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Sexual Assault and Emergency Contraception

Case Study

Dr R is called down to the hospital emergency department to examine Ms S, who complains that she has been sexually assaulted. She says that her boyfriend raped her and that she wants to avoid pregnancy because she is not ready to bear its consequences. The local law permits abortion in the case of rape, when a complaint is filed with the police, and they conclude their inquiries into the circumstances. Ms S says her boyfriend has denied raping her, and Dr R knows police inquiries are often prolonged. What are Dr R's obligations in light of medical, ethical, legal, and human rights considerations?

1. *Background*

Violence against women is increasingly recognized as a serious public health problem.[1] Women have always been vulnerable to the horrendous crime of rape. Reliable data on the incidence of rape are not available, as it tends to be hidden and under-reported. Surveys in some countries have shown that between 10 and 20 per cent of young women had been raped.[2] The majority of perpetrators, contrary to common belief, are not strangers, but people known to the victim. A substantial group of victims are very young girls. For example, in one Latin American country, it is estimated that only seventy-two cases of sexual assault are reported of the 360 that happen each day, and that 60 per cent of pregnancies among 12- to 14-year-old girls result from rape by family members or persons close to the victims.[3]

Rape and sexual assaults, more than other types of injuries, cause both physical and profound emotional trauma. Victims also face the risk of unwanted pregnancy and sexually transmitted diseases (STDs), including HIV

[1] L. Heise, M. Ellsberg, and M. Gottemoeller, 'Ending Violence against Women', *Population Reports, Series L*, 11 (1999).
[2] Ibid.
[3] S. Tuesta, *The Search for Justice* (Lima: Movimiento Manuela Ramos, 2000), 5.

infection, and in many societies a social stigma. Psychological healing after rape takes a long time, particularly if the woman was raped by someone she trusted in a place that was 'safe' to her. She feels she has no safe place left as a refuge for her. One victim remarked that the body mends soon enough. Only the scars remain. But the wounds inflicted upon the soul take much longer to heal. And each time the victim relives these moments, the wounds start bleeding all over again. The broken spirit takes longest to mend; the damage to the personality may be the most difficult to overcome.

Women at all ages are vulnerable to sexual abuse. Child prostitution and sexual abuse have received recent international attention. Sex may also be economically coerced on adolescent girls, as in the case of African schoolgirls having to take up with 'sugar daddies' to afford school.[4] Sexual harassment is a reality that many women face in their communities, in the workplace and in various institutional settings, including those designed for their safety, and sometimes in their own homes, and that has received attention only recently.

Women do not usually wage war but they suffer more from the consequences. Women are often displaced as refugees and face sexual abuse by refugee camp guards and security patrols.[5] Forced prostitution and sexual exploitation by military forces is an enduring violation. In the Second World War, thousands of Korean, Philippino, and Indonesian women were forced into sexual slavery for Japanese troops in East and South-East Asia.[6] Rape and forced pregnancy were used as instruments of war in the more recent conflicts in the Former Yugoslavia[7] and, for example, in Rwanda.[8] Even though rape and other acts of sexual violence were formally recognized as international crimes, they were not prosecuted as such until the creation of the International Criminal Tribunal for the Former Yugoslavia (ICTY) in 1993 and the International Criminal Tribunal for Rwanda (ICTR) in 1994. The ICTR found that the accused ordered, instigated, and otherwise aided and abetted sexual violence,[9] and the ICTY found that rape can amount to a form of

[4] G. S. Mpangile, M. T. Leshabari, and D. J. Kihwele, 'Induced Abortion in Dar Es Salaam, Tanzania: The Plight of Adolescents', in A. I. Mundigo and C. Indriso (eds.), *Abortion in the Developing World* (New Dehli: Vistaar Publications, 1999).

[5] Human Rights Watch, *Seeking Refuge, Finding Terror: The Widespread Rape of Somali Women Refugees in North Eastern Kenya* (New York: Human Rights Watch, 1993); Human Rights Watch, *Seeking Protection: Addressing Sexual and Domestic Violence in Tanzania's Refugee Camp* (New York: Human Rights Watch, 2000).

