JRHUNR

ISSN: 2181-0990
DOI: 10.26739/2181-0990

JOURNAL OF REPRODUCTIVE HEALTH AND URO-NEPHROLOGY RESEARCH

VOLUME 1, ISSUE 1

2020

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ
РЕСПУБЛИКИ УЗБЕКИСТАН

Журнал репродуктивного здоровья и уро-нефрологических исследований

JOURNAL OF REPRODUCTIVE HEALTH AND URO-NEPHROLOGY RESEARCH

Главный редактор- Б.Б. НЕГМАДЖАНОВ

Учредитель:

Самаркандский государственный медицинский институт

Tadqiqot.uz

Ежеквартальный научно-практический журнал

ISSN: 2181-0990
DOI 10.26739/2181-0990

№ 1
2020

ЖУРНАЛ РЕПРОДУКТИВНОГО ЗДОРОВЬЯ И УРО-НЕФРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ
JOURNAL OF REPRODUCTIVE HEALTH AND URO-NEPHROLOGY RESEARCH

№1 (2020) DOI http://dx.doi.org/10.26739/2181-0990-2020-1

Главный редактор:
Chief Editor:

Негмаджанов Баходур Болтаевич
доктор медицинских наук, профессор, заведующий кафедрой Акушерства и гинекологии №2 Самаркандского Государственного Медицинского Института

Заместитель главного редактора:
Deputy Chief Editor:

Каттаходжаева Махмуда Хамдамовна
доктор медицинских наук, профессор Кафедры акушерства и гинекологии Ташкентского Государственного стоматологического института

ЧЛЕНЫ РЕДАКЦИОННОЙ КОЛЛЕГИИ:
MEMBERS OF THE EDITORIAL BOARD:

Луис Альфондо де ла Фуэнте Эрнандес
профессор, Медицинский директор IEFertility, член Европейского общества репродукции человека и эмбриологии (Prof. Medical Director of the Instituto Europeo de Fertilidad. Madrid (Spain)

Ramašauskaitė Diana
профессор, руководитель центра акушерства и гинекологии в больнице Вильнюсского университета Santaros klinikos (Prof. Clinic of Obstetrics and Gynecology Vilnius University Faculty of Medicine (Литва)

Аюпова Фарида Мирзаевна
Доктор медицинских наук, профессор, заведующая кафедрой Акушерства и гинекологии №1 Ташкентской Медицинской Академии.

Зокирова Нодира Исламовна
Доктор медицинских наук, профессор кафедры акушерства и гинекологии №1, Самаркандского Государственного Медицинского Института

Кадыров Зиёратшо Абдуллоевич
Доктор медицинских наук, профессор заведующий кафедрой Эндоскопической урологии факультета непрерывного медицинского образования медицинского института РУДН, (Россия).

Негматуллаева Мастура Нуруллаевна
Доктор медицинских наук, профессор кафедры акушерства и гинекологии №2, Бухарского Медицинского института.

Окулов Алексей Борисович
Доктор медицинских наук., профессор, андро-гинеколог, главный научный сотрудник кафедры Детской хирургии педиатрического факультета РМАНПО, профессор кафедры медицинской репродуктологии и хирургии Московского государственного медико-стоматологического университета (Россия).

Махмудова Севара Эркиновна
ассистент кафедры Акушерства и гинекологии факультета последипломного образования Самаркандского Государственного Медицинского Института (**ответственный секретарь**)

ЧЛЕНЫ РЕДАКЦИОННОГО СОВЕТА:
MEMBERS OF THE EDITORIAL BOARD:

Boris Chertin
MD Chairman, Departments of Urology & Pediatric Urology, Shaare Zedek Medical Center, Clinical Professor in Surgery/ Urology, Faculty of Medicine, Hebrew University, Jerusalem (Israel). Председатель кафедры урологии и детской урологии, Медицинский центр Шааре-Зедек, Клинический профессор хирургии/урологии, медицинский факультет, Иерусалим, Израиль

