
If You are Pregnant



Also available in Spanish

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This publication was produced in compliance with K.S.A. 65-6708, thru 65-6710 known as the “Woman’s Right-to-Know Act.” The “Woman’s Right-to-Know-Act” requires that the physician inform the woman of the following language. No person shall perform or induce an abortion when the fetus is viable unless such person is a physician and has a documented referral from another physician not financially associated with the physician performing or inducing the abortion and both physicians determine that: (1) The abortion is necessary to preserve the life of the pregnant woman; or (2) that a continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman. (K.S.A. 65-6709)

The Kansas Department of Health and Environment acknowledges contributions for this publication, photographs from: Lennart Nilsson (in utero photographs used by permission, *A Child is Born*, Dell Publishing, 1990); Alexander Tsiaras (*from Conception to Birth: a Life Unfolds*, Doubleday, 2002); Moore et al (*Color Atlas of Clinical Embryology*, Elsevier, 2000); and text from Louisiana Department of Health and Hospitals.

INTRODUCTION

Kansas law requires your doctor to tell you about the nature of the physical and emotional risks of both the abortion procedure and carrying a child to term. The doctor must tell you how long you have been pregnant and must give you a chance to ask questions and discuss your decision about the pregnancy carefully and privately.

This handbook offers some basic facts to help you make an informed decision about whether or not you want to have an abortion or carry the fetus to term. The information will tell you about normal human embryonic and fetal development and about the methods and risks of abortions and medical risks of childbirth.

The term embryo refers to a developing human from conception until the eighth week. An embryo becomes a fetus after the eighth week. Embryo and fetal ages in this handbook are listed from the first day of the last normal menstrual period. Fetal lengths are measured from the top of the head to the rump.

A directory of services is also available. By calling or visiting the agencies and offices in the directory you can find out about alternatives to abortion, assistance to make an adoption plan for your baby, and/or locate public and private agencies that offer medical and financial help during pregnancy, during childbirth and while you are raising your child.

Furthermore, you should know:

- It is unlawful for any individual to coerce you to undergo an abortion;
- Any physician who intentionally, knowingly or recklessly fails to provide informed consent prior to performing an abortion may be guilty of unprofessional conduct;
- You are not required to pay any amount for the abortion procedure until the 24-hour waiting period has expired;
- The father of your child is legally responsible to assist in the support of the child, even in instances where he has offered to pay for an abortion; and
- The law permits adoptive parents to pay costs of prenatal care, childbirth and neonatal care.

“Many public and private agencies exist to provide counseling and information on available services. You are strongly urged to seek their assistance to obtain guidance during your pregnancy. In addition, you are encouraged to seek information on abortion services, alternatives to abortion, including adoption, and resources available to postpartum mothers. The law requires that your physician or the physician’s agent provide the enclosed information.” (K.S.A. 65-6708 et. seq.)

FETAL DEVELOPMENT

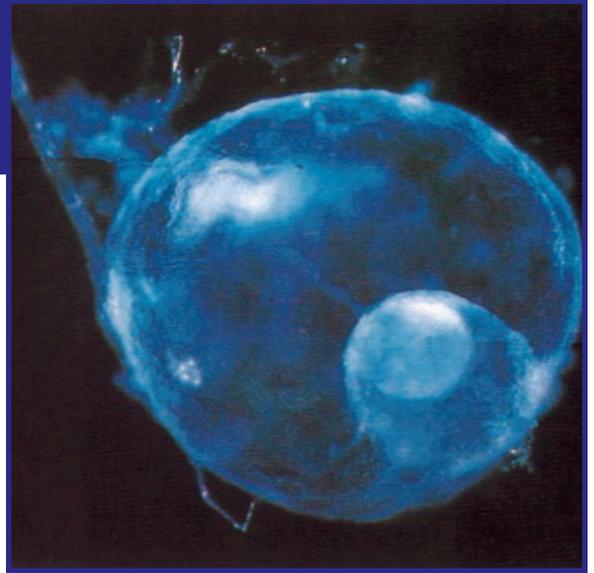
How old is the fetus?