[6] U. Dolgopol and S. Paranjape, *Comfort Women—An Unfinished Ordeal: A Report of a Mission* (Geneva: International Commission of Jurists, 1994).

[7] UN, *Report on the Situation of Human Rights in the Territory of the Former Yugoslavia* (New York: UN, 1993), UN Doc. E/CN.4/1993/50, at 19–20, 63–4, 67–73.

[8] Human Rights Watch, *Shattered Lives: Sexual Violence during the Rwandan Genocide and its Aftermath* (New York: Human Rights Watch, 1996).

[9] *Prosecutor v. Akayesu*, Judgment, ICTR-96-4-T (2 Sept. 1998) (International Criminal Tribunal for Rwanda).

torture when it is used during the interrogation as means of intimidating the victim.[10]

2. *Medical Aspects*

Victimization by sexual assault is multidimensional. Many health care providers, especially physicians, may feel best able to treat the presenting physical results of assault, and the risk of infection to which the victim has been exposed. It is clearly important that treatment be delivered as promptly as possible. Assault has wider consequences, however, because it has psychological effects that may be long-term, affecting a woman's self-esteem and self-confidence, in dealing with particular men and with how they believe they are perceived in their societies.[11] Accordingly, medical responses to sexual assault must be based on the immediate trauma, the risk of pregnancy, the possibility of STD infection, and the immediate and longer term psychological injury the victim may suffer.

If the woman reports early for treatment, emergency contraception may save her from the risk of an imposed pregnancy. Emergency contraception (EC) refers to contraceptive methods that can be used by women in the first few days following unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptive methods are effective and safe for the majority of women who may need them, as well as being simple to use.[12]

Two emergency hormonal contraceptive pill regimens can be used. The standard regimen consists of the combined oral contraceptive pills containing both oestrogen and progestagen in relatively high doses. This regimen is known as the 'Yuzpe method', named after Dr Yuzpe who developed the regimen. Two pills should be taken as the first dose as soon as convenient but no later than seventy-two hours after unprotected intercourse. These should be followed by two other pills twelve hours later. A new alternative is the levonorgestrel-only pill (with no oestrogen) containing 0.75 mgm. One pill is taken as the first dose, followed by another pill twelve hours later. It is equally effective as the Yuzpe method and has fewer side effects.[13]

The mechanism of action of emergency contraceptive pills has not been clearly established. Several studies have shown that they can inhibit or delay

[10] *Prosecutor v. Furundzija*, Judgment, IT-95-17/1, para. 163 (10 Dec. 1998) (International Criminal Tribunal for the Former Yugoslavia).

[11] WHO, *Women's Mental Health: An Evidence Based Review* (Geneva: WHO, 2000), WHO/MSD/MHP/00.1, Part 4: Violence Against Women.

[12] WHO, *Emergency Contraception: A Guide for Service Delivery* (Geneva: WHO, 1998), WHO/FRH/FPP/98.19.

[13] Task Force on Postovulatory Methods of Fertility Regulation, 'Randomized Controlled Trial of Levonorgestrel versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency Contraception', *Lancet*, 352 (1998), 428–33.

ovulation. It has also been suggested, but not proven, that they may prevent implantation, fertilization, or transport of sperm or ova. What is definitely known is that they are effective only within three days of unprotected sexual intercourse, that is, before implantation takes place, and therefore do not interrupt pregnancy. Thus, they are not medically considered to be a form of abortion.[14]

The failure rate of emergency contraception is about 2 per cent after a single act of unprotected sexual intercourse. Emergency contraception is not a substitute for regular contraceptive use. Moreover, emergency contraceptive pills offer no protection against sexually transmitted infection, including HIV. Psychological counselling on this topic should be provided along with diagnostic services and referral as needed.

A less commonly used method for emergency contraception is the insertion of a copper-releasing intra-uterine device within five days of unprotected sexual intercourse.[15] The available evidence is that it acts by interference with fertilization rather than implantation. It is not a suitable method if the woman is at risk of sexually transmitted infection.