Fisun Vural
Doçent Bilimleri Üniversitesi, Haydarpaşa Numune Eğitim ve Araştırma Hastanesi Kadın Hastalıkları ve Doğum Kliniği İdari ve Eğitim Sorumlusu (Доцент Dr.Фисун Вурал Университет медицинских наук. Репродуктолог. Ведущий специалист по вспомогательной репродуктивной технологии (Турция)

Melike Betül Öğütmen
SBÜ Haydarpaşa Numune SUAM Nefroloji Kliniği idari ve Eğitim Sorumlusu (Доцент. Dr. Малике Бетул Угутмен. Нефролог. Университет медицинских наук (Турция)

Аллазов Салах Аллазович
доктор медицинских наук, профессор кафедры урологии, Самаркандского Государственного Медицинского Института

Ахмеджанова Наргиза Исмаиловна
доктор медицинских наук, Самаркандского Государственного Медицинского Института, нефролог

Локшин Вячеслав Нотанович
акушер-гинеколог, репродуктолог, доктор медицинских наук, профессор, президент Казахстанской ассоциации репродуктивной медицины (Казахстан).

Никольская Ирина Георгиевна
Доктор медицинских наук, профессор ГБУ МО МОНИАГ. Ученый секретарь научного совета (Россия).

Шалина Раиса Ивановна
Доктор медицинских наук, профессор кафедры акушерства и гинекологии педиатрического факультета РНИМУ им.Н.И.Пирогова (Россия).

Page Maker | Верстка: Хуршид Мирзахмедов

Контакт редакций журналов. www.tadqiqot.uz
ООО Tadqiqot город Ташкент,
улица Амира Темура пр.1, дом-2.
Web: http://www.tadqiqot.uz/; Email: info@tadqiqot.uz
Телефон: +998 (94) 404-0000

Editorial staff of the journals of www.tadqiqot.uz
Tadqiqot LLC the city of Tashkent,
Amir Temur Street pr.1, House 2.
Web: http://www.tadqiqot.uz/; Email: info@tadqiqot.uz
Phone: (+998-94) 404-0000

СОДЕРЖАНИЕ/CONTENT

Обращение ректора Самаркандского государственного медицинского института д.м.н, профессора Ж.А. Ризаева и главного редактора д.м.н., профессора Б.Б. Негмаджанова…………………………………………………………………..6

Ramašauskaitė Diana. Best wishes to the new journal……………………………………………….…7

ОБЗОРНЫЕ СТАТЬИ

1. Ахмедов Я.А.
ОСНОВЫ ЛУЧЕВОЙ ДИАГНОСТИКИ ЗАБОЛЕВАНИЙ МОЧЕВЫДЕЛИТЕЛЬНОЙ СИСТЕМЫ У ДЕТЕЙ (ОБЗОР)…………………………………………………………………………..8

2. Аюпова Ф.М., Солиева У.Х., Миродилова Ф.Б.
ПРИМЕНЕНИЕ МИКРОНИЗИРОВАННОГО ПРОГЕСТЕРОНА В КОМПЛЕКСЕ ПРОФИЛАКТИКИ И ЛЕЧЕНИЯ НЕВЫНАШИВАНИЯ БЕРЕМЕННОСТИ (ОБЗОР)……………..13

3. Кадыров З.А., Фаниев М.Д., Сергеев В.В.
СОВРЕМЕННОЕ СОСТОЯНИЕ ПРОБЛЕМЫ ОСТРОГО ГЕСТАЦИОННОГО ПИЕЛОНЕФРИТА (ОБЗОР)…………………………………………………………………………...17

4. Каттоходжаева М.Х., Сулейманова Н.Ж., Амонова З.Д., Шакирова Н.Г.
АКТУАЛЬНОСТЬ ПРОБЛЕМЫ ГЕНИТАЛЬНОЙ ПАПИЛЛОМАВИРУСНОЙ ИНФЕКЦИИ И РАК ШЕЙКИ МАТКИ. СТРАТЕГИИ ПРОФИЛАКТИКИ (ОБЗОР)………………22

