

A Woman's Right to Know



August 2024

The Unborn Child Pain Awareness and Prevention ACT of 2005

By twenty (20) weeks gestation, the unborn child has the physical structures necessary to experience pain. There is evidence that by twenty (20) weeks gestation unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain. Anesthesia is routinely administered to unborn children who are twenty (20) weeks gestational age or more who undergo prenatal surgery.

INTRODUCTION

The information in this booklet has been developed to give a woman basic information before making a decision about having an abortion. It illustrates and describes, at two week intervals, how an unborn child grows during the stages of a woman's pregnancy. Also provided is information about the chances of a baby's survival when born at a given gestational age. Survival here is defined as living 28 days after birth.

Information is given about abortion methods and the medical risks and emotional reactions of abortion. Also described are the medical risks of childbirth. However, it should be emphasized that as technology and medical advances occur, the medical risks associated with abortion and childbirth are diminishing.

State health care programs that pay or help pay for medical bills for prenatal care, childbirth and neonatal care are explained in this publication. A directory of names, addresses and telephone numbers of public and private adoption agencies, county assistance offices and social service agencies must be provided to you. The directory is broken down by county so callers can get information and help from places located close to where they live. You can request an additional copy of the directory by calling the State Health Information Line at 1-800-235-0002. The Directory of Services is also available on the Arkansas Department of Health website at www.healthy.arkansas.gov.

By calling or visiting the agencies and offices, a woman can find out about alternatives to abortion, adoption and the kinds of assistance available to help her through pregnancy and childbirth and while she is raising her child.

Furthermore, every woman should know that:

- It is unlawful for any individual to coerce a woman to undergo an abortion.
- Any physician who performs an abortion upon a woman without obtaining her informed consent or without affording her a private medical consultation may be liable to her for damages in a civil action.
- The father of a child is liable to assist in the support of the child, even in instances where the father has offered to pay for an abortion.
- The law permits adoptive parents to pay costs of prenatal care, childbirth and neonatal care.
- If a minor is denied financial support by the minor's parents, guardian or custodian due to the minor's refusal to undergo an abortion, the minor shall be deemed emancipated for the purposes of eligibility for public assistance benefits. Benefits may not be used to obtain an abortion.

HUMAN DEVELOPMENT PRIOR TO BIRTH

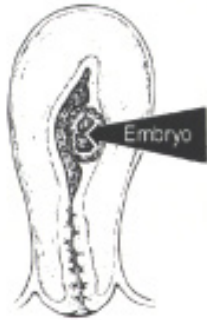
The age of an unborn child (gestational age) is measured in two different ways. Embryologists (doctors and scientists who study the early stages of pregnancy) measure the age of a fetus from the estimated day of conception (the time when you actually become pregnant). This book refers to that measurement as "weeks fertilization."

On the other hand, practicing doctors measure an unborn child's age from the first day of your last menstrual period which usually occurs two weeks before fertilization (conception). This book refers to that measurement of gestational age as "weeks menstrual." On the following pages are pictures and descriptions of how an embryo and fetus grow in a woman's body.

After fertilization, the egg divides and multiplies to form the embryo.

2 WEEKS FERTILIZATION 4 WEEKS MENSTRUAL

The developing embryo is about the size of a pin-head and is now inside a protective shell of special cells in the uterus wall. The cells are beginning to grow into groups that will be parts of the embryo.



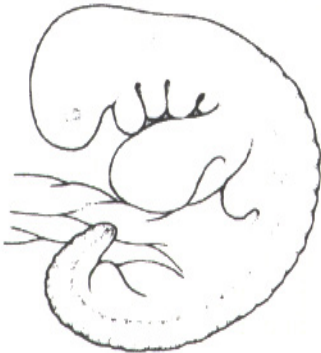
3 WEEKS FERTILIZATION 5 WEEKS MENSTRUAL

The embryo and first nerve cells have formed.



4 WEEKS FERTILIZATION

The embryo is about $\frac{1}{4}$ inch long (5 millimeters). A blood vessel forms which will later develop into the heart and circulatory system. It begins to pump blood. 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. Arm and leg buds are present.



