dispensing EC is, therefore, confidential but not anonymous.

Applicable to all category A and B (and C) drugs, the legal counseling requirement is generally concretized by pharmacists on an individual basis. For EC, however, a unique standard dispensing protocol was created through **professional self-regulation** by a self-designated "Interdisciplinary Group of Experts on EC" (IENK).[71] This group brings together gynecologists, pharmacists, and family planning center health workers. It is noteworthy that the IENK does not act in an official capacity. Its role and intervention are not established or mandated by law. The legitimacy and normative force of its work are thus limited, while in practice, the standards set are adhered to by pharmacies. Through its own initiative, the IENK has developed a **standard pharmacy dispensing protocol** for EC, establishing the steps to be followed and detailing the questions to be asked and written information to be shared by the women seeking access.[72] The alleged purpose of this standard protocol is to strengthen pharmacists' capacity to provide EC counseling and offer similar services all over Switzerland.[73] The protocol is also supposed to assure "neutral" counseling and an appropriate and prejudice-free conversation with women seeking access to EC.[74] Initially published in 2014, the IENK updated its protocol in 2020 to reflect new recommendations and research findings on EC provision.[75]

***169** According to the IENK, mandatory counseling takes place in a **pharmacy backroom**, separate from the general pharmacy sales area, to guarantee privacy and confidentiality.[76] This physical location is unique for dispensing medicines in a pharmacy, as no such requirement exists for other patients' needs. To be specific with language, EC is not a behind-the-counter drug but a pharmacy backroom drug. The separate room for mandatory counseling can be helpful, as it allows for a discreet conversation between women and pharmacists.[77] However, it can also involve feelings of fear, exposure, and unsafety.[78] The requirement for counseling in a separate pharmacy

backroom has imposed additional challenges for access to EC during the COVID-19 pandemic due to the impossibility of adhering to social distancing in a small, enclosed space.[79]

The standard pharmacy dispensing protocol also includes a **written questionnaire** to be filled out by women seeking access to EC.[80] Women must first fill in this written questionnaire during the counseling session. Again, this IENK-imposed procedural step is unique for dispensing medicines in a pharmacy, as no such requirement exists for other drugs. This questionnaire covers detailed questions, including the number of hours since the last unprotected sexual intercourse (UPSI); the reason for pregnancy risk (no contraception, condom breakage/slippage, incorrect use of hormonal contraception (HC), etc.); the number of hours since incorrect use of HC; further UPSI since last menstruation; information about cycle (start of last menstruation, how was the last menstruation?, absent regular cycle?, cycle length); other medications; precautions and contraindications; BMI; EC already taken in the past (details of circumstances).

The amount of information to be shared by women in this written questionnaire is broad and not always directly relevant for safely dispensing EC. Beyond its medically unnecessary intrusiveness, the written questionnaire raises questions about protecting women's privacy, as it involves the treatment (use, storage, destruction, etc.) of sensitive data.[81] Switzerland recently ***170** prolonged the statute of limitations to increase patient safety. Pharmacists must thus keep the written questionnaire for twenty years (ten years before the law reform). As Switzerland lags in digitalizing its healthcare system, most pharmacies use a paper questionnaire, which has to be archived for this lengthy period. It is unclear how pharmacies protect women's sensitive data in paper form for such a long time, since this situation is unique to EC, and pharmacists do not have expertise in data protection measures.

Once completed, pharmacists use the written questionnaire to clarify if taking EC is an option, *i.e.*, whether there are any health risks (allergies, drug interactions, etc.).[82] They also inform the women of EC's possible side effects, how to react to vomiting after taking EC, and how to proceed with contraception in the following days.[83] Based on the IENK standard dispensing protocol, pharmacists are also instructed to address the risks of STDs, share information about regular contraceptive methods, and make recommendations for regular gynecological check-ups.[84] The purpose of such **additional information** is public health protection. While pharmacists' prevention messages may not be irrelevant, they seem inadequate in this context. Is it part of a pharmacist's professional capacity to inform a woman, in the urgency or distress of a situation necessitating EC, about STDs, contraception, and doctor's appointments?

After going through all the steps of the standard dispensing protocol, the pharmacist delivers the EC to the woman, who, in principle, must **take the pill in the counseling room**.[85]

Overall, the IENK standard dispensing protocol significantly impacts how access to EC is realized in Swiss pharmacies. This begs the question of the legitimacy and power of this expert group to establish such a protocol. Moreover, what is its normative force? As mentioned, the IENK intervention is not mandated by law, nor are the procedural steps imposed by its standard dispensing protocol. Furthermore, EC access is subject to exceptional procedural mechanisms unknown in any other area of access to pharmaceuticals in Switzerland. Why single out access to EC for unique counseling requirements in terms of physical location, form, and content?

As the IENK is a group of experts composed of gynecologists, pharmacists, and family planning center health workers, one could assume that medical considerations would guide the detailed dispensing requirements. ***171** However, the procedural steps imposed do not seem necessary from a medical point of view, as the risk profile of EC is low.[86] The IENK might seek to offer similar procedures and questions in all Swiss pharmacies and thus guarantee formal equality through standardized procedures. However, what is the impact of this alleged pursuit of formal equality or equal treatment on substantive equality?

From a women's rights and public health policy perspective, broad, easy, and quick access to EC is paramount. The time window for taking EC after unprotected sex is, at the most, five days. The earlier the pill is taken, the more effective it is. Access obstacles lead to delays in taking EC or not taking it at all, thereby increasing the risk of unwanted pregnancy. Although the pharmacy requirement is a significant improvement over the prescription requirement, the procedural steps and practical obstacles imposed by the IENK standard pharmacy dispensing protocol create hurdles for women's access to EC. Such professional gatekeeping in the pharmacy opens the door to substantive inequality. It can undermine access to EC, particularly for vulnerable women due to their young age, minority status, migration background, and geographic location.

In its two 2022 decisions, the Federal Administrative Tribunal is oblivious to these access barriers. It states: “*The need for quick and uncomplicated availability is guaranteed with the classification in dispensing category B, because there is a dense network of pharmacies in Switzerland, which would also offer an emergency service*”;[87] as if the mere geographical presence of pharmacies equates with the absence of access hurdles. Detached from the reality of the standard dispensing protocol for EC, the Tribunal notes: “*It is also not clear to what extent the documentation requirement, as alleged by the complainant, could prevent women in need from obtaining the “morning after pill” more and to a significant extent than with a visit to a drugstore* ” (translation by the author).).[88] The Tribunal is silent regarding the critical role of the IENK and the dispensing requirements it added beyond what is provided for by law. Sticking to a formal view of equality, it ignores the unique, myriad, and intersectional barriers regarding practical access to EC.

*172 *Minors: the issue of age*

Based on its market authorization, EC is approved for all women, regardless of age.[89] However, as illustrated by empirical evidence, it is significantly more challenging for young women under sixteen to access EC, as pharmacists regularly refuse to dispense and sell the drug.[90]

In this regard, the IENK has also played a crucial role. Its standard dispensing protocol refers to the age of the woman requesting access to EC and sets an age limit of sixteen.[91] For women under sixteen, the standard protocol allows for dispensing EC without parents or legal representatives being present, but only if the pharmacist confirms a woman's decisional capacity. Thus, the pharmacist must examine the young woman's capacity to give legally valid consent.[92]

The age limit of sixteen for establishing a differentiated regime to dispense EC is erroneous. It is based on a mistaken link between access to pharmaceuticals, consent, and criminal law. The age of "sexual maturity" ("age of consent"), relevant in a criminal setting and set at sixteen by the Swiss Criminal Code (art. 187), protects children and young people from sexual acts with adults. This age limit is irrelevant in the context of health law and access to healthcare services.

The only relevant criterion for administering medicines and medical treatments is the capacity to make a legally valid decision. Decisional capacity is the *conditio sine qua non* for giving valid consent to drug dispensing and administration. The Swiss Civil Code does not set a specific age limit for this decisional capacity. Based on case law regarding medical decisionmaking, this age limit is situated at twelve or thirteen, depending on the individual's situation and their comprehension of it.[93] From this age, the capacity to give legally valid consent for medical treatment, such as EC, is ***173** presumed. In other words, above the age of twelve or thirteen, there is a general presumption of capacity to comprehend medical information and give legally valid consent. Parents or legal representatives do not have to be present or consulted from this age. This position was confirmed, most recently, in the context of the Covid-19 vaccination campaign.[94] The same is true for access to EC. Only for young girls under the age of twelve or thirteen does the capacity to give legally valid consent have to be evaluated on a case-by-case basis. Without decision-making capacity, parents or legal representatives must be involved.[95]

The age of sixteen referred to in the standard pharmacy dispensing protocol is thus irrelevant from a consent-to-EC perspective. Refusing to dispense EC to young women under sixteen with reference to such an age limit constitutes a violation of their rights, as is the requirement that they must be accompanied by their parents or their automatic referral to a hospital, which further delays EC intake.[96] In addition, systematically submitting young women between the ages of twelve

and sixteen to an exam of their capacity to give consent creates practical obstacles and unequal treatment for young women based on their age.

Finally, a minor's privacy vis-à-vis their parents has to be guaranteed. In the case of an underage girl with decision-making capacity, informing the parents without her consent violates professional secrecy and data protection law.[97]

Unequal financial access: absence of insurance coverage and market pricing

Women pay access to EC, including drug price and consultation fee, out-of-pocket, as there is no insurance coverage. Contraceptives, including regular and emergency hormonal contraception, are not part of the compulsory social health insurance benefits regulated by the Swiss Federal Health Insurance Act.[98] Social health insurance covers the costs of services used to diagnose or treat an illness, specific preventive medical measures, and benefits in the event of maternity. Oral contraceptives are not used to prevent or treat ***174** disease and do not constitute a benefit in the event of maternity. Their reimbursement is, therefore, not covered by social health insurance.[99]

The prices for the two types of EC are as follows: Levonorgestrel Sandoz costs about CHF 50.- (including consultation); ellaOne costs about CHF 65.- (including consultation). The counseling fee charged separately (in case of non-dispensing of EC) costs about CHF 20.-.

However, these prices and fees are only approximative. Switzerland has no price regulation mechanism for medicines not reimbursed through social health insurance. There is no transparency in price and fee-setting mechanisms. Each pharmacy can set the price for EC and the mandatory counseling fee. Several pharmacy chains operating numerous pharmacies probably have internal recommendations regarding prices and fees to be charged. These chains, however, refuse to communicate such internal recommendations, should they exist.

Prices for EC vary depending on the geographical location of the pharmacy, between urban centers and the periphery.[100] Due to market mechanisms, pricing also varies depending on the day and hour. The price may be considerably higher if EC is dispensed outside regular business hours (*e.g.*, at night or on weekends).[101] This phenomenon illustrates the capitalist slogan: "When you need it most, it is even more expensive!". Providing access to medicines during exceptional hours can certainly explain higher pricing. However, pharmacists act not only in the capacity of economic actors who want to make profits but they also provide an essential service, being the actor designated by law to provide access to EC, as discussed above.

Market pricing mechanisms reinforce financial access obstacles since the need and demand for access to EC are highest at the end of the weekend (Sunday) and during night hours. Access to

EC is particularly precarious for low-income population groups. Due to the federal state structure, support for individuals with financial difficulties is the responsibility of cantons and municipalities. Some cantons address the issue of unequal financial access to EC for specific populations, such as migrants or young women, through family planning centers that can dispense subsidized means of contraception.[102] EC is also available in cantonal hospitals, but prices are usually higher.[103]

In brief, financial obstacles hinder equal access to EC.[104] Access to contraceptive methods for vulnerable populations and the financial subsidies ***175** available in this context depend on the canton of residence. This fact adds an additional layer of inequality regarding access to EC. The Swiss Federal Government acknowledges this inequality by stating that the "*fact that the people of our country cannot all receive the same support is a direct consequence of federalism*" (!).[105]

Empirical evidence depicting shame and intrusive behavior

Despite the IENK standard dispensing protocol allegedly imposing requirements for neutral and objective counseling, empirical research and media reporting have produced evidence illustrating a narrative of shame, moralizing behavior, and intrusive questions by pharmacists.[106] Women felt humiliated by pharmacists or had to listen to a moral sermon because they asked for EC. Some were condemned and patronized in the pharmacy. The phenomenon of shame and shaming is not unique to the Swiss context. Empirical evidence from various states paints a similar picture, with women feeling ashamed, uncomfortable, embarrassed, judged, powerless, vulnerable, and concerned for their reputation.[107] In Italy, for example, where over-the-counter EC was approved in 2015, and uptake rates are among the lowest in Europe, interviews revealed that keeping the medication behind the counter created an impediment because of the embarrassment and fear of being labeled irresponsible that some consumers perceived when they had to request it.[108]

Requesting access to EC in a pharmacy involves several aspects relating to shame.[109] First, there is women's internal fear of being judged.[110] ***176** Women's inner perception of shame is often conditioned by the societal stigma associated with seeking EC, as it relates to women's sexually active behavior and alluded lack of responsible behavior. Having to expose the fact of being sexually active and that a "problem" has occurred during a sexual act is complex information to share with a stranger when asking for access to EC, regardless of the client's age.