5. Нигматова Г.М., Агзамова М
СОВРЕМЕННОЕ СОСТОЯНИЕ ЭТИОПАТОГЕНЕЗЕ ПРЕЖДЕВРЕМЕННЫХ РОДОВ (ОБЗОР)…………………………………………………………..29

6. Agababyan L.R., Makhmudova S.E.
COMPARISON OF PLACENTAL PATHOLOGY BETWEEN SEVERE PREECLAMPSIA AND HELLP SYNDROME (REVIEW)……………………………………………...34

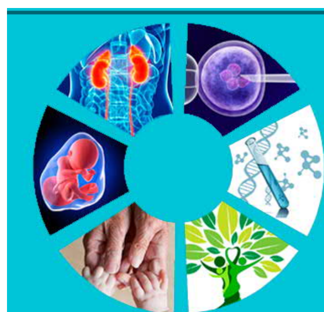
7. Ashurova U.A., Abdullaeva L.M., Klychev S.I.,Ahmedova A.T.
SURGICAL APPROACH TO THE TREATMENT OF ENDOMETRIOID OVARIAN CYSTS IN PATIENT WITH INFERTILITY: «FOR» AND «AGAINST» (REVIEW)……………….……38

8. Nasirova Z.A.
REPRODUCTIVE BEHAVIOR OF WOMEN AFTER CESAREAN SECTION (REVIEW)………………………………………………………….…...42

ОРИГИНАЛЬНЫЕ СТАТЬИ

9. Ахмедова А.Т.
ВЛИЯНИЕ ФИТОГОРМОНОВ НА КАЧЕСТВО ЖИЗНИ ЖЕНЩИН С ЭНДОМЕТРИОЗОМ В ПЕРИОДЕ ПЕРИМЕНОПАУЗЫ………………………………………………….46

10. Гарифулина Л.М., Гайибов Н.С.
СОСТОЯНИЕ ПОЧЕК У ДЕТЕЙ С ЭКЗОГЕННО-КОНСТИТУЦИОНАЛЬНЫМ ОЖИРЕНИЕМ……………………………………………………………………………………...50



JOURNAL OF REPRODUCTIVE HEALTH AND URO-NEPHROLOGY RESEARCH
ЖУРНАЛ РЕПРОДУКТИВНОГО ЗДОРОВЬЯ И УРО-НЕФРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ

УДК 611-013.36

Nasirova Zebiniso Azizovna
Assistant at Samarkand State Medical Institute.
Faculty of Postgraduate Education,
Department of Obstetrics and Gynecology,
Samarkand, Uzbekistan.

REPRODUCTIVE BEHAVIOR OF WOMEN AFTER CESAREAN SECTION (REVIEW)

For citation: Nasirova Zebiniso Azizovna, Reproductive behavior of women after cesarean section (review), Journal of reproductive health and uro-nephrology research. 2020, vol. 1, issue 1, pp.

http://dx.doi.org/10.26739/2181-0990-2020-1-8

Насирова Зебинисо Азизовна
Ассистент Самаркандского Государственного Медицинского института
Кафедры Акушерства и гинекологии, факультета последипломного образования, Самарканд, Узбекистан.

РЕПРОДУКТИВНОЕ ПОВЕДЕНИЕ ЖЕНЩИН ПОСЛЕ КЕСАРЕВА СЕЧЕНИЯ (ОБЗОР)

Nasirova Zebiniso Azizovna
Samarqand Davlat Tibbiyot instituti
Diplomdan keying ta'lim fakulteti
Akusherlik va ginekologiya kafedrasi assistenti,
Samarqand, O'zbekiston

KESAR KESISH JARROHLIGIDA AYOLLARNING REPRODUKTIV SALOMATLIGI (ADABIYOTLAR TAHLILI)

The development and improvement of obstetric science and modern technologies in many areas of medicine has contributed to a significant expansion of indications for delivery by cesarean section. This has led to the fact that today cesarean section is the most common delivery surgery [3,9,13]. Caesarean section is becoming less dangerous and its prevalence is growing significantly. Previously, WHO has already indicated that the ideal safe frequency of the CS implementation is 15%. A sharp increase in caesarean section is due to many reasons, including:

1. Growth of maternal obesity;
2. Low availability of services for the care of women in labor;
3. The problem of breech presentation;
4. The preference of CS compared with forceps delivery of the fetus;
5. The prevalence of inducing labor by artificial methods;
6. Preferences of women in labor (due to convenience, fear of labor pain);
7. Preferences of obstetrician-gynecologists (schedule of procedures, to make profit).