6 WEEKS MENSTRUAL



6 WEEKS FERTILIZATION

The embryo is about $\frac{3}{4}$ inch long (23 millimeters). Cells of the embryo continue to multiply and start to form the brain. At the other end is a tail bud which will become the end of the spine. Fingers and toes are starting to appear. Cells which also are multiplying in other parts of the embryo are starting to form the eyes, ears, jaws, lungs, stomach, intestines and liver



8 WEEKS MENSTRUAL



8 WEEKS FERTILIZATION

The embryo is called a fetus. The length of the fetus, measured from the top of the head to the bottom trunk (crown to rump), is about $1\frac{1}{2}$ inches (40 millimeters). Structures which will form the eyes, ears, arms and legs are identifiable. Muscles and skeleton are developing. The fetal heartbeat can be detected electronically.



10 WEEKS MENSTRUAL



10 WEEKS FERTILIZATION

All major external body features have appeared. The fetus from crown to rump is approximately 2½ inches long (60 millimeters), and weighs roughly ½ ounce (14 grams). The muscles continue to develop. Fingers and toes are distinct and have nails.



12 WEEKS MENSTRUAL

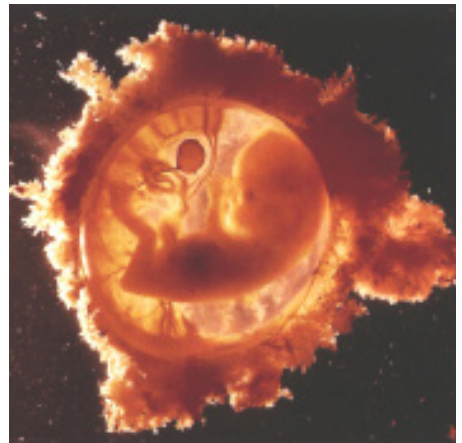


12 WEEKS FERTILIZATION

The fetus measures approximately 3½ inches long (87 millimeters), and weighs roughly 1½ ounces (45 grams). The head is still the dominant part of the fetus. The eyes are beginning to grow toward the front of the head and 20 buds are present for baby teeth. There are eyelids and the nose is developing a bridge. External genitals have been developing so that the sex can be identified.



14 WEEKS MENSTRUAL



14 WEEKS FERTILIZATION

The length of the fetus is approximately 5 inches (120 millimeters), crown to rump, and the weight is roughly 4 ounces (110 grams). Limbs are well developed. The skin appears transparent. The head is large compared to other body structures.



16 WEEKS MENSTRUAL



16 WEEKS FERTILIZATION

The fetus from crown to rump is now roughly 5½ inches long (140 millimeters). Weight is almost 8 ounces (200 grams). Skin is pink and transparent.



18 WEEKS MENSTRUAL

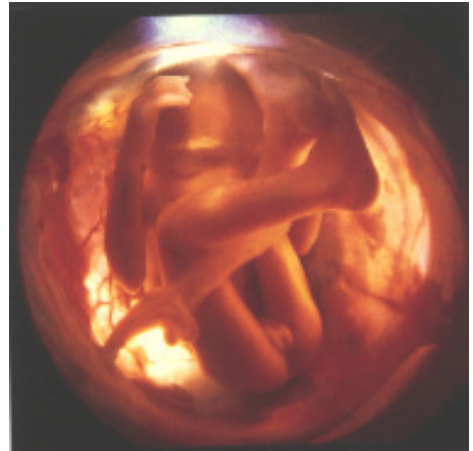


18 WEEKS FERTILIZATION

Crown to rump length is about $6\frac{1}{4}$ inches (160 millimeters). Weight is almost $\frac{3}{4}$ pound (320 grams). Fine, downy hair as well as scalp hair appears on the fetus. Respiratory movements occur, but the lungs have not developed enough to permit survival outside the uterus. By this time the woman can feel the fetus moving.

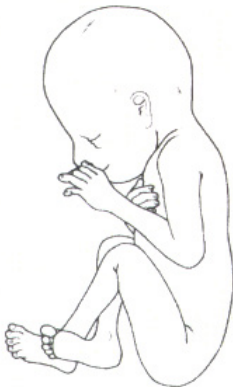


20 WEEKS MENSTRUAL



20 WEEKS FERTILIZATION

Crown to rump length is about $7\frac{1}{2}$ inches (190 millimeters). Weight is about one pound (460 grams). The kidneys are starting to work and the air sacs of the lungs are starting to develop. Rapid brain growth continues. The fetus is more active turning from side to side. Up to this time, there is very little chance that a baby would survive outside the uterus. It is estimated that 7% of babies born at this age and treated in the neonatal intensive care unit of hospitals survived to the day when they were discharged from the intensive care unit.