3. *Ethical Aspects*

The microethical duties in cases of sexual assault are to address the gynaecological condition of the woman, to consider her request for maximum protection against pregnancy, to protect her as far as possible against suffering any sexually transmitted infection, and to address her psychological needs following the sexual assault. A wider duty is preservation of evidence that may confirm an assault, perhaps including semen and other tissue samples that may be relevant to subsequent enquiries. This duty is not contingent on being satisfied that an assault occurred, but arises out of respect for the explanation a woman gives of her request for care, and forensic requirements of legally admissible evidence.

The ethical right to autonomy that the woman enjoys entitles her to obtain protection against pregnancy. Not all practitioners who object to participation in abortion procedures are equally opposed to contraception. In any event, the health care provider is ethically obliged to ensure that the victim has access to the medical care indicated for her. Treatment is not dependent on police enquiries into the rape allegation, since emergency contraception may avoid the need for legal abortion. Indeed, the ethical duty to do no harm requires the doctor to act promptly in order to prevent unintended pregnancy and any of its consequences. This is so whether or not the sexual act amounted

[14] WHO, *Emergency Contraception.* [15] Ibid.

in law to an assault, since the key issue is that the woman was involved in unprotected intercourse. The first ethical response owed to the woman, in accordance with her request, is to prevent any risk of pregnancy. Subsequent responses should address protection against risks that she has suffered transmission of infection, and against psychological injury.

4. *Legal Aspects*

The law reflects the medical distinction between contraception and abortion. In many countries legal controls over abortion have remained more rigid than over use of contraceptive means, so the critical legal distinction is between medical use of abortifacient and non-abortifacient means. Emergency contraception is non-abortifacient, since it is intended to prevent pregnancy, not to terminate pregnancy. Legal analysis has responded to the practice of *in vitro* fertilization, where achievement of ovum fertilization in a petri dish does not constitute the ovum donor's (or any other woman's) pregnancy. It is usually accepted in law that only when the fertilized ovum is embedded in a woman's uterus has her pregnancy begun.[16]

The legal definition of pregnancy follows the medical definition. A WHO Technical Report considered that pregnancy begins when implantation is complete, and that implantation is the process that starts with the attachment of the zona-free blastocyst to the uterine wall (days 5–6 post-fertilization); the blastocyst then penetrates the uterine epithelium and invades the stroma. The process is complete when the blastocyst develops primary villi and the surface defect on the epithelium is closed (days 13–14 post-fertilization).[17] In its 1998 definition of pregnancy, the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health stated that pregnancy is that part of the process of human reproduction 'that commences with the implantation of the conceptus in a woman'.[18]

A practitioner who, on grounds of conscience, will not provide emergency contraception where it is the standard of care[19] is legally obliged to refer

[16] R. J. Cook, B. M. Dickens, C. Ngwena, and M. I. Plata, 'The Legal Status of Emergency Contraception', *Int. J. Gynecol. Obstet.* 75 (2001), 185–91.

[17] WHO, *Mechanism of Action, Safety and Efficacy of Intrauterine Devices: Report of a WHO Scientific Group. Technical Report Series 753* (Geneva: WHO, 1987), 12.

[18] International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproduction and Women's Health, *Definition of Pregnancy, Recommendations on Ethical Issues in Obstetrics and Gynecology* (London: FIGO, 2000), 38, available at http://www.figo.org/default.asp?id=6082, last accessed 6 May 2002; repr. in *Int. J. Gynecol. Obstet.* 64 (1999), 317.

[19] American College of Obstetricians and Gynecologists (ACOG), *Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists No. 25 (Emergency Oral Contraception)* (Washington, DC: ACOG, 2001); repr. in *Int. J. Gynecol. Obstet.* 78 (2002), 191.

women eligible to receive it to alternative practitioners or facilities where it will be available. Refusal or failure of appropriate referral constitutes legally actionable negligence through abandonment. Further, the practitioner who continues patient care without disclosure of the option lacks patients' adequately informed consent, possibly rendering the care an assault and childbirth that emergency contraception would have prevented an injury to patients, compensation for which could include costs of child support.