Second, due to the IENK standard dispensing protocol, mandatory counseling takes place in a pharmacy backroom. Some women perceive the walk from the pharmacy counter to this designated backroom as a "*walk of shame*".[111] The separate counseling room is sometimes designated as the "*booth of doom*".[112]

Third, the mandatory backroom counseling and the written questionnaire that women have to complete open the door for shaming. Pharmacists' behavior can create shame or shaming through inappropriate, intrusive, moralizing, and humiliating questions or inferences concerning women's sexual promiscuity and social respectability.[113] Pharmacists' behavior might go as far as asking questions about sexual positions or insulting women.[114] Empirical evidence also testifies to pharmacists communicating their hostility toward EC and the women who use it.[115]

Finally, shame is linked to the notion of legitimate use. Factors impacting the legitimacy of EC use, as purported by pharmacists, are access age, relationship duration, and repeated use.[116] Evaluating such (moral) legitimacy for medication use is unusual. As mentioned before, it seems to boil down to the dubious distinction between authentic couples and party girls or the legitimacy of sexually active behavior.[117] The situation is paradoxical: women's efforts to obtain EC is a responsible action, while pharmacists may perceive the need for this medication as irresponsible (and thus triggering moralizing questions regarding legitimate use).[118]

Shaming by healthcare professionals as a prevention strategy in public health is not unique and strongly criticized in the literature.[119] Furthermore, ***177** in the context of EC, the need for access occurs in a post-risk-exposure scenario. The public health objective at stake here is avoiding unwanted pregnancies. As the risky behavior has already happened, shaming behavior by pharmacists in the lead-up to dispensing EC is contrary to this objective.

The empirical evidence about shame, moralizing behavior, and intrusive questions by pharmacists indicates that some women are discouraged from going to a pharmacy.[120] Without the IENK standard dispensing protocol being designed for this, shame plays a role in restricting autonomy due to societal perceptions and the specific circumstances of the pharmacist's gatekeeping. Such evidence illustrates an obstacle to realizing women's equal access to EC. In addition, old patterns of regional differences and urban/rural distinctions seem to play a role as well, as is the case regarding access to abortion services in Switzerland.[121] Shame and societal stigma lead to “pharmacy tourism”, as women feel more comfortable asking for EC in a pharmacy in an anonymous environment outside their place of residence.[122] The fear of being recognized by pharmacists and other clients at local pharmacies often compels women in vulnerable circumstances to seek services elsewhere. This need to relocate exacerbates unequal access to healthcare, as the financial and logistical challenges disproportionately affect these women in precarious situations.[123]

Beyond the personal and the political: professional gatekeeping as an equality issue

Based on the phenomenon of backsliding on women's sexual and reproductive rights through the backdoor of professional self-regulation, dissected above, this paper offers a conceptual framework and critical analysis to deconstruct what is happening here. The premise of the proposed conceptual framework is the need to reframe the public/private divide in the context of women's sexual and reproductive rights. The critical analysis focuses on control and dependency, misuse of patient safety and informed consent, and a contradiction with the liberal paradigm of individual responsibility.

*178 *Public/private divide reframed*

The feminist slogan “the personal is political” challenges the seemingly clear divide between the private and the public spheres of women's lives.[124] Created by Carol Hanisch in 1968, the slogan conveys “the then-shocking idea that there were political dimensions to private life, that power relations shaped life in marriage, in the kitchen, the bedroom, the nursery, and at work.”.”[125] This fundamental idea has since been proven repeatedly by empirical evidence testifying to just how political the personal is in all matters related to women's rights, status, and bodies.[126] The slogan is an inherent part of “the feminist conviction that to politicize what is considered the personal is necessary for women's emancipation from patriarchy.”.”.”.”.”.”[127]

The public/private divide regarding women's bodies is particularly contested, if nonexistent.[128] In the intimate matters of access to contraception or abortion, the political undeniably plays a role in how legal frameworks are designed and judicial decisions are rendered.[129] These frameworks and decisions have a profound impact on women's private sphere, including their sexual and reproductive health and the choices and decisions to be made. However, the idea of politicizing ordinary women's everyday life, as captured by the slogan “the personal is political”, is incomplete considering women's health-related human rights. The slogan leaves out a critical actor: healthcare professionals, including pharmacists. Through their gatekeeping functions, healthcare professionals can create, maintain, and reinforce practical obstacles affecting women's sexual and reproductive rights, even when *179 the positive legal framework guarantees such rights.[130] Access equality for sexual and reproductive health services depends on the role and behavior of healthcare professionals, including pharmacists.[131]

The slogan “the personal is political”, while capturing the challenge to the public-private divide raised by feminist movements, does not unmask professional gatekeeping mechanisms exercised in the context of women's health-related human rights. Through the case study on access to EC, this paper sheds light on this blind spot affecting women's agency and equality regarding their sexual and reproductive rights. It exemplifies that a “rethinking of the personal and the political”[132] might

be in order, in this context, to include "the professional," *i.e.*, professional gatekeeping mechanisms such as shaming and procedural hurdles.

This rethinking or reframing of the debate is critical since access to contraception is usually presented as an issue of gender equality and gender equity.[133] While essential, the focus on gender equality and gender equity does not account for the fact that equal access to EC is threatened by professional gatekeeping through the power imbalance (hierarchy, dependency) between pharmacists and women and the practical hurdles imposed. The paper's case study illustrates that in the context of sexual and reproductive rights, women's bodies are both a political battleground and a professional battleground.

Pharmacists' professional gatekeeping reflects the classic playbook to keep women in their place by moralizing or shaming sexually active behavior unrelated to potential childbearing, making it challenging to obtain contraception.[134] Going beyond the feminist critique stating that the law maintains patriarchal structures, the paper's case study highlights the need to critically engage with and deconstruct professional gatekeeping critically.

In the recent *Dobbs* decision of the US Supreme Court regarding abortion, the dissenting opinion of Justices Breyer, Sotomayor, and Kagan states:

"To allow a State to exert control over one of 'the most intimate and personal choices' a woman may make is not only to affect the course of her life, monumental as those effects might be. It is to alter her 'views of ***180** [herself]' & her understanding of her 'place in society' as someone w/ the recognized dignity and authority to make these choices"[135]

The same reasoning applies to access to EC. Professional gatekeeping, and the situation of hierarchy and dependency it expresses, is not predominantly about care but control of women's bodies and choices. It reflects on what kind of decisions women are allowed to make on their own.[136]

Control and dependency

Medical and social sciences literature depicts patients' increasing empowerment in their relationship with healthcare professionals over the last decades.[137] Recognizing patients' rights has played a significant role in this development.[138] Nevertheless, hierarchies and unequal relationships between doctors and patients remain in many areas of medical practice.[139] This is true particularly regarding sexual and reproductive health services for women, such as abortion and childbirth.[140]

In feminist scholarship about health and healthcare, taxonomies of power over women's bodies usually consider men (husband, father, brother) and medical doctors.[141] However, the doctor is not the only professional actor to whom a power imbalance and unequal relationship exist. The pharmacist plays an equivalent role, with a similar hierarchy in terms of power, expertise, and dependency. Interestingly, the pharmacist's role is much less analyzed as an element of control over women's bodies and choices. This paper completes this gap in the literature.

The law in the books treats EC like any other medication. However, “*the woman who tries to obtain it in practice could meet, and often does meet, barriers whose nature and importance are difficult to predict*.”[142] Professional gatekeeping, shame, and financial barriers expose “*women to uncertainty in a matter crucial to their personal self-determination and makes them most vulnerable to disrespect, humiliation, and paternalistic interference with their rights*.”[143]

Access to EC in Switzerland illustrates that the pharmacy is a physical and professional space for controlling and disciplining women's bodies and ***181** choices in the context of sexual and reproductive health.[144] Following the regulatory liberalization of access to EC in pharmacies, two elements of this situation of hierarchy and dependency appear.[145] First, there is the relational aspect between the pharmacist's professional capacity and the woman seeking access to EC. Women's rights to autonomy, self-determination, and equal access to EC depend on the professionals (*i.e.*, pharmacists) fulfilling their legal duties.[146] The pharmacists' professional status, pharmaceutical knowledge, and expertise create a hierarchical relationship with the women seeking access to EC. Combined with the imposed standard dispensing protocol, this hierarchical relationship produces dependency. Furthermore, the economic aspect of market domination exists, as the current Swiss legal framework grants pharmacists a quasi-monopoly position in dispensing EC.[147] Pharmacists are not only experts. They are also salespersons. The quasi-monopoly situation again creates dependency.

Conscientious objection is an example highlighting how women's sexual and reproductive rights can be restricted through the professional gatekeeping of non-state actors such as pharmacists. The right to conscientious objection is the right to refuse to perform an act contrary to one's conscience granted to healthcare professionals.[148] This right has traditionally been protected in the context of healthcare services such as abortion and for doctors and nurses only.[149] However, even if no evidence has appeared yet in Switzerland, the question of pharmacists' right to conscientious objection to abortive and contraceptive medications, including EC, has arisen over the last few years and is discussed in the literature.[150]

***182** Two precedents on pharmacists' right to conscientious objection are noteworthy. In 2001, the European Court of Human Rights recognized that the contraceptive pill was legally available for sale in France and, by law, could only be sold on prescription in pharmacies; accordingly, the applicants (all of them pharmacists) could not rely on their religious beliefs or impose them on others to justify refusing to sell that product.[151] The Court added that there were many ways in which they could manifest their beliefs outside the professional sphere. In an opposing decision, the Spanish Constitutional Court in 2015 recognized pharmacists' right to refuse to sell EC based on conscientious objection.[152]

What are the specific issues with conscientious objection in the context of EC? First, a right to conscientious objection for pharmacists raises questions as they provide an essential service and act in a quasi-monopoly position to dispense EC. Women depend on pharmacists to be able to exercise their right to access EC. Furthermore, time is of the essence, considering the limited time frame during which EC effectively prevents pregnancy. Pharmacists who do not wish to sell EC can, in principle, take measures for the woman to receive the drug within a reasonable time (for example, by referring her to a colleague). However, referral to another pharmacy or a hospital might discourage women or take too much time. Admitting conscientious objection for pharmacists creates additional burdens and access inequalities, depending on women's possibilities to visit another pharmacy and thus preponderantly weighing on those already disadvantaged (lower socio-economic backgrounds, rural communities, minorities, women facing ***183** transportation barriers).[153] The possibility of conscientious objection for pharmacists highlights the elements of control and dependency described above and adds to the backsliding on women's sexual and reproductive rights.

Women's health-related human rights do not merely protect the liberty to decide whether to become a mother, including freedom of choice, decision-making, autonomy, self-determination, and control over one's body and life.[154] According to international human rights law, women's sexual and reproductive rights contain two elements: (1) access to sexual and reproductive healthcare services, including contraception, information, and education on family planning, and (2) equal and non-discriminatory access to these services.[155] Furthermore, equal and non-discriminatory access to contraception is not only an issue of sexual and reproductive health rights. It relates more broadly to realizing women's rights to equality and non-discrimination in other areas of life.[156] Equal access to treatments and services relevant to sexual and reproductive health is a tool for equal opportunities.[157]

Human rights generally apply in the vertical relationship between the individual and the State, including the agents acting on its behalf.[158] Healthcare professionals often act as agents of the State in the exercise of a public capacity (in a public hospital, for example). Based on the three-pronged structure of human rights, States are obligated to respect, protect, and fulfill women's sexual and

reproductive rights.[159] The obligation to respect relates to the State's negative duty not to interfere with women's exercise of their rights. The obligation to protect relates to the State's positive duty to protect women from the conduct of non-State actors that interfere with the enjoyment of human rights (indirect horizontal effect).[160] The obligation to fulfill ***184** relates to the State's positive duty to put women in a position to exercise their rights and thus control over procreation.