22 WEEKS MENSTRUAL



22 WEEKS FERTILIZATION

24 WEEKS MENSTRUAL

Crown to rump length is about 8¼ inches (210 millimeters) and weight has increased to about 1¼ pounds (630 grams). Head and body hair are evident. The skin is wrinkled and still extremely thin. Eyebrows and eyelashes are more evident. Fat is beginning to form on the fetus and, usually, evidence of the fetal skeleton can be detected. At this time, changes are occurring in lung development so that some babies at this stage may be able to survive outside the uterus, given the technology and intensive care services provided in many hospitals. Still, chances of survival are poor. It is estimated that for babies born at this time and treated in the neonatal intensive care units of hospitals, up to 62% survived to the day when they were discharged from the neonatal intensive care unit. If the baby lives, there is a likelihood it will have long term disabilities.



24 WEEKS FERTILIZATION

26 WEEKS MENSTRUAL

Crown to rump length is about 9 inches (230 millimeters) and the average weight is two pounds (820 grams). Lungs continue to develop. Body movements are stronger. Skin is red and wrinkled and covered with fine soft hair. It is estimated that for babies born at this time and treated in the neonatal intensive care unit of hospitals, up to 85% survived to the day when they were discharged from the neonatal intensive care unit.



26 WEEKS FERTILIZATION

Crown to rump length is about 10 inches (250 millimeters). Weight is about 2½ pounds (1,000 grams). The fetus continues to develop and grow. Eyes are partially open. It is estimated that 94% of babies born at 28 through 29 weeks menstrual survive.



28 WEEKS FERTILIZATION

Crown to rump length is about 10½ inches (270 millimeters) and weighs 1,300 grams or almost 3 pounds. Fat is accumulating and the body is more rounded. Fetus can open and close its eyes, suck its thumb and cry. Infants born from 30-40 weeks menstrual stand a very good chance of survival.



30 WEEKS FERTILIZATION

Crown to rump length is about 11 inches (280 millimeters). Weight is more than 3 pounds (1,700 grams). The fetus continues to develop with wrinkles appearing on the soles of the feet.



32 WEEKS MENSTRUAL



32 WEEKS FERTILIZATION

Crown to rump length is about 12 inches (300 millimeters). Weight is about 4½ pounds (2,100 grams). Skin is pink and smooth. Fat continues to accumulate, and the fetus continues to gain weight steadily.



34 WEEKS MENSTRUAL



34 WEEKS FERTILIZATION

Crown to rump length is about 12½ inches (320 millimeters). Weight is about 5½ pounds (2,500 grams). The unborn child is more round and plump and is almost fully developed. The face is less wrinkled.



36 WEEKS MENSTRUAL



36 WEEKS FERTILIZATION

Crown to rump length is about 13½ inches (340 millimeters). Weight is 6½ pounds (2,900 grams). At this time, in most cases, the unborn child is fully developed.



38 WEEKS MENSTRUAL



ABORTION METHODS AND MEDICAL RISKS

There are three ways a pregnancy can end: a woman can give birth, a woman can have a miscarriage or she can elect 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.

The First Trimester

Doctors use a vacuum aspiration method during the first trimester (the first three months of pregnancy). The doctor must first check the size of your uterus. Your doctor will ask you to lie on your back and bend your knees. He or she will place one hand in your vagina and the other on your abdomen (belly). Then the doctor will look at the opening of your uterus (the cervix) using a speculum (a special instrument). Next, the doctor will spray or inject medicine on your cervix. This prevents you from feeling much pain. The doctor will put a catheter (a soft, clear tube similar to a long straw) into your cervix. The catheter is connected to a machine that acts like a vacuum cleaner. The fetus and remaining products of conception are sucked out of the womb through the catheter.

If more than six weeks have passed since your last normal period, the doctor must first gently open (dilate) the cervix. He or she will use a larger, firmer plastic tube (a curette) to remove (evacuate) the fetus.