Many abortion laws make it an offence to act, as the widely followed English law of 1861 provided, 'with intent to procure the miscarriage of any woman whether she be or be not with child'. This language was designed to punish acts intended to induce abortion even when a prosecutor could not show biological evidence that the woman was actually pregnant by implantation of a fertilized ovum in her uterus. The law accordingly recognizes three conditions, namely pregnancy, possible pregnancy, and non-pregnancy. An act intended to terminate pregnancy or possible pregnancy will be governed by the abortion law, but an act intended to preserve non-pregnancy is not so governed. Emergency contraception, which is only effective if undertaken within seventy-two hours or three days of unprotected intercourse, is accordingly non-abortifacient.

As the time since intercourse grows, the possibility of pregnancy increases. That is, as time widens between unprotected intercourse and the medical intervention, the easier it is for a prosecutor to show that the initiator of the intervention must have been aware of the possibility of pregnancy, and had the intention to terminate it had it occurred. Accordingly, the sooner action is undertaken, the more secure is its legal status as non-abortifacient.

Laws concerning evidence necessary to convict men of rape have in the past been gendered. Evidence was usually required at least of women being injured in ways to which women would not normally consent, and of ejaculation. Accordingly, forensic inquiries had to show evidence of bruising and/or tearing, and semen had to be recovered from inside the woman's body, through invasive techniques.

Laws in many countries have evolved, however, to recognize that women can be terrified into passive submission to unwanted intercourse, and that some women's counsellors have advised women's passive submission in order to minimize risk of serious injury, as a preferable alternative to subjection to violent rape. Further, laws have evolved to be satisfied with evidence of forceful penetration without ejaculation, and to accept penetration by objects as constituting rape. Modern criminal investigations of allegations of rape recognize that men, including in positions in authority over women, based for instance, on their social status, can take sexual advantage of women in ways that the law should prohibit.

Advanced laws no longer include a category of 'rape', but differentially punish assaults by distinguishing among sexual assaults, aggravated sexual

assaults, sexual assaults by persons in authority, and, for instance, sexual assaults by threats or use of weapons. Accordingly, for purposes of criminal prosecution, evidence of semen, bruising, or sexual penetration is not required, and distinctions are not drawn among proven victims of sexual assault between those who suffered sexual penetration and those who did not. This reduces the need for invasive examination of women to acquire forensic evidence.

5. *Human Rights Aspects*

States commit themselves to address and eliminate all forms of violence against women through general international human rights conventions, conventions specific to women, such as the Convention on the Elimination of All Forms of Discrimination against Women, and more focused conventions, such as the Inter-American Convention on the Prohibition of Violence against Women. These conventions are increasingly applied to require states effectively to enforce laws against women's victimization by violence. General Recommendation 19 on Violence against Women of the Committee on the Elimination of Discrimination against Women (CEDAW) explains that discrimination against women 'includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty' (see Pt. III, Ch. 6, Sect. 1, para. 6). Significantly, this General Recommendation explains that gender-based violence breaches specific human rights, regardless of whether those provisions expressly mention violence. The rights include: the right to life, the right not to be subject to torture or to cruel, inhuman, or degrading treatment or punishment, the right to liberty and security of the person, the right to equality within the family, the right to just and favourable working conditions, and the right to the highest attainable standard of health.

CEDAW General Recommendation 24 on Women and Health places violence in the context of women's health by requiring states to address distinctive features and factors which differ for women in comparison to men, such as biological, socio-economic, and psycho-social factors, including post-partum depression (see Pt. III, Ch. 6, Sect. 2, para. 12). Human rights issues concern prevention of unplanned pregnancy, protection against sexually transmissible infection, and safeguarding of the victim's mental health. The transcending concern, conditioning responses to immediate pressing concerns, is that women complaining of assault be treated with respect for their human dignity, and not be subject to condemnatory, impersonal, or indifferent care that constitutes inhuman and degrading treatment.

The human rights violations of rape go beyond the danger to health from sexual assault because it places in peril women's control of their fertility, pregnancy, childbearing, and family building. The right to found a family includes a woman's right not to have a pregnancy imposed upon her by violence. Accordingly, the human right to physical and mental health and the right to found a family of her choice entitle a woman to emergency contraception to avoid unplanned pregnancy by rape.

Additional rights may be invoked in support of a woman's right to health and family integrity. A woman's right to the highest attainable standard of health justifies health care providers' treatment, and her rights to the benefits of scientific progress justify employment of the most effective, least invasive means for this purpose, including emergency contraception.

