

Informed Consent Information



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This booklet is designed to provide you with information about pregnancy and issues that relate to it, including:

- The development of your unborn child from conception until birth
- Abortion methods and risks
- Adoption
- Birth control options

Development

The Age of Your Developing Baby

In women with regular menstrual periods (about every 28 days), pregnancies are commonly dated by the number of weeks since your last menstrual period (LMP). Fertilization occurs about 2 weeks from the **first** day of your LMP, so the age of your embryo or fetus is 2 weeks less than the date calculated from your LMP. For example, if your doctor tells you that you are 6 weeks pregnant then your embryo is actually 4 weeks old. Ideally, an obstetric sonogram (ultrasound) is used to determine the number of weeks of pregnancy and your delivery date.

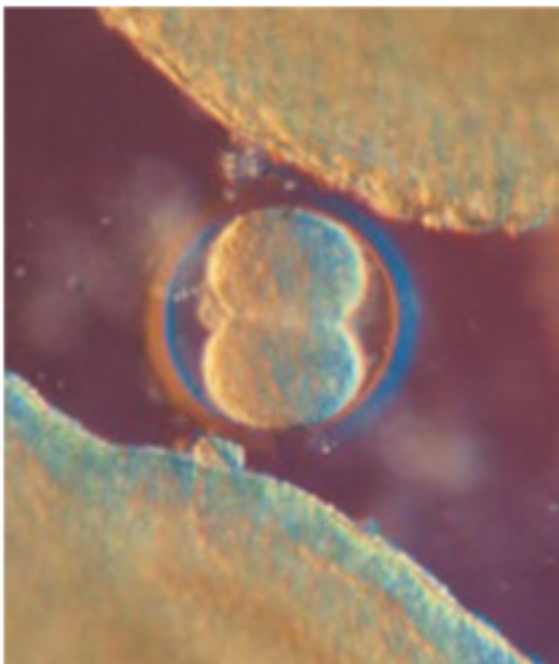
Some women have regular menstrual periods that are longer or shorter than 4 weeks apart. For these women, adjustments are necessary when dating the pregnancy based on the last menstrual period.

The size of the embryo and fetus is commonly measured using the crown-rump (CR) length. This measurement is the straight-line distance from the top of the head to the bottom of the rump or buttocks. The measurements referred to in this section are crown-rump lengths.

In the first 12 weeks of pregnancy (10 weeks from fertilization) a developing child is a group of cells usually called an **embryo**.

After 12 weeks since LMP, an unborn child is referred to as a **fetus**.

Timeline of Growth



Fertilization (2 weeks LMP)

- Size: about the size of a pinhead.
- Cell division and growth begins just hours after fertilization of the ovum (egg).

The fertilized ovum becomes known as a *zygote*.



2 weeks after fertilization (4 weeks LMP)

- Size: about 1mm long (less than 4 hundredths of an inch).
- During the days following fertilization, cell division continues while the fertilized ovum moves down the fallopian tube toward the uterus.
- About 6 days after fertilization, the fertilized ovum begins to implant itself into the wall of the uterus.

Photo shows an embryo at five weeks after the first day of the last menstrual period (three weeks after fertilization).



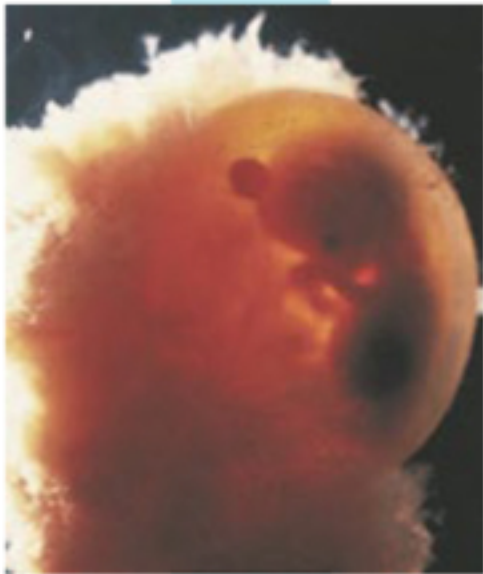
4 weeks after fertilization (6 weeks LMP)

- Size: 4 to 5 mm long (less than 1/4 of an inch).
- Heart is forming and begins to beat.
- Arm and leg buds are present.
- The central nervous system and other organs are developing.
- Development of the brain and spinal cord begins.