A pregnant woman may notice her first missed menstrual period at the end of the second week after conception, or about four weeks after the first day of her last normal period. There are different kinds of tests for pregnancy. Some may not be accurate for up to three weeks after conception, or five weeks after the first day of the last normal period.

The *Week* in the blue block beside each picture is the age of the embryo or fetus from the last menstrual period.

Week 4

- Implantation begins the first week and the embryo continues to grow. The embryo is about 1/100 of an inch long at this time.
- The embryo has implanted in the uterus and the swelling bulges into the uterine cavity.



Week 6

- Embryo is now about 1/4 inch long.
- Upper limbs are flipper-like.
- Blood is beginning to be pumped through fetal circulation.
- Heartbeat is visible by ultrasound.

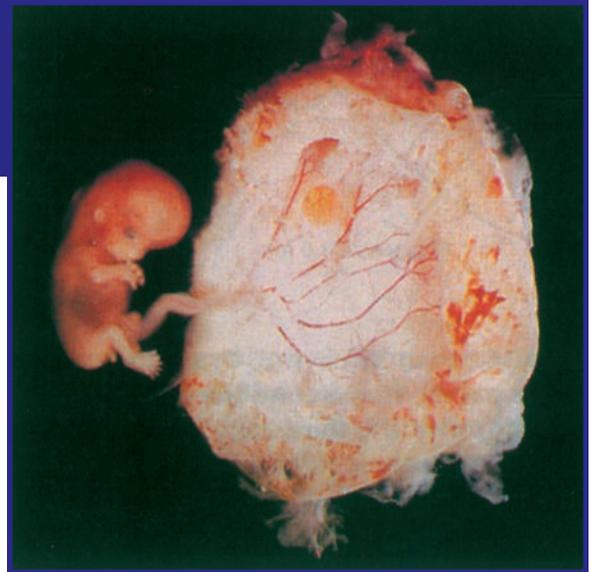


Week 8

- The embryo is about 1/2 inch long.
- Fingers are beginning to form on hand.
- Reflex activity begins.

Week 10

- Eyelids and ears are forming.
- Still sexless appearance.
- Head more rounded and human-like.
- Slightly over 1 inch long.



Week 12

- The fetus is about 1 1/2 inches from head to rump.
- Early fingernail development occurs.
- The fetus begins small, random movements, too slight to be felt.
- The fetal heartbeat can be detected with a doppler or heart monitor.



Week 14

- The fetus is over 3 inches from head to rump and weighs about 1 ounce.
- Different fetuses make different facial expressions.
- Sucking muscles fill out cheeks.
- Sex distinguishable externally.



Week 16

- The fetus is about 4 3/4 inches from head to rump and weighs 4 ounces.
- The head is erect and the arms and legs are developed.
- The skin is loose and wrinkled with fingerprints beginning.

Week 18

- The fetus is about 5 inches from head to rump and weighs about 6 ounces.
- The skin is pink and transparent and the ears stick out from the head.



Week 20

- The fetus is about 8 inches from head to rump, weighing about 8 ounces.
- All organs and structures have been formed, and a period of simple growth begins.
- Respiratory movements occur, but the lungs have not developed enough to permit survival outside the uterus.
- By this time the woman may feel the fetus moving.



Week 22

- The fetus has fingerprints and perhaps some head and body hair, weighing about one pound (16 ounces).
- There is no chance to survive outside the woman's body.
- Fetal heartbeat can be heard with a stethoscope.



Week 24

- The fetus is about 12 inches from head to rump and weighs about 1 1/2 pounds.
- Survival rate is 55 percent.
- Surviving babies may have disabilities and require long-term intensive care.
- 65 percent have major handicaps, 70 percent have learning disabilities

Week 26

- Eyes open during alert times
- Survival rate is 83 percent.
- 30 percent have major handicaps, 40 percent have learning disabilities.



Week 28

- The fetus is about 10 inches from head to rump and weighs about 2 1/4 pounds.
- About 9 out of 10 babies born now will survive (*with intensive care services*).
- 10 percent have major handicaps, 25 percent have disabilities.