Today, frequency of caesarean section in the world is quite variable and it has reached the "epidemic scale". The medical need for cesarean section occurs in 10-15% of births. However, according to a new study, the number of operations since the beginning of the century has grown rapidly from 12% to 21% in 2015 [11,19]. In some countries, such as Dominican Republic, 58% of children are born by caesarean section, in Egypt the cesarean section makes 63% of all deliveries. In Brazil, where caesarean section without medical indications is performed in 55% of cases. In Australia, vaginal delivery is considered to be a sign of poverty, so the frequency of abdominal delivery in various hospitals ranges from 11.8% to 47.4% [4,8,11]. In the USA, the caesarean section is 30.8% in primiparous and 11.5% in multiparous. Recently, there has been a steady upward trend in the frequency of abdominal delivery in Russian Federation, which in 2017 reached 29.3% [1,5,8].

In Uzbekistan, a frequency of caesarean section is also increasing. Over the past 10-15 years, the frequency of this operation has more than doubled and according to the statistics department of Republican Specialized Scientific Practical Medical Center of Obstetrics and Gynecology (RSSPMCOG**)** in 2017 amounted to 18%, reaching up to 35-40% in some institutions.

But, when deciding to overcome a caesarean section, contraindications should be taken into account. It is known that the risk of maternal complications in abdominal delivery increases 10 times or more, and the risk of maternal mortality doubles [18].

Despite the apparent technical simplicity of Caesarean section, this operation (especially repeated) should be classified as complex surgical intervention with a high frequency of postoperative inflammatory complications with frequency from 3.3% to 54.3% in different clinics [5,8].

Postoperative morbidity most commonly includes endometritis, which can become a source of generalized infection in the absence of adequate prevention and treatment [28].

To select a method for prevention and treatment of septic diseases associated with cesarean section, an important role is played by modern microbiological studies which make it possible to isolate and identify most pathogens of aerobic and anaerobic bacterial microflora as well as to determine their sensitivity to antibiotics [8].

Thus, the importance of caesarean section in modern obstetrics continues to increase, and it rightfully occupies a leading position among all delivery operations by providing favorable outcomes both for mother and fetus in a number of severe obstetric complications and extragenital diseases. But despite the solution of many aspects, there is still the problem of increasing frequency of this operation and therefore the problem of “operated uterus”. It is necessary to improve contraceptive issues in women who have had a cesarean section.

A high frequency of surgical labor has led to an annual increase in the number of women of fertile age with an operated uterus [8,20]. According to the data of I.V. Ignatko and co-authors (2018), uterine scars take the second place in the structure of indications for cesarean section and make up 13% - 19.6%. Maternal morbidity during repeated surgery is 3-4 times higher compared to childbirth through the natural birth canal [13,14].

The rational dispensary management of women with a scar on uterus largely determines their reproductive future. Family planning issues, especially introducing safe methods of contraception, play the most important role not only by preventing abortion, but also for the rehabilitation of women in the postpartum period [21, 29]. An effective and safe type of contraception is especially relevant for women after cesarean section [2,7].

But at the same time, the problem of contraception in women after childbirth remains largely unresolved [6,8]. An analysis of the literature data shows that one of the reasons for insufficient use of contraceptives is lack of adequate information about these methods. [4,7,9].

According to the literature, up to 87% of puerperas leave maternity hospitals without receiving adequate information about the existence of effective and safe contraceptives to use in postpartum period [8].

