



MONITORING THE COUPLE'S HEALTH AS PREMISE FOR BIRTH RATE IMPROVEMENT – A FAMILY MEDICINE PERSPECTIVE

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The role of family physicians/general practitioners (GPs) in supporting birth policies is fundamental. A comprehensive strategic plan covering the physiological tasks, birth and postpartum period for both mother and newborn is the image of any predictable and well-established healthcare system. As only 6 to 8% of all pregnancies are considered “high risk”, the complexity of the case should be evaluated by GPs on the basis of clear algorithms that could select the pregnant woman at risk. Obstetrician assessments should only be recommended for these cases for more detailed monitoring.

In this article, we follow the different government strategies implemented in Romania in recent years and present their impact on the birth rate and its variations. At the same time, several other statistically significant factors are illustrated. In conclusion, future government strategies should help increase the role of GPs in supporting the birth rate, monitoring the health of the family and the couple, and advising on the pro-birth attitude of fertile women.

Keywords: couple's health, monitoring, pro-birth counseling, family physicians/general practitioners.

INTRODUCTION

By the fall of the year 1966, the birth rate in Romania was 14.3 births /1000 inhabitants. On the 1st of October 1966, the communist regime led by N. Ceausescu signed decree nr. 770 and refuted a prior decision (dating back to 1957) which deemed abortions legal. Abortion was incriminated as a felony. The hope was that by 1990, the birth rate would steadily rise close to 20% which would (in theory) generate a population of 24–25 million inhabitants. As part of the same strategy, oral contraceptives and condoms were banned, monthly gynecological check-ups for the early diagnosis of pregnancy (and follow-up until birth) became mandatory and taxes for unmarried people over the

age of 25 (or couples without children in the absence of a medical reason) went up by 30%. During the same period, no financial incentives or maternity leave were granted, mainly due to the financial crisis that Romania was going through¹. As poverty, systemic scarcity of common household items, lack of heating in houses and other malignant effects of communism plagued society, new families refused to have children and decree 770 was brutally enforced by the authorities (including the secret police – Securitate). The results of this policy were monstrous, with implications stretching up to the year 2022: thousands of clandestine abortions, hundreds of doctors and medical personnel sentenced to jail, families under constant investigation, more than 10.000 women dead following complications after ill-performed attempts

at pregnancy termination and last but not least, more than 100.000 abandoned children in orphanages by the year 1989.

The official report of condemnation of the communist regime (elaborated by the Romanian Presidential Committee of Analysis of the Communist Dictatorship in 2006) stated that Decree 770 had been a unique situation in the countries of the Eastern Block (the Soviet Union included) and that 87% of all maternal deaths (EG:170 maternal deaths per 100.000 inhabitants in 1989) were related to attempts at pregnancy termination.

MULTIFACTORIAL CHANGES OF BIRTH RATE IN ROMANIA AFTER ABOLISHMENT OF COMMUNISM IN 1989

Following the violent abolishment of communism in 1989, the birth rate in Romania has changed considerably (See Table 1). Multiple factors have influenced the negative trend of birth rate between 1989 to 2019: the massive migration of the young population, an increasing rate of divorce, aging population, an increase in the rate of mortality, the facilitation of abortions on request, high expectations for women in terms of career and material gains, available contraception etc².

Table 1

Evolution of the birth rate in the period 1989–2019^{3,4}

Year	Live births	Deaths	Marriages	Divorces
1989	369.544	247.306	177.943	36.008
1990	314.746	247.086	192.652	32.966
1991	275.275	251.760	183.388	37.031
1992	260.393	263.855	174.593	29.290
1993	249.994	263.323	161.595	31.193
1994	246.736	266.101	154.221	39.663
1995	236.640	271.672	153.943	34.906
1996	231.348	286.158	150.388	35.586
1997	236.891	279.315	147.105	34.752
1998	237.297	269.166	145.303	39.985
1999	234.600	265.194	140.014	34.408
2000	234.521	255.820	135.808	30.725
2001	220.368	259.603	129.930	31.135
2002	210.529	269.666	129.018	31.790
2003	212.459	266.575	133.953	33.073
2004	216.261	258.890	143.304	35.225
2005	221.020	262.101	141.832	33.193
2006	219.483	258.094	146.637	32.672
2007	214.728	251.965	189.240	36.308
2008	221.900	253.202	149.439	35.685
2009	222.388	257.213	134.275	32.341