6 weeks after fertilization (8 weeks LMP)

- Size: 22-24 mm long (greater than 3/4 of an inch)
- Head is large in comparison to trunk
- Fingers and toes are developing.
- Eyes and ears are beginning to form.



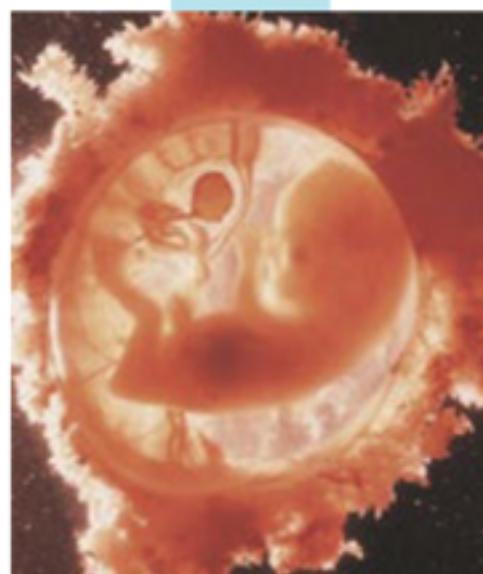
8 weeks after fertilization (10 weeks LMP)

- Size: 40 mm (1.5 inches) long
- All major body organs have started to form.
- Skeletal bones are forming.
- Sex organs begin to develop.
- Eyelids developing.



10 weeks after fertilization (12 weeks LMP)

- Size: about 60 mm (2.3 inches) long
- Weight: about 14 grams, or 1/2 ounce
- Eyelids closing or closed at 11 weeks. They won't reopen until the 28th week.
- Fingers and toes differentiated and fingernails are developing.
- Fetus is beginning to show signs of sex: male or female.
- Some hair begins to appear.
- Organs and structures continue to grow.



12 weeks after fertilization (14 weeks LMP)

- Size: about 87 mm (3.4 inches) long
- Weight: about 45 grams, or 1.5 ounces
- Sex of fetus is distinguishable externally.
- Neck is well defined.



14 weeks after fertilization (16 weeks LMP)

- Size: about 120 mm (4.7 inches) long
- Weight: about 110 grams, or 3.8 ounces
- Head is erect.
- Lower limbs are well developed.
- Skin is transparent.
- Fetus makes active movements.



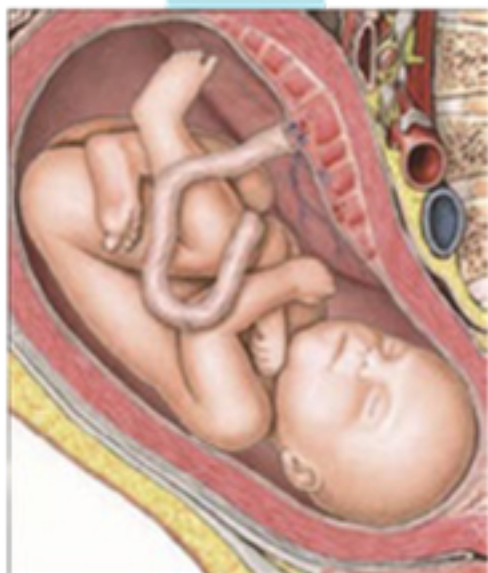
16 weeks after fertilization (18 weeks LMP)

- Size: about 140 mm (5.5 inches) long
- Weight: about 200 grams, or 7 ounces
- Ears stand out from head. Fetus can hear sound.
- Fetus is able to swallow.



18 weeks after fertilization (20 weeks LMP)

- Size: about 160 mm (6.3 inches) long
- Weight: about 320 grams or 11.3 ounces
- Hair called *lanugo* covers body.
- A waxy substance called *Vernix caseosa* covers the fetus and keeps the skin from becoming chapped from the amniotic fluid.
- Early toenail development taking place.