Week 30

- The fetus is about 16 inches from head to heel and weighs 3 pounds.
- The fetus has lungs that are capable of breathing air, although medical help may be needed.
- The fetus can open and close its eyes, suck its thumb and respond to sound.
- Nearly all babies born now will survive (*with intensive care services*).
- Less than 10 percent have major handicaps, less than 20 percent have learning disabilities.



Week 32

- Measures over 16 1/2 inches from head to heel.
- Weighs 3 pounds 13 ounces.

Week 34

- The fetus is about 17 3/4 inches from head to heel and weighs about 4 pounds 12 oz.
- Ears begin to hold shape.
- Almost all babies born now will live (*with intensive care services*).



Week 36

- The fetus is about 18 1/2 inches from head to heel and weighs about 6 pounds.
- Scalp hair is silky and lays against the head.
- Fetus can scratch itself.
- Almost all babies born now will live.
- May not need NICU.



Week 40

- The fetus is about 20 inches from head to heel and may weigh from 6 1/2 to 10 pounds.
- The baby is full-term and ready to be born.

METHODS & MEDICAL RISKS

There are three ways a pregnancy can end: a woman can give birth, have a miscarriage or she can choose to have an abortion. If you make an informed decision to have an abortion, you and your doctor will need to consider how long you have been pregnant before deciding which abortion method to use.

Based on data from the Centers for Disease Control and Prevention (CDC), the risk of dying as a direct result of a legally induced abortion is less than one per 100,000.

FROM 2-12 WEEKS

Abortion Methods: Early non-surgical abortion or Vacuum Aspiration

Early non-surgical abortion

- A drug is given to stop the development of the pregnancy
- A second drug is given by mouth or placed in the vagina, causing the uterus to contract and expel the fetus and placenta.

Vacuum Aspiration

- Local anesthetic is applied or injected into or near the cervix to prevent pain.
- Opening of the cervix is gradually stretched. This is done by the insertion of a series of dilators, each one thicker than the previous one, into the opening of the cervix. The thickest dilator used is about the width of a fountain pen.
- After opening is stretched, a clear plastic tube is inserted into the uterus and attached to a suction system. The fetus and placenta are then removed.
- After the tube has been removed, a spoon-like instrument, called a curette may be used to gently scrape the walls of the uterus to be sure it has been completely emptied of the pregnancy.

Medical Risks

- Immediate medical risks may include the following, which are discussed on pages 16-17: blood clots in the uterus, heavy bleeding, cut or torn cervix, perforation of the wall of the uterus, pelvic infection, incomplete abortion, anesthesia-related complications.
- Possible long-term medical risks are discussed on page 17.

FROM 13-21/22 WEEKS

Abortion Methods: Dilatation and Evacuation (D&E) or Labor Induction

Dilatation and Evacuation (D&E)

- Sponge-like tapered pieces of absorbent material are placed into the cervix. This material becomes moist and slowly opens the cervix.
- Sponge-like material will remain in place for several hours or overnight.
- A second or third application of the material may be necessary.
- Intravenous medications may be given to ease pain and prevent infection.
- After a local or general anesthesia is given, the fetus and placenta are removed from the uterus with medical instruments such as forceps and suction curettage. Occasionally for removal, it will be necessary to dismember the fetus.

Medical Risks

- Immediate medical risks may include the following, which are discussed on pages 16-17: blood clots in the uterus, heavy bleeding, cut or torn cervix, perforation of the wall of the uterus, pelvic infection, incomplete abortion, anesthesia-related complications.
- Possible long-term medical risks are discussed on page 17.

Labor Induction

- Labor induction may require a hospital stay.
- Medicine is given to start labor in one of three ways: medicine is placed in the cervix, directly into the woman's vein or by inserting a needle through the mother's abdomen and into the amniotic sac (bag of waters).
- Labor will usually begin in 2-4 hours.
- If the afterbirth (placenta) is not completely removed during labor induction, the doctor must open the cervix and use suction curettage.

Medical Risks

- Labor induction abortion carries the highest risk for problems, such as infection and heavy bleeding.
- When medicines are used to start labor, there is a risk of rupture of the uterus.
- Other immediate medical risks may include the following, which are discussed on pages 16-17: blood clots in the uterus, heavy bleeding, cut or torn cervix, perforation of the wall of the uterus, pelvic infection, incomplete abortion, anesthesia-related complications.
- Possible long-term medical risks are discussed on page 17.