Pharmacists provide an essential service in the context of access to EC. Due to their quasi-monopoly position and the many aspects of their professional gatekeeping, they are in a powerful position to uphold or undermine the equal realization of women's sexual and reproductive rights.[161] The Swiss legal framework on access to EC guarantees formal equality. The purpose of liberalizing EC and making it a prescription-free drug was to facilitate access. However, beyond the explicit legal framework, the procedural steps and practical obstacles imposed by professional gatekeeping opened the door to substantive inequalities for women, in particular, based on their young age, minority status, or migration background. In addition, these mechanisms undermine women's equal access to EC in rural areas, on weekends, at night, or during the holiday season.[162] Backsliding on women's sexual and reproductive rights was introduced through the backdoor of professional self-regulation, resulting in intersecting layers of substantive inequality regarding access to EC.

Equal access to EC, both formal and substantive, is an issue of women's rights.[163] Beauvoir already pointed to the need for the feminist cause to go beyond the procurement of formal equality.[164] "*Rather, feminism is about women's living as free and autonomous individuals on women's terms*.""[165] Referring to the three-pronged structure of human rights, it is with regard to the State's obligation to protect and fulfill that the equality issues discussed arise. Equal realization of women's sexual and reproductive rights, including equal access to EC, depends on how pharmacists exercise their professional gatekeeping. Protecting and fulfilling women's sexual and reproductive rights allows and obliges States to address the substantive inequalities resulting from hierarchy and dependency created through professional gatekeeping mechanisms.

***185** *Misuse of patient safety and informed consent*

Beyond control, hierarchy, and dependency, the issue of patient safety is lingering. The IENK justifies the standard pharmacy dispensing protocol as necessary to guarantee patient safety and allow pharmacists to execute their professional obligations diligently.[166] Furthermore, patient safety is put in the spotlight in media outlets and social media.[167] It is also part of the judicial discourse on access to EC. The 2022 Swiss Federal Administrative Tribunal decisions dealing with the drug dispensing category of EC insist on the alleged health risks.[168]

However, EC is a safe medication.[169] It does not involve risks of overdose or addiction. The dosage is always the same. The side effects are mild and temporary. There are no significant interactions or contraindications. Repeated dosing is well tolerated, even within the same menstrual cycle. EC is also safe for breastfeeding women. It does not interfere with or harm an existing pregnancy, and there is no known threat to future fertility. Based on this evaluation, the WHO has added EC to its list of essential medicines and has placed no restrictions on the medical eligibility of those women who can use EC.[170]

Beyond the myths and misinformation about EC's mechanisms of action (*i.e.*, preventing conception and not implementation), other myths and misinformation circulate regarding side effects such as future infertility.[171] Evaluating the health risks arguments through the lenses of urban legends or professional misinformation for the purpose of fear-mongering goes beyond the scope of this paper. From a legal perspective, one can address patient safety and informed consent arguments as tools to restrict women's health-related human rights.

Informed consent is essential in women's sexual and reproductive health decisions. However, a growing literature, focusing mainly on the USA for now, highlights that, in the context of abortion, informed consent is misused ***186** to restrict women's sexual and reproductive health choices and control over their bodies.[172] Scholars show that the legal doctrine of informed consent is misappropriated to coerce pregnant women into becoming mothers, depicting the fetus in early-stage pregnancy as an actual future child and selling a romantic idea of the idyllic life of motherhood.[173] The heart-beating laws adopted in many states in the USA are also based, normatively speaking, on the doctrine of informed consent. In other words, too much information is given to women to create obstacles to abortion.[174]

These developments reveal an intriguing phenomenon of using (or distorting) a legal principle, such as informed consent, originally designed to liberate and empower patients in the unequal, hierarchical relationship with healthcare professionals,[175] to control and discipline women, their bodies, and their choices about sexual and reproductive health.[176]

This analytical lens translates to EC. The procedural steps of the standard pharmacy dispensing protocol force women who want to purchase EC to share and register in writing detailed, intimate information about their sexual and reproductive health. Health literacy studies, in particular, show that written questionnaires create access obstacles for vulnerable populations.[177] Furthermore, the dispensing protocol and the supposedly neutral or medical information of the written questionnaire implicitly open the door to intrusive, moralizing, or shaming questioning about women's sexually active behavior.[178] In addition, the dispensing protocol forces women to hear or read not directly

relevant information (*e.g.*, such as the risk of STDs). These procedural steps create additional access obstacles for EC.[179]

Under the guise of informed consent and patient safety, pharmacists intrude in women's balanced decision-making processes and push aside the obvious that women are entitled to decide on their sexual and reproductive health. This disciplining mechanism interferes with and tempers women's sexual and reproductive choices. From the point of view of contested equalities, two aspects are noteworthy.

First, these intrusions contradict an equality-based conception of sexual and reproductive rights, as they rely on gender stereotypes. Media reporting on EC highlights fears of sexual promiscuity and women's irresponsible, ***187** careless, sexually active behavior despite scientific evidence to the contrary.[180] These fears, in combination with the standard pharmacy dispensing protocol established by the IENK, express and maintain sex-based stereotypes. They reflect a protective, patronizing, patriarchal view of women's autonomy and sexual and reproductive choices.[181] The same is true when alleged EC abuse is portrayed through the assumption of increased sexual risk behavior and replacement of regular contraception through EC.[182]

Second, this intrusive process, whose alleged purpose is informed consent and patient safety, is unique among medicines in the same drug dispensing category as EC (category B). It is only partially imposed by the Federal Therapeutic Products Act and its executive order (*i.e.*, documentation requirements). Most procedural steps, including the standard pharmacy dispensing protocol and the written questionnaire, were created and imposed by an expert group, the IENK. This self-designated group has no authority or legitimacy to impose such a detailed, intrusive procedure. In addition, there is no medical justification related to patient safety, which again illustrates that this is about control and not predominantly about care.[183]

Finally, a comparison must be made with other medicines in the same dispensing category as EC. Since 2019, access to a broad range of treatments has been facilitated, by empowering pharmacists to sell these drugs over-the-counter, or from behind the counter, without a medical prescription. Interestingly, Viagra, a drug to treat male erectile dysfunction, followed the same regulatory liberalization pathway as EC. In April 2020, Viagra switched its drug category from prescription to behind-the-counter (category B).[184] As with all drugs of this category, the pharmacist is subject to counseling requirements when selling Viagra, in addition to in-person dispensing and documentation requirements. What is critical to note here, however, is that for ***188** Viagra, no specific, detailed standard pharmacy dispensing protocol was created. This situation is counterintuitive since a medical condition related to erectile dysfunction might be a sensitive topic to address in the general sales area of a pharmacy. The need for privacy and confidentiality might impose pharmacy backroom counseling. Considering the increased health

risks associated with Viagra, for patients with pre-existing cardiovascular conditions or diseases in particular,[185] a written questionnaire would make sense. Buying Viagra also implicates evidence that someone is sexually active, which provides a pivotal opportunity to share information about the risk of STDs. Despite the similarities of context for dispensing both EC and Viagra from behind the counter in a pharmacy, it is only for EC that detailed formal and substantive counseling requirements with all the above-discussed specificities were created. The regulatory liberalization of access to Viagra thus followed a very different path of practical implementation.

This begs the question: Why, of all possible drugs, does only EC necessitate such a unique way of dispensing and selling in the pharmacy context? The medical risks of taking EC, compared to Viagra, for example, are negligent.[186] Patient safety, the central paradigm and normative principle in pharmaceutical law, is thus not particularly relevant. What becomes apparent here is a misuse of patient safety and informed consent, with the underlying purpose of controlling women's bodies and sexual and reproductive choices. Gender-based stereotypes are revealed, which hinder the realization of women's sexual and reproductive rights. These obstacles contradict an equality-based conception of women's health-related human rights. The comparison with Viagra and the incoherence of the regulatory solutions adopted project how genderized and gender-biased pharmaceutical law can operate, revealing a double standard.[187]

Additional evidence stems from the obligation to take EC immediately in the pharmacy backroom before leaving the pharmacy. The argument advanced for the immediate intake is that EC shall not be delivered to someone else outside the pharmacy. However, the uniqueness of this regime and the underlying suspicions about potential abuse depict once again a patronizing or paternalizing way of addressing women's sexual and reproductive health needs. A similar requirement for Viagra is simply unimaginable.

***189** More generally, patient safety and informed consent arguments must be considered in light of the underlying issue of the contested legitimacy of EC use. The notion of legitimate EC use relates to the perceived legitimacy of women's sexually active behavior, depending on age, relationship status, and frequency of use. The very act of demanding access to EC creates visibility for women's sexually active behavior.[188] Imposing lengthy procedures in the name of patient safety and informed consent creates space for such legitimacy debates to grow, which once more points back to the issue of control over women's bodies and choices. The legitimacy debate is another exceptional feature of EC, which is not present for other medications.

Contradiction with the liberal paradigm of individual responsibility

Financial access to contraception is built on the liberal paradigm of individual responsibility in Switzerland. Both regular and emergency hormonal contraception are not covered through

social health insurance.[189] In 2013, a parliamentary instrument entitled “Free contraceptives for women under twenty” was submitted to the Swiss Federal Parliament.[190] This instrument aimed to reduce unintended pregnancies and abortions. The Federal Council rejected the instrument in 2015. In its rejection, the government focused on individual behavior, stating that it is every woman's individual responsibility to avoid undesired pregnancies.[191] It also mentioned that public authorities were already involved in preventing unwanted pregnancies through counseling.[192] Other parliamentary instruments requested legislative changes to include contraception among the healthcare services covered by social health insurance. However, the government has refused all requests, based on the rhetoric of individual responsibility and the significant financial burden imposed on social health insurance should contraception receive coverage.[193]

Two critical contradictions arise here. Individual responsibility for access to EC is an illusion for vulnerable population groups, such as impoverished people, social assistance recipients, refugees, or young people, who cannot afford to buy EC on their own.

Beyond the issue of financial access, the pronounced liberal paradigm of individual responsibility for contraception and avoiding undesired pregnancies contrasts the practical obstacles imposed through professional ***190** gatekeeping in pharmacies. There is an inherent contradiction between the liberal paradigm of individual responsibility for contraception and professional gatekeeping hindering access to EC for women who want to take responsibility for their sexual and reproductive health.

Beyond these contradictions, one could argue that the combination of individual responsibility and professional gatekeeping creates a double burden or layer of inequality. Both individual responsibility and professional gatekeeping result in unequal access to EC.

Conclusion

Access to contraception is at the core of women's autonomy and ability to make choices about their bodies and lives. Beyond sexual and reproductive rights, access to contraception also intrinsically relates to women's equality rights. After decades of progress and liberalization, these rights have recently come under attack. The pathway of contesting women's rights is not limited to direct restrictions outlawing certain sexual and reproductive health services for women, as witnessed in the abortion context. Through the case study of access to EC in Switzerland, the paper highlights a more subtle threat: the backsliding on women's sexual and reproductive rights despite formal legal liberalization through the backdoor of professional self-regulation.

The Swiss legal framework on pharmaceuticals was liberalized decades ago and has since allowed for access to EC. A state actor, Swissmedic, has given market authorization for two types of

hormonal EC, which can be obtained in pharmacies without a doctor's prescription since 2002 and 2016. The regulatory change from a prescription to a behind-the-counter drug has facilitated access to EC with the public health purpose of preventing unwanted pregnancies. The pharmacy as a place for dispensing EC is accessible, offering short waiting times and extended opening hours. The exceptional circumstances of the COVID-19 pandemic have shown, particularly regarding access to contraception and early abortion, that pharmacies play a critical role in realizing women's health-related human rights.[194]

However, regulatory liberalization does not necessarily mean deregulation and increased agency and empowerment for women regarding their choices and bodies. With liberalization came a power shift to pharmacies, granting them a quasi-monopoly position for providing access to EC. This paper illustrates how dispensing EC from behind the counter in pharmacies has created obstacles to realizing women's sexual and reproductive rights and guaranteeing equal access.