20 weeks after fertilization (22 weeks LMP)

Midpoint of pregnancy

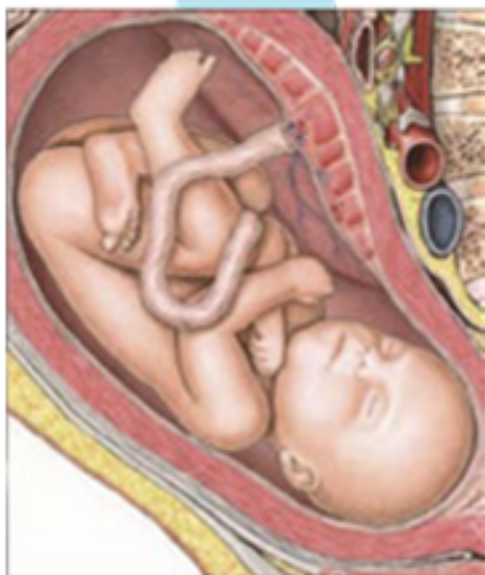
- Size: about 190 mm (7.5 inches) long
- Weight: about 460 grams, or 1 pound
- Head and body hair (lanugo) is visible.
- Fetus can feel touch.

An infant born now has a small chance of surviving.



22 weeks after fertilization (24 weeks LMP)

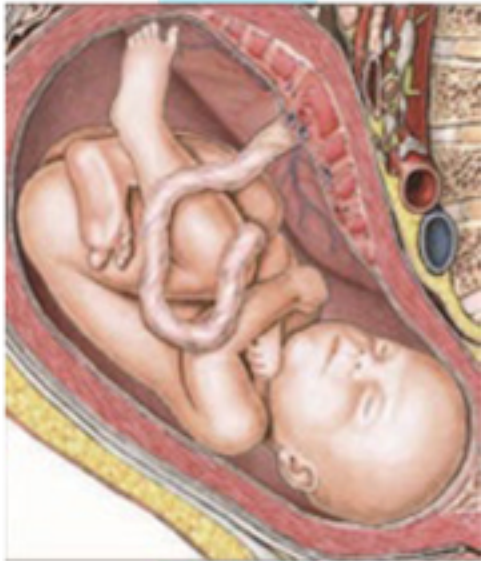
- Size: about 210 mm (8 inches) long
- Weight: about 630 grams, or 1.4 pounds
- Eyebrows and eyelashes are recognizable.
- Skin is wrinkled and red.
- Inner ear is developed, which means the fetus may be able to tell when it is upside down or right side up.
- Lungs continue to develop.



24 weeks after fertilization (26 weeks LMP)

- Size: about 230 mm (9 inches) long
- Weight: about 850 grams, or 1.8 pounds
- Fingernails are present.
- The body of the fetus is thin. Fetus will begin to store fat.

About 4 out of 5 infants born now survive with proper medical care.



26 weeks after fertilization (28 weeks LMP)

- Size: about 250 mm (9.8 inches) long
- Weight: about 1,100 grams, or 2.4 pounds
- Fetus has thin red skin.
- Eyes are partially open and eyelashes are growing.

More than 9 out of 10 infants born now survive with proper medical care.



28 weeks after fertilization (30 weeks LMP)

- Size: about 270 mm (10.6 inches) long
- Weight: about 1,300 grams, or 2.9 pounds
- Eyes are open.
- Hair is visible on the head.
- Skin is slightly wrinkled.
- Fetus is making breathing movements.



30 weeks after fertilization (32 weeks LMP)

- Size: about 280 mm (11 inches) long
- Weight: about 1,800 grams, or 4 pounds
- Toenails are present.
- Body is filling out.
- Testes descending in males.

Infants born at this age usually survive.



32 weeks after fertilization (34 weeks LMP)

- Size: about 300 mm (11.8 inches) long
- Weight: about 2,100 grams, or 4.6 pounds
- Fingernails now reach fingertips.
- Skin is pink and smooth.



34 weeks after fertilization (36 weeks LMP)

- Size: about 320 mm (12.5 inches) long
- Weight: about 2,500 grams, or 5.5 pounds
- Fetus continues to increase body fat.

Infants born now have an excellent chance of survival.