2010	212.199	259.723	115.778	32.632
2011	180.414	251.439	5.2/1000 loc	1.8
2012	185.394	255.539	5.4 la 1000 loc	1.6
2013	196.272	250.466	107.507	28.507
2014	186.088	255.604	5.9 la 1000 loc	1.4
2015	189.704	262.981	6.3 la 1000 loc	1.6
2016	187.265	258.896	6.8 la 1000 loc	1.5
2017	189.971	261.745	7.3 la 1000 loc	1.6
2018	177.573	263.463	7.4 la 1000 loc	1.6
2019	188.189	259.721	6.6 la 1000 loc	1.6

As a result, the average age at which couples have their first child has steadily increased. (See Table 2)⁵.

Table 2

Evolution of maternal age at birth in the period 1990–2010⁶

Year	Average age of mother at first birth			Average age of mother at all births		
	Total	Urban	Rural	Total	Urban	Rural
1990	22.3	23.7	21.3	25.0	25.7	24.5
1991	22.2	23.9	21.0	24.5	25.1	23.9
1992	22.3	23.8	21.3	24.4	25.1	23.8
1993	22.4	23.7	21.4	24.3	25.1	23.6
1994	22.5	23.6	21.5	24.4	25.2	23.7
1995	22.7	23.8	21.6	24.6	25.4	23.9
1996	22.9	24.0	21.8	24.8	25.6	24.1
1997	23.1	24.2	21.9	24.9	25.7	24.2
1998	23.3	24.4	22.1	25.1	25.9	24.4
1999	23.5	24.6	22.2	25.3	26.0	24.6
2000	23.7	24.9	22.3	25.5	26.3	24.9
2001	23.9	25.2	22.4	25.8	26.6	25.1
2002	24.2	25.5	22.5	26.0	26.9	25.3
2003	24.3	25.7	22.5	26.2	27.1	25.4
2004	24.6	26.0	22.6	26.4	27.3	25.5
2005	24.9	26.3	22.7	26.7	27.6	25.7
2006	25.2	26.6	22.9	26.9	27.8	25.8
2007	25.3	26.7	22.9	27.0	28.0	25.9
2008	25.5	27.0	23.1	27.1	28.1	25.9
2009	25.6	27.1	23.1	27.3	28.3	26.0
2010	26.0	27.5	23.4	27.6	28.6	26.2
2019	27.4	27.4	18.8	26.9	27	25.2

Furthermore, infertility is considered one of the most common pathologies of the early 21st century, with approximately 15% of couples being diagnosed with primary or secondary infertility. (See Table 3)⁷