If the labor induction method is used, there is a small chance that a baby could live for a short period of time. (See “*What if the fetus is determined to be viable?*”, page 15.)

FROM 22-38 WEEKS

Abortion Methods: Labor Induction or Hysterotomy

Labor Induction

(See “*What if the fetus is determined to be viable?*”, page 15.)

- Labor induction may require a hospital stay.
- Medicine is given to start labor in one of three ways: medicine is placed in the cervix, directly into the woman’s vein or by inserting a needle through the mother’s abdomen and into the amniotic sac (bag of waters).
- If the afterbirth (placenta) is not completely removed during labor induction, the doctor must open the cervix and use suction or instrumental curettage.
- Labor and delivery of the fetus during this period are similar to childbirth.
- The duration of labor depends on the size of the baby and the readiness of the uterus.

Medical Risks

- As with childbirth, possible complications of labor induction include infection and heavy bleeding.
- When medicines are used to start labor, there is a risk that the uterus could rupture.
- Other immediate medical risks may include the following, which are discussed on pages 16-17: blood clots in the uterus, heavy bleeding, cut or torn cervix, perforation of the wall of the uterus, pelvic infection, incomplete abortion, anesthesia-related complications.

Hysterotomy (similar to a Caesarean Section)

- This method requires that the woman be admitted into a hospital.
- A hysterotomy may be performed if labor cannot be started by inducing labor, or if the woman or her fetus is too sick to undergo labor.
- A hysterotomy is the removal of the fetus by surgically cutting open the abdomen and uterus. Anesthetic medication, given intravenously or into the woman's back, or by breathing the anesthetic, is administered so the woman will not feel the pain of the surgery.

Medical Risks

- Complications are similar to those seen with other abdominal surgeries and administration of anesthesia, such as severe infection (sepsis); blood clots to the heart and brain (emboli); stomach contents breathed into the lungs (aspiration pneumonia); severe bleeding (hemorrhage); and injury to the urinary tract.
- Other possible immediate risks include: blood clots in the uterus, heavy bleeding, pelvic infection, retention of pieces of the placenta, anesthesia-related complications.
- Possible long-term risks are discussed on page 17.

WHAT IF THE FETUS IS DETERMINED TO BE VIABLE?

- The chance of the fetus living outside the uterus (viability) increases as the gestational age increases. The doctor must tell you the probable gestational age of the fetus at the time the abortion would be performed.
- No person shall perform or induce an abortion when the fetus is viable unless such a person is a physician and has a documented referral.

The following steps must be taken:

1. The physician who performs or induces an abortion when the fetus is viable must have a documented referral from another physician not legally or financially affiliated with the physician performing or inducing the abortion.
 2. Both physicians determine that the abortion is necessary to preserve the life of the pregnant woman or a continuation of the pregnancy will cause substantial and irreversible impairment of a major bodily function of the pregnant woman. (K.S.A. 65-6709)
- If the child is born alive, the attending physician has the legal obligation to take all reasonable steps necessary to maintain the life and health of the child. (K.S.A. 65-6709)

Medical Emergencies

When a medical emergency requires the performance of an abortion, the physician shall tell the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to prevent substantial and permanent damage to any of the woman's major bodily functions.

In the case of a medical emergency, a physician also is not required to comply with any condition listed above which, in the physician's medical judgment, he or she is prevented from satisfying because of the medical emergency.

MEDICAL RISKS OF ABORTION

Medical Risks

The risk of complications for the woman increases with advancing gestational age. (See the previous pages for a description of the abortion procedure that your doctor will be using and the specific risks listed in those pages.)

The following is a description of the risks cited in those pages:

Pelvic Infection (sepsis): Bacteria (germs) from the vagina or cervix may enter the uterus and cause an infection. Antibiotics may clear up such an infection. In rare cases, a repeat suction, hospitalization or surgery may be needed. Infection rates are less than 1% for suction curettage, 1.5% for D&E, and 5% for labor induction.