***191** Three major access obstacles appear in practice. First, access to EC through pharmacies is subject to a detailed dispensing procedure. Professional self-regulation through an expert group (*i.e.*, the IENK) has led to pharmacy gatekeeping mechanisms, creating procedural hurdles and thus restricting equal access to EC. These mechanisms are unique in Swiss pharmaceutical law. No other medication in the same dispensing category is accompanied by as many requirements or a standard dispensing protocol not provided for by law. What justifies the exceptional procedure preceding access to EC compared to other drugs? EC does not pose particular risks to patient safety. The paper illustrates that the exceptionalism surrounding access to EC rather stems from the drug's close connection to women's bodies and choices, revealing gender bias. Furthermore, shame - triggered through pharmacists' behavior and societal stigmatization - plays a role in restricting women's access to EC. Finally, social health insurance does not cover EC, creating financial access barriers, particularly for vulnerable women.

These access barriers reveal normative misalignments as various actors adhering to a plurality of potentially divergent normative frameworks intervene. Legal norms establish a framework focused on formal equality in access to EC, entrenched in the pillars of liberalization, individual responsibility, and the absence of social health insurance coverage. Professional norms, created by the IENK and professional self-regulation, impose extensive gatekeeping mechanisms. A perplexing contradiction exists between the liberal paradigm of individual responsibility and professional gatekeeping. Finally, societal and pharmacists' personal norms indicate intricate ambiguities about the visibility of women's sexually active behavior revealed when requesting access to EC in pharmacies.[195] Despite regulatory liberalization, the detraditionalization regarding intimacy and women's sexually active behavior is limited.[196] In addition to this plurality of entangled normative frameworks lies the hierarchical, dependent power relationship between pharmacists and women seeking access to EC. The discourse about EC abuse, construed as

increased sexual risk behavior and replacement of regular contraception through EC, reveals that providing access to EC involves disciplining women's bodies and choices.[197]

All three access hurdles for EC (professional gatekeeping, shame, finances) impose restrictions on women's sexual and reproductive rights, implying a loss of choice and control over procreation. These barriers disproportionately affect vulnerable women, such as minority and young women, and women on the financial, socio-economic, and geographic margins. These barriers threaten to broaden and accentuate existing inequities and ***192** disparities in women's sexual and reproductive health. Access to EC in Switzerland thus provides an example of how, despite formal regulatory liberalization, women's sexual and reproductive rights can be contested. It exposes multiple and intersecting layers of inequalities or intersectional inequalities.[198]

From a women's rights and health policy perspective, easy and equal access to EC is paramount. A lot remains to be done to remove access barriers for EC in Switzerland and achieve substantive equality, or, in other words, reproductive justice.[199] For now, there is circumstantial evidence of bottomup grassroots movements, through local social networks in particular, which pursue informal information sharing and circulating lists of women-friendly pharmacists.[200]

Options for regulatory action include making EC available outside pharmacies, in drugstores, supermarkets, and online pharmacies.[201] Another innovative delivery system developed on US college and university campuses is vending machines, which offer privacy, convenience, extended hours, and fixed pricing.[202] EC access in vending machines can easily be extended to other public spaces such as public transportation stations, shopping centers, and other strategic access points. As Cleland *et al*. suggest, the logistics of such a system are burdenless, as EC can be included in existing vending machines.[203] Dispensing EC outside of pharmacies would imply moving the drug from dispensing category B to D (no prescription required; dispensing in pharmacies and drugstores after specialist advice) or E (over-the-counter sale without customer advice); a regulatory decision to be made by Swissmedic.

***193** The pluralization of actors that may dispense EC can reduce the impact of specific barriers on women's sexual and reproductive choices. It prevents the realization of women's rights depending on the discretion of one category of professionals.[204] Beyond the pluralization of actors, the pluralization of physical spaces where EC can be accessed is also critical. Recent scholarship insists on the importance of remote reproductive rights.[205] Such remote rights were essential in securing access to sexual and reproductive healthcare services during the COVID-19 pandemic but are critical also beyond.[206]

Innovative drug regulation will play a critical role in the future of women's sexual and reproductive rights, particularly considering the restrictions being introduced in some states regarding other healthcare services such as clinicor hospital-based abortion.[207] Eventually, addressing existing inequalities in access to EC is not only about women's sexual and reproductive rights but also equal opportunities. The spillover effects of health inequalities affect many other areas of women's rights. Access to sexual and reproductive health services is essential for individuals to achieve full and equal participation in society.

Footnotes

a1 Melanie Levy is an assistant professor at the Faculty of Law and co-director of the Health Law Institute at the University of Neuchâtel. She is also an adjunct lecturer at the Buchmann Faculty of Law at Tel Aviv University. Her research interests lie at the intersection of law, health, technology, and society. University of Neuchâtel, Faculty of Law, Neuchâtel, Switzerland; melanie.levy@unine.ch.

1 *See* Rebecca J. Cook, Frontiers of Gender Equality: Transnational Legal Perspectives 1, 326-341 (2023); Alicia Ely Yamin, When Misfortune Becomes Injustice: Evolving Human Rights Struggles for Health and Social Equality 158-62 (2nd ed. 2023); Clare Wenham, Feminist Global Health Security 31-52 (2021); Rocío R. García, *Review of Reproductive Rights as Human Rights: Women of Color and the Fight for Reproductive Justice*, 100 Soc. Forces 1, 1-2 (2021) (reviewing Zakiya Luna, Reproductive Rights as Human Rights: Women of Color and the Fight for Reproductive Justice (2020)); Michele Goodwin, Policing the Womb: Invisible Women and the Criminalization of Motherhood 47, 105, 164-190 (2020); Martha F. Davis & Rajat Khosla, *Infertility and Human Rights: A Jurisprudential Survey*, 40 Columbia J. Gend. L. 1, 1-3 (2020); Aziza Ahmed & Terry McGovern, *Equity in Health: Sexual and Reproductive Health and Rights*, *in* Foundations of Global Health & Human Rights 307, 307-10, 313 (Lawrence O. Gostin & Benjamin Mason Meier eds., 2020); Belinda Bennett & Sara E. Davies, *Looking to the Future: Gender, Health and International Law, in* Susan Harris Rimmer & Kate Ogg, Research Handbook on Feminist Engagement with International Law 323, 323-25 (2019); Adrienne Germain, *The Global Movement for Sexual and Reproductive Health and Rights: Intellectual Underpinnings, in* Colleen O'Manique & Pieter Fourie, Global Health and Security: Critical Feminist Perspectives, 78, 78-80, 88-90 (2018); Michele Goodwin, *How the Criminalization of Pregnancy Robs Women of Reproductive Autonomy*, 47 Hastings Ctr. Rep. S19, S20 (2017); Joanna N. Erdman, *The Procedural Turn; Abortion at the European Court of Human Rights, in* Rebecca J. Cook et al., Abortion Law in Transnational Perspective: Cases and Controversies, 121, 122-28 (2014); Eric A. Friedman & Lawrence O. Gostin, *Pillars for Progress on the Right to Health, in* José M. Zuniga et al., Advancing the Human Right to Health 69, 70-83 (2013); Giuseppe Benagiano, *Reproductive Health as an Essential Human Right*, 12 Advances in Contraception 243, 244, 248-49 (1996); Gayle Binion, *Human Rights: A Feminist Perspective*, 17 Hum. Rts. Q. 509, 513-14 (1995); Carla Makhlouf Obermeyer, *A Cross-Cultural Perspective on Reproductive Rights*, 17 Hum. Rts. Q. 366, 366-67, 369-70 (1995); Charlotte Bunch, *Women's Rights as Human Rights: Toward a Re-Vision of Human Rights*, 12 Hum. Rts. Q 486, 487, 492-98 (1990).

2 Disclaimer: This paper generally refers to women's access to emergency contraception (hereafter: EC). However, it is essential to note that not all individuals seeking access to EC identify as women. I acknowledge that not all individuals who have a uterus identify as female. Persons who identify as transgender, gender nonbinary, or are on the gender spectrum can experience pregnancy and may seek contraception. The gender stereotypes and access obstacles to EC discussed in this paper have historically been applied to women who seek such access. Both the professional and the patient information accompanying EC refer to women exclusively in their written explanations--so does the standard pharmacy counseling questionnaire before administering EC in Switzerland. While not addressing the issue in this paper, I suspect that nonbinary or transgender persons who seek access to EC are subjected to similar or equally concerning obstacles, including professional gatekeeping, shaming and stigmatizing, and financial difficulties.

3 Emily Ottley et al., *Dobbs v Jackson Women's Health Organization (2022): Consequences One Year On*, Med. L. Rev. 457, 467 (2023); Alina Salganicoff & Usha Ranji, *A Focus on Contraception in the Wake of Dobbs*, 33 Womens. Health Issues 341, 343 (2023); Rachel Rebouché & Mary Ziegler, *Fracture: Abortion Law and Politics After Dobbs*, 76 SMU L. Rev. 27, 47-48 (2023);

Margaret Hamburg & Joshua Sharfstein, Editorial, *Judicial Interference With Mifepristone*, 380 Sci. 223, 223 (2023); Grace Wang, Conscientious Objection and Contraceptive Access in a Post-Roe v. Wade Illinois, (Apr. 17, 2023) (B.A thesis, University of Chicago) (https://knowledge.uchicago.edu/record/6774); Maya Manian, *The Ripple Effects of Dobbs on Health Care Beyond Wanted Abortion*, 76 SMU L. Rev. 77, 80 (2023); Owen Dyer, *Protests Flare up Across Poland as Another Pregnant Woman's Death is Blamed on Abortion Law*,381 BMJ1, 1 (2023) [hereinafter *Protests Flare*]; John Dinan, *The Constitutional Politics of Abortion Policy After Dobbs: State Courts, Constitutions, and Lawmaking*, 84 Mont. L. Rev. 27, 28-31 (2023); Daniel G. Aaron et al., Viewpoint Article, *Court Intrusion Into Science and Medicine-The Mifepristone Decisions*, 329 JAMA 1735, 1735-36 (2023); Kelly Cleland et al., *Now is The Time to Safeguard Access to Emergency Contraception as Abortion Restrictions Sweep the United States*, 114 Contraception 6, 7 (2022); Aaron Tang, *After Dobbs: History, Tradition, and the Uncertain Future of a Nationwide Abortion Ban*, 75 Stan. L. Rev. 1091, 1095-96 (2023); Sonia M. Suter, *Alito Is Wrong: We Can Assess the Impact of Dobbs, and It Is Bad for Women's Health*, 53 Seton Hall L. Rev. 1477, 1495 (2022); Elizabeth Tobin-Tyler, *Putting Your Money Where Your Mouth Is: Maternal Health Policy After Dobbs*, 53 Seton Hall L. Rev. 1577, 1583-85 (2022); Richard A. Stein et al., *Emergency Contraception: Access and Challenges at Times of Uncertainty*, 29 Am. J. Therapeutics e553, e557 (2022); Owen Dyer, *Hungary Requires Doctors to Present Women with Fetal Vital Signs Before Abortion*,378 BMJ1, 1 (2022) [hereinafter *Hungary Requires Doctors*]; Marta Bucholc, *Abortion Law and Human Rights in Poland: The Closing of the Jurisprudential Horizon*, 14 Hague J. on the Rule of L. 73, 73 (2022); Rachel Rebouché, *Remote Reproductive Rights*, 48 Am. J. L. & Med. 244, 255 (2022) [hereinafter *Remote Reproductive Rights*]; Rachel Rebouché, *Medication Abortion and the Post-Dobbs Legal Landscape*, 53 Seton Hall L. Rev. 1633, 1638 (2023) [hereinafter *Medication Abortion*]; Kornelia Zaręba et al., *Abortion in Countries with Restrictive Abortion Laws--Possible Directions and Solutions from the Perspective of Poland*, 9 Healthcare 1, 7 (2021); Clarke D. Forsythe & Donna Harrison, *State Regulation of Chemical Abortion After Dobbs*, 16 Liberty U. L. Rev. 377, 410 (2022); Julia Hussein et al., *Abortion in Poland: Politics, Progression and Regression*, 26 Reproductive Health Matters 11, 12 (2018); Camille Fischer & Jaye Kasper, *Access to Contraception*, 15 Geo. J. Gender & L. 37, 39 (2014).

4 *Cf. ‘Pendulum’ Will Swing Back, Says Supreme Court Judge,* BBC (Feb. 23, 2017), https://www.bbc.com/news/av/world-us-canada-39065541 (“Supreme Court Justice Ruth Bader Ginsburg says the US is “not experiencing the best of times” - but the “pendulum” will swing back.”).