It is known that abortion in a few months right after birth has very adverse effect on general health of a woman and her reproductive system, being one of the main reasons of gynecological morbidity and subsequent disfunction of the hypothalamus - pituitary system. According to specialists, there is no surgical intervention that carries such a risk to women's health as abortion and it can lead to serious consequences, as well as irreversible sometimes [26].

Artificial abortions performed after surgical delivery sharply worsen the prognosis of subsequent pregnancy. According to researchers, the risk of uterine scar failure increases by 1.3 times, premature placental abruption by 2.3 times [3,29]. Serious consequences of abortion also include: recurrent inflammatory processes that cause not only functional disorders, but also benign and malignant diseases of mammary glands and the female reproductive system [7,26].

Pregnancy in the first two years after cesarean section leads to development of placental insufficiency, as well as birth of fetus with signs of functional immaturity and malnutrition (18.7–26%) [58]. Such pregnancy is accompanied by an increased risk of spontaneous miscarriage or premature birth [6]. In addition, abnormal fetal position and premature detachment of the placenta are much more common among these women.

There is no consensus on the optimal timing of subsequent pregnancy in women who have had a cesarean section. Most obstetricians recommend to plan the next pregnancy after 1.5 to 3 years of performed surgery [3]. Studies of pregnancy after cesarean section show that the lowest risk of uterine scar failure is determined during pregnancy at least one year after surgery [25].

According to experts, the development of a strategy of family planning should be based on the study a reproductive behavior of population [6,23,30].

In recent years, studies have appeared devoted to the determination of reproductive behavior and its impact on key indicators of public health. They have shown the impact of life conditions and lifestyles of individual population groups on formation of reproductive attitudes, the relationship of educational and general cultural level with family planning [5,18]. However, social studies among women with an uterine scar after cesarean section have not been conducted.

Although all methods of contraception are suitable for women after childbirth, choosing each of them depends on a number of factors, most importantly on breastfeeding. Obstetricians and gynecologists agree that counseling doctors should strongly recommend women exclusively breast-feed in the postpartum period and do not stop it to use contraceptives [18,28].

The contraceptive methods used by nursing mothers should not have a harmful effect on lactation and health of their babies. It should be remembered that no matter which method of contraception a woman chooses with the approval of a doctor, the benefits of using it far exceed the potential risk, and they are not comparable with risks associated with abortion [20,21].

Thus, obstetricians and gynecologists are responsible to help women finding a reliable method of contraception which will provide her enough time to rehabilitate and to take care after newborn in the absence of a negative effect on lactation and baby's development.

According to experts, the development of a reproductive health strategy should be based on a study of reproductive behavior of population. Such studies are conducted in each country, helping to assess the “responsibility of the population for their reproductive choice”, as well as adjust the government’s measures to create conditions that ensure this choice [15]. In the process of development of specific directions for solving family planning issues, an important place is occupied by the results of sociological studies that highlight hidden aspects of social and psychological sides of a woman’s life and her prevailing personal attitudes to contraceptives [8,13].

Reproductive behavior serves as the principal unit of reproduction mechanism. It is based on reproductive attitude and birth control. By reproductive attitude we understand the predisposition of an individual with normal fertility to birth of a certain number of children, and it’s quantitative parameter is expressed by planned and actual number of children in the family. Birth control is recognized as an intra-family birth control, mainly by contraception and / or intentional abortion [19, 26].

In recent years, studies have appeared showing the impact of conditions and lifestyles of individual population groups on formation of reproductive attitudes, as well as relationship of their educational level with solving family planning problems [27]. Similar social studies among women with a scar on uterus after cesarean section have not been conducted yet.

According to literature, out of 8517864 women of fertile age 59.1% (5026391) of women use contraceptives, and only 56.5% of women of fertile age use modern highly effective contraceptives (statistics department RSSPMCOG, 2017). The remaining part of women is protected either by biological methods, or for some reason is not protected from conception. Pregnancy protection by contraceptives is due to a complex of interrelated factors of social, economic, moral and psychological nature.