The human rights context of respect for a woman's personal dignity and protection from inhuman and degrading treatment require the woman to be in charge of the context of her care. Even where emergency interventions are medically justified, they cannot be imposed over the woman's objections, based for instance on her religious or other convictions. Similarly, she should not be subject to the religious objections others may have to providing indicated treatment for the conditions she presents. Accordingly, health care providers who consider emergency contraception to constitute abortion may invoke conscientious objection, but cannot refuse promptly to refer patients to providers who do not share this conviction. Laws that deny emergency contraception as constituting abortion are questionable under human rights provisions, for instance on inhuman and degrading treatment and, depending on the context, perhaps on torture.

Human rights provisions also address the longer term mental impact on women of sexual assault.[20] Mental health treatment may be indicated in itself, and processes of medical investigation, forensic testing, police inquiry, and, for instance, criminal trial, should be such as not to obstruct a woman's physical or mental health recovery, and not to aggravate her victimization. The traditional legal approach to rape is to treat accusations conservatively and sceptically because accusations of rape are easily made and difficult to defend, especially when made against male friends. This traditional approach is yielding to recognition of the frequency of rape, and that women can be so deterred and intimidated by processes of legal inquiry as to withhold complaints, and thereby afford assailants legal immunity. Women's human rights protections from inhuman and degrading treatment extend beyond the duties owed by health care providers to those binding police and judicial officers. It may fall to health care providers to protect women against insensitivity and inhumanity from these officers.

[20] L. Gulcur, 'Evaluating the Role of Gender Inequalities and Rights Violations in Women's Mental Health', *Health and Human Rights*, 5 (2000), 46–67.

6. *Approaches*

6.1. *Clinical duty*

Dr R should provide Ms S with emergency contraception, and manage this case of post-coital contraception like a request for pre-coital contraception. In addition, responses to rape should be initiated such as sexually transmitted disease (STD) protection, although more invasive techniques should be avoided, such as to recover semen samples for forensic purposes, because there is no need to identify an unknown assailant, unless local law still requires proof of ejaculation. The boyfriend's denial of rape may consist in denial of intercourse, but he is as likely to deny that admitted intercourse with Ms S was non-consensual. In either case, recovery of semen samples will usually be unnecessary, since most legal systems' definitions of rape are met by evidence only of sexual penetration. A wider concern is the boyfriend's HIV status, since Ms S may require treatment for exposure to HIV infection and appropriate counselling. Some legal systems mandate HIV testing of men accused of rape or sexual assault.

The psychological sequelae need careful attention, and proper counselling. In many industrialized and some developing countries, support groups play an integral role in healing and consciousness raising. Where such groups are available, Dr R should refer Ms S. In a support group, she will be able to communicate with women who have been through similar experiences and who have recovered from them. She will get hope that she can also recover.

6.2. *Health care systems obligations*

If modern means of emergency contraception are unfamiliar to Dr R's hospital, it may be necessary to confirm their clinical propriety, and to make clear that they do not involve abortion. Some agencies hostile to inducement of abortion are equally hostile to artificial contraception, and equate the latter with the former, but Dr R may have to show that medically, ethically, and legally, emergency contraception is not abortion, but like pre-coital contraception, is intended to prevent pregnancy, not terminate it. The FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health in its Guidelines in Emergency Contraception explained that 'emergency contraception is highly effective in diminishing the number of unwanted pregnancies without the need of an abortion . . . [and recommended] that the medical professional should advocate that emergency contraception be easily available and accessible at all times to women'.[21]

[21] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 'Guidelines on Emergency Contraception', *Int. J. Gynecol. Obstet.* 77 (2002), 174.

Dr R might also address how sensitively the hospital examines victims of rape, because examinations may be unduly invasive, to the extent of being experienced as 'a second rape'. The risk may be greater where forensic evidence is sought for police enquiries, and to establish legal grounds for pregnancy termination. Proof beyond reasonable doubt is required before an alleged rapist can be criminally convicted, but proof of rape to this level is not necessarily required to justify emergency contraception or even termination of pregnancy on this ground. The woman's authentic sense of being violated justifies the procedure, even if adequate proof for legal conviction is not obtainable, for instance because an assailant cannot be found or identified or is mentally disordered and so cannot stand trial or be convicted.