5 The move towards more conservative regulatory approaches like restricting women's health-related human rights can be observed in a number of states, such as the USA, and parts of Eastern Europe (Poland, Hungary). *See, e.g.*, Ottley et al., *supra* note 3, at 468; Salganicoff & Ranji, *supra* note 3, at 342; Rebouché & Ziegler, *supra* note 3, at 40; Hamburg & Sharfstein, *supra* note 3, at 223; Wang, *supra* note 3, at 44-45; Manian, *supra* note 3, at 94; *Protests Flare*, *supra* note 3, at 1; Dinan, *supra* note 3, at 29-30; Aaron et al., *supra* note 3, at 1735; Cleland et al., *supra* note 3, at 7; Suter, *supra* note 3, at 1495; Tobin-Tyler, *supra* note 3, at 1583; Stein et al., *supra* note 3, at e557-60; *Hungary Requires Doctors, supra* note 3, at 1; Bucholc, *supra* note 3, at 94; Tang, *supra* note 3, at 1095; *Remote Reproductive Rights, supra* note 3, at 255; *Medication Abortion, supra* note 3, at 1638; Zaręba et al., *supra* note 3, at 7; Forsythe & Harrison, *supra* note 3, at 410; Hussein et al., *supra* note 3, at 12; Fischer & Kasper, *supra* note 3, at 39. It is relevant to note, however, that opposite normative developments are happening as well. In France, for example, the right to an abortion is in the process of being inscribed in the French Constitution. Ireland has been moved towards a more liberalized stance as well. *See* Maeve Taylor et al., *The Irish Journey: Removing the Shackles of Abortion Restrictions in Ireland*, 62 Best Prac. & Rsch. Clinical Obstetrics & Gynecology 36, 37 (2020).

6 For literature on the US context regarding access to contraception, *see* Rebouché & Ziegler, *supra* note 3, at 34-35, 65; Manian, *supra* note 3, at 81-82; Stein et al., *supra* note 3, at e554; Lewis A. Grossman, *Pushing Back with Pills - Enhancing Access to Reproductive Health Drugs after Dobbs*, 387 New Eng. J. Med. 1056, 1056-57 (2022); Forsythe & Harrison, *supra* note 3, at 379-81; Fischer & Kasper, *supra* note 3, at 45-46; Samantha Harper, ‘‘*The Morning After”: How Far Can States Go to Restrict Access to Emergency Contraception?*, 38 Colum. Hum. Rts. L. Rev. 221, 235 (2006). For Poland, *see* Daniel Boffey, *Polish Government Widely Condemned Over Morning-After Pill Law*, The Guardian (June 26, 2017, 9:47 AM), https://www.theguardian.com/world/2017/jun/26/polish-president-signs-off-widely-condemned-morning-after-pill-law.

7 Stein et al., *supra* note 3, at e554.

8 *Id.*; Kristina Gemzell-Danielsson et al., *Emergency Contraception - Mechanisms of Action*, 87 Contraception 300, 301 (2013).

9 Stein et al., *supra* note 3, at e556; Christopher ChoGlueck, *The FDA Ought to Change Plan B's Label*, 106 Contraception 6, 7 (2022); Christopher ChoGlueck, *Drug Facts, Values, and the Morning-After Pill*, 35 Public Aff. Q. 51, 54 (2021).

10 Stein et al., *supra* note 3, at e556; Gemzell-Danielsson et al., *supra* note 8, at 301.

11 *The FDA Ought to Change Plan B's Label, supra* note 9, at 7; L. L. Wynn & James Trussell, *The Social Life of Emergency Contraception in the United States: disciplining pharmaceutical use, disciplining sexuality, constructing zygotic bodies*, 20 Med. Anthropol. Q. 297, 309 (2006).

12 Stein et al., *supra* note 3, at 556; *The FDA Ought to Change Plan B's Label, supra* note 9, at 7; Cleland et al., *"It prevents a fertilized egg from attaching ... and causes a miscarriage of the baby": A Qualitative Assessment of How People Understand the Mechanism of action of Emergency Contraceptive P ills*, 103 Contraception 408, 412 (2021); Wynn & Trussell, *supra* note 11, at 301 n.7.

13 *Emergency Contraception, Fact Sheet*, World Health Org. (Nov. 9, 2021), https://www.who.int/news-room/fact-sheets/detail/emergency-contraception); Vera Halpern et al., *Repeated Use of Pre- and Postcoital Hormonal Contraception for Prevention of Pregnancy*, 9 cochrane Database Syst. Rev. 1, 1-2 (2014); Lin Zhang et al., *Pregnancy Outcome After Levonorgestrel-Only Emergency Contraception Failure: A Prospective Cohort Study*, 24 Hum. Reprod. 1605, 1605 (2009); Elizabeth G. Raymond et al., *Comprehension of a Prototype Emergency Contraception Package Label by Female Adolescents*, 79 Contraception 199, 203-04 (2009); Nancy C. Sambol et al., *Pharmacokinetics of Single-dose Levonorgestrel in Adolescents*, 74 Contraception 104, 108 (2006); Marco De Santis et al., *Failure of the Emergency Contraceptive Levonorgestrel and the Risk of Adverse Effects in Pregnancy and on Fetal Development: An Observational Cohort Study*, 84 Fertility and Sterility 296, 298 (2005); Karin Kook et al., *Pharmacokinetics of Levonorgestrel 0.75 mg Tablets*, 66 Contraception 73, 75 (2002); American College of Obstetricians and Gynecologists Committee on Practice Bulletins, *Clinical Management Guidelines for Obstetrician-Gynecologist* 37 Obstet. Gynecol. 387 (Aug. 2022); American College of Obstetricians and Gynecologists, *Thyroid Disease in Pregnancy*, 100 Obstet. Gynecol. 387, 388 (2002); D. A. Grimes et al., *Emergency Contraception Over-the-Counter: The Medical and Legal Imperatives*, 98 Obstet. Gynecol. 151, 154 (2001); Task Force on Postovulatory Methods of Fertility Regulation, *Randomized Controlled Trial of Levonorgestrel Versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency Contraception*, 352 Lancet 428, 431 (1998) [hereinafter Randomized Controlled Trial].

14 *Emergency Contraception, Fact Sheet, supra* note 13.

15 Fabienne Riklin, *Folge der natürlichen Verhütung: Jedes Jahr über Pillen danach verschrieben* [*Over 100,000 morning after pills are sold every year*], Argovia Today (Aug. 21, 2022, 7:00 PM), https://www.argoviatoday.ch/schweiz/folge-der-natuerlichen-verhuetung-jedes-jahr-ueber-100000-pillen-danach-verschrieben.

16 Yara Barrense-Dias et al., *From Request to Dispensation: How Adolescent and Young Adult Females Experience Access to Emergency Contraception in Pharmacies*, 27 Eur. J. Contraception Reprod. Health Care 403 (2022); *see generally*, Claudia Blumer, *#Jeden Sonntag holen sich 35 Frauen die <Pille danach># ["Every Sunday, 35 women take the morning-after pill"],* 20 Minutes (Feb. 17, 2023), https://www.20min.ch/story/jeden-sonntag-holen-sich-35-frauen-die-pille-danach; Christina Pirskanen & Claudia Blumer, *#Den Frauen wird nicht genügend Vertrauen entgegengebracht# ['Women are not given enough trust'],* 20 Minutes (Feb. 17, 2023), https://www.20min.ch/story/sp-funiciello-und-pharma-wollen-dass-frauen-leichter-an-pille-danach-kommen; Fairy Anabelle Riebeling, *No, the morning after pill does not make you infertile,* 20 Minutes (Feb. 18, 2023), https://www.20min.ch/story/nein-die-pille-danach-macht-nicht-unfruchtbar; Pirskanen & Blumber, *#Die Apothekerin warf mir vor, ein Geschenk Gottes zu vernichten# ["The pharmacist accused me of destroying a gift from God"],*20 Minutes (Feb. 17, 2023) https://www.20min.ch/story/die-apothekerin-sagte-ich-wuerde-ein-geschenk-gottes-vernichten-425714081710; *La contraception d'urgence, une "marche de la honte" pour certaines femmes,* L'Info (Feb. 20, 2021), https://www.rts.ch/info/suisse/11987873-la-contraception-durgence-une-marche-de-la-honte-pour-certaines-femmes.html; Nadine Nikles, *Morning after pill: condemned and patronized in the pharmacy,* SRF (Aug. 10, 2018), www.srf.ch/radio-srf-virus/kompass/kompass-pille-danach-verurteilt-und-bevormundet-in-der-apotheke; *The*

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18 Manuela Farris et al., *Attitudes of women and pharmacists on the opportunity to obtain a progestogen-only pill over the counter - Italian outcomes*, 39 Gynecol. Endocrinol., 14 (2023); Emilio Arisi et al., *The views of women and pharmacists on the desirability of a progestogen-only pill over the counter. Results of a survey in Germany, Italy and Spain*, 27 Eur. J. Contracept. & Reprod. Health Care 494, 502 (2022); L. Cantarero Arevalo & E. Merchant, “*Little girl, where do you think you go with this method?”: shame and use of emergency contraception*, 30 Eur. J. of Pub. Health 1, 1 (2020); Rachael Eastham et al., *Qualitative findings about stigma as a barrier to contraception use: the case of Emergency Hormonal Contraception in Britain and implications for future contraceptive interventions*, 25 Eur. J. Contracept. & Reprod. Health Care 334, 337 (2020); Clare Murphy & Verity Pooke, *Emergency contraception in the UK: stigma as a key ingredient of a fundamental women's healthcare product*, 27 Sex. Reprod. & Health Matters 1, 2-3 (2019); Julia Hussein & Laura Ferguson, *Eliminating stigma and discrimination in sexual and reproductive health care: a public health imperative*, 27 Sex. Reprod. Health Matters 1, 4 (2019); Debbie Fallon, ‘*They're Gonna Think it Now’: Narratives of Shame in the Sexual Health Experiences of Young People*, 47 Socio 318, 321 (2012).

19 Switzerland has ratified the ICCPR, the ICESCR and the CEDAW. The Swiss Federal Constitution guarantees equal and non-discriminatory access to healthcare (art. 8), even though there is no explicit right to health--or healthcare for that matter--recognized within its legal framework. *See* Anne-Sylvie Dupont et al., Service de recher du Parlement européen, Le droit a la sante, une perspective de droit compare, SuisseE 1, 15 (Ignacio Díez Parra, 2022).

20 Christopher ChoGlueck, *Imposing Values and Enforcing Gender through Knowledge: Epistemic Oppression with the Morning-after Pill's Drug Label*, 37 Hypatia 315, 319 (2022); Wynn & Trussell, *supra* note 11, at 314.

21 Marco Evola et al., *Human Rights Law Through the Lens of the Gender Perspective, in* 1 Gender-Competent Legal Educ. 217, 248 (2023); Lucía Berro Pizzarossa, *Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law*, 7 Laws 1, 1 (2018).

22 Stein et al., *supra* note 3, at 556; *Imposing Values and Enforcing Gender through Knowledge: Epistemic Oppression with the Morning-after Pill's Drug Label*, *supra* note 20, at 325.

23 *Cf. Emergency Contraception in Europe: Switzwerald,* Eur. Consortium for Emergency Contraception (Mar. 2023), https://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information/switzerland/ (Different companies sell these two types of oral hormonal EC in Switzerland: Levonorgestrel (Levonorgestrel Sandoz®; Levonesse®; NorLevo®, Generika)); Ulipristalacetat (ellaOne®).

24 According to the WHO, essential medicines refer to medications meeting the primary healthcare requirements of a population. These drugs are carefully chosen, taking into consideration disease prevalence, their significance to public health, proven effectiveness, safety, and cost-effectiveness compared to alternatives. The aim is to ensure their constant availability within well-functioning health systems, offering suitable dosage forms, guaranteed quality, and affordability for both individuals and healthcare providers. *Cf.* World Health Org, WHO Model List of Essential Medicine 22nd List 1**,** 48-49 (2021).

25 Yara Barrense-Dias et al., *supra* note 16, at 403 (This regime still applies for regular hormonal contraception, which is designated as part of drug category B. Regular hormonal contraception cannot in principle be bought in Switzerland without a medical prescription); *Cf.* Tamara Yous et al., *Physicians' Opinion Regarding Extended Access to Hormonal Contraception in Switzerland*, 9 Pharmacy 1, 2 (2021); Tamara Yous, *Extended Access to Hormonal Contraception in Pharmacies: A Survey among Swiss Pharmacists*, 8 Pharmacy 1, 2 (2020).