Incomplete abortion: Fetal parts or other products of pregnancy may not be completely emptied from the uterus, requiring further medical procedures. Incomplete abortion may result in infection and bleeding. The reported rate of such complications is less than 1% after a D&E; whereas, following a labor induction procedure, the rate may be as high as 36%.

Blood clots in the uterus: Blood clots that cause severe cramping occur in about 1% of all abortions. The clots usually are removed by a repeat suction curettage.

Heavy bleeding (hemorrhage): Some amount of bleeding is common following an abortion. Heavy bleeding (hemorrhaging) is not common and may be treated by repeat suction, medication or, rarely, surgery. Ask the doctor to explain heavy bleeding and what to do if it occurs.

Cut or torn cervix: The opening of the uterus (cervix) may be torn while it is being stretched open to allow medical instruments to pass through and into the uterus. This happens in less than 1% of first trimester abortions.

Perforation of the uterus wall: A medical instrument may go through the wall of the uterus. The reported rate is 1 out of every 500 abortions. Depending on the severity, perforation can lead to infection, heavy bleeding or both. Surgery may be required to repair the uterine tissue, and in the most severe cases hysterectomy may be required.

Anesthesia-related complications: As with other surgical procedures, anesthesia increases the risk of complications associated with abortion. The reported risks of anesthesia-related complications is around 1 per 5,000 abortions.

Rh Immune Globulin Therapy: Protein material found on the surface of red blood cells is known as the Rh Factor. If a woman and her fetus have different Rh factors, she must receive medication to prevent the development of antibodies that would endanger future pregnancies. (See page 18 for additional information on Rh Immune Globulin Therapy.)

LONG-TERM MEDICAL RISKS

Future childbearing: Early abortions that are not complicated by infection do not cause infertility or make it more difficult to carry a later pregnancy to term. Complications associated with an abortion may make it difficult to become pregnant in the future or carry a pregnancy to term.

Cancer of the breast: A National Cancer Institute panel concluded that “Having an abortion or miscarriage, does not increase a woman’s subsequent risk of developing breast cancer.”

EMOTIONAL REACTIONS

Because every person is different, one woman’s emotional reaction to an abortion may be different from another’s. After an abortion, a woman may have both positive and negative feelings, even at the same time. One woman may feel relief, both that the procedure is over and that she is no longer pregnant.

Another woman may feel sad that she was in a position where all of her choices were hard ones. She may feel sad about ending the pregnancy. For a while after the abortion she also may feel a sense of emptiness or guilt, wondering whether or not her decision was right.

Some women who describe these feelings find they go away with time. Others find them more difficult to overcome.

Certain factors can increase the chance that a woman may have a difficult adjustment to an abortion. One of these is not having any counseling before consenting

to an abortion. When help and support from family and friends are not available, a woman's adjustment to the decision may be more of a problem.

Other reasons why a woman's long-term response to an abortion can be poor may be related to past events in her life. For example, negative feelings could last longer if she has not had much practice making major life decisions or already has serious emotional problems.

Talking with a counselor or physician may help a woman to consider her decision fully before she takes any action.

MEDICAL RISKS OF CHILDBIRTH

Women who are more likely to experience problems during and after a pregnancy are those who did not obtain prenatal care early in the pregnancy and/or didn't continue with that care and those with generally poor health and life styles, e.g. smoking, alcohol and drug use. Continuing a pregnancy and delivering a baby is usually a safe, healthy process. Based on data from the CDC, the risk of the woman dying as a direct result of pregnancy and childbirth is less than 10 in 100,000 live births.

Continuing your pregnancy also includes a risk of experiencing complications that are not always life-threatening.

- **Caesarean section (C/S) delivery.** Occurs in about 30 out of every 100 births.
- **Infection.** Approximately 4 out of every 100 women experience an infection after childbirth and are treated with antibiotics. Lack of treatment may lead to infertility or more serious infections.
- **Bleeding.** Heavy bleeding may occur as a result of clotting problems, tears in the placenta prior to delivery or if pieces of the placenta remain in the uterus after delivery.

