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ORGANIZATIONAL AND SOCIAL ASPECTS OF OBSTETRIC CARE DURING THE COVID-19 PANDEMIC

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Abstract. *The COVID-19 pandemic has had a profound impact on global health systems, with pregnant women facing unique challenges. This review examines the organizational and social aspects of obstetric care during the pandemic, exploring how different countries have adapted their health strategies to protect maternal and newborn health. The article highlights the restructuring of health services, the introduction of telemedicine, and the importance of standardized guidelines for managing health risks associated with COVID-19 in pregnant women.*

Keywords: *COVID-19, pregnancy, organizational and social aspects, obstetric care.*

INTRODUCTION

The outbreak of the COVID-19 pandemic in late 2019 and its rapid global spread in 2020 created a public health emergency that placed immense pressure on healthcare systems worldwide [1, 2]. Obstetric care, as a critical component of healthcare services, was not immune to these challenges. Pregnant women, who were initially not considered to be at higher risk for severe COVID-19 complications, soon became a focal point for healthcare providers as emerging data indicated potential risks to both maternal and fetal health [3].

The need to protect vulnerable populations, including pregnant women, from exposure to the virus led to significant changes in how obstetric care was delivered. Hospitals and maternity units had to quickly adapt to new safety protocols, which included strict infection control measures, limiting hospital visits, and in many cases, reorganizing entire departments to create separate pathways for COVID-19 patients [4, 5]. These changes were necessary to reduce the risk of virus transmission but also introduced new challenges for both healthcare providers and patients [6, 7].

In addition to the clinical challenges, the pandemic had profound social implications. Pregnant women faced increased anxiety and stress due to the uncertainty surrounding the virus and its potential impact on their pregnancies. Social distancing measures further isolated them from their support networks, compounding the psychological toll. This review seeks to explore these organizational and social aspects of obstetric care during the COVID-19 pandemic, drawing on experiences from various healthcare settings around the world [8, 9].

REORGANIZATION OF OBSTETRIC SERVICES

The COVID-19 pandemic necessitated the implementation of stringent infection prevention and control measures in obstetric units. Hospitals developed protocols that included screening all patients for COVID-19 symptoms before admission, testing for the virus, and creating isolation wards for those who tested positive. For example, hospitals in Italy and the UK reported early adoption of these measures to protect both patients and healthcare workers [1, 4, 10].

Routine antenatal visits were reduced or replaced with telemedicine consultations to minimize the risk of exposure. In many cases, non-urgent procedures were postponed, and the focus shifted to managing high-risk pregnancies. The use of personal protective equipment (PPE)

became mandatory, and the number of visitors allowed in delivery rooms was significantly reduced or completely banned. These changes, while necessary, posed new challenges for healthcare providers who had to adapt to a rapidly evolving situation with limited resources [2, 7, 11, 12].

One of the critical areas of concern was the management of pregnant women who contracted COVID-19. Early studies suggested that severe illness in pregnant women was associated with an increased risk of preterm birth, preeclampsia, and cesarean delivery [3, 6, 13]. As a result, obstetric units developed specific guidelines for the management of COVID-19-positive pregnant women, including the timing of delivery, the use of corticosteroids to enhance fetal lung maturity, and the provision of respiratory support if needed [4, 8, 14].

At the onset of the pandemic, several prominent medical institutions and national obstetrics and gynecology associations provided guidelines for organizing perinatal care. However, these guidelines often lacked sufficient details for healthcare facilities at different levels to develop their own protocols for managing pregnant women with COVID-19 [11, 12, 15]. Later recommendations were based on newly acquired and more precise data [6, 9, 16].

In response to the pandemic, local healthcare systems for pregnant women, those in labor, and postpartum women with COVID-19 were restructured to include not only medical care but also the creation of safe environments within healthcare facilities, emergency transport protocols, and centralized data collection for suspected or confirmed cases [17, 18]. For instance, in Lombardy, Italy, out of 59 maternity hospitals (serving approximately 10 million people with 75,000 births per year), five were designated specifically for pregnant women, postpartum women, and newborns with suspected or confirmed COVID-19. These centers were chosen based on their location, availability of isolation facilities for mothers and infants, 24/7 access to infectious disease consultants, adult intensive care units, and staff trained to handle such cases. Each "COVID-19" center had defined pathways for caring for mothers and infants depending on the severity of their conditions, including negative pressure rooms in maternity wards [19-23].