36 weeks after fertilization (38 weeks LMP)

- Size: about 340 mm (13.4 inches) long
- Weight: about 2,900 grams, or 6.4 pounds
- Body of fetus is plump.
- Toenails reach tips of toes.



37 weeks after fertilization (39 weeks LMP)

- Size: about 350 mm (13.7 inches) long
- Weight: about 3,175 grams, or 7 pounds

Fetus is now considered full-term.

38 weeks after fertilization (40 weeks LMP)

- Size: about 360 mm (14 inches) long
- Weight: about 3,400 grams, or 7.5 pounds
- Fetus receives antibodies from the mother that will strengthen its immune system.

All measurements referred to in this section are crown-rump lengths.

Risks of Pregnancy

The most common pregnancy complications according to the Centers for Disease Control and Prevention (CDC) include:

Miscarriage: The loss of a pregnancy from natural causes before the embryo/fetus can survive outside the womb.

Ectopic pregnancy: A pregnancy in which the fertilized egg grows outside of the uterus.

Hemorrhage: Excessive bleeding before, during or after delivery that may require medical or surgical treatment.

Infection

Diabetes: Gestational diabetes is high blood sugar in the mother that develops during pregnancy. The condition usually resolves after delivery, but those mothers are at a higher risk of becoming diabetics in months or years to come.

High blood pressure

Excessive vomiting

Premature labor: Labor that starts before the end of 37 weeks of pregnancy.

Need for a Cesarean delivery: Surgical delivery of the baby may be needed if the woman cannot have a vaginal delivery.

Depression: Women may experience feelings of sadness, fear, anger and anxiety after having a baby. These feelings are normal and usually go away after a week or two. If a woman experiences lingering depression, she should talk with her doctor or a professional counselor.

The risk of the mother dying from pregnancy is determined by a variety of factors including age, race, ethnicity and country of birth. Maternal death can be caused by:

- Hemorrhage (excessive bleeding)
- Infection
- Amniotic fluid in the bloodstream
- Blood Clots
- High blood pressure
- Stroke
- Heart muscle disease

The risk of dying is greater for women over 40.

The risk to you will depend on your individual health, age, and condition or other factors. You should consult with your physician concerning risks to you.

Abortion Methods and Risks

There are two types of induced abortion methods that can be used to end a pregnancy.

- **Medical** (non-surgical) abortions involve the use of medications to end pregnancy.
- **Surgical** abortions require invasive procedures or the use of surgical instruments.

Prior to any procedure, a medical professional must confirm that you are pregnant and determine how long you have been pregnant. The age of the embryo or fetus and your health determine the types of abortion methods available to you.

Medical (Non-Surgical) Abortion

- Involves the use of specialized medications to end a pregnancy.
- Is usually an option early in pregnancy – up to 49 days (7 weeks) after LMP.
- Does not usually require an invasive procedure.
- Requires at least two visits to provider.
- May take from days to weeks to complete, depending on what method is chosen.
- Requires a follow-up visit to ensure that abortion is complete.
- May involve more bleeding and cramping than with surgical abortion.
- Some of the process may happen at home.

Women should avoid medical abortion if they:

- Have chronic adrenal failure.
- Take medicine to thin blood.
- Have a bleeding problem.
- Take certain steroid medicines.
- Have an intrauterine device (IUD). The IUD must be removed before a medical abortion.
- Have inherited porphyrias.
- Cannot attend required visits or does not understand the effects of treatment.
- Have an allergy to medicines used in procedure.
- Don't have access to emergency care.
- Are unwilling to undergo a surgical abortion if the medical abortion is not complete.

In addition, the medications mifepristone and misoprostol should not be used if a woman has or might have a tubal pregnancy. Be sure that your physician is aware of any special medical conditions that you have.

Drugs used in medical abortions

- **Mifepristone** (Mifeprex or RU-486) blocks the hormone progesterone, causing the lining of the uterus to thin, and leading to detachment of the embryo.
- **Methotrexate** stops the implantation process that takes place during the first few weeks after conception.
- **Misoprostol** causes the uterus to contract and expel the embryo or fetus.