26 While drug market authorization was a cantonal competence for a long time, the Federal Drug Agency Swissmedic is responsible for the entire Swiss market since 2002. Swissmedic decides whether or not to grant marketing authorization for a medicinal product after examining the application file. It specifies the indication for which the drug is authorized on the market, its dosage, the duration of the treatment, the patients concerned, etc. Swissmedic also specifies the dispensing category of the medicine (prescription drug or not, most importantly). Market authorization information is also part of the professional information available for healthcare professionals. *See* Art. 23 and 23a Federal Drug Act on Medicinal Products and Medical Devices (Therapeutic Products Act, TPA), Dec. 15, 2000, SR 812.21, art. 23, art. 23a (Switz.).

27 Barrense-Dias et al., *supra* note 16, at 403. (In 2002, another regulatory change towards liberalization in the context of women's sexual and reproductive rights occurred. Access to abortion was partially decriminalized, through the introduction of the first-trimester rule. Since 2002, abortion is not punishable if a woman demands the abortion in writing within twelve weeks of the start of her last period and can claim a situation of distress).

28 Over-the-counter medicines (OTC) may be dispensed in normal retail outlets (*e.g.*, in grocery stores or supermarkets, but also in pharmacies), without a doctor or pharmacist having to be involved. Behind-the-counter medicines (BTC) are available from pharmacies: Although no prescription is required, the product may only be sold in a pharmacy over the counter by a pharmacist. Prescription-drugs: A drug that requires a prescription from a doctor, to be presented at the pharmacy, unless the drug is administered directly by a clinic.

29 Barrense-Dias et al., *supra* note 16, at 405.

30 For EC with ulipristal acetate, Swissmedic's decision to re-classify the drug from prescription to nonprescription status followed a similar decision by the European Commission, based on the advice of the European Medicine Agency. In the context of the EU, this was the first-ever decision of its type regarding any oral contraceptive product to be made available without prescription in all EU member states. *Cf. Emergency Contraception Availability in Europe,* Eur. Consortium For Emergency Contraception (Feb. 2022), https://www.ec-ec.org/emergency-contraception-in.

31 Ordonnance sur les médicaments (OMéd) [Ordinance on Medicinal Products], Sept. 21, 2018, SR 812.212.21, art. 45, ¶ 1 (Switz.); *Cf. Reclassification des médicaments de la catégorie de remise C: fin de l'évaluation [Reclassification of medications from dispensing category C: end of the evaluation]*, SwissMedic (Nov. 16, 2018), https://www.swissmedic.ch/swissmedic/fr/home/news/mitteilungen/hmg2-umteilung-arzneimittel-abgabekategorie; *Révision du droit sur les produits thérapeutiques - Liste des médicaments de la catégorie C reclassés dans la catégorie [Revision of the law on therapeutic products - List of category C medications reclassified into category B]*, SwissMedic (June 14, 2019), https://www.swissmedic.ch/swissmedic/fr/home/news/mitteilungen/liste_abgabekategorie_c_abgabeka-tegorie_bumgeteilten_am; *Remise simplifiée de médicaments de la liste B [Simplified delivery of drugs from list B]*, Fed. Office Public Health OFSP (May 31, 2023), https://www.bag.ad-min.ch/bag/fr/home/medizin-und-forschung/heilmittel/abgabe-von-arzneimitteln.html.

32 This was likely the main driver for the pharmaceutical companies to take this re-classification to court.

33 *Decision C-3188/2019 dated 19 December 2022*, WalderWyss (Jan. 20, 2023), https://www.walderwyss.com/de/news/2023-01-20_decision-c-3188-2019-dated-19-december-2022.

34 *Cf.* Alexandra Fitz, *Pille danach jetzt ganz ohne Rezept - werden Frauen jetzt leichtsinnig?* [*Morningafter pill now without a prescription - are women now becoming careless?*], TaggBlatt (Feb. 17, 2016), https://www.tagblatt.ch/leben/gesundheit/pille-danach-jetzt-ganz-ohne-rezept-werden-frauen-jetzt-leichtsinnig. For similar rhetoric *see, e.g.*, Murphy & Pooke, *supra* note 18; Paul Bissell & Claire Anderson, *Supplying emergency contraception via community pharmacies in the UK: reflections on the experiences of users and providers*, 57 Soc. Sci. Med. 2367 (2003).

35 Stein et al., *supra* note 3, at 560.

36 *Cf.* Alexandra Fitz, *supra* note 34.

37 Isabelle Arnet et al., *Emergency hormonal contraception in Switzerland: a comparison of the user profile before and three years after deregulation*, 14 Eur. J. of Contraception & Reprod. Health Care 349, 353 (2009); *see also* Eleftherios P. Samartzis et al., *Six years after deregulation of emergency contraception in Switzerland: has free access induced changes in the profile of clients attending an emergency pharmacy in Zürich?*, 17 Eur. J. of Contraception & Reprod. Health Care 197, 202 (2012) (The fears regarding increased risky sexual behaviors among young women and increased frequencies of STDs has been refuted elsewhere too.); *see also* Kristin O. Haeger et al., *State of emergency contraception in the U.S., 2018*, 3 Contraception & Reprod. Med. 6, https://rdcu.be/dDQGk (2018); ST Cameron et al., *Current controversies with oral emergency contraception*, 124 BJOG 1948, 1953 (2017); Petra M. Sander et al.,, *Emergency contraceptive use as a marker of future risky sex, pregnancy, and sexually transmitted infection*, 201 Am. J. Obstet. Gynecol. 1, 2 (2009). The fears regarding increased risky sexual behaviors among young women and increased frequencies of STDs has been refuted elsewhere too. *See* Kristin O. Haeger, Jacqueline Lamme & Kelly Cleland, *State of emergency contraception in the U.S., 2018*, 3 Contraception & Reprod. Med. 20 (2018); S. T. Cameron, Hwr Li & K. Gemzell-Danielsson, *Current controversies with oral emergency contraception*, 124 BJOG 1948 (2017); Petra M. Sander, Elizabeth G. Raymond & Mark A. Weaver, *Emergency contraceptive use as a marker of future risky sex, pregnancy, and sexually transmitted infection*, 201 Am. J. Obstet. Gynecol. 1, 2 (2009).

38 According to the Executive Order on Advertisement for Medicines, the advertising of non-prescription medicines, which nevertheless require advice from a person exercising a medical profession (category C), was in itself permitted. Today, such an advertising campaign would not be possible anymore, since Swissmedic re-classified EC drugs from category C to B, for which any type of advertisement is prohibited.

39 *Cf.* B. Zanni, *Pilule du lendemain: la pub dans les discos fâche [Morning after pill: advertising in discos is annoying]*, 20 Minutes (Jan. 24, 2017), https://www.20min.ch/fr/story/pilule-du-lendemain-la-pub-dans-les-discos-fache; *Pharmafirmen würden die Pille danach am liebsten wie Kaugummi am Kiosk verkaufen [Pharmaceutical companies would prefer to sell the morning-after pill like chewing gum at a kiosk]*, Watson (Sep. 25, 2017), watson.ch/schweiz/interview/424838391-pharmafirmen-wuerden-die-pille-danach-am-liebsten-wie-kaugummis-am-kiosk-verkaufen.

40 *Cf.* Riklin, *supra* note 15.

41 *Cf. 25 Jahre Viagra: Wie 1998 in der Schweiz über die Wunderpille berichtet wurde [25 years of Viagra: How the miracle pill was reported in Switzerland in 1998], supra* note 17.

42 *Cf.* Vazquez, *supra* note 17; Keusch, *supra* note 17.

43 Yara Barrense-Dias et al., *Remise de la contraception d'urgence en pharmacie: une étude qualitative sur l'expérience des clients*, Lausanne, Unisante - University Centre for General Medicine and Public Health (2020) https://serval.unil.ch/resource/serval:BIB_9D5FB3D7E904.P001/REF.pdf [*Dispensing emergency contraception in pharmacies: a qualitative study on customer experience*].

44 Jessica Dacey, *Morning-after pill highlights education needs*, Swiss Info (Mar. 26, 2009), https://www.swissinfo.ch/eng/morning-after-pill-highlights-education-needs/1001988.

45 Riklin, *supra* note 15.

46 Salvatore Italia, Peter Schröder-Bäck & Helmut Brand, *Switching emergency contraceptives to nonprescription status and unwanted pregnancy among adult and teenage women: A long-term European comparative study*, SEEJPH (Jan. 2020), at 12, https://www.biejournals.de/index.php/seejph/article/view/3277/33632023), (last visited Apr. 6, 2024).

47 Interestingly, the historical drug development trajectory of EC was not pursued based on the idea of EC as a “back-up only” method. Historically, EC was designed “as an additional method for women having sporadic sex to take as a matter of choice rather than need”. This is also how the drug was initially marketed in a number of European states: “Offering a postcoital option for women to keep at home and use when they choose to, differs drastically from the framing around EHC today.” *See* Murphy & Pooke, *supra* note 18.

48 Samartzis et al., *supra* note 37; Arnet et al., *supra* note 37.

49 *Id*.

50 Riklin, *supra* note 15.

51 When the pill was approved in Switzerland more than 60 years ago, it was considered a sexual revolution. However, young women today increasingly consider the pill dangerous to their health because of headlines about cases of thrombosis and strokes. The sales figures for the pill have declined significantly in recent years. In the last, few years, sales in Switzerland have dropped by 30 percent. *Id*.

52 *Id*.

53 *See* Katrina Kimport, *More than a Physical Burden: Women's Emotional and Mental Work in Preventing Pregnancy*, 55 J. Sex Rsch. 1, 10.

54 *Cf*. Fitz, *supra* note 34. *See also* Bissell & Anderson, *supra* note 34; Murphy & Pooke, *supra* note 18.

55 Tribunal administratif fédéral [TAF] [Federal Administrative Court] Dec. 19, 2020, C-3188/2019, at 32 (Switz.) (translation by the author).

56 Bundesverwaltungsgericht [BVGE] [Federal Administrative Court] Dec. 19, 2022, C-3189/2019, C-3190/2019, at 36 (Switz.) (translation by the author). 19, 2022,

57 Arnet et al., *supra* note 37, at 354; *see also* Samartzis et al., *supra* note 37, at 202.

58 *See* European Consortium for Emergency Contraception, *Switzerland*, (Mar. 2023), https://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-info/switzerland/.

59 *See* Murphy & Pooke, *supra* note 18, at 2-3 (showing the same reality in the UK).

60 *25 Jahre Viagra: Wie 1998 in der Schweiz über die Wunderpille berichtet wurde* [*25 years of Viagra: How the miracle pill was reported in Switzerland in 1998]*, *supra* note 17; Keusch, *supra* note 17; Vazquez, *supra* note 17.

61 Yous et al., *supra* note 25, at 2.

62 *Dispensing emergency contraception in pharmacies: a qualitative study on customer experience, supra* note 43.

63 *Id*.

64 Loi sur les professions médicales [LPMéd] [Medical Professions Act] June 23, 2006, SR 811.11, art. 1, ¶ 1 (Switz.).

65 Loi sur les produits thérapeutiques [LPTh] [Therpeutic Products Act] Dec. 15, 2000, SR 812.21, art. 9, ¶ 1 (Switz.).

66 LPTh art. 24; Ordonnance sur les medicaments [OMéd] [Medical Ordinance] Sept. 21, 2018, art. 47.

67 LPth art. 24,; OMéd, art. 48.

68 LPTh art. 24; OMéd art. 45, 50 (family planning services).

69 Professional information on drugs with market authorization in Switzerland can be found here: https://compendium.ch/de; https://www.swissmedicinfo.ch/.

70 Schweizerisches Strafgesetzbuch [STGB] [Criminal Code] art. 321 (Switz.) (law stating that pharmacists are bound by professional secrecy).

71 *Cf. Networking work*, Sante Sexuelle, https://www.sante-sexuelle.ch/nos-activites/travail-de-re-seautage-ienk-groupe-interdisciplinaire-d-expert-es-en-contraception-d-urgence (Last visited Apr. 6, 2024).

72 *Id*.

73 *Id*.

74 *Id*.