Table 3

Evolution of the fertility rate by age ranges between 1989–2010⁸

Year	General fertility rate	Age group (years)							Total fertility rate
		15–19	20–24	25–29	30–34	35–39	40–44	45–49	
1989	66.3	59.3	169.1	118.0	58.8	25.6	7.1	0.4	2.2
1990	59.2	51.5	145.2	97.8	46.4	19.4	5.5	0.4	1.8
1991	48.7	49.8	131.1	78.6	34.2	13.9	4.0	0.3	1.6
1992	46.6	47.4	127.1	77.1	31.1	12.9	3.7	0.2	1.5
1993	44.3	47.0	124.6	74.2	28.3	11.4	3.2	0.3	1.4
1994	43.3	45.0	119.3	75.8	28.7	11.3	3.2	0.2	1.4
1995	41.1	42.0	109.5	73.4	29.4	11.0	3.1	0.2	1.3
1996	39.9	40.0	102.2	72.4	30.1	10.9	2.9	0.2	1.3
1997	40.6	40.8	100.7	72.6	33.9	11.2	2.9	0.2	1.3
1998	40.6	40.3	96.9	77.6	36.3	11.7	2.8	0.2	1.3
1999	40.2	40.0	93.3	77.6	37.3	12.4	2.8	0.2	1.3
2000	40.3	39.0	90.2	78.5	38.7	13.4	3.1	0.2	1.3
2001	37.8	35.8	82.2	73.8	37.4	13.7	3.0	0.2	1.2
2002	37.5	32.7	81.5	77.6	38.3	15.0	3.0	0.2	1.3
2003	37.8	33.4	79.7	79.0	41.7	16.1	3.1	0.2	1.3
2004	37.4	33.8	77.2	80.7	46.2	17.6	3.4	0.2	1.3
2005	39.4	33.5	73.3	83.9	51.8	18.7	3.6	0.2	1.3
2006	39.5	35.2	69.8	82.7	54.0	19.0	3.5	0.2	1.3
2007	38.9	35.2	66.5	81.0	54.4	18.3	3.9	0.2	1.3
2008	40.6	38.5	67.9	83.1	57.4	20.5	4.4	0.2	1.3
2009	41.0	39.3	67.5	82.7	59.4	22.1	4.7	0.2	1.4
2010	39.4	36.9	62.3	79.9	59.2	23.3	4.6	0.2	1.3

Such unfavorable determinants of the birthrate should be counterbalanced by a national strategic response doubled by a series of financial incentives and medical strategies applied by the GPs.

MONITORING THE COUPLE'S HEALTH AND PRO-BIRTH COUNSELING IN FAMILY MEDICINE, AS PART OF THE NATIONAL STRATEGY

The family doctor is the fundamental link between the patient and the specialist doctor, providing primary and continuous medical care to the individual, family and community.^[4] This process is the basis for transmission of medical information and a cornerstone for supporting positive birthrate programs in Romania and the European Union. National strategies should start with basic characteristics of the populations and couples such as age and weight, prevention of comorbidities and infections leading to infertility, educating couples about conception, the risks of contracting sexually transmitted diseases, conception at an advanced age and its risks, vices and their impact on pregnancy, the risk of teenage pregnancy etc.⁹ A pre-conception screening

program is recommended for the most common sexually transmitted diseases such as HIV, VDRL, Hepatitis B, Hepatitis C, Chlamydia, genital herpes, gonorrhea, by collecting blood, urine and secretion samples. Following these, positive patients start treatment and, postponement of conception is recommended if necessary.¹⁰ Pre-existing pathologies should always be compensated before conception. (See Table 4)^{11–13}

Table 4

Preconception interventions for women with selected specific risk factors¹⁴

Risk factor	Intervention	Prevention of
Alcohol	Avoid all alcohol intake	Congenital anomalies, mental retardation
Asthma	Management following National Asthma Education and Prevention Program (NAEPP)	PTB, perinatal mortality, LBW, preeclampsia
Cancer	Stabilization of the neoplasia, usually no effect on pregnancy [28]	Congenital malformations if radio- or chemotherapy are administered in the first trimester of pregnancy [28]