Ending a pregnancy in the first trimester is considered minor surgery. However, in one out of every one hundred abortions, the uterus may not be completely emptied or it may become infected. Both problems are treatable. Also, in one out of every 500 abortions the catheter may go through the wall of the uterus by accident. If this happens, the woman would need surgery to fix the tear.

The Second Trimester

Usually during a second trimester (the fourth, fifth, and six months of pregnancy), to perform an abortion, the doctor opens (dilates) the cervix and empties (evacuates) the uterus. This method is known as dilation and evacuation (D & E).

When this abortion method is used in the second trimester, the doctor may insert sponge-like material into the cervix. As the sponge gets wet it becomes larger, opening the mouth of the cervix. The doctor will remove the sponge two to sixteen hours later. The doctor uses forceps to remove the fetus or fetal parts; the doctor may also suction the fetus or fetal parts by vacuum aspiration using a larger catheter than described for the first trimester. The afterbirth is most commonly removed by vacuum aspiration.

Before the doctor will perform this procedure, he or she needs to feel the size of the uterus to determine the gestational age of the fetus. If the age is determined to be late in the second trimester, the doctor may elect to perform the abortion by labor induction.

During labor induction, labor can be started (induced) by injecting medicines or salt water into the fetal bag of water (amniotic sac). The medicine can be injected into the bag of water by cleaning the belly (abdomen) to kill germs on the skin; putting numbing medicine (anesthetic) into the skin; and pushing a needle through the skin into the bag of water. Medicine may also be injected into the woman's bloodstream through her vein to induce labor. Labor will usually begin in two to four hours.

Generally, labor induction requires a longer stay and is not performed in a clinic setting. If the afterbirth is not removed with the fetus during labor induction, the doctor must open the cervix and suction the uterus as described in the vacuum aspiration method.

When an abortion is performed by the D&E method, there is virtually no chance that the fetus will live through the procedure. When an abortion is performed late in the second trimester, the doctor may elect to inject medicine into the fetus to terminate it before doing the vacuum aspiration. If the labor induced method is used, there is minimal chance that a baby could live for a short period of time. The chance of living outside the uterus increases as gestational age increases. In the event the baby removed is alive, any physician or other medical personnel attending the baby is required by law to provide the type and degree of care and treatment which in the good faith judgement of the physician is commonly provided to any other person under similar conditions and circumstances.

Complications involved in second trimester abortions from D & E are the same as in the first trimester: the uterus may not be completely emptied, an infection may occur or instruments may tear a hole in the uterus. In second trimester abortions, there may also be heavy bleeding for a few days after the pregnancy has ended. These problems do not happen often and can be medically treated.

Complications in abortions are less frequent in the first eight weeks of pregnancy than later. Labor induction abortion carries the highest risk for problems.

Women who end their pregnancies by vacuum aspiration, labor induction or D & E, do not usually have problems getting pregnant later in life. However, it is possible that having many abortions may make it difficult to have children.

Remember, every method used to end a pregnancy may cause problems. Ask your doctor about all possible problems so he or she can provide you with advice.

The Third Trimester

Your physician may advise you to end your pregnancy early between 24 and 38 weeks gestation (weeks menstrual). Should this advice call for the use of any means to end your pregnancy with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child, then the termination of pregnancy using such means is an abortion. An abortion at this stage of your pregnancy may only be done if your physician reasonably believes that it is necessary to prevent either your death or a substantial and irreversible impairment of one of your major bodily functions.

When a pregnancy is ended at this stage, one of two procedures is performed: labor induction or cesarean section.

If pregnancy is ended by labor induction during the third trimester, it is quite different from the description above. In the third trimester, labor can be started by injecting medicine directly into the bloodstream (vein) of the pregnant woman. Labor and delivery of the fetus during the third trimester are similar to childbirth. The duration of labor depends on the size of the baby and the "readiness" of the womb.

As with childbirth, the complications of labor induction during the third trimester include: infection, heavy bleeding, stroke and high blood pressure. When medicines are used to start labor, there is a greater risk of rupture of the womb than during normal childbirth.

