
IF YOU ARE PREGNANT

*Information on Fetal Development,
Abortion and Alternatives*



If You Are Pregnant: Information on Fetal Development, Abortion and Alternatives

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INTRODUCTION

The information provided in this booklet is designed to provide you with basic, medically accurate information on the fetal development of your unborn child in two-week intervals from implantation to birth. It will include such details as average weight and length, organ development and movement for that age.

This booklet also includes information on the methods of abortion, as well as the medical risks associated with abortion. In addition, this booklet discusses the possible emotional side effects of abortion, the possibility of fetal pain, and some common medical risks associated with carrying a baby to term.

If You are Pregnant: Information on Fetal Development, Abortion and Alternatives presents current, medically reliable information. However, each mother and unborn child is unique. A woman considering an abortion should first talk to her doctor about the procedures and alternatives. It is a woman's right to be fully informed about the procedures, complications and risks involved in an abortion. It is a doctor's legal responsibility to provide that information. Additionally, the law requires that your doctor must tell you how old your unborn child is and must give you an opportunity to ask questions.

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, obtain assistance in making an adoption plan for your baby; and locate public and private agencies that offer medical and financial help during pregnancy, childbirth and while a child is dependent. *If You Are Pregnant: A Directory of Services Available in Minnesota* is available online at: <http://www.health.state.mn.us/wrtk/>.

This document was developed by the Minnesota Department of Health in response to the 2003 legislative passage of the Woman's Right to Know Act. Minnesota laws related to abortion include:

Minnesota Statutes section 145.4241 - 145.4249 [Woman's Right to Know Act] requires that a woman be provided the following information at least 24 hours before an abortion, except in the case of a medical emergency:

- 1) the particular medical risks associated with the particular abortion procedure to be employed;
- 2) the probable gestational age of the unborn child at the time the abortion is to

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- be performed;
 - 3) the medical risks associated with carrying her child to term;
 - 4) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic. A physician must also provide the woman with any additional costs associated with the administration of an anesthetic or analgesic.
 - 5) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;
 - 6) that the father is liable to assist in the support of her child even in instances when the father has offered to pay for an abortion; and
 - 7) that she has the right to review materials made available by the Minnesota Department of Health.

The woman must certify in writing, prior to the abortion, that all of the required information has been furnished to her.

Prior to administering an anesthetic or analgesic to eliminate or alleviate organic pain to the unborn child, the physician must disclose to the woman any additional cost associated with the administration of the anesthetic or analgesic.

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion, if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Minnesota Statutes section 145.423 [Abortion; Live Births] requires that a physician, other than the physician performing the abortion, must be immediately accessible to take all reasonable measures consistent with good medical practice to preserve the life and health of any live birth that is the result of an abortion if the abortion is performed after the twentieth week of pregnancy.

Minnesota Statutes section 145.412 [Criminal Acts] requires that an abortion be performed in a hospital or abortion facility if the abortion is performed after the first trimester, and in a hospital if the abortion is performed during the second half of the gestation period.

Minnesota Statutes section 144.343 [Pregnancy, Venereal Disease, Alcohol or Drug Abuse, Abortion] requires that parents be notified at least 48 hours before an abortion is performed on an unemancipated minor unless:

- 1) the abortion is necessary to prevent the woman's death and there is not enough time to provide the parental notice;
- 2) the parents authorize the abortion in writing;
- 3) the woman declares that she is a victim of sexual abuse, neglect, or physical abuse, as defined in Minnesota Statutes section 626.556; or
- 4) the woman elects not to allow the notification, and a judge, after an appropriate hearing, authorizes a physician to perform an abortion.

Minnesota Statutes section 145.1621 [Disposition of Aborted or Miscarried Fetuses] requires that hospitals, clinics, and medical facilities in which an abortion or miscarriage takes place, and laboratories to which the remains of a human fetus is delivered, must provide for the disposal of the remains of the human fetus by cremation, interment by burial, or in a manner directed by the commissioner of health. "Remains of a human fetus" are defined as remains of the offspring of a human being that has died through abortion or miscarriage, and that has reached a stage of development so that there are cartilaginous structures, or fetal or skeletal parts.

FETAL DEVELOPMENT OF THE UNBORN CHILD

Conception begins on the day a woman's egg is fertilized by a sperm penetrating it. Within a day, the egg begins to develop rapidly. Within a few days the cluster of between 13 and 32 cells leave the fallopian tube and move into the uterus. This group of cells is now called a blastocyst and has increased in size to hundreds of cells. By the eighth day after conception the blastocyst has begun to attach to the wall of the uterus where it will grow at a rapid rate.