Methods

The following is the FDA-approved procedure for medical abortion. However, individual clinics may have somewhat different protocols. Variations of the FDA procedures have been shown to be effective.

Mifepristone and Misoprostol

This method requires three visits to the doctor. Before treatment you should tell your doctor if you smoke 10 or more cigarettes a day.

During the first visit, a woman will be given three pills of mifepristone (Mifeprex) to take by mouth. Two days later, the woman returns to the doctor and takes two tablets of misoprostol. Misoprostol causes contractions; however, both medications cause vaginal bleeding. After taking misoprostol, the patient normally stays at the office/clinic for about 4 hours. Within a few hours, bleeding and cramping will begin, and the woman may also experience nausea, vomiting, diarrhea, fever, chills, and/or feel tired. During this time she may expel the embryo. If the embryo is not expelled after four hours she may be examined before she leaves to determine whether the abortion has occurred. The woman may then pass the embryo at home.

At the follow-up visit that occurs within 10-15 days the woman is examined to make sure the abortion is complete and that there are no complications. If it is determined that the embryo is still growing, a surgical abortion would be required to terminate the pregnancy since these medications can cause birth defects if the pregnancy is allowed to continue. Therefore, medical abortion should be considered irreversible once the first drug has been taken.

Methotrexate and Misoprostol

On the first visit, the woman receives a dose of methotrexate. A shot is the most common way to administer this drug, although it can be taken in pill form. This stops the process of implantation into the uterus. Three to seven days later the woman self-administers the misoprostol tablets vaginally. The misoprostol causes the uterus to contract and empty.

A follow-up visit should be made within 24 hours of taking misoprostol. This appointment typically falls about one week after the methotrexate is given. At the follow-up visit a vaginal ultrasound examination will be performed to determine whether the embryo has been expelled. If a complete abortion has not occurred, then the misoprostol dose may be repeated. If the ultrasound shows no embryonic cardiac (heart) activity, the woman returns for a follow-up in four weeks. If cardiac activity is present then the woman must return in one week.

On the return visit, if cardiac activity is still present two weeks after the treatment began, or if expulsion of the embryo has not occurred by the 4-week follow-up visit, a surgical abortion would be required to terminate the pregnancy since these medications can cause birth defects if the pregnancy is allowed to continue. Therefore, medical abortion should be considered irreversible once the first drug has been taken.

Side Effects

Common side effects from both methods of medical abortion include:

- Bleeding and pain
- Nausea
- Vomiting
- Diarrhea
- Warmth or chills
- Headache
- Dizziness
- Fatigue

Surgical Abortion

- Involves the use of surgical instruments.
- Allows use of sedatives if desired.
- Usually requires one or two visits, plus a follow-up visit.

Methods

The surgical abortion procedures described below are general models. Individual clinic protocols (procedures) may differ.

First Trimester Procedures

- **Manual vacuum aspiration** (Menstrual aspiration or extraction)
(1-3 weeks after the first day of last menstrual period)

This is a procedure used very early in pregnancy. The cervix is dilated and a tube (cannula) is inserted into the uterus. The tube is attached to a syringe. The syringe creates a vacuum that removes the embryo and pregnancy tissue from the uterus.

- **Vacuum aspiration** (suction curettage, vacuum curettage)
(Up to 12 weeks after the first day of last menstrual period)

During a surgical abortion, sedatives may be used to relax the patient. In some instances, general anesthesia may be used. This puts the patient to sleep for the procedure.

Prior to the abortion, local anesthetic is applied to the area around the cervix to numb the area. The patient lies on the exam table with her feet in the stirrups just as she would for a pelvic exam. A speculum (medical instrument) is used to hold the vagina open. Before the doctor can perform the abortion he/she must open or dilate the cervix (the cervix is a ring of tissue located at the lower end of the uterus). Two different methods can be used to dilate the cervix. The first involves inserting thin rods (luminaria) into the cervix which expand slowly over a period of time. It might take hours or even days to complete the dilation. The other method involves using tapered rods to dilate the cervix. Once dilated, a small, flexible tube or *cannula* is inserted into the uterus. The tube is attached to a suction or vacuum pump. The suction of the machine removes the embryo or fetus from the uterus. This part of the procedure usually takes between 5 and 10 minutes. The doctor will check the walls of the uterus to see if the abortion is complete. Some patients may experience cramping during or after the procedure. Bleeding may last for up to two weeks following the procedure.