The attitude of doctors (not always positive) play another significant role towards certain types of contraception. Hence, according to the author, lack of doctors' awareness in contraceptives, their formal approach to contraindications for using contraception have led to discrediting of modern methods of contraception and forming mass negative opinion of population about supposedly harmful effects of highly effective methods of contraception in our country. Another most often cited reason for refusing to use highly effective contraceptives is fear of side effects, indicated by 36% of those who have never taken contraceptives [4]. An analysis of the literature data

shows that one of the reasons for insufficient use of contraceptives is a lack of sufficient and adequate information about these methods [5,10,16].

Also, according to the author, there are following medical barriers to use highly effective contraceptives. They include:

- Incorrect data and recommendations (interruptions in admission, excessive contraindications, excessive examination, effect on reproductive function)
- Lack of attention to choice individualization for ensuring adequate compliance, as well as due to various patterns of using drugs and their non-contraceptive effects
- Lack of attention to risk groups for unplanned pregnancies - adolescents, women after childbirth, after abortion, women of a higher reproductive age and menopausal transition, socially disadvantaged groups, rural residents.
- Lack of understanding of contraceptive problems by other specialists (not gynecologists and gynecologists that are not involved in reproductive health)
- Lack of counseling - reduced access to adequate information and deliberate choice of contraceptive method

Although most of the indicators reflecting particular aspects of reproductive health can be improved through the work of health services and medical knowledge, it is necessary to emphasize that social order serves as a key factor, especially education, lifestyle, legal and legislative functions of the government [4,7].

To date, despite emerging studies of this complex and multifaceted issue, there are practically no comprehensive investigations of medical and social aspects of protecting women's reproductive health after childbirth. [8,18]. As well as factors affecting reproductive choice of women after caesarean section are not studied well. There is not enough data about women's sources of information about contraception, the reliability of that sources, and reasons for preference or denial of any contraceptive methods.

Among women of active reproductive age, women after cesarean section need proper counseling on contraception. Some of them no longer want to have children, and some want to wait for birth of their next child for several years [1,3,4].

References.