The term embryo refers to a developing human from implantation until the eighth week of pregnancy. After the eight week, the unborn child is referred to as a fetus. Ages in this handbook are listed from both the estimated day of conception and from the first day of the last normal menstrual period. Lengths are measured from the top of the head to the rump.

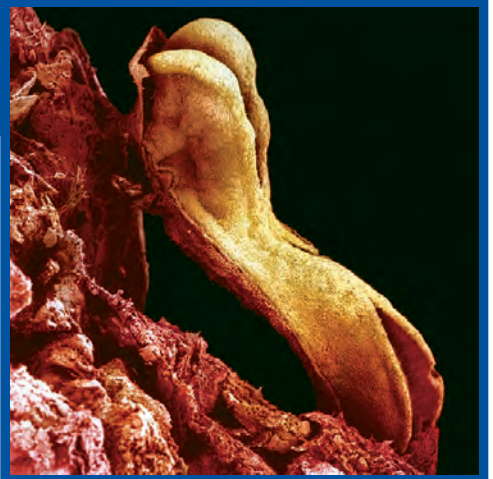
A pregnant woman may notice her first missed menstrual period at the end of the second week after conception, or about four weeks after the first day of her last normal period. There are different kinds of tests for pregnancy. Some may not be accurate for up to three weeks after conception, or five weeks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

FIRST TRIMESTER

2 WEEKS

(4 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- Following implantation the blastocyst is called an embryo.
- The embryo is about 1/100 of an inch long at this time.
- The embryo continues to grow.



4 WEEKS

(6 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The embryo is about 1/6 to 1/4 inch long and has developed a head and a trunk.
- Structures that will become arms and legs, called limb buds, begin to appear.
- A blood vessel forms which will later develop into the heart and circulatory system. Blood is beginning to be pumped and is visible by ultrasound.
- At about the same time, a ridge of tissue forms down the length of the embryo. That tissue will later develop into the brain and spinal cord.

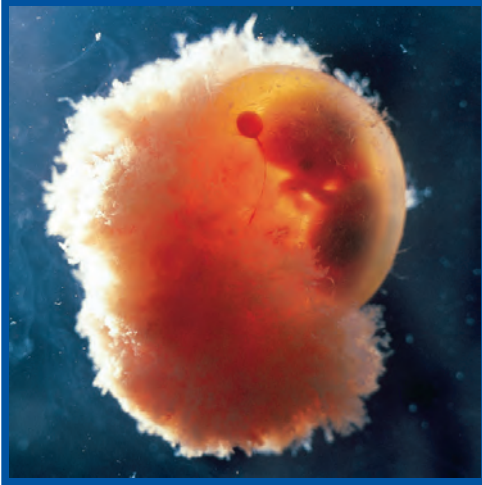


6 WEEKS

(8 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The embryo is about 1/2 to 3/4 inches.
- The heart now has four chambers.
- Fingers and toes begin to form.
- Reflex activity begins with the development of the brain and nervous system.
- Cells are starting to form the eyes, ears, jaws, lungs, stomach, intestines and liver.





8 WEEKS

(10 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

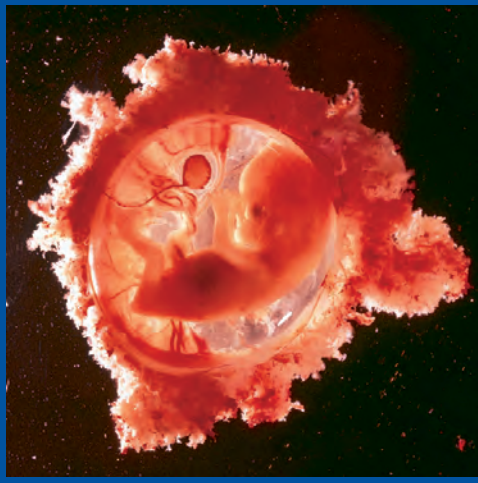
- The fetus, until now called an embryo, is about 1-1/4 to 1-1/2 inches long (with the head making up about half this size) and weighs less than 1/2 ounce.
- The beginnings of all key body parts are present, although they are not completely positioned in their final locations.
- Structures that will form eyes, ears, arms and legs are identifiable.
- Muscles and skeleton are developing and the nervous system becomes more responsive.