Second Trimester Procedures

- **Dilation and Evacuation (D & E)**

(Greater than 13 weeks from first day of last menstrual period)

The D&E procedure is the most common for second trimester abortions. The D&E procedure is essentially the same as the procedure used for vacuum aspiration. The doctor will insert dilators into the cervix in order to open the cervix. This could take place quickly or it could take place over a couple of days depending on the method used to dilate the cervix. After dilation, the doctor will use a suction tube to remove the fetus. The doctor may also use forceps to remove fetal parts that are too large to pass through the suction tube. The doctor will check to see if the abortion is complete by inspecting the walls of the uterus. The procedure takes from 10 to 30 minutes.

- **Labor Induction**

(Used later in pregnancy)

Most abortion procedures are performed on an outpatient basis in a doctor's office or a clinic, but the labor induction method normally involves a hospital stay. This procedure involves using drugs to cause contractions. The drugs may be administered vaginally, by injection into the uterus, or through an IV (intravenous line). Typically, the drugs used are prostaglandins which cause the uterus to contract. Sometimes saline, urea, oxytocin or a combination of drugs are used to induce labor. Normally within 12 hours the drugs cause the patient to go into labor to expel the fetus. The labor-inducing drugs may cause nausea, diarrhea, fever and vomiting.

Risks of abortion

- **Incomplete abortion:** Occurs when the embryo or fetus is not completely removed and requires additional procedures.
- **Infection:** May occur if bacteria from the cervix or vagina enter the uterus after an abortion. Infection may complicate becoming pregnant in the future and may increase chances of a tubal pregnancy.
- **Hemorrhage:** Excessive bleeding following an abortion may include clots. In rare cases, it could require a blood transfusion.
- **Damage to the uterus:** Can occur in surgical abortions if surgical instruments go through the wall of the uterus. May cause damage to other organs as well which may necessitate further surgery.
- **Tear in the cervix:** Can occur in surgical abortions and may be repaired with stitches.
- **Death:** The risks associated with abortion increase with the length of pregnancy.
- **Emotional Reactions:** Emotional effects from an induced abortion are difficult to study scientifically. People are different and may not react in the same way after having an abortion. A woman may have both positive and negative feelings. She may feel relief, sadness, guilt or regret. A woman's current situation and emotional well-being can be factors that affect her reaction. Talking with a professional, objective counselor before taking any action may help a woman to completely consider her decision. If emotional problems persist after having an abortion, a woman should talk about her feelings with a professional counselor.

- **Repeat abortions** may increase your risk of some complications in future pregnancies.

Any risk to you will depend on your individual health, age, and condition, or other factors. You should consult with your physician concerning risks to you.

Things to watch for following an abortion

- Severe abdominal or back pain
- Bleeding that is heavier than a normal menstrual period (soaking two or more sanitary pads in one hour)
- Foul-smelling discharge or drainage from the vagina
- A fever above 100°F
- Passage of a blood clot as large or larger than three centimeters, or one and one-fourth inches in diameter (the approximate size of a fifty-cent piece)
- Passage of tissue

If any of the problems listed above occur you should call your doctor immediately.

Adoption

Women or couples facing an unplanned pregnancy who cannot or do not wish to take on the responsibilities of parenthood also have the option of adoption. The [Mississippi Department of Child Protection Services](#) is the public agency responsible for adoptions in Mississippi, and there are licensed private adoption agencies in the state as well.

The [informed consent resources directory](#) on the Mississippi State Department of Health website ([HealthyMS.com/informed](#)) contains listings of public and private child placing agencies that are licensed in Mississippi. You can find out about the different types of adoption by contacting an agency that provides adoption services.

Placing a child for adoption can be a hard decision to make. You may want to take advantage of counseling and support services that are available for individuals who decide to place a child for adoption.

State law permits adoptive parents to pay the cost of prenatal care, childbirth, and neonatal care.

The Father's Duty

The father of a child has a legal responsibility to provide support for that child. That duty may include child support payments.