If labor cannot be started by injecting medicine into the pregnant woman, or if the pregnant woman is too sick to undergo labor, a cesarean section may be done. A cesarean section is surgery to remove the baby from the womb. Generally, the woman is made numb and sleepy by a combination of medicines injected in the vein or spine and/or medicine inhaled into the lungs. Then the belly is prepared by washing with a soapy solution (antiseptic) to kill the germs. The belly and womb are then surgically cut open and the baby removed.

The complications seen with cesarean section are similar to those seen with childbirth and with administration of anesthesia: sepsis (severe infection); emboli (blood clots to the heart and brain); aspiration pneumonia (stomach contents breathed into the lungs); hemorrhage (severe bleeding); and injury to the urinary tract.

The likelihood that your baby will live after it is delivered during this stage of your pregnancy depends on the baby's gestational age and health at the time of delivery. When an abortion is performed during the third trimester the following steps must be taken:

1. The physician who terminates the pregnancy must certify in writing that based upon the physician's medical examination and medical judgement, the abortion is necessary to prevent either your death or substantial and irreversible impairment to one of your major bodily functions.
2. A second physician must also examine you and certify in writing that based upon that physician's medical examination and medical judgement, the abortion is necessary to prevent either your death or substantial and irreversible impairment of one of your major bodily functions.
3. The abortion must take place in a hospital.
4. The physician must select a procedure that is most likely to allow the unborn baby to live.
5. A second physician must also be present in the room in which the procedure is performed. That physician will take charge of medical care for the baby immediately after it is delivered and must take all reasonable steps necessary to preserve the baby's life and health.

The physician is not required to use the abortion method that would provide the best opportunity for the baby to live if the physician determines in his or her good faith medical judgement that use of that method poses a significantly greater risk to your life or to the substantial and irreversible impairment of one of your major bodily functions than would another method.

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

CHEMICAL METHODS (MEDICAL ABORTION)

Women who want to end their pregnancies in the early stages may choose to use medications (mifepristone and misoprostol). Mifepristone (known as the abortion pill or RU- 486) was specifically developed and tested as an abortion-inducing drug. It has been used safely by millions of women worldwide since 1988. It was approved for use in the United States by the Food and Drug Administration (FDA) in September 2000. It causes changes in the lining of the uterus (womb) that result in loss of the pregnancy. The second medication is misoprostol. It was invented initially to prevent stomach ulcers but has also been used to induce labor. When used for medical abortions, it causes the uterus (womb) to contract and empty.

According to the protocol approved by FDA, you can use this abortion process if you are no more than 49 days past your last menstrual period and have been carefully screened to ensure that you do not have any physical conditions, such as adrenal or bleeding problems, allergic reactions to either of the drugs, or long term steroid use that could make the drugs dangerous for you. Occasionally these drugs have been used up to nine weeks after the last menstrual period (or 63 days). Generally, surgical methods are a safer and a better option after this time. The shorter the time you have been pregnant, the better the medication will work.

At your first clinic visit, you will undergo the screening and will learn about the process and what to expect. You will be asked to take an ultrasound to determine the age of the fetus or the location of

the pregnancy. These are important things to know because the drugs' effectiveness decreases with gestational age and they do not treat ectopic pregnancy—a condition that can prove fatal if it is not detected and treated. Typically, a medical abortion requires anywhere from one day to four weeks to work. Approximately 95% of women will have a complete abortion within a week.

Bleeding may range from light to something like a heavy menstrual period and may last for 1 to 2 weeks after the abortion. You will get written and verbal guidelines to help you understand what to expect and when to call the clinic for further evaluation. The most common side effects of a medical abortion are cramping, bleeding, headache, nausea, vomiting, diarrhea, fever, chills, and/or fatigue. The embryo at seven weeks is less than 1/2 of an inch and usually not seen when passed. If your bleeding or pain is excessive or goes on for an extended period of time, seek help immediately.

Approximately 95% - 98% of women choosing this method will have a successful abortion. Up to 1-5% of women will have non-viable retained tissue and will need a D&C (dilatation and curettage) or suction aspiration (like a surgical abortion) in order to complete this procedure and prevent prolonged heavy bleeding, cramping, and/or infection. Your first menstrual period after this procedure may be heavier than your normal menstrual cycle. The majority of women returned to normal cycles by their second menstrual cycle after the procedure. In cases of excessive bleeding or fever above 100.4°F, you should contact your provider immediately or go to an emergency room. Rarely, a transfusion may be necessary.