10 WEEKS

(12 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 2-1/2 inches from head to rump, weighing about 1-1/2 ounces.
- Fingers and toes are distinct and have nails.
- The fetus begins small, random movements, too slight to be felt.
- The fetal heartbeat can be detected with a doppler or heart monitor.
- All major external body features have appeared.
- Muscles continue to develop.





12 WEEKS

(14 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 3-1/2 inches from head to rump and weighs about 2 ounces.
- The fetus begins to swallow, the kidneys make urine, and blood begins to form in the bone marrow.
- Joints and muscles allow full body movement.
- There are eyelids and the nose is developing a bridge.
- External genitals have been developing so that the sex can be identified.

SECOND TRIMESTER

14 WEEKS

(16 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 4-3/4 to 5 inches from head to rump and weighs 4 ounces.
- The head is erect and the arms and legs are developed.
- The skin appears transparent.
- A fine layer of hair has begun to grow on the head.
- Limb movements become more coordinated.



16 WEEKS

(18 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 5 to 5-1/2 inches from head to rump and weighs about 6 to 8 ounces.
- The skin is pink and transparent and the ears are clearly visible.
- All the body and facial features are now recognizable.
- The fetus can now blink, grasp, move its mouth.
- Hair and nails begin to grow.
- The fetus has begun to kick, although women may not be able to feel the movement.

18 WEEKS

(20 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 6-1/4 inches from head to rump, weighing about 10 to 12 ounces.
- All organs and structures have been formed, and a period of simple growth begins.
- The skin is covered with vernix - a greasy material that protects the skin.
- 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.
- If an ultrasound is performed at this-time, the parents may be told the sex.

20 WEEKS

(22 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 7-1/2 inches from head to rump, has fingerprints and perhaps some head and body hair, weighing about one pound (16 ounces).
- Fetus may suck thumb and is more active.
- Time of extremely rapid brain growth.
- Fetal heartbeat can be heard with a stethoscope.
- The kidneys are starting to work.
- There is little chance that a baby could survive outside the woman's body.

22 WEEKS

(24 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 8-1/4 to 8-1/2 inches from head to rump and weighs about 1-1/4 pounds.
- Bones of the ears harden making sound conduction possible. Fetus hears mother's sounds such as breathing, heartbeat and voice.
- The first layers of fat are beginning to form.
- This is the beginning of substantial weight gain for the fetus.
- Changes are occurring in lung development so that some babies are able to survive (with intensive care services).
- Surviving babies may have disabilities and require long-term intensive care.

THIRD TRIMESTER

24 WEEKS

(26 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 9 inches from head to rump and weighs about 2 pounds.
- The fetus can respond to sound from both inside and outside the uterus.
- Reflex movements improve and body movements are stronger.
- Lungs continue to develop.
- The fetus now wakes and sleeps.
- The skin has turned red and wrinkled and is covered with fine hair.
- Almost 8 out of 10 babies born now may survive (with intensive care services).

26 WEEKS

(28 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 10 inches from head to rump and weighs about 2-1/2 pounds.
- Mouth and lips show more sensitivity.
- The eyes are partially open and can perceive light.
- Brain wave patterns resemble those of a full term baby at birth.
- About 9 out of 10 babies born now will survive (with intensive care services).

28 WEEKS

(30 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 10-1/2 inches from head to rump and weighs almost 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, cry and respond to sound.
- Rhythmic breathing and body temperature are now controlled by the brain (or Central Nervous System).
- Nearly all babies born now will survive (with intensive care services).

30 WEEKS

(32 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)



- The fetus is about 11 inches from head to rump and weighs more than 3 pounds.
- Skin is thicker and more pink.
- There is an increase in the connections between the nerve cells in the brain.
- From this stage on, fetal development centers mostly around growth.
- Almost all babies born now will survive (with intensive care services).

32 WEEKS

(34 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 11-3/4 to 12 inches from head to rump and weighs about 4-1/2 pounds.
- Ears begin to hold shape.
- Eyes open during alert times and close during sleep.
- The skin is now pink and smooth.
- Almost all babies born now will survive (some will need intensive care services).

34 WEEKS

(36 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 12-1/2 inches from head to rump and weighs about 5-1/2 pounds.
- Scalp hair is silky and lays against the head.
- Muscle tone has now developed and the fetus can turn and lift its head.
- Almost all babies born now will survive.