75 *Cf.* Spinatsch et al., *Contraception d'urgence: Recommendations du groupe IENK pur la remise du levonorgestrel et de l'ulipristal*, IENK (Jun. 2020), https://www.ec-ec.org/wp-content/up-loads/2020/08/IENK-Recommandations-2020-French.pdf. From the latest IENK document of 2020: “*Framework conditions concerning the rules of good practice for issuing CEs in pharmacies: Separate advice area; If the woman is accompanied (friend, relative, etc.), it is up to her alone to decide whether the presence of this person is required in the listening space; Transparent communication of the price of the service before the consultation; Inform about the procedure, data protection and the need to register personal data when issuing the UC (medicines subject to documentation); Evaluator of the ability to discern; Provide oral and written information on adverse effects of EC as well as contraceptive measures following intake of EC; If desired, provide oral and written information on other sexual health topics (contraception, preventive gynecological examinations, STDs, etc.”* (translation by the author).

76 *Id*.

77 *See Id*.

78 *Id*.

79 Eliza Morgan et. al., *Should emergency contraception be a general sales medicine?* 47 BMJ Sex Reprod, Health 67 (2021).

80 *Cf. Dispensing protocol for oral emergency contraception*, IENK (Jan. 2021), https://www.imail-offi-zin.ch/storage/.

81 *See* Barrense-Dias et al., *supra* note 16. Despite the absence of health insurance coverage, pharmacists might still ask for the woman's health insurance card to swipe it and keep her contact details. This creates a significant privacy issue, in particular, if the health insurance company then sends a written confirmation of the pharmacy visit to the woman's postal address (*e.g.*, in the case of a minor and a letter being opened by the parents).

82 *Dispensing protocol for oral emergency contraception, supra* note 80.

83 *Cf. Id*.

84 *Id.; see also* Barrense-Dias et al., *supra* note 16, at 403; Melanie Haag et al., *Do Swiss Community Pharmacists Address the Risk of Sexually Transmitted Infections During a Consultation on Emergency Contraception? A Simulated Patient Study,* 24 Eur. J. Contraception & Contracept. Reprod. Health Care 407, 407 (2019).

85 Barrense-Dias et al., *supra* note 16, at 403.

86 World Health Organization, *supra* note 24, at 49; Halpern et al., *supra* note 13, at 1-2; Gabriela Noé et al., *Contaceptive efficacy of emergency contraception with levonorgestrel given before or after* ovulation, 84 Contraception 486 (2011); Zhang et al., *supra* note 13, at 1605; Raymond et al., *supra* note 13, at 199; Sambol et al., *supra* note 13, at 104; De Santis et al., *supra* note 13, at 296; Kook et al., *supra* note 13, at 75; Sander et al., *supra* note 37, at 1; Grimes et al., *supra* note 13, at 151; *Randomised Controlled Trial, supra* note 13, at 428.

87 Tribunal administratif fédéral [TAF] [Federal Administrative Court] Dec. 19, 2020, C-3188/2019 (Switz.); Bundesverwaltungsgericht [BVGE] [Federal Administrative Court] Dec. 19, 2022, C-3189/2019, C-3190/2019 (Switz.) (translation by the author).

88 *Id*.

89 *See SAI - Legal mandate of the Refdata Foundation*, refdata, https://sai.refdata.ch/home/legalman-date; *NORLEVO Tabl 1.5 mg*, refdata (Jul. 3, 2023), https://sai.refdata.ch/detail/46694; *POSTINOR Tabl 1.5 mg*, refdata (Jan. 1, 2023), https://sai.refdata.ch/detail/31168; *LEVONORGESTREL Sandoz Tabl 1.5 mg*, refdata (Jan. 1, 2023), https://sai.refdata.ch/detail/19503; *LEVONESSE Tabl 1.5 mg*, refdata (Sept. 1, 2023), https://sai.refdata.ch/detail/26718; *ELLAONE Filmtabl 30 mg*, refdata (Jul. 3, 2023), https://sai.refdata.ch/detail/46693; *ULLANESSE Filmtabl 30 mg*, refdata (June 29, 2023), https://sai.refdata.ch/detail/59563 (the professional and patient information published in the official online database of all drugs with market authorization in Switzerland).

90 Yara Barrense-Dias et al., *supra* note 16, at 403.

91 *Cf.* PharmaSuisse & IENK, *Commentaires sur le protocole pour la remise de la contraception d'urgence orale [Comments on the Protocol for Providing Oral Emergency Contraception],* Sante Sexuelle Suisse*]* (Nov. 2022), https://www.sante-sexuelle.ch/assets/docs/2022_Commentaires-sur-le-protocole-pour-la-remise.pdf.

92 *Cf. Id*.

93 *See, e.g.,* Tribunal fédéral [TF] [Federal Supreme Court] Apr. 2, 2008, 134 Arrêts du Tribunal fédéral suisse [ATF] II 235 (Switz.).

94 Tribunal cantonal de l'Etat de Fribourg [Cantonal Court of the State of Fribourg], IIIe Cour administrative [Third Administrative Court] Jul. 29, 2021 (603 2021 102 / 603 2021 114) (Switz.).

95 *See, e.g.,* TF Apr. 2, 2008, 134 ATF II 235 (Switz.).

96 The hospital setting implies extra administrative burdens and paperwork that might reach the parents.

97 Schweizerisches Strafgesetzbuch [StGB] [Swiss Criminal Code] Dec. 21, 1937, art. 321, ¶ 1 (Based on art. 321 of the Swiss Criminal Code, pharmacists are liable to prosecution if they inform the parents of the minor who has decision-making capacity about the content of the treatment contract without her consent.).

98 *Cf.,* Eur. Parliamentary F. for Sexual & Reprod. Rts. Europe 2 (2023).

99 In a stark contrast, abortion is fully covered through social health insurance.

100 *Dispensing emergency contraception in pharmacies: a qualitative study on customer experience, supra* note 43.

101 *Id*.

102 *Id*. at 50.

103 *Id*. at 47.

104 *See* Murphy & Pooke, *supra* note 18, at 1 (On the issue of EC pricing as an access obstacle in the UK); Stein et al., *supra* note 3, at 557-58 (For the USA); Kelly Cleland et al., *Access to Emergency Contraception in the Over-the-Counter Era*, 26 Women's Health Issues 622, 622 (2016).

105 *Cf.* Stump Doris, *Means of contraception for young people and people in precarious situations*, The Federal Assembly--The Swiss Parliament (Dec. 17, 2021), https://www.parlament.ch/fr/ratsbe-trieb/suche-curia-vista/geschaeft.

106 *Dispensing emergency contraception in pharmacies: a qualitative study on customer experience, supra* note 43; Pirskanen & Blumer, *supra* note 16; Blumer, *supra* note 16; Pirskanen & Blumber, *[“Gift from God”] surpa*, note 16; Riebeling, *supra* note 16; Sophie Davaris, *Morning-after pill: “The pharmacist must avoid any moralizing reflection* TDG (Jun. 10, 2016), www.tdg.ch/geneve/actu-genevoise/pil-ule-lendemain-pharmacien-doit-eviter-reflexion-morali-sante/story/18663642www.rts.ch/info/suisse/11987873-la-contraception-durgence-une-marche-de-la-honte-pour-certaines-femmes.html;

La contraception d'urgence, une “marche de la honte” pour certaines femmes [Emergency contraception, a “walk of shame” for some women], *supra* note 16; Nikles, *supra* note 15.

107 Farris et al., *supra* note 18; Arisi et al., *supra* note 18, at 496; Arevalo & Merchant, *supra* note 18, at 824; Eastham et al., *supra* note 18, at 334; Murphy & Pooke, *supra* note 18, at 3; Hussein & Ferguson, *supra* note 18, at 3; Fallon, *supra* note 18, at 326.

108 Stephanie Meier et al., *Messaging and access strategies for improving emergency contraceptive knowledge and uptake among Italians*, 27 Eur. J. Contraception & Reprod. Health Care, 166, 170 (2022).

109 Farris et al., *supra* note 18; Yara Barrense-Dias et al., *supra* note 16; Arisi et al., *supra* note 18, at 501; Eastham et al., *supra* note 18, at 334; Murphy & Pooke, *supra* note 18, at 3; Hussein & Ferguson, *supra* note 18, at 3; Fallon, *supra* note 18, at 326.

110 *Id*.

111 *La contraception d'urgence,* -durgence-*une “-marche-de-la-honte”-pour-certaines-femmes* [Emergency contraception, a “walk of shame” for some women], *supra* note 106.

112 Fallon, *supra* note 18, at 327.

113 Barrense-Dias et al., *supra* note 16; Arisi et al., *supra* note 18, at 501; Eastham et al., *supra* note 18, at 335-36; Arevalo & Merchant, *supra* note 18; Murphy & Pooke, *supra* note 18, at 2; Hussein & Ferguson, *supra* note 18 at 2; Fallon, *supra* note 18, at 326-27.

114 Barrense-Dias et al., *supra* note 16, at 38-39.

115 *Id*.; Arevalo & Merchant, *supra* note 18; Murphy and Pooke, *supra* note 18, at 2; Hussein and Ferguson, *supra* note 18, at 2; Fallon, *supra* note 18, at 327.

116 Farris et al., *supra* note 18, at 3, 8; Barrense-Dias et al., *supra* note 16, at 39; Arisi et al., *supra* note 18, at 501; Eastham, et al., *supra* note 18; Arevalo & Merchant, *supra* note 18; Fallon, *supra* note 18.

117 Eastham et al., *supra* note 18, at 335-36; Fallon, *supra* note 18, at 329.

118 *Id*.

119 *See, e.g*. Diana Duong, *Does Shaming Have a Place in Public Health?*, 193 Can. Med. Ass'n J. E59, E59-60 (2021); Alexandra Brewis & Amber Wutich, *Why We Should Never Do It: Stigma as a Behaviour Change tool in Global Health*, BMJ Glob. Health 1, 1-2 (2019); Luna Dolezal & Barry Lyons, *Health-Related Shame: An Affective Determinant of Health?*, 43 Med. Humanities 257, 258 (2017).

120 Barrense-Dias et al., *supra* note 16; Emanuela Ceva & Sofia Moratti, *Whose Self-Determination? Determination Barriers to Access to Emergency Hormonal Contraception in Italy*, 23 Kennedy Inst. Ethics J. 139, 147 (2013); Fallon, *supra* note 18, at 322, 327.

121 Valentina Chiofalo & Marlene Wagner, *Der Schwangerschaftsabbruch in Deutschland und der Schweiz:* Cognitio 1, 22 (2022). For abortion, regional differences indicates that “‘gynecological tourism”’ is still being practiced from conservative to liberal cantons.”

122 Barrense-Dias et al., *supra* note 16.

123 Chiofalo & Wagner, *supra* note 121, at 22.

124 Carol Hanisch, *The Personal is Political, in* Feminist Revolution 204 (Kathie Sarachild et al. eds., 1976). For a detailed analysis, see Renee Heberle, *The Personal Is Political, in* The Oxford Handbook of Feminist Theory (Lisa Disch & Mary Hawkesworth eds., 2018).

125 Ruth Rosen, The World Split Open: How the Modern Women's Movement Changed America 196 (2000); *see also* Simone de Beauvoir, The Second Sex: The Classic Manifesto of the Liberated Woman 272-290 (2011).

126 Clare Bambra et. al, *The Unequal Pandemic COVID-19 and Health Inequalities,* Policy Press 5, 18(2021).

127 Theresa Man Ling Lee, *Rethinking the Personal and the Political: Feminist Activism and Civic Engagement*, 22 Hypatia 163, 166165 (2007).

128 Rose Weitz, *A History of Women's Bodies*, *in* The Politics of Women's Bodies: Sexuality, Appearance, and Behavior 8 (Rose Weitz & Samantha Kwan eds., 2003); *see also* Joan B. Landes, Feminism, the Public and the Private (1998).

129 *Policing the Womb, supra* note 1, at 47; Wynn & Trussell, *supra* note 11, at 298; Christy A. Sherman, *Emergency contraception: The Politics of Post-Coital Contraception*, 61 J. Soc. Issues 139, 139 (2005). There is extensive literature on the politics of birth control and abortion. *See e.g.* Rachel VanSickleWard & Kevin Wallsten, The Politics of the Pill: Gender, Framing, and Policymaking in the Battle Over Birth Control (2019); Betsy Hartmann, Reproductive Rights and Wrongs: The Global Politics of Population Control (2016); Elizabeth C. Newnham, *Birth control: Power/Knowledge in the Politics of Birth*, 23 Health Sociol. Rev. 254, (2014); Donald T. Critchlow, Politics of Abortion and Birth Control in Historical Perspective (2010).