As the pandemic intensified, the need for collaboration among specialists from various medical fields became evident, not only to establish treatment strategies for COVID-19 in pregnant women [21, 24] but also to address a range of urgent organizational challenges [22, 23, 25].

Triage based on the severity of patient's condition, combined with extensive testing, proved to be an essential tool for identifying patients with symptoms of the highly contagious COVID-19 [3, 16]. To manage patient flow, Indian specialists developed a primary triage protocol for COVID-19 patients arriving at hospitals, which included a comprehensive questionnaire [26].

The unprecedented strain on healthcare facilities underscored the importance of standardizing care criteria for pregnant women, those in labor, and postpartum women with COVID-19 (or suspected infection) in both outpatient and inpatient settings [16, 27, 28, 29].

For pregnant women with mild or no symptoms of COVID-19, outpatient monitoring, including a 14-day quarantine, was recommended. The concept of "Outpatient Care for COVID-19" emphasized the importance of close monitoring to detect any worsening of symptoms. Pregnant women were required to assess their health daily according to an approved checklist. A crucial aspect of recommending outpatient care by an obstetrician-gynecologist was the presence of a reliable feedback mechanism and the ability to perform home pulse oximetry. This was necessary for the early detection of deteriorating conditions, monitoring obstetric complications, and ensuring maternal and fetal well-being [28, 29].

To reduce the risk of infection among pregnant women and limit the spread of the virus, it was advised to revise the schedule of routine medical visits, combining appointments such as laboratory glucose testing and ultrasound scans [18, 30]. Different entry points, routes within healthcare facilities, examination and procedure rooms, and dedicated medical teams were established for managing pregnant women with and without COVID-19 symptoms [29].

TELEMEDICINE IN OBSTETRIC CARE

The rapid adoption of telemedicine was one of the most significant changes in obstetric care during the pandemic. Telemedicine allowed healthcare providers to maintain contact with patients, monitor pregnancies, and provide guidance without requiring physical visits. This approach was particularly beneficial in reducing the risk of COVID-19 transmission, especially for pregnant women with underlying health conditions who were at higher risk of severe illness [5, 11, 25].

Studies have shown that telemedicine was effective in managing prenatal care, with patients reporting high levels of satisfaction due to the convenience and reduced exposure to the virus. However, the transition to telemedicine also highlighted existing disparities in access to healthcare. For instance, women in rural areas or from low-income backgrounds often had limited access to the necessary technology or internet services required for telemedicine consultations [6, 9, 14].

The success of telemedicine in obstetric care during the pandemic suggests that it could become a permanent component of prenatal care, particularly for low-risk pregnancies. However, it is essential to address the barriers to access to ensure that all women can benefit from these services [7, 21, 27].

Telemedicine, including phone and online consultations, became an effective approach to monitor pregnant women during the pandemic [26, 27]. In Uzbekistan, healthcare providers were encouraged to quickly organize remote consultations through the internet, video calls, and other means, and to determine which categories of pregnant women could be managed remotely. Self-administered preliminary COVID-19 testing could be conducted through the official Ministry of Health website or via the Telegram bot @checkCoronavirusBot (Temporary Clinical Guidelines for Managing Pregnant Women with COVID-19, 2020).

These consultations could be scheduled in advance by the attending obstetrician-gynecologist or a physician from a specialized COVID-19 clinic. However, this is only a temporary measure, as remote consultations offer limited opportunities, such as assessing fetal heart rates and monitoring women with complicated pregnancies [15, 23, 30].

Research has suggested that digital health (mHealth) and telemedicine could serve as effective platforms for improving clinical management, such as in women with gestational diabetes. However, further studies are needed to develop, evaluate, and implement applications that are better adapted to the cultural practices and digital literacy of pregnant women in different countries, as well as to enhance the effectiveness of these applications in improving maternal and child health outcomes [31, 32].

In this regard, it is relevant to mention a study by Canadian researchers, where participants demonstrated digital literacy skills ranging from moderate to excellent (above the Canadian average). Nonetheless, almost half of the participants reported negative health and well-being outcomes due to the use of digital technologies [32].

Similar findings were reported in a study conducted by the University of Florida (USA). Most pregnant women who participated in the study found virtual prenatal care accessible and an acceptable alternative during the pandemic, though they expressed a preference to return to in-person prenatal visits [33].

