Did you know...
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Weeks of Pregnancy</td>
<td>4</td>
</tr>
<tr>
<td>Risks of Pregnancy</td>
<td>15</td>
</tr>
<tr>
<td>Abortion Methods and Risks</td>
<td>17</td>
</tr>
<tr>
<td>Adoption</td>
<td>25</td>
</tr>
<tr>
<td>The Father’s Duty</td>
<td>26</td>
</tr>
<tr>
<td>Birth Control Options</td>
<td>27</td>
</tr>
<tr>
<td>Copyrights and References</td>
<td>31</td>
</tr>
<tr>
<td>General Information</td>
<td>32</td>
</tr>
</tbody>
</table>

These materials are published by the Alabama Department of Public Health as required by Act No. 2002-419, enacted by the Alabama Legislature, Regular Session 2002.

Informational materials in alternative formats will be made available upon request.
As the title suggests, this booklet is designed to provide you with information about pregnancy including:

- the developmental characteristics of an unborn child from conception until birth;
- abortion methods and risks; and
- other resources that are available to women facing a pregnancy.

We hope you find it clear and easy to understand.

Did you know…

Pregnancies are commonly dated by the number of weeks since your last menstrual period (LMP), but since fertilization occurs approximately 2 weeks after the start of your last period the embryo or fetus is actually 2 weeks younger.

For example, if your doctor tells you that you are 6 weeks pregnant then you are carrying a 4-week-old embryo. You may see information that refers to the unborn child’s age as postconception age or age since fertilization.

Some women have regular menstrual periods that are longer or shorter than 4 weeks apart, for example, 3 to 5 weeks apart. For these women, adjustments are necessary when dating the pregnancy based on the last menstrual period.
Prenatal development can be categorized into three stages of development: cell division, embryonic development (weeks 5-10 since last menstrual period, or LMP) and fetal development (weeks 11-40 since LMP).

You may hear doctors refer to an unborn child as either an embryo which is Latin for “bud” or a fetus which is Latin for “offspring.” The unborn child is called an embryo during the first 10 weeks of a pregnancy (or 8 weeks from fertilization). After 10 weeks since LMP the unborn child is called a fetus.

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.

Did you know…

The most active period of development in an unborn child takes place between weeks 5 and 10 (LMP) when most of the organ systems develop.  
Fertilization (2 weeks LMP)
Ovulation/fertilization/conception
• Size: About the size of a pinhead.
• Sperm fertilizes the ovum or egg within hours after ovulation in the far end of the fallopian tube.
• Cell division begins just hours after fertilization and the fertilized ovum becomes known as a zygote.

2 weeks after fertilization (4 weeks LMP)
• Size: Approximately 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.
• Approximately 6 days after conception (fertilization) the fertilized ovum, now referred to as a blastocyst, begins to implant itself into the wall of the uterus.
WEEKS OF PREGNANCY

4 weeks after fertilization (6 weeks LMP)
- Size: 4 to 5 mm long from crown to rump (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 from crown to rump (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 or 1.5 inches long from crown to rump.
• Embryo now known as a fetus.
• 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: 60 mm or 2.3 inches long from crown to rump.
• Weight: 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 gender.
• Some hair begins to appear.
• Organs and structures continue to grow.
12 weeks after fertilization (14 weeks LMP)
- Size: 87 mm or 3.4 inches long from crown to rump.
- Weight: 45 grams or 1.5 ounces.
- Sex of fetus is distinguishable externally.
- Neck is well defined.

14 weeks after fertilization (16 weeks LMP)
- Size: 120 mm or 4.7 inches long from crown to rump.
- Weight: 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: 140 mm or 5.5 inches long from crown to rump.  
• Weight: 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)  
Midpoint of pregnancy  
• Size: 160 mm or 6.3 inches long from crown to rump.  
• Weight: 320 grams or 11.3 ounces.  
• Hair called lanugo covers body.  
• Vernix caseosa is present. This waxy substance 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)
• Size: 190 mm or 7.5 inches long from crown to rump.
• Weight: 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: 210 mm or 8.2 inches long from crown to rump.
• Weight: 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.
• Less than half of the infants born
24 weeks after fertilization (26 weeks LMP)
• Size: 230 mm or 9 inches long from crown to rump.
• Weight: 820 grams or 1.8 pounds.
• Fingernails are present.
• The body of the fetus is thin. Fetus will begin to store fat.
• Approximately 4 out of 5 infants born now survive with proper care.

26 weeks after fertilization (28 weeks LMP)
• Size: 250 mm or 9.8 inches long from crown to rump.
• Weight: 1100 grams or 2.4 pounds.
• Fetus has thin red skin.
• Vernix caseosa covers the fetus.
• Eyes are partially open and eyelashes are growing.
• More than 9 out of 10 infants born now survive with proper care.
28 weeks after fertilization (30 weeks LMP)
- Size: 270 mm or 10.6 inches long from crown to rump.
- Weight: 1300 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: 280 mm or 11 inches long from crown to rump.
- Weight: 1800 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: 300 mm or 11.8 inches long from crown to rump.
• Weight: 2100 grams or 4.6 pounds.
• Fingernails now reach fingertips.
• Skin is pink and smooth.
• Lanugo hair is decreasing.