Diabetes	Hemoglobin A1C<7%; screening for asymptomatic bacteriuria	Congenital anomalies, length of NICU admission, perinatal mortality and long-term health consequences in infant, miscarriage, maternal hospitalizations, maternal renal disease
HIV	Initiate or modify antiviral agents with goals of: HIV-1 RNA viral load level <1000 copies/mL or below the limit of detection; avoid teratogenic agents	Perinatal HIV infection
Hypertension	Avoid angiotensin-converting enzyme inhibitors and angiotensin-receptor blockers. If long-standing HTN, assess for renal disease, ventricular hypertrophy and retinopathy	Congenital anomalies, HTN complications, CD, placental abruption, PTB, IUGR, perinatal death
Hyperthyroidism	Propylthiouracil supplementation to maintain FT4 in high normal range, and TSH in low normal range	Spontaneous pregnancy loss, PTB, preeclampsia, fetal death, FGR, maternal congestive heart failure, and thyroid storm; neonatal Graves' disease
Hypothyroidism	Thyroxine supplementation to maintain normal TSH levels (0,5-2,0 mcu/ml)	Infertility, maternal HTN, preeclampsia, anemia, PTB, fetal death, LBW, neurological disease in infant
Obesity	Diet and exercise to achieve normal BMI; screening for diabetes	Infertility, fetal NTDs, PTB, CD, HTN-disorders, diabetes, VTE
Other drugs of abuse	Avoid all drugs of abuse	PTB, IUGR, neonatal withdrawal
PKU	Low-phenylalanine diet	PKU-related mental retardation
Seizure disorders	Lowest dose of safest effective anticonvulsant monotherapy; folic acid supplement	Congenital anomalies
Sexually transmitted disease	Screen at-risk population	Ectopic pregnancy, perinatal infection

Social issues (e.g. abuse)	Counseling; referral to the appropriate agency	Physical and emotional trauma and their consequences
Supplements and over-the-counter medications	Review and counsel: avoid excess of recommended daily allowance	Congenital anomalies
Systemic lupus erythematosus	≥ 6 months of quiescence on stable therapy	HTN, preeclampsia, PTB, fetal death, IUGR, neonatal lupus
Teratogenic drugs	Avoid them	Congenital anomalies

PTB – preterm birth; LBW – low birth weight; IUGR – intrauterine growth restriction; NICU – neonatal intensive care unit; BMI – body mass index; NTD – neural tube defects; CD – cesarean delivery; HTN – hypertension; VTE – venous thromboembolism; TSH – thyroid stimulating hormone; FT4 – free thyroxine; HIV – human immunodeficiency virus; RNA – ribonucleic acid; PKU-phenylketonuria.

It might also be advisable to avoid conception after certain treatments with antipsychotics, dermato-cosmetics based on retinoids, acetylcholinesterase inhibitors, anticoagulants, antimalarials, antivirals, high doses of steroids and many others due to their teratogen side effects (See Table 5)¹⁵⁻¹⁷ All of the above are recommended to be included in a prenatal primary care screening for both members of the couple. Other crucial aspects such as vaccination history, the woman's obstetrical and gynecological history, medical history, risk behaviors (smoking, alcohol and illicit drugs use), and recent medication exposure should be noted by the family physicians.¹⁸ Prenatal counseling in the family doctor's office will also include specific interventions to stop smoking, alcohol consumption and self-medication. Investigations for genetically transmitted diseases are also recommended if there is a pathology inherited in the family history^{19,20}. Last but not least, the administration of prenatal vitamin supplements and pre-conceptional folic acid can and should be performed by the GP.

Table 5
Teratogens²¹

Prescribed drugs	Androgens and testosterone derivatives
	Angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers
	Coumadin derivatives
	Carbamazepine
	Diethylstilbestrol
	Folic acid antagonists (Methotrexate and aminopterin)

	HMG-CoA reductase inhibitors (statins)
	Lithium
	Phenytoin
	Primidone
	Streptomycin and kanamycin
	Tetracycline
	Thalidomide and leflunomide
	Trimethadione and paramethadione
	Valproic acid
	Vitamin A and its derivatives
Chemicals	Lead
	Mercury
Drugs of abuse	Alcohol
	Cocaine
Infections	Cytomegalovirus
	Rubella
	Syphilis
	Toxoplasmosis
	Varicella
Radiation	