The outpatient treatment protocol proposed in 2020 by T. Halscott et al. outlined nine signs of worsening conditions that would require shifting from "Outpatient Care" to "Inpatient Treatment": increasing shortness of breath; tachypnea; persistent fever above 39°C; inability to tolerate oral hydration or necessary medications; oxygen saturation $\leq 95\%$ at rest or during physical activity; persistent chest pain; new confusion or lethargy; cyanosis of the lips; and obstetric complaints (preterm contractions, vaginal bleeding, or decreased fetal movement) [27].

Inpatient treatment protocols for COVID-19 typically include discharge criteria for pregnant women, those in labor, and postpartum women with COVID-19, which generally comprise: (1) normalization of body temperature for at least three days; (2) normalization of laboratory parameters; (3) absence of clinical symptoms, including respiratory symptoms; (4) two consecutive negative COVID-19 tests conducted at least 24 hours apart using PCR; (5) SpO₂ > 93% without additional respiratory oxygen support (Temporary Clinical Guidelines (Uzbekistan), 2020).

CHANGES IN BIRTH PRACTICES

The pandemic led to significant changes in birth practices, as hospitals implemented new protocols to protect patients and staff from COVID-19. One of the most notable changes was the restriction on the presence of birth companions in delivery rooms. In many hospitals, women were required to give birth alone, without the support of their partners or loved ones [17, 21].

These changes were particularly challenging for women from cultures where the presence of family members during childbirth is considered essential. The lack of support during labor and delivery added to the psychological burden on expectant mothers, contributing to increased levels of anxiety and stress [17, 28].

In response to these challenges, some hospitals introduced virtual birth support programs, allowing partners and family members to participate in the birth process via video calls. While this approach helped mitigate some of the psychological impact, it could not fully replace the physical presence of a support person during childbirth [18, 25].

Several publications during the pandemic and the following two years have focused on the topic of planned home births (PHB) [14, 20].

However, expert opinions on this matter have been divided, even within the same country. For instance, the Association of Obstetricians and Gynecologists of the United Kingdom strongly recommended that women suspected of having COVID-19 should give birth in a hospital, considering all risks to the mother and newborn [16, 31]. In contrast, the National Health Service released guidance supporting the view that PHB is safer for women at low risk of complications, noting that it also helps reduce the burden on hospitals during the pandemic [34].

The International Confederation of Midwives supported the idea of PHB during the COVID-19 epidemic but emphasized that this process should be conducted under the supervision of the national healthcare system [35].

In Uzbekistan, the prevailing view is that "Under any circumstances, home births are considered unsafe" (Temporary Clinical Guidelines, Uzbekistan, 2020). It is important to note that

there is extensive literature outside the pandemic context that supports the safety of PHB for both mother and newborn.

The high transmissibility of the SARS-CoV-2 virus required healthcare facilities providing care for pregnant women, those in labor, and postpartum women to implement a working regime previously seen only in infectious disease hospitals, including measures to prevent nosocomial transmission [14, 19, 27].

IMPACT ON HEALTHCARE WORKERS

Healthcare workers in obstetric units faced unprecedented challenges during the COVID-19 pandemic. The increased workload, coupled with the need to adhere to strict infection control measures, led to high levels of stress and burnout among healthcare providers. A survey conducted among obstetricians and midwives in New York City found that nearly 70% of respondents reported feeling overwhelmed by the demands of their job during the pandemic [8, 15, 27].

The psychological impact of working during the pandemic was also significant. Healthcare workers were constantly exposed to the risk of contracting the virus, and many feared transmitting it to their families. The need to wear PPE for extended periods added to the physical and mental strain, as did the emotional toll of caring for critically ill patients, including pregnant women who developed severe COVID-19 [9, 15].

In response to these challenges, many hospitals implemented support programs for healthcare workers. These included mental health services, counseling, and peer support groups to help staff cope with the stress and anxiety associated with their work. The importance of providing adequate support to healthcare workers during a pandemic cannot be overstated, as their well-being is critical to the functioning of the healthcare system [10, 17].

TRAINING AND SUPPORT

The rapidly changing nature of the COVID-19 pandemic required healthcare workers to undergo additional training to stay updated on the latest protocols and treatment guidelines. Obstetricians, midwives, and nurses received training on the proper use of PPE, the management of COVID-19 in pregnant women, and the implementation of new clinical protocols.