130 Linda Gordon, *The Politics of Birth Control, 1920-1940: The Impact of Professionals, in* Women and Health: The Politics of Sex in Medicine 151, 154 (Elizabeth Fee ed., 2019); Karen B. Farris et al., *Preventing Unintended Pregnancy: Pharmacists' Roles in Practice and Policy Via Partnerships*, 50 J. Am. Pharm. Assoc. 604, 604-05 (2010); Wynn & Trussell, *supra* note 11 at 312; Judith A. Soon et al., *The Developing Role of Pharmacists in Patient Access to Emergency Contraception*, 10 Disease Mgmt. & Health Outcomes 601, 603 (2002).

131 Gordon, *supra* note 130, at 151; Farris et al., *supra* note 18, at 604; Wynn & Trussell, *supra* note 11, at 310; Soon et al., *supra* note 130, at 601.

132 Lee, *supra* note 127, at 163.

133 Martha Bailey, *Equal Opportunities Begin With Contraception*, 588 Nature S177 (2020).

134 Ruth Colker, *Uninformed Consent*, 101 Bos. Univ. L. Rev. 431, 485 (2021); Wynn and Trussell, *supra* note 11, at 302.

135 *Dobbs v. Jackson Women's Health Org.*, 597 U.S. (2022).

136 Wynn and Trussell, *supra* note 11, at 302.

137 Jay Katz, The Silent World of Doctor and Patient 130, 1-47 (2002).

138 *Id*.

139 *Id*.

140 Wynn & Trussell, *supra* note 11.

141 Amanda J. Grigg & Anna Kirkland, *Divergent Disciplinary Roots for Feminist Thought About Health, in* The Oxford Handbook of Feminist Theory (Lisa Disch & Mary Hawkesworth eds., 2018).

142 Ceva & Moratti, *supra* note 120, at 161.

143 *Id*.

144 A similar framework has been used to describe the situation in the USA. *See* Wynn & Trussell, *supra* note 11, at 298.259.

145 *Drug Facts, Values, and the Morning-After Pill*, *supra* note 9, at 60.

146 Lianne Gonsalves & Michelle J. Hindin, *Pharmacy Provision of Sexual and Reproductive Health Commodities to Young People: a systematic literature review and Synthesis of the Evidence*, 95 Contraception 339, 359 (2017).

147 *Switzerland*, European Consortium for Emergency Contraception, https://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information/switzerland/ (last visited Apr. 4, 2024). EC can also be dispensed by family planning centers and hospitals. Access to these two options is less straightforward than for pharmacies. *See e.g.*, *Emergency Contraception in New York, NY*, Planned Parenthood, https://www.plannedparenthood.org/health-center/new-york/new-york/10012/manhattan-health-center-3325-91110/emergency-contraception (last visited Jan. 19, 2024).

148 Mark Campbell, *Conscientious Objection, Health Care and Article 9 of the European Convention on Human Rights*, 11 Med. L. Int. 284, 285 (2011).

149 Wendy Chavkin et al., *Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study*, 19 Health & Hum. Rights J. 55, 61 (2017); Wendy Chavkin, *Conscientious Objection to the Provision of Reproductive Healthcare*, 123 Suppl 3 Int. J. Gynaecol. Obstet. S39 (2013); Tom Goffin, *The Physician's Right to Conscientious Objection: An Evolving Recognition in Europe*, 29 Med. L. 227, 228 (2010).

150 Conscientious objection of pharmacists is based predominantly on the scientifically erroneous argument that EC prevents implementation after conception, as opposed to the scientific fact of delaying ovulation. For relevant papers in the medical and philosophical literature, *see* Corrado del Bò, *Conscientious Objection and the Morning-After Pill*, 29 J. Appl. Phil. 133, 134 (2012); J. P. Kelleher, *Emergency Contraception and Conscientious Objection*, 27 J. Appl. Phil. 290, 290 (2010); Eva LaFollette & Hugh LaFollette, *Private Conscience, Public Arts*, 33 J. Med. Ethics 249, 249 (2007); R. Alto Charo, *Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience*, Adv. Eng. Educ. 119, 119 (2007); Mark R. Wicclair, *Pharmacies, Pharmacists, and Conscientious Objection*, 16 Kennedy Inst. Ethics J. 225, 226 (2006); Julie Cantor & Ken Baum, *The Limits of Conscientious Objection--May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 N. Engl. J. Med. 2008, 2008 (2004). For the U.S. context, *see* Wang, *supra* note 3, at 5; Jonathan F. Will, *Conscience Legislation, the Personhood Movement, and Access to Emergency Contraception*, 4 Falkner L. Rev. 411, 411 (2015); Lynne Marie Kohm, *From Eisenstadt to Plan B: A*

Discussion of Conscientious Objections to Emergency Contraception, 33 Wm. Mitchell L. Rev. 787, 797 (2006). For Poland, *see* Barbara Marlewska, *Ella One et l'objection de conscience des pharmaciens: des perspectives polonaises*, Revue Generale de Droit Medical 215, 215 (2016), https://www.bnds.fr/edition-numerique/re-vue/rgdm/panorama-de-droit-pharmaceutique-2015/ellaone-et-l-objection-de-conscience-des-pharma-ciens-des-perspectives-polonaises-6103.html (last visited Jan. 19, 2024).

151 *European Court of Human Rights, Reports of Judgments and Decisions (Eur. Ct. H.R.)*, Decision *Pichon and Sajous v. France* No. 49853/99),) (Oct. 2, 2001), https://hudoc.echr.coe.int/eng. For further details, *see* Campbell, *supra* note 148, at 288-95; Goffin, *supra* note 149, at 233-36; Adriana Lamacková, *Conscientious Objection in Reproductive Health Care: Analysis of Pichon and Sajous v. France*, 15 Eur. J. Health L. 7, 7-9, 16-36 (2008).

152 June 25, 2015 B.O.E., No. 412-2012, (Spain), http://www.tribunalconstitucional.es/es/salaPrensa/Documents/NP_2015_052/2012-00412STC.pdf. For a detailed discussion, *see* G. Rousset & A. L. de la Osa Escribano, *Objection de Conscience et Médicament en Droit Franco-Espagnol: Utiles éclaircissements du Tribunal Constitutionnel Espagnol*, 69 Rev. Int. Droit Comp. 407 (2017).

153 Stein et al., *supra* note 3, at e557; Chelsey Yang, *The Inequity of Conscientious Objection: Refusal of Emergency Contraception*, 27 Nursing Ethics 1408, 1409-10, 1413-15 (2020); Christian Fiala & Joyce H. Arthur, *“Dishonourable Disobedience” - Why Refusal to Treat in Reproductive Healthcare is Not Conscientious Objection*, 1 Woman - Psychosomatic Gynaecol. Obstetrics 12, 13, 15-19 (2014).

154 International human rights treaties such as the ICESCR (art. 12), the ICCPR (art. 6 and 7), and the CEDAW (art. 10, 12, 14, 16), establishing a broadly ratified normative framework, protect women's health-related human rights.

155 U.N. Econ. and Soc. Council Gen. Com. No. 14 (Aug. 11, 2000) [hereinafter *CESCR Com. 14*]; U.N. Econ. and Soc. Council Gen. Com. No. 22 (May 2, 2016) [hereinafter *CESCR Com. 22*].

156 U.N. Off, of High Comm'r, World Contraception Day, 26 September 2021 (Sept. 23, 2021), https://www.ohchr.org/en/statements/2021/09/world-contraception-day-26-september-2021. (“*Contraceptives enable women and adolescent girls to exercise their right to decide whether to be pregnant, the number and spacing of their children and to have pleasurable and safe sexual experiences without the risk of unintended pregnancies. Contraception also improves the socioeconomic opportunities for women and open up more educational opportunities for adolescent girls*.”)

157 Bailey, *supra* note 133, at S177.

158 CESCR Com. 14, *supra* note 155; CESCR Com. 22, *supra* note 155.

159 Pizzarossa, *supra* note 21, at 11; CESCR Com. 22, *supra* note 155; U.N. Gen. Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 Dec. 1979, 1249 U.N.T.S. 13.

160 Art. 35 of the Swiss Constitution fédérale [Cst] [Constitution] Apr. 18, 1999, RO 101, art. 35, (Switz.) (“Realization of fundamental rights” notes that fundamental rights must be upheld throughout the legal system: “*Whoever acts on behalf of the state is bound by fundamental rights and is under a duty to contribute to their implementation*.”).

161 Gonsalves & Hindin, *supra* note 146, at 359.

162 Dacey, *supra* note 44; Sandrine Ottesen et al., *Emergency Contraception Among Teenagers in Switzerland: A Cross-Sectional Survey on the Sexuality of 16- to 20-Year-Olds*, 31 J. Adolesc. Health 101 (2002).

163 Some authors address the difficulties in accessing EC under the conceptual umbrella of harm to women. The Harm to Decisional Autonomy: the decisional injury in losing control over choice and procreation. *See* Colker, *supra* note 134, at 474-76; L. L. Wynn et al., *Harm Reduction or Women's Rights? Debating Access to Emergency Contraceptive in Canada and the United States*, 38 Stud. Fam. Plan. 253, 254 (2007).

164 Simone de Beauvoir, *The Second Sex 25 Years Later*, 13 Society 79, 82, 84 (1976).

165 Lee, *supra* note 127, at 166.

166 *Cf.* Spinatsch et al., *Contraception d'urgence: Recommandations du groupe IENK pur la remise du levonorgestrel et de l'ulipristal*, IENK (Jun. 2020), https://www.ec-ec.org/wp-content/uploads/2020/08/IENK-Recommandations-2020-French.pdf.

167 Stein et al., *supra* note 3, at 556-57.

168 Tribunal administratif federal [TAF] [Federal Administrative Court] Dec. 19, 2020, C-3188/2019 (Switz.); Bundesverwaltungsgericht [BVGE] [Federal Administrative Court] Dec. 19, 2022, C-3189/2019, C-3190/2019 (Switz.) (translation by author).

169 World Health Org., *supra* note 13; Zhang et al., *supra* note 13 at 1607, 1609; Raymond et al., *supra* note 13 at 205; Sambol et al., *supra* note 13 at 109; De Santis et al., *supra* note 13 at 298; Grimes et al., *supra* note 13.

170 World Health Org, *supra* note 13.

171 Stein et al., *supra* note 3 at 559, 562; *Drug Facts, Values, and the Morning-After Pill, supra* note 9, at 57-58.

172 Colker, *supra* note 134 at 434-36; Wynn & Trussell, *supra* note 11 at 311.

173 Colker, *supra* note 134 at 448.

174 *Id*. at 460 (“[O]ver information harms or weakens a person's informed consent.”).

175 Katz, *supra* note 137 at x-xii.

176 Wynn & Trussell, *supra* note 11 at 311-12.

177 Paula Allen-Meares et al., *Health Literacy Barriers in the Health Care System: Barriers and Opportunities for the Profession*, 45 Health Soc. Work 62, 63 (2020).

178 Sheryl A. Kingsberg, et al., *Female Sexual Health: Barriers to Optimal Outcomes and a Roadmap for Improved Patient-Clinician Communications*, J Women's Health (Larchmt) (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/.

179 *Id*.

180 Samartzis et al., *supra* note 37 at 198; Arnet et al., *supra* note 37 at 354.

181 One counterargument invoked here by certain authors is the protection of vulnerable women. “*Some people have criticized plans to make EC available as a general sales medicine, as by keeping it under a prescription it can be used as a form of safeguarding to ensure the welfare of vulnerable individuals. Evidence suggests that victims of domestic violence and abuse are twice as likely to use EC than other women, due to the higher chance that their partners have raped them or pressured them into having unprotected sex. Thus, healthcare services are a critical point of contact for many abuse victims and survivors, and as pharmacists dispense 50% of all EC, this is an important opportunity for safeguarding*.” *See* Morgan et al., *supra* note 79 at 67-68; Wynn & Trussell, *supra* note 11 at 297. Similar questions arise in the Swiss context. However, pharmacists in Switzerland do not receive any training on how to identify domestic violence and abuse and how to refer vulnerable individuals to relevant specialist services. It is therefore unlikely that pharmacists intervene in support of such vulnerable women. In addition, pharmacists are bound by professional secrecy by art. 321 of the Swiss Criminal Code. They can thus not in principle alert the authorities should they encounter a case of domestic violence or abuse in the context of a mandatory counselling session for dispensing EC.

182 *See* Arnet et al., *supra* note 37 at 353.

183 Wynn & Trussell, *supra* note 11 at 298.

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45 WRLR 151

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