DISCUSSION

The process of “medicalizing” the act of giving birth was supported by family doctors, who referred the maternity period exclusively to obstetricians. This process has led to a higher rate of cesarean section procedures during pregnancy.²² According to the World Health Organization (WHO) the rate of cesarean section surgery should be between 5% and 15%²³, nevertheless this percentage is higher in reality. For example, in 2018, Romania had a 44.50% rate, Bulgaria – 44.58 %, Poland – 38.92%, and Hungary – 38.03%.²⁴ The only way to stop this process is to realize that pregnancy and childbirth are two physiological processes, which do not require medical intervention except in selected cases. A study conducted in 12 countries of the European Union showed that 66% of family physicians who responded to the survey were involved in antenatal care, while only 15% of them were involved in intrapartum care.²⁵ More than 90% of GPs in Ireland, Denmark, the UK and Portugal reported involvement in antenatal care, while intrapartum care is rarely provided by the GP. Do note that in the late 1980s, about 40% of GPs attended births. The percentage dropped to 26% in 1990 and subsequently to 16% in 1998.^{26,27}

The postnatal follow-up of both the pregnant woman and the newborn can be performed in most

cases by the GP, who will send the patient to the specialist doctor only in selected cases. The most common postpartum condition is depression, affecting about 90% of all mothers. Furthermore, over 80% of them did not report symptoms to a medical professional.^{28,29} In this regard, the GP may recognize the severe forms of postpartum depression and many other psycho-emotional disorders of this period in early forms, their prognosis, following a correct treatment performed being much better than in the case those diagnosed late. Breastfeeding is another crucial aspect of the peripartum period. There are many breastfeeding specialists lately, trained in various fields of medicine. These methods can be mastered by GPs, who are supposed to be more accessible.^{30–33} In Romania almost all mothers (95.7%) breastfed their child at least once, 54.2% of them continue to breastfeed until one year and only 30.3% of them until the age of 2 years.^{34,35}

In addition, the follow up of the pre-existing diseases during pregnancy such as diabetes mellitus, obesity, cardiovascular disease is important to early identifying their complications.^{37–39}

From many perspectives, family medicine is involved in monitoring pregnancy and childbirth, including complications that may occur such as anaphylactic shock in pregnant women requiring a high degree of vigilance, multispecialty cooperation, and rapid intervention.³⁶

CONCLUSIONS

Following this family medicine perspective on monitoring the couple's health as a premise for birth rate improvement, certain things stand out.

First, the GP's role in intrapartum care is considerably reduced in this era, for several reasons: fear of moral and financial litigation, insufficient training, limited competence in childbirth assistance, lack of patient trust, and desire to give birth in a maternity ward with an obstetrician.

Second, GPs who monitor pregnancy are generally double-specialized physicians in family medicine and obstetrics. They provide care during pregnancy for low-risk pregnancies but also for high-risk ones, due to nationwide lack of physicians – an aspect frequently noted in rural areas.

Third, GPs are often caught in competition between midwives and obstetricians for low-risk pregnancies. Thus, their contribution is considerably

reduced, although they have significant knowledge about the family, unlike midwives, and can better follow the newborn's development. However, family physicians are the most appropriate health professionals to support the improvement of the birth rate by monitoring the health of the family and the couple and advising on the pro birth attitude of fertile women.