Training programs were also developed to address the specific challenges posed by the pandemic, such as the management of COVID-19-positive patients during labor and delivery. Simulation exercises were conducted to prepare healthcare workers for emergency situations, such as the need for rapid intubation or cesarean delivery in a COVID-19-positive patient [11, 18].

In addition to clinical training, healthcare workers were provided with resources to help them manage the psychological impact of the pandemic. This included access to mental health professionals, stress management workshops, and support hotlines. These measures were essential in helping healthcare workers cope with the demands of their job during a challenging time [12, 25, 32].

SOCIO-CULTURAL IMPLICATIONS

The COVID-19 pandemic significantly affected the psychological well-being of pregnant women. The uncertainty surrounding the virus, coupled with the fear of contracting it, led to increased levels of anxiety and stress among expectant mothers. A study conducted in Spain found that nearly 60% of pregnant women reported experiencing moderate to severe anxiety during the pandemic [13, 19, 27].

Social distancing measures further compounded the psychological impact, as many women were unable to receive support from family and friends during their pregnancy and childbirth. The

restrictions on hospital visits meant that many women had to give birth without their partners or loved ones by their side, leading to feelings of isolation and loneliness [14, 31].

The pandemic also brought about changes in birth practices, with a significant increase in home births reported in several countries. Some women opted for home births to avoid the risk of infection in hospitals, while others chose this option due to the restrictions on hospital visits. However, the increase in home births also raised concerns about the potential risks associated with giving birth outside of a hospital setting, particularly for high-risk pregnancies [15].

EQUITY IN ACCESS TO CARE

The COVID-19 pandemic exacerbated existing disparities in access to obstetric care, particularly among marginalized communities. Women from low-income backgrounds, ethnic minorities, and rural areas faced greater difficulties in accessing prenatal care and delivery services. These disparities were compounded by the digital divide, which limited access to telemedicine services for many women [19].

Studies have shown that women from ethnic minority groups were disproportionately affected by COVID-19, with higher rates of severe illness and complications reported in these populations. For example, a study in the United States found that Black and Hispanic women were more likely to be hospitalized with COVID-19 during pregnancy compared to their White counterparts [20].

The disparities in access to care also extended to maternal and neonatal outcomes. Women from marginalized communities were more likely to experience adverse outcomes, such as preterm birth, low birth weight, and perinatal death, during the pandemic. These findings highlight the need for targeted interventions to address the unique challenges faced by these populations [13, 21].

In response to the disparities in access to care, some healthcare systems introduced targeted interventions to ensure that vulnerable populations received adequate care during the pandemic. Mobile health units were deployed in rural areas to provide prenatal care to women who could not access telemedicine services. Community outreach programs were also established to educate women about the importance of seeking care during pregnancy, even during a pandemic [9, 29].

These policy responses underscore the importance of equity in healthcare access, particularly during a global health crisis. Moving forward, it is essential to develop policies that address the social determinants of health and ensure that all women, regardless of their socio-economic background, have access to high-quality obstetric care [7, 23, 31].

CONCLUSION

The COVID-19 pandemic has had a profound impact on obstetric care, necessitating significant changes and delivery services in the organization. The reorganization of obstetric units, the adoption of telemedicine, and the implementation of new clinical protocols were critical in ensuring the safety of both patients and healthcare workers. However, these changes also had significant social implications, particularly for pregnant women who faced increased anxiety and isolation during the pandemic.

The pandemic also highlighted existing disparities in access to care, with marginalized communities facing greater challenges in accessing obstetric services. The policy responses to these disparities, such as the deployment of mobile health units and community outreach programs, underscore the importance of equity in healthcare access.

Moving forward, it is essential to incorporate the lessons learned during the pandemic into future practices in obstetric care. This includes strengthening healthcare systems, enhancing

support for healthcare workers, and addressing the social determinants of health. By doing so, we can ensure that obstetric care remains safe, equitable, and responsive to the needs of all women, regardless of their socio-economic background.