1. Дикке Г.Б., Профилактика повторной нежелательной беременности, выбор метода контрацепции//акушерство и гинекология. – 2014.-№4. Стр. 81-87.
2. Додхоева М.Ф., Юлдошева М.У. Реабилитация и диспансеризация женщин после абдоминального родоразрешения //Вестник Авиценны. 2016. № 2 [67]. С. 42-47.
3. Курбанова З.А., Омаров Н.С.М., Кантаева Д.К. Особенности контрацептивного поведения женщин после кесарева сечения //В сборнике: Перспективы развития научных исследований в 21 веке сборник материалов X Международной научно-практической конференции. 2016. С. 102-103.
4. Курбанова З.А., Омаров Н.С.М., Омарова Х.М. Различные виды контрацепции у женщин с рубцом на матке //Уральский медицинский журнал. 2017. № 11 [155]. С. 33-36.
5. Мальцева Л.И. Выбор контрацепции после кесарева сечения// Вопросы гинекологии, акушерства и перинатологии. 2014. Т. 13. № 2. С. 88-94.
6. Насирова З.А., Агабабян Л.Р. Постплацентарное введение внутриматочных спиралей у женщин, родоразрешенных абдоминальным путем //Проблемы репродукции. 2017. Т. 23. № 2. С. 81-83.
7. Advances in contraception: new options for postpartum women Taub RL and Jensen JT. Expert Opin Pharmacother 2017 - Review.
8. Barbosa RM, et al. Differences in the Access to Sterilization between Women Living and Not Living with HIV: Results from the GENIH Study, Brazil PLoS One 2016.
9. Basendowah M., Alabdulqader M., Alabdulqader O., Hakami M. Cureus. 2020 12[1]: c6644. Doi: 10,7759/ cureus.6644
10. Borges A. L. V., dos Santos O. A., Fujimori E. Concordance between intention to use and current use of contraceptives among six-month postpartum women in Brazil: The role of unplanned pregnancy //Midwifery. – 2018. – Т. 56. – С. 94-101.
11. Brunson M. R. et al. Postpartum contraception: initiation and effectiveness in a large universal healthcare system //American journal of obstetrics and gynecology. – 2017. – Т. 217. – №. 1. – С. 55. e1-55. e9.
12. Daniele MAS, et al. Provider and lay perspectives on intra-uterine contraception: a global review. Reprod Health 2017 - Review.
13. Diedrich JT, et al. Long-acting reversible contraception in adolescents: a systematic review and meta-analysis Am J Obstet Gynecol 2017 - Review.
14. Garcia G. et al. Trends and disparities in postpartum sterilization after cesarean section, 2000 through 2008 //Women's Health Issues. – 2015. – Т. 25. – №. 6. – С. 634-640.
15. Goldthwaite LM and Shaw KA. Immediate postpartum provision of long-acting reversible contraception Curr Opin Obstet Gynecol 2015 - Review.
16. Goldthwaite LM, et al. Postpartum intrauterine devices: clinical and programmatic review Am J Obstet Gynecol 2018 - Review.
17. Guidelines Fleming N, et al. J Adolescent Pregnancy Obstet Gynaecol Can 2015.
18. Haider S. et al. A Novel Approach to Postpartum Contraception Provision Combined with Infant Care: A Randomized, Controlled Trial //Women's Health Issues. – 2020. – Т. 30. – №. 2. – С. 83-92.
19. Hormonal contraception and breast cancer, what more do we need to know? Marsden J. Post Reprod Health 2017 - Review.
20. Hubacher D, et al. Long-acting reversible contraceptive acceptability and unintended pregnancy among women presenting for short-acting methods: a randomized patient preference trial Am J Obstet Gynecol 2017 - Clinical Trial.
21. Kumar S. et al. Women's experience with postpartum intrauterine contraceptive device use in India //Reproductive health. – 2014. – Т. 11. – №. 1. – С. 32.
22. Makins A., Cameron S. Post Pregnancy Contraception //Best Practice & Research Clinical Obstetrics & Gynaecology. – 2020.
23. MacDonald EJ, et al. Contraception post severe maternal morbidity: a retrospective audit Contraception 2015.
24. Mishra S. Evaluation of safety, efficacy, and expulsion of post-placental and intra-cesarean insertion of intrauterine contraceptive devices [PPIUCD] //The Journal of Obstetrics and Gynecology of India. – 2014. – Т. 64. – №. 5. – С. 337-343.
25. Raine TR, Foster-Rosales A, Upadhyay UD, Boyer CB, Brown BA, Sokoloff A, et al. One-year contraceptive continuation and pregnancy in adolescent girls and women initiating hormonal contraceptives. Obstet Gynecol. 2011;117:363-71.
26. Samuel E., Myers E., Morse J. IUD insertion after cesarean section: a cost decision analysis of insertion at time of delivery versus at postpartum follow-up //Contraception. – 2014. – Т. 90. – №. 3. – С. 327-328.

27. Shanavas A., Jacob S., Chelamma N. Outcome of immediate postpartum intrauterine contraceptive device in caesarean versus vaginal insertion: a comparative study //International Journal of Reproduction, Contraception, Obstetrics and Gynecology. – 2017. – Т. 6. – №. 2. – С. 695.
28. Starr K. A. et al. Postpartum contraception use by urban/rural status: an analysis of the Michigan pregnancy risk assessment monitoring system data //Women's Health Issues. – 2015. – Т. 25. – №. 6. – С. 622-627.
29. Wilkie G. L. et al. Effects of obstetric complications on adolescent postpartum contraception and rapid repeat pregnancy //Journal of pediatric and adolescent gynecology. – 2016. – Т. 29. – №. 6. – С. 612-616.
30. Zaconeta A. M. et al. Intrauterine Device Insertion during Cesarean Section in Women without Prenatal Contraception Counseling: Lessons from a Country with High Cesarean Rates //Revista Brasileira de Ginecologia e Obstetrícia/RBGO Gynecology and Obstetrics. – 2019. – Т. 41. – №. 08. – С. 485-492.