REFERENCES

- Haupt A. How Romania tries to govern fertility. *Popul Today*. **1987** Feb;15(2):3-4. PMID: 12268504.
- Simionescu A.; Tindecu C.; Marcuța L.; Marcuța A.; Relationship between sustainable development and public health. case study Romania., *Papers Series Management, Economic Engineering in Agriculture and Rural Development Vol. 18, Issue 3*, **2018** PRINT ISSN 284-7995, E-ISSN 2285-3952.
- www.insse.ro, *The Romanian Statistical Yearbook 2011*, pp.54-55.
- <https://ec.europa.eu/eurostat/cache/digpub/demography/bl oc-4b.html?lang=en>
- Discussion on Demography and Human Development: An Examination of Natality and Mortality in Post-Communist Romania. *Revista de Stiinte Politice*, **2015**, Issue 48, p151-168. <https://www.thefreelibrary.com/Discussion+on+demography+and+human+development+%3a+an+examination+of...a0449929944>.
- www.insse.ro, Average age of mother at birth, by area. *The Romanian Statistical Yearbook 2011*, p.62 and *The Romanian Statistical Yearbook 2010*, 2.10.
- Cui, Weiyuan. "Mother or nothing: the agony of infertility." *World Health Organization. Bulletin of the World Health Organization* **2010**, 88, 12: 881.
- www.insse.ro, *The Romanian Statistical Yearbook 2011*, p. 63.
- Jung H. P.; Wensing, M. & Grol, R. What makes a good general practitioner: do patients and doctors have different views? *The British journal of general practice: the journal of the Royal College of General Practitioners*, **1997**, 47(425), 805–809.
- Landon M.B.; Driscoll D.A.; Jauniaux E.R.M.; Galan H.L.; Grobman W.A.; Berghella V. *Gabbe's Obstetrics Essentials: Normal & Problem Pregnancies E-Book. 8th edition*, Elsevier, **2020**.
- Keighley CL.; Skrzypek HJ.; Wilson A.; Bonning M.A.; Gilbert G.L. Infections in pregnancy. *Med J Aust*. **2019** Aug;211(3):134-141. doi: 10.5694/mja2.50261. Epub 2019 Jul 4. PMID: 31271467.
- King P. Pregnancy in women with diabetes or with gestational diabetes: a primary care perspective. *Pract.Diabetes* **2019**; 36(5):171-176.
- Greer I.; Steegers E. Periconceptional Medicine. London, *United Kingdom: Informa Healthcare*, **2008**.
- Berghella V.; Buchanan E.; Pereira L.; & Baxter J. K. Preconception care. *Obstetrical & gynecological survey*, **2010**, 65(2), 119-131.
- Jack B.W.; Atrash H.; Coonrod D.V.; et al. The clinical content of preconception care: an overview and preparation of this supplement. *Am J Obstet Gynecol* **2008**;199(suppl 2):S266–S279.
- Van Gelder M. M.; Van Rooij I. A.; Miller R. K.; Zielhuis G. A.; de Jong-van den Berg, L. T.; & Roeleveld, N. Teratogenic mechanisms of medical drugs. *Human reproduction update*, **2010**, 16(4), 378-394.
- Tomson T.; & Battino D. Teratogenic effects of antiepileptic drugs. *The Lancet Neurology*, **2012**, 11(9), 803-813.
- Zomerdijk I. M.; Ruiter R.; Houweling L. M.; Herings, R. M.; Straus S. M.; & Stricker B. H. Dispensing of potentially teratogenic drugs before conception and during pregnancy: a population based study. *BJOG: An International Journal of Obstetrics & Gynaecology*, **2015**, 122(8), 1119-1129.
- Hunt S.; Vollenhoven B. Assessment of female fertility in the general practice setting. *Aust J Gen Pract*. **2020** Jun;49(6):304-308. doi: 10.31128/AJGP-01-20-5205. PMID: 32464730.
- Dinc L.; & Terzioglu F. The psychological impact of genetic testing on parents. *Journal of clinical nursing*, **2016**, 15(1), 45-51.
- French JA. First-choice drug for newly diagnosed epilepsy. *Lancet*. **2007**; 24;369(9566):970-1. doi: 10.1016/S0140-6736(07)60470-X.
- Nevin, S. M.; Wakefield, C. E.; Barlow Stewart, K.; McGill, B. C.; Bye, A.; Palmer, E. E.; & Sachdev, R. Psychosocial impact of genetic testing on parents of children with developmental and epileptic encephalopathy. *Developmental Medicine & Child Neurology*, **2022**, 64(1), 95-104.
- Wald N.J. Folic acid and the prevention of neural-tube defects. *N Engl J Med* **2004**; 350:101–103
- Wagner M. Fish can't see water: the need to humanize birth. *International Journal of Gynaecology and Obstetrics* **2001**;75:S25/37.
- Chalmers B.; Mangiaterra V.; Porter R. WHO principles of perinatal care: the essential antenatal, perinatal, and postpartum care course. *Birth* **2001**;28:202/7.
- STATISTA : <https://www.statista.com/topics/5217/cesarean-sections/> accessed on October **2020**
- Boerma W.G.W; Fleming D.M. The role of general practice in Primary Health Care. *WHO regional office for Europe* **1998**.
- Wiegers T.; Hingstman L. Inventarisatie "verloskundig actieve huisartsen". Utrecht, Nivel **1999**
- Whitton A.; Warner R.; Appleby L. The pathway to care in post-natal depression: women's attitudes to post-natal depression and its treatment. *Br J Gen Pract*. **1996** Jul; 46(408):427-8. PMID: 8776916; PMCID: PMC1239697.
- Gibbins S. A.; Green, P. E.; Scott P. A.; & MacDonell, J. W. The role of the clinical nurse specialist/neonatal nurse practitioner in a breastfeeding clinic: a model of advanced practice. *Clinical Nurse Specialist*, **2000**, 14(2), 56-59.
- Lawlor-Smith, C.; McIntyre, E.; & Bruce, J. Effective breastfeeding support in a general practice. *Australian Family Physician*, **1997**, 26(5), 573-5.
- Hegney D.; Brodribb W.; Fallon A. B.; & Jackson C. Breastfeeding and the responsibilities of GPs: a qualitative study of general practice registrars. *Australian family physician*, **2007**, 36(4).
- Biggs K. V.; Fidler K. J.; Shenker, N. S.; & Brown, H. Are the doctors of the future ready to support breastfeeding? A cross-sectional study in the UK. *International breastfeeding journal*, **2020**, 15, 1-8.

