

Permanent contraception with special reference to neonatology and pediatrics

Abstract

Birth control has been obfuscated in some countries by presumed national interests. Demographic growth is used to strengthen defenses and economy. In Russia, popular TV series depict unexpected pregnancies both in and out of wedlock as natural and unavoidable. Risks associated with abortions and contraception are exaggerated or invented by some authors, including medical professionals. The mass misinformation can be seen as reproductive coercion sanctioned by the state, which may lead to unwanted pregnancies, impaired mothering, child abuse and neglect. Tubal sterilization and vasectomy are reliable methods of permanent contraception. Cesarean section (CS) is an opportunity to perform sterilization without additional trauma. Salpingectomy at the time of cesarean delivery is safe. Majority of women are pleased with their decision to be sterilized. The worldwide increasing CS rates have resulted in the lowering of neonatal morbidity and mortality rates. Planned CS is associated with lower rates of neonatal complications such as birth trauma, tube feeding and hypotonia, when compared to planned vaginal delivery. Birth is a time of stress, manifested among others in tooth enamel by stria known as the neonatal line, which is on average thicker after vaginal delivery than after CS. This is an additional argument in favor of CS, which is less stressful for the newborn. In conclusion, cesarean tubal sterilization should be more often considered by women not planning further pregnancies.

Keywords: Birth control, Sterilization, Fallopian tube occlusion, Cesarean section; Neonatal morbidity

Introduction

Birth control has been obfuscated in some countries by presumed national interests. Demographic growth is used to strengthen defenses and economy [1]. In Russian Federation (RF), popular TV series depict unexpected pregnancies both in and out of wedlock as natural and unavoidable. The risks associated with contraception and abortions are exaggerated or invented by some authors, including med-

Review Article

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Received: 13 May, 2026; **Accepted:** 26 May, 2026;

Published: 02 June, 2026

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ical professionals e.g. [2]. The mass misinformation can be seen as reproductive coercion sanctioned by the state. Sexual and reproductive coercion can lead not only to abortions and unwanted pregnancies but also to unfavorable pregnancy outcomes, sexually transmitted and hereditary diseases, psychiatric and other derangements [3-6]. Moreover, reproductive coercion may have consequences for mothering and relationships with children. Growing up as unwanted child is sometimes a miserable destiny; it may be associated with child abuse and neglect, psychiatric and other abnormalities in children [7-10].

The tubal sterilization and vasectomy are reliable methods of permanent contraception. Male sterilization (vasectomy) is a minor outpatient procedure taking 5-20 min to perform under local anesthesia [11]. Traditions of male dominance sometimes work against men choosing vasectomy, which is in fact sexism. Public information should create awareness about vasectomy. Availability of good quality service is important. Sterilization methods in women such as tubal ligation, laparoscopic tubal disruption or hysteroscopic occlusion are generally regarded to be safe [12,13].

Cesarean Tubal Sterilization

Cesarean Section (CS) is an opportunity to provide permanent contraception without additional incisions and anesthesia [14,15]. Cesarean Tubal Sterilization (CTS) was associated neither with an increased rate of surgical complications nor with perioperative morbidity [16-20]. Bilateral salpingectomy at the time of cesarean delivery is safe. Operative time may be increased up to 15 minutes compared

with standard tubal ligation [16]. It is possible to perform tubal sterilization immediately after a vaginal delivery via mini-laparotomy; but the method is not available in many obstetric institutions around the world.

Majority of women are pleased with their decision to be sterilized [21,22]. Patients are more likely to regret declining a tubal ligation during CS than to regret accepting one [22]. Salpingectomy has been associated with a decreased risk of ovarian cancer, and possibly has a positive impact upon sexuality [19,20,23]. Apart from the birth control, systematic performance of CTS could counteract the gender imbalance in some regions. For example, in China, the male-to-female ratio at birth is elevated, being proportional to the age and number of parities [24]. The gender imbalance at birth was reported from some other countries [25].