36 WEEKS

(38 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 13-1/2 inches from head to rump and weighs about 6-1/2 pounds.
- Lungs are usually mature.
- The fetus can grasp firmly.
- Fetus turns toward light sources.
- Almost all babies born now will survive.

38 WEEKS

(40 WEEKS AFTER THE FIRST DAY OF THE LAST NORMAL MENSTRUAL PERIOD)

- The fetus is about 14 inches from head to rump, may be more than 20 inches overall, and may weigh from 6-1/2 to 10 pounds.
- At the time of birth, a baby can display more than 70 reflex behaviors which are automatic and unlearned behaviors necessary for survival.
- The baby is full-term and ready to be born.



ABORTION METHODS & THEIR ASSOCIATED MEDICAL RISKS

If a woman has made an informed decision and chosen to have an abortion, she and her doctor must first determine how far her pregnancy has progressed. The stage of a woman's pregnancy will directly affect the appropriateness or method of abortion. The doctor will use a different method for women at different stages of pregnancy. In order to determine the gestational age of the embryo or fetus, the doctor will perform a pelvic exam and/or an ultrasound.

Abortion Risks

At or prior to eight weeks after the first day of the last normal menstrual period is considered the safest time to have an abortion. The complication rate doubles with each two-week delay after that time. The risk of complications for the woman increases with advancing gestational age.

According to 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. This risk increases with the length of pregnancy. For example:

- 1 death for every 530,000 abortions at 8 or fewer weeks
- 1 death per 17,000 at 16-20 weeks
- 1 death per 6,000 at 21 or more weeks

The risk of dying in childbirth is less than 1 in 10,000 births.

The risks or possible complications associated with an abortion are listed under each abortion procedure and are further described on pages 20 and 21 under Medical Risks of Abortions and Long-Term Medical Risks sections of this booklet.

METHODS USED PRIOR TO FOURTEEN WEEKS

■ Early Non-Surgical Abortion

- A drug is given that stops the hormones needed for the fetus to grow. In addition, it causes the placenta to separate from the uterus, ending the pregnancy.

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- A second drug is given by mouth or placed in the vagina causing the uterus to contract and expel the fetus and placenta.
 - A return visit to the doctor is required for follow up to make sure the abortion is completed.

Possible Complications

- incomplete abortion
- allergic reaction to the medications
- painful cramping
- nausea and/or vomiting
- diarrhea
- fever
- infection
- heavy bleeding

■ **Vacuum Aspiration Abortion**

- A local anesthetic is applied or injected into or near the cervix to prevent discomfort or pain.
- The opening of the cervix is gradually stretched with a series of dilators. The thickest dilator used is about the width of a fountain pen.
- A tube is inserted into the uterus and is attached to a suction system that will remove the fetus, placenta and membranes from the woman's uterus.
- A follow up appointment should be made with the doctor.

Possible Complications

- incomplete abortion
- pelvic infection
- heavy bleeding
- torn cervix
- perforated uterus
- blood clots in uterus.

■ **Dilation and Curettage Abortion**

- A local anesthetic is applied or injected into or near the cervix to prevent discomfort or pain.
- The opening of the cervix is gradually stretched with a series of dilators.
- The thickest dilator used is about the width of a fountain pen.

- A spoon-like instrument (curette) is used to gently scrape the walls of the uterus to remove the fetus, placenta, and membranes.
- A follow up appointment should be made with the doctor.

Possible Complications

- incomplete abortion requiring vacuum aspiration
- pelvic infection
- heavy bleeding
- torn cervix
- perforated uterus
- blood clots in uterus.

METHODS USED AFTER FOURTEEN WEEKS

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. It will remain in place for several hours or overnight. A second or third application of the material may be necessary.
- Following dilation of the cervix, intravenous medications may be given to ease discomfort or pain and prevent infection.
- After a local or general anesthesia has been administered, the fetus and placenta are removed from the uterus with medical instruments such as forceps and suction curettage. Occasionally for removal, it may be necessary to dismember the fetus.

Possible Complications

- 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.

Labor Induction (Including Intra-Uterine Instillation)

- Labor induction may require a hospital stay.
- Medicine is placed in the cervix to soften and dilate it.