REFERENCES

1. Poorolajal J. The global pandemics are getting more frequent and severe (англ.) // Journal of Research in Health Sciences.- 2021.- Vol. 21, no. 1.- P. e00502.- doi:10.34172/jrhs.2021.40. - PMID 34024760. Архивировано 22 октября 2021 года.
2. World Health Organization/ Coronavirus (COVID-19) Dashboard. data.who.int/covid19/cases. Дата обращения: 23 мая 2024;
3. Singh P, Bhuriya V, Nanda S, et al. COVID-19 suspicion and diagnosis in pregnancy: A big conundrum! J Family Med Prim Care. 2022 Oct;11(10):6029-6035. doi: 10.4103/jfmpc.jfmpc_145_22.
4. Allotey J et al. for PregCOV-19 Living Systematic Review Consortium. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis. BMJ. 2020 Sep 1;370:m3320. doi: 10.1136/bmj.m3320. Update in: BMJ. 2022 May 30;377: o1205. doi: 10.1136/bmj. o1205.
5. Hashim NAF, Mahdy ZA, Abdul Rahman R, Kalok AHM, Sutan R. Universal Testing Policy for COVID-19 in Pregnancy: A Systematic Review. Front Public Health. 2022 Feb 8;10:588269;
6. Koyucu RG, Karaca PP. The Covid 19 outbreak: Maternal Mental Health and Associated Factors. Midwifery. 2021 Aug;99:103013. doi: 10.1016/j.midw.2021.103013.
7. Di Mascio D, Khalil A, Saccone G, Rizzo G, Buca D, Liberati M, Vecchiet J, Nappi L, Scambia G, Berghella V, D'Antonio F. Outcome of coronavirus spectrum infections (SARS, MERS, COVID-19) during pregnancy: a systematic review and meta-analysis. Am J Obstet Gynecol MFM. 2020 May;2(2):100107. doi: 10.1016/j.ajogmf.2020.100107
8. Diriba K et al. The effect of coronavirus infection (SARS-CoV-2, MERS-CoV, and SARS-CoV) during pregnancy and the possibility of vertical maternal-fetal transmission: a systematic review and meta-analysis. Eur J Med Res. 2020;25(1):39.
9. Galang R.R. et al. Severe coronavirus infections in pregnancy: a systematic review // Obstet Gynecol. 2020; 136 (2): 262-272.; Diriba K et al. The effect of coronavirus infection (SARS-CoV-2, MERS-CoV, and SARS-CoV) during pregnancy and the possibility of vertical maternal-fetal transmission: a systematic review and meta-analysis. Eur J Med Res. 2020;25(1):39.
10. Rebutini P.Z et al. Association between COVID-19 Pregnant Women Symptoms Severity and Placental Morphologic Features.
11. ACOG. COVID-19 FAQs for Obstetrician-Gynecologists Obstetrics. 2020;
12. Larki M, Sharifi F, Roudsari RL, et al. Models of maternity care for pregnant women during the COVID-19 pandemic. East Mediterr Health J. 2020 Sep 24; 26(9): 994-998. doi: 10.26719/emhj.20.097
13. Poon 2020: Poon LC, Yang H, Dumont S, et al. ISUOG interim guidance on coronavirus disease 2019 (COVID-19) during pregnancy and puerperium: information for healthcare professionals - an update. Ultrasound Obstet Gynecol. 2020;55(6):848–62. doi: 10.1002/uog.2206