The Mississippi Department of Human Services has a Child Support Division that helps to secure financial, medical and emotional support for children and families. The program helps families establish paternity, obtain orders for payment of child support, and secure compliance with child support orders. The amount of child support is determined by a judge and is based on income levels and other factors.

With paternity establishment, the child will know who his or her father is and have the benefit of knowing his or her own medical history. More information concerning paternity establishment may be obtained from the [Mississippi Department of Human Services](#), or one of its county offices. Call 601-359-4500 for more information.

Birth Control Options

[Almost half the pregnancies that occur in the United States each year are unplanned.](#)

Birth control helps prevent pregnancy by using medications, devices or other methods.

How well does birth control work?

How well birth control will work for you depends on the method you choose, and using it consistently and correctly. Birth control methods such as the pill, Depo-Provera shots, or an IUD are highly effective; they work almost all the time (99 percent of the time or more) if used the right way.

Other methods like the diaphragm, condoms (rubbers) or sperm-killing foams and creams can work well but depend on your using them correctly every time you have sex. Natural family planning only works if both partners are willing to learn how to do it and to not have sex for up to half of each month.

Abstinence (not having sex) is the only way to prevent pregnancy that works 100 percent of the time.

If you are sexually active and do not use any birth control, you have about an 85 percent chance of getting pregnant.

Birth Control Choices

The basic types of birth control are:

Abstinence: Abstinence means deciding not to have sex and sticking with that decision.

Barrier: Barrier methods make a “wall” that blocks sperm from entering a woman’s uterus.

Some examples:

- Diaphragm: Cap-shaped device put over the cervix each time you have sex
- Spermicides: Foam, cream, jelly or film put in the vagina each time you have sex
- Condoms (Rubbers): Latex sheath worn by the man each time you have sex

Hormonal: Hormonal methods use medicines to stop the woman from making an egg that could be fertilized.

Some examples:

- Pills: pills that you take by mouth once a day
- Depo-Provera Shots: shots that you take once every three months

Natural family planning: The natural method requires that a woman check her body temperature, cervical mucus and calendar each day to predict when it is safe to have sex.

IUD: This small plastic object is placed in the uterus for a year or more and prevents pregnancy by not allowing an egg to implant itself in the uterus.

Sterilization: This is an operation which makes a woman permanently unable to have children in the future, or for a man to father children in the future.

Choosing a form of birth control

What's the best birth control choice for me?

Many women use different birth control methods during their lives. What method you use depends on whether you have any health problems, how your partner feels about birth control, any side effects and how easy it is to use, among other things.

There is no "perfect" birth control method. Each method can work and some methods work better than others. Before you decide, you need to know how each kind of birth control works, what the good points are for each one and what problems you might have. Each woman must decide for herself what will work best.

How can I choose?

Find out everything you need to know about the methods you might want to use. Talk to your partner about birth control. Birth control works best when the man and the woman pick out the birth control method together. This is even more important if you pick a method that you use each time you have sex.

Pick out a birth control method you like and learn to use it the right way.

Plan ahead. Be sure you have what you need before you have sex. For example, if you miss a pill, get some condoms to use.

What if I have problems?

It may take a little while to learn how to use birth control or for your body to get used to it. If you try one kind of birth control and do not like it, there are other kinds to try. If you continue to have problems, you should contact your doctor. It's important to use birth control if you are having sex and do not want to get pregnant.

Where do I get birth control?

You can get free or low cost birth control supplies or medicines in private at county health department clinics or community health centers. You can also buy condoms and spermicides (foams, creams and jelly) at drug or grocery stores.

What if I can't afford birth control?

Your county health department can help you get the birth control you need. For information, call a county health department near you.

Acknowledgements

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This document is available online at the website of the Mississippi State Department of Health:
<http://HealthyMS.com>

Further Resources

The Mississippi State Department of Health website has a list of resources for adoption, abortion and family counseling at HealthyMS.com/informed.

Agencies

Mississippi Department of Human Services

<http://www.mdhs.ms.gov>

Mississippi Department of Child Protection Services

<https://www.mdcps.ms.gov>

Mississippi State Department of Health

<https://msdh.ms.gov>



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