34 weeks after fertilization
(36 weeks LMP)
• Size: 320 mm or 12.5 inches long from crown to rump.
• Weight: 2500 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: 340 mm or 13.4 inches long from crown to rump.
- Weight: 2900 grams or 6.4 pounds.
- Body of fetus is plump.
- Lanugo hairs are almost absent.
- Toenails reach tips of toes.
- Fetus is considered full term.

38 weeks after fertilization (40 weeks LMP)
- Size: 360 mm or 14 inches long from crown to rump.
- Weight: 3400 grams or 7.5 pounds.
- Fetus is fully developed.
- Fetus receives antibodies from the mother that will strengthen its immune system.
RISKS OF PREGNANCY

Did you know…

Approximately 6 million women become pregnant each year in the United States and more than 10,000 give birth each day.

– Source: Centers for Disease Control and Prevention (CDC), 2002
Pregnancy Risks and Complications

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 (tubal) 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 may develop during pregnancy causing high blood sugar levels; however, the condition usually goes away after the baby is born.
- 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. The risk of dying is greater for women over 40.

- hemorrhage
- blood clot
- high blood pressure
- infection
- stroke
- amniotic fluid in the bloodstream
- heart muscle disease

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.
Did you know…

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 while surgical abortions require the use of surgical instruments.
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 while 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 determines the types of abortion methods available to you.

**MEDICAL (NON-SURGICAL) ABORTION**
- Involves the use of medications to end a pregnancy.
- Is an option generally limited to 49 days (7 weeks) after LMP.
- Usually avoids 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 follow-up to ensure abortion is complete.
- The woman may be more aware of 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, 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. Without progesterone, the lining of the uterus thins causing the embryo to detach.

*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 described medical abortion procedures are models. Individual clinic protocol (procedure) may differ.

**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 approximately 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 if 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 because the medication can cause birth defects in that pregnancy. Therefore, medical abortion should be considered irreversible once the first drug has been taken.

Note: The treatment described above is the FDA approved regimen; however, variations from this regimen have been tested and shown to be just as effective.
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 implantation process. 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 if 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 then 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 because the medication can cause birth defects in that pregnancy. Therefore, medical abortion should be considered irreversible once the first drug has been taken.

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 described surgical abortion procedures are 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 laminaria (thin rods) 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

Did you know…

In 1996, there were 1.5 million adopted children in the United States.
– Source: U.S. Census Bureau, April 2001

Women or couples facing an unplanned pregnancy who do not wish to take on the responsibilities of parenthood also have the option of adoption.

The resource directory that accompanies this booklet contains listings of public and private child placing agencies that are licensed by the Alabama Department of Human Resources. 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 of a child is liable to assist in the support of that child.
– Source: Act No. 2002-419, enacted by the Alabama Legislature, Regular Session 2002

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

The Alabama Department of Human Resources has a Child Support Enforcement Division. 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 Alabama Department of Human Resources, or your county Child Support Office, both of which may be reached by calling 334-242-9300.
Did you know…

Approximately 48% of the 6 million pregnancies that occur in the United States each year are unplanned.
– Source: Alan Guttmacher Institute (AGI), 2002
What is birth control?
Birth control means using a certain method, medicine and/or device to prevent pregnancy.

How well does birth control work?
How well birth control will work for you depends on the method you choose and if you use it the right way. Birth control methods like the pill, Depo-Provera shots and the IUD 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 the right way 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.

What choices do I have?
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.

Remember: You can always choose not to have sex. No matter what, no one has the right to force you to have sex if you do not want to. There are people who care about you and can help you if someone is trying to hurt you or make you have sex when you do not want to. Call the number at the end of this section to talk to someone in private.

How do I know what is the best birth control choice for me? Many women use different birth control methods during their lives. What method you use depends on if 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.
What do I do?
Get the facts. 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 a public or private health clinic, your county health department, and other places. 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 (and most public clinics) can help you get the birth control you need.

For information call the toll-free family health line at 1-800-654-1385.
COPYRIGHTS AND REFERENCES

© 2002 Alabama Department of Public Health
All rights reserved. No portion of this book may be
copied or otherwise reproduced without the written
permission of the Alabama Department of
Public Health.

Photographs on pages 5, 6, 7, 8, 9, 10, 12, 13 and 14
are by Lennart Nilsson/Albert Bonniers Forlag AG,
A CHILD IS BORN, Dell Publishing Company, and are
used with permission.

Illustrations on pages 10, 11, 12, 13 and 14 are by
A.D.A.M., Inc., ©2002, and are used with permission.

The dimensions of the embryo/fetus are based on
information presented by Williams Obstetrics, 21st

A list of references used in the preparation of this
material and/or additional copies may be obtained by
contacting:
Alabama Department of Public Health
Division of Provider Services
P.O. Box 303017
Montgomery, AL 36130-3017
334-206-5175
Did you know…

- It is unlawful for any individual to coerce a woman to undergo an abortion.
- Any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action at law.
- Alabama Act #02-419 states, “There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or place him or her for adoption. The State of Alabama strongly urges you to contact those agencies before making a final decision about abortion. The law requires that your physician or his or her agent give you the opportunity to call agencies like these before you undergo an abortion.”
- The father of a child is liable to assist in the support of that child. The Alabama Department of Human Resources has a Child Support Enforcement Division. 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.
- State law permits adoptive parents to pay the cost of prenatal care, childbirth and neonatal care. You may refer to the Resource Directory for a list of licensed adoption agencies in your area.