Although the medical abortion method is successful in most cases, sometimes this method does not work. This happens less than one time out of 100, and the pregnancy must be terminated by a surgical (suction) procedure. Continuing the pregnancy at this point is risky because mifepristone can cause birth defects. A follow-up visit is required to be sure that the abortion has been completed. This method, like all procedures, has risks.

The potential exists for a qualified person to reverse the effects of abortion-inducing drugs such as mifepristone and misoprostol. However, the safety and efficacy of this process have not been established. For more information, please contact your physician or medical provider.

ABORTION REVERSAL

Notice to Patients Having Medication Abortions That Use Mifepristone: Mifepristone, also known as RU-486 or Mifeprex, alone is not always effective in ending a pregnancy. It may be possible to reverse its intended effect if the second pill or tablet has not been taken or administered. If you change your mind and wish to try to continue the pregnancy, you can locate immediate help by searching the term "abortion pill reversal" on the internet. However, the safety and efficacy of this process has not been established. You may also get more information by contacting your physician or medical provider.

EMOTIONAL REACTION TO ABORTION

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 awhile after the abortion she may also feel a sense of emptiness or guilt, wondering whether her decision was right. Some women who describe these feelings find they go away with time. Other women 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 professional and objective counselor can help a woman fully consider her decision before she takes any action.

MEDICAL RISKS OF CHILDBIRTH

Continuing a pregnancy and delivering a baby is usually a safe, healthy process. Based on data from the Centers for Disease Control and Prevention (CDC), the risk of dying as a direct result of pregnancy and childbirth is less than 10 in 100,000 live births. This risk is higher for African American women (22.0 in 100,000).

The most common causes of death of a pregnant woman are:

- Emboli (blood clots affecting the heart and brain).
- Eclampsia (high blood pressure complications affecting pregnancy).
- Hemorrhage (severe bleeding).
- Sepsis (severe infection).
- Cerebral vascular accidents (stroke, bleeding in the brain).
- Anesthesia-related deaths.

Together, these causes account for 80% of all deaths relating to a woman's pregnancy. Unknown or uncommon causes account for the remaining 20% of deaths relating to pregnancy. Women who have chronic severe diseases are at a greater risk of death than healthy women. Continuing your pregnancy also includes a risk of experiencing complications that are not always life threatening.

- Approximately 15 to 20 of every 100 pregnant women require cesarean delivery (delivery by cutting open the abdomen).
- One in 10 women may develop infection during or after delivery.
- Approximately one in 20 pregnant women have blood pressure problems.
- One in 20 women suffer from excessive blood loss at delivery.

INFORMATION ABOUT STATE HEALTH CARE PROGRAMS THAT PAY FOR PRENATAL CARE, CHILDBIRTH AND NEONATAL CARE

There are many public and private agencies willing and able to help you carry your child to term and assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of Arkansas strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician and his or her agent give you the opportunity to call agencies like these before you undergo an abortion.

You may or may not qualify for financial help for prenatal, childbirth and neonatal care, depending on your income. If you qualify, programs such as the Arkansas Medicaid program 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. Contact your local Department of Human Services (DHS) county office or your local Arkansas Department of Health local health unit for more information.

THE FATHER'S RESPONSIBILITY

Paternity may be established by a father's signature on a birth certificate, by a statement of paternity, or by court action. More information concerning establishment of paternity and child support services may be obtained by calling your local Child Support Enforcement Office. To locate an office in your area, or for more information, call 501-682-8398. A complete list of Child Support Enforcement offices can also be found in the Directory of Services provided to you, or on the Arkansas Department of Finance & Administration website at www.dfa.arkansas.gov.

DIRECTORY

The decision to have an abortion or have a baby must be carefully considered. If you need more help or guidance, a directory of county and social service agencies and organizations along with public and private adoption agencies has been provided to you. You are encouraged to contact any of these organizations or agencies if you need more information so that you can make an informed decision.

Your doctor is required to give you a copy of the directory. If you want to obtain an additional copy of the directory, call the toll-free State Health Information Line at 1-800-235-0002 or visit the Arkansas Department of Health website at www.healthy.arkansas.gov.

For more information go to:
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