- There are three ways to start labor early:
 - Medication is given directly into the bloodstream (vein) of the pregnant woman starting uterine contractions.
 - Medication inserted into the vagina to start uterine contractions.
 - Medication injected (instillation) directly into the amniotic sac by inserting a needle through the mother's abdomen and into the amniotic sac (bag of waters). This stops the pregnancy and starts uterine contractions.
- Labor and delivery of the fetus during this period are similar to the experiences of childbirth.
- The duration of labor depends on the size of the baby and the contractility of the uterus.
- There is a small chance that a baby could live for a short period of time depending on the baby's gestational age and health at the time of delivery.

Possible Complications

- If the placenta is not completely removed during labor induction, the doctor must open the cervix and use suction curettage (removal of uterine contents by low-pressure suction).
- 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.
- As with childbirth, possible complications of labor induction include infection, heavy bleeding, stroke and high blood pressure.
- Other medical risks may include 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 induction, 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 into the woman's vein or back, or inhaled into the lungs, is administered so the woman will not feel the surgery.

Possible Complications

- Complications are similar to those seen with other abdominal surgeries and administration of anesthesia
- Severe infection (sepsis)
- Blood clots to the heart and brain (emboli)
- Stomach contents breathed into the lungs (aspiration pneumonia)
- Severe bleeding (hemorrhage)
- Injury to the urinary tract
- Blood clots in the uterus
- Heavy bleeding
- Pelvic infection
- Retention of pieces of the placenta
- Anesthesia related complications

■ Dilation and Extraction

- This method may be performed between 20 and 32 weeks gestation.
- Sponge-like tapered pieces of absorbent material are placed into the cervix. This material becomes moist and slowly opens in the cervix. It will remain in place for one to two days. A second or third application of the material may be necessary.
- After a local or general anesthesia has been administered, the fetus and placenta are removed from the uterus with medical instruments such as forceps, suction and curette (a spoon-like instrument). It may be necessary to dismember the fetus.

Possible Complications

- Risks are similar to childbirth
- Uterine infection
- Heavy bleeding
- High blood pressure
- Rare events such as blood clot, stroke or anesthesia-related death

MEDICAL RISKS OF ABORTION

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

Pelvic Infection (Sepsis): Bacteria (germs) from the vagina may enter the cervix and

uterus and cause an infection. Antibiotics are used to treat an infection. In rare cases, a repeat suction, hospitalization or surgery may be needed. Infection rates are less than 1% for dilation and suction curettage/vacuum aspiration abortion, 1.5% for dilation and evacuation (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 dilation and evacuation (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 dilation and 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 1000 with early abortions and 3 out of every 1000 with dilation and evacuation (D & E). 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. Most are allergic reactions producing fever, rash and discomfort.

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: Findings from earlier studies suggested there was an increased risk of breast cancer among women who had an abortion.

In March 2003 the National Cancer Institute (NCI) released a consensus report finding no link between abortion and breast cancer. An additional report issued in March 2004 by a cancer research group at Oxford University also indicated there is no link between abortion and breast cancer. These summary reports may be found at <http://www.health.state.mn.us/wrtk/resources.html>.

Women who have a strong family history of cancer or who have clinical findings of breast disease should seek medical advice from a physician regardless of their decision to become pregnant or have an abortion.

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 avert her death or that a 24-hour delay will create serious risk of substantial and permanent impairment of a major bodily function.

FETAL PAIN

Some experts have concluded the unborn child feels physical pain after 20 weeks gestation. Other experts have concluded pain is felt later in gestational development. This issue may need further study.

THE EMOTIONAL SIDE OF ABORTION

Each woman having an abortion may experience different emotions before and after the procedure. Women often have both positive and negative feelings after having an abortion. Some women say that these feelings go away quickly, while others say they last for a length of time. These feelings may include emptiness and guilt as well as sadness. A woman may question whether she made the right decision. Some women

may feel relief about their decision and that the procedure is over. Other women may feel anger at having to make the choice. Women who experience sadness, guilt or difficulty after the procedure may be those women who were forced into the decision by a partner or family member, or who have had serious psychiatric counseling before the procedure or who were uncertain of their decision.

Counseling or support before and after your abortion is very important. If family help and support is not available to the woman, the feelings that appear after an abortion may be harder to adjust to. Talking with a professional and objective counselor before having an abortion can help a woman better understand her decision and the feelings she may experience after the procedure. If counseling is available to the woman, these feelings may be easier to handle.

Remember, it is your right and the doctor's responsibility to fully inform you prior to the procedures. Be encouraged to ask all of your questions.