14. Rasmussen 2020: Rasmussen SA, Smulian JC, Lednický JA, et al. Coronavirus Disease 2019 (COVID-19) and pregnancy: what obstetricians need to know. *Am J Obstet Gynecol.* 2020;222:415–26. doi: 10.1016/j.ajog.2020.02.017
15. Jardine 2021: Jardine J, Relph S, von Dadelszen P, et al. Maternity services in the UK during the coronavirus disease 2019 pandemic: a national survey of modifications to standard care. *BJOG: An International J Obstet Gynaecol.* 2021;128(5):880–889. doi: 10.1111/1471-0528.16547
16. RCOG 2022: RCOG. Coronavirus infection and pregnancy. Version 16.0: updated Thursday 15 December 2022.
17. Perlman J, Oxford C, Chang C, et al. Delivery Room Preparedness and Early Neonatal Outcomes During COVID-19 Pandemic in New York City. *Pediatrics.* 2020 Aug;146(2):e20201567. doi: 10.1542/peds.2020-1567;
18. Trocadero V, Silvestre-Machado J, Azevedo L, et al. Pregnancy and COVID-19: a systematic review of maternal, obstetric and neonatal outcomes. *J Matern Neonatal Med.* 2022;35(12):2362-74. <http://dx.doi.org/10.1080/14767058.2020.1781809>;
19. Favilli A, Mattei Gentili M, De Paola F, COVID-19 and Pregnancy: An Updated Review about Evidence-Based Therapeutic Strategies. *J Pers Med.* 2023 Jun 23;13(7):1035. doi: 10.3390/jpm13071035;
20. Jackson C, Brawner J, Ball M, et al. Being pregnant and becoming a parent during the COVID-19 pandemic: a longitudinal qualitative study with women in the Born in Bradford COVID-19 research study. *BMC Pregnancy Childbirth.* 2023 Jul 4;23(1):494. doi: 10.1186/s12884-023-05774-4.
21. Madkhali AM, Al Ghamdi SO, Al-Sum H, et al. Framework for obstetrics and gynecology department change management in response to COVID-19 pandemic: A tertiary center experience. *Ann Thorac Med.* 2021 Jan-Mar;16(1):57-63. doi: 10.4103/atm.ATM_602_20.
22. London V, McLaren R Jr, Stein J, et al. Caring for pregnant patients with COVID-19: practical tips getting from policy to practice. *Am J Perinatol.* 2020;37(8):850–3. doi: 10.1055/s-0040-1710539;
23. Fischhoff B. Making decisions in a COVID-19 world. *JAMA.* 2020;324(2):139–40. doi: 10.1001/jama.2020.10178;
24. Olson HL et al., 2020: Olson HL, Towner D, Hiraoka M, et al. Academic clinical learning environment in obstetrics and gynecology during the COVID-19 pandemic: Responses and lessons learned. *J Perinat Med.* 2020;48:1013–6. doi: 10.1515/jpm-2020-0239.
25. Rasmussen SA, Jamieson DJ, 2022: Jamieson DJ, Rasmussen SA. An update on COVID-19 and pregnancy. *Am J Obstet Gynecol.* 2022 Feb;226(2):177-186. doi: 10.1016/j.ajog.2021.08.054.
26. Guidelines (India), 2021: Guidelines on operationalization of maternal health services during Covid-19 pandemic. Maternal Health Division Ministry of Health & Family Welfare (India). September 2021.
27. Halscott T, et al., (Management), 2020: Halscott T, Vaught J, Miller E. Management Considerations for Pregnant Patients with COVID-19. Society for Maternal-Fetal Medicine 2020.

28. Soffer MD, Shook LL, James K et al. Protocol-Driven Intensive Outpatient Management of Pregnant Patients With Symptomatic Coronavirus Disease 2019. *Open Forum Infect Dis.* 2020 Oct 27;7(11): ofaa524. doi: 10.1093/ofid/ofaa524;
29. Surita FG, Luz AG, Hsu LP, et al. FEBRASGO Position Statement. Outpatient care for pregnant and puerperal women during the COVID-19 pandemic. September 2020; 3. doi: <https://doi.org/10.1055/s-0040-1718473>.
30. Bourne T, et al., 2020: Bourne T, Leonardi M, Kyriacou C, et al. ISUOG Consensus Statement on rationalization of gynecological ultrasound services in context of SARS-CoV-2. *Ultrasound Obstet Gynecol.* 2020 Jun;55(6):879-885. doi: 10.1002/uog.22047
31. Birati Y, Yefet E, Perlitz Y, et al. Cultural and Digital Health Literacy Appropriateness of App- and Web-Based Systems Designed for Pregnant Women With Gestational Diabetes Mellitus: Scoping Review. *J Med Internet Res.* 2022 Oct 14;24(10):e37844. doi: 10.2196/37844
32. Donelle L, Hiebert B, Hall J, et al. An investigation of mHealth and digital health literacy among new parents during COVID-19. *Front Digit Health.* 2024 Jan 25;5:1212694. doi: 10.3389/fdgth.2023.1212694.
33. Delgado A, et al., 2023: Delgado A, Reid CN, Hale E, et al. Evaluation of Virtual Prenatal Care for Obstetric Care Delivery During the COVID-19 Pandemic: A Mixed Method Research Study Using the Consolidated Framework in Implementation Research. *Int J MCH AIDS.* 2023;12(2). doi: 10.21106/ijma.649.
34. ICM, 2020: ICM (International Confederation of Midwives). Women's rights in childbirth must be upheld during the coronavirus pandemic [Internet]. Países Baixos: ICM; 2020.
35. NHS, 2020: NHS. Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic [Internet]. Inglaterra: NHS; 2020.



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