34. Cozma-Petruț A.; Filip L.; Banc R.; Mîrza O.; Gavrițaș L.; Ciobârcă D.; & Miere D. Breastfeeding Practices and Determinant Factors of Exclusive Breastfeeding among Mothers of Children Aged 0–23 Months in Northwestern Romania. *Nutrients*, **2021**, *13*(11), 3998.
35. Pereg D.; Koren G.; & Lishner M. Cancer in pregnancy: gaps, challenges and solutions. *Cancer treatment reviews*, **2008**, *34*(4), 302-312.
36. Simionescu A.A.; Danciu B.M.; Stanescu A.M.A. Severe Anaphylaxis in Pregnancy: A Systematic Review of Clinical Presentation to Determine Outcomes. *Journal of Personalized Medicine*. **2021**; *11*(11):1060. <https://doi.org/10.3390/jpm11111060>.
37. Simionescu A.A.; Danciu B.M.; Stanescu A.M.A. State-of-the-Art Review of Pregnancy-Related Psoriasis. *Medicina*. **2021**; *57*(8):804. <https://doi.org/10.3390/medicina57080804>
38. Dumitrascu M. C.; Stanescu A. M. A.; Bejan C.; Sandru F.; Toader D. O.; Radavoi D. G.; & Diaconu C. C. Obesity and its implications on stress urinary incontinence. *Revista de Chimie*, **2019**, *70*(10), 3660-3662.
39. Iorga R.A.; Bacalbasa N.; Carsote M.; Bratu O.G.; Stanescu, A.A.; Bungau S.; Diaconu C.C. Metabolic and cardiovascular benefits of GLP-1 agonists, besides the hypoglycemic effect (Review). *Experimental and Therapeutic Medicine*, **2020**, *20*, 2396-2400. <https://doi.org/10.3892/etm.2020.8714>.