Practitioners in hospital emergency departments and those responsible for training and equipping emergency care workers may consider contraception to be a preventive service or a part of family rather than emergency medicine. The service of emergency contraception should be available within family practice medicine, of course, but emergency personnel should also be encouraged, educated, and equipped to see emergency contraception as analogous to other forms of post-traumatic care for women who have been sexually violated. Further, emergency services should make this care available as a community service, not dependent on evidence of rape. That is, women who believe their contraceptive precautions to have failed should have prompt access to emergency contraception, delivered in the same conscientious, non-judgemental way as any other medical service. Such women's request and receipt of care should provide an occasion for their counselling on general precoital contraception, so that emergency contraception serves only as a fail-safe or back-up method, and does not become a means of primary contraception.

CEDAW's General Recommendation 24 on Women and Health calls on governments and those acting under the authority of government, such as hospitals, to develop treatment protocols for the care of victims of violence (see Pt. III, Ch. 6, Sect. 2, para. 15). Guidelines and protocols do exist,[22] and need to be reviewed for their applicability in different settings and how they guide the health care provider in the delivery of emergency contraception.

To ensure wide availability of emergency contraception, Dr R might explore with the health ministry switching emergency contraception from prescription only to over-the-counter distribution. Medical evidence indicates that emergency contraception is safe for self-medication, its inappropriate use does not cause serious harm, it has no documented medical contraindications, and no

[22] Brazil, Ministry of Health, *Prevention and Treatment of Harms Resulting from Sexual Violence against Women and Adolescent Girls* (Brazilia: Ministry of Health, 1999); S. MacDonald, J. Wyman, and M. Addision, *Guidelines and Protocols for the Sexual Assault Nurse Examiner* (Toronto: Sexual Assault Care Centre, Women's College Hospital, 1995).

medical intermediary is needed for its distribution. Moreover, it is in the public health interest because it will prevent abortion.[23]

6.3. *Social action for underlying conditions*

Societies' image of women may need to be corrected. There is sometimes a tendency to blame the victim. During a debate on the reform of rape law, one parliamentarian once commented that women should wear purdah (head-to-toe covering) to ensure that innocent men do not get unnecessarily excited by women's bodies and are not unconsciously forced into becoming rapists. If women do not want to fall prey to such men, he said, they should take the necessary precautions instead of forever blaming the men.[24] When a nursing student in a Latin American country reported being sexually molested by police officers while in custody, the response by the assistant to the public prosecutor was: 'Are you a virgin? If you are not a virgin, why do you complain?' In some Latin American countries—for example, Brazil, Costa Rica, Ecuador, and Guatemala—the law defines certain sexual offences as crimes only if they are committed against 'honest'—that is, virginal—women or girls.[25]

The International Federation of Gynecology and Obstetrics (FIGO) General Assembly in 1997 recommended that obstetricians and gynaecologists work with others to gain insight into the causes of the problem, and assist in the legal prosecution of cases of sexual abuse and rape by careful and sensitive documentation of the evidence.[26] Some societies of obstetricians and gynaecologists have taken initiatives to address the problem in comprehensive ways.[27]

[23] D. Grimes, 'Switching Emergency Contraception to Over-the-Counter Status', *New England Journal of Medicine*, 347 (2002), 846–9.

[24] H. Epstein, *The Intimate Enemy: Gender Violence and Reproductive Health. Panos Briefing No. 27* (London: Panos Institute, 1998), 6.

[25] L. L. Heise, J. Pitanguy, and A. Germain, *Violence against Women: The Hidden Health Burden. World Bank Discussion Paper*, 255 (Washington, DC: World Bank, 1994), 31.

[26] WHO, *FIGO General Assembly Resolution on Violence against Women, FIGO/WHO, Pre-Congress Workshop on Violence against Women: In Search of Solutions* (Geneva: WHO, 1998), WHO/FRH/WHD/97.38, at 33–4.

[27] R. F. Jones and D. L. Horan, 'The American College of Obstetricians and Gynecologists: A Decade of Responding to Violence against Women', *Int. J. Gynecol. Obstet.* 58 (1997), 43–50.