THE MEDICAL RISKS OF CHILDBIRTH

Labor is the process in which a woman's uterus contracts and pushes, or delivers, the fetus from her body. The fetus may be delivered through the woman's vagina, or by caesarean section.

A woman choosing to carry a child to full term (40 menstrual weeks, 38 weeks after fertilization) can usually expect to experience a safe and healthy process. For a woman's best health, she should visit her physician before becoming pregnant, early in her pregnancy, and at regular intervals throughout her pregnancy.

POSSIBLE COMPLICATIONS

- Uterine infection – 10% may develop during or after delivery, and on rare occasions cause death
- Blood pressure problems – 1 in 20 pregnant women have during or after pregnancy, especially first pregnancies
- Blood loss – 1 in 20 women experience during delivery
- Rare events such as blood clot, stroke or anesthesia – related death
- Women with severe chronic diseases are at greater risk of developing complications during pregnancy, labor and delivery.
- Risk of dying as the result of a pregnancy complication is 12 per 100,000 women.

PREGNANCY, CHILDBIRTH, AND NEWBORN CARE

You may qualify for financial help for prenatal (pregnancy), childbirth and neonatal (newborn) care, depending on your income. For people who qualify, programs such as Medical Assistance (MA) or MinnesotaCare may pay or help pay the cost of doctor, clinic, hospital and other related medical expenses to help with prenatal care, childbirth delivery services and care for newborns. You can call the Minnesota Department of Human Services at 651-431-2670 (Twin Cities metro area) or 1-800-657-3739 (out state) for more information on Medical Assistance or visit their website at <http://mn.gov/dhs/>. You can call the Minnesota Department of Human Services at 651-297-3862 (Twin Cities metro area) or 1-800-657-3672 (out state) for more information on MinnesotaCare or visit their website at <http://www.dhs.state.mn.us/HealthCare/mncare>.

ADOPTION AS AN OPTION

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 number of adoption agencies, both public and private. Further information and a list of adoption agencies can be found in the Minnesota Department of Health resource guide, *If You Are Pregnant: A Directory of Services Available in Minnesota* at <http://www.health.state.mn.us/wrtk/> or, you could call the Minnesota Department of Human Services at 651-431-4656 or visit their website at: <http://mn.gov/dhs/> and click on "Children and Families," then on "Services".

There are several ways to consent to the adoption of a child. Talking with a Minnesota Licensed Adoption Agency or an attorney familiar with adoption will help identify the method that will best serve the child and yourself. Birth parents decide whether they want to remain anonymous or participate in a more open adoption-including identifying adoptive parents and establishing a plan for communication over time.

THE FATHER'S RESPONSIBILITY

The father of a child has a legal responsibility to provide for the support, medical and other needs of his child. In Minnesota, that responsibility includes child support payments to the child's mother or legal guardian. Children have 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. Additionally, children benefit from knowing their father's medical history and any potential health problems that can be passed genetically.

Paternity can be established in Minnesota by:

1. *Recognition of Parentage*: The biological parents state under oath that they are the parents of the child. This statement will assure benefits to the child. It also will establish the father's parental rights.
2. *Adjudication*: A legal action can be brought in court to determine the biological and legal father of a minor child. This process, in addition to obtaining all of the benefits of a Recognition of Parentage, establishes child support orders, custody and visitation rights. An adjudication also establishes paternity when paternity is contested. It provides legal safeguards to all parties involved.

Issues of paternity affect the legal rights of both parents and of the child. You can get general information about paternity establishment, federal regulations and state statutes about child support, and related issues 24 hours a day, seven days a week by calling:

651-431-4199 (General Information Line)

Or you can write to:

Minnesota Department of Human Services
Child Support Enforcement Division
P.O. Box 64946
St. Paul, MN 55164-0946

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.

You can find what resources may be available to you in the Minnesota Department of Health resource guide, *If You Are Pregnant: A Directory of Services Available in Minnesota*, at <http://www.health.state.mn.us/wrtk/> or you can call 651-201-3580 or 1-888-234-1137.



For additional copies of this handbook or if you require this document in another format, such as large print, Braille or cassette tape, contact:

Division of Community and Family Health

85 East Seventh Place

P.O. Box 64882

St. Paul, MN 55164-0882

651-201-3580

Toll Free: 888-234-1137

<http://www.health.state.mn.us>

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