Need for Rh Immune Globulin: As part of prenatal care, the woman will have a blood test to find out her blood type. If the pregnant woman is Rh negative and the father is Rh positive, she can make antibodies (sensitization) that can attack the red blood cells of the fetus if the fetus is Rh positive. This sensitization can occur any time fetal blood mixes with the mothers' blood; during pregnancy or after an abortion, miscarriage, ectopic pregnancy, or amniocentesis.

To prevent the development of antibodies the woman can receive shots (immunizations) of Rh immune globulin (RhIg), one at 28 weeks of pregnancy and the other following a miscarriage or delivery of a baby. The only known side effect of the immunization for the woman is soreness from the shot or a slight fever. There is no risk of infection with human immunodeficiency virus (HIV) with the globulin. The approximate cost of the immunizations is fifty dollars (\$50).

If the woman who is Rh negative does not receive the Rh immune globulin, the fetus' red blood cells may be damaged, leading to anemia, serious illness or death of the fetus or newborn. *(See page 17 for additional information on Rh Immune Globulin Therapy relating to an abortion.)*

Causes of Complications in Pregnancy

- Severe bleeding
- Blood clots in the lungs
- High blood pressure
- Seizures, strokes
- Severe infection
- Abnormal functioning of the heart
- Anesthesia-related complications and death.

Altogether, these causes account for 80% of all deaths relating to pregnancy. Unknown or uncommon causes account for the remaining 20% of deaths relating to pregnancy. Women who have chronic severe diseases are at greater risk of death than are healthy women.

PREGNANCY, CHILDBIRTH, AND NEWBORN CARE

You may or may not qualify for financial help for prenatal (pregnancy), childbirth and neonatal (newborn) care, depending on your income. If you qualify, programs such as the state's medical assistance program, called Medicaid, will pay or help pay the cost of doctor, clinic, hospital and other related medical expenses to help you with prenatal care, childbirth delivery services and care for your newborn baby.

A listing of agencies that are available to provide or assist you to access financial assistance or medical care is available by calling toll free 1-888-744-4825.

WHAT ABOUT ADOPTION?

Women or couples facing an untimely pregnancy who choose not to take on the full responsibilities of parenthood have another option: **adoption**.

Making a plan for adoption is rarely an easy decision. Counseling and support services are a key part of adoption and are available from a variety of adoption agencies and parent support groups across the state. A list of adoption agencies is available by calling toll free 1-888-744-4825.

There are several ways to make a plan for adoption, including through a child placement agency or through a private attorney. Although fully anonymous adoptions are available, some degree of openness in adoption is more common, such as permitting the birth mother to choose the adoptive parents.

If a father wishes to have the right to consent to an adoption, or refuse consent and raise the child, he must upon having reasonable notice of the pregnancy provide support for the mother during the last 6 months of the pregnancy.

THE FATHERS RESPONSIBILITY

The father of a child has a legal responsibility to provide for the support, educational, medical and other needs of that child. In Kansas that responsibility includes child support payments to the child's mother or legal guardian. A child has rights of inheritance from their father and may be eligible through him for benefits such as life insurance, Social Security, pension, veteran's or disability benefits. Further, the child benefits from knowing the father's medical history and any potential health problems that can be passed genetically. A father's and mother's rights are equal regarding access, care and custody.

Paternity can be established in Kansas by two methods:

1. The father and mother, at the time of birth, can sign forms provided by the hospital acknowledging paternity and the father's name is added to the birth certificate.

2. A legal action can be brought in a court of law to determine paternity and establish a child support order.

Issues of paternity effect your legal rights and the rights of the child. More information concerning paternity establishment and child support may be obtained from any regional office of the Kansas Department of Social and Rehabilitation Services, Division of Child Support Enforcement.

INFORMATION DIRECTORY

The decision to have an abortion, have a baby or make an adoption plan, must be carefully considered. There are lists of state, county and local health and social service agencies and organizations available to assist you. You are encouraged to contact these groups if you need more information so you can make an informed decision.

Individuals may call the Kansas Department of Health and Environment's toll free line at 1-888-744-4825 to receive a copy of this directory, "*If You are Pregnant: Directory of Available Services*" and information regarding the services available. Service providers (e.g. physicians, hospitals, abortion clinics) may obtain copies and certification forms by calling toll free 1-888-744-4825.

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