The worldwide increasing CS rates have resulted in lowering of neonatal morbidity and mortality [26]. This association becomes stronger after adjustment for maternal risks factors [27]. In particular, pre-labor CS is protective against low Apgar score in term [28]. In a recent meta-analysis, planned CS was associated with significantly lower rates of adverse neonatal outcomes such as the birth trauma, tube feeding and hypotonia, when compared to planned vaginal delivery [29]. Admittedly, the evidence is inconsistent; no lowering of some neonatal risks after CS without medical indication were reported by some researchers [30]. Birth is a time of stress, manifested among others in tooth enamel by marked stria known as the neonatal line, which is on average thicker after vaginal delivery than after CS [31]. This is an additional argument in favor of CS, which is less stressful for the newborn.

Associations of CS with increased risk of hemorrhage, hysterectomy, complications of anesthesia, thromboembolism and post-partum infections have been reported [26,32,33], although the data are partly inconsistent [34]. A correlation was found between an increase in maternal morbimortality and the rise in cesarean birth rates [28,33-35]. However, obstetric surgery has made progress in improving post-surgical outcomes [36]. In particular, postoperative interventions according to the concept of enhanced recovery after surgery (prophylactic antibiotics, thromboprophylaxis, maintenance of fluid balance) contribute to an improvement of maternal recovery and outcomes [37]. For example, pre-incision prophylactic cefazolin has reduced the risk of postoperative infections up to 60%. Additionally, the introduction of tranexamic acid was shown to reduce maternal mortality related to hemorrhage [36]. Adoption of enhanced recovery pathways for CS is increasing; but there remains a paucity of published evidence on improvement of health indicators. Further research is needed to assess potential benefits of the increased frequency of CS and of its technical improvements [38]. In more developed countries, CS is widely regarded as a safe intervention owing to mastered surgical techniques and improved anesthesia [39]. A part of maternal mortality associated with CS is secondary to confounders like maternal diseases and age [40,41]. In a large

study (264,755 births), CS was associated with older maternal age, vaginal bleeding, labor induction, previous CS, pre-term gestational age, low birth weight, malpresentation as well as maternal morbimortality including hypertension, diabetes, urinary tract infections and pyelonephritis [35].

On the contrary, several studies have shown a correlation between CS rates and decreased maternal and neonatal mortality [26,42,43]. In Brazil, the increasing CS rate in the last three decades has been followed by a significant decrease in maternal mortality; although the causality is not entirely clear [44]. A large-scale ecological study concluded that national cesarean delivery rates of up to 19 per 100 live births were associated with lower maternal or neonatal mortality among WHO member states, so that the previously recommended target rates for CS are probably too low [43,44]. With regard to certain maternal complications such as the pelvic floor injury and urinary incontinence, elective CS is protective compared to the vaginal delivery [45-47]. Planned CS led to a significant decrease in chorioamnionitis and urinary incontinence [29,48]. An advantage of SC is the absence of pain during childbirth [44]. Last but not least important, granted requests for elective CS were associated with a decrease in postpartum depression [49].

CTS should be considered for women not planning further pregnancies especially in regions where some contraception options are not easily available. The age, attitude of the male partner and other data may be taken into account formulating recommendations for permanent contraceptive methods. Vladimir Putin called the decision to have a child a family matter [50], which can be understood as approval of reproductive coercion by family members, in agreement with his policy of elevating birthrate. It should be stressed that the male partner's consent is required neither for sterilization nor for elective CS [51]. The patient's autonomy is a cornerstone of modern healthcare. It is the woman's right to choose the vaginal or cesarean delivery route [44,52,53]. However, the debate on this topic is going on [54]. This review provides additional argument: acceptance of CS on a maternal request as a human right would facilitate CTS, which is favorable in view of the global overpopulation. Advice by a medical professional and shared decision-making has the potential of improving willingness to undergo SC and sterilization in low-income countries [55]. Advising patients, it is important to preserve objectivity, so that all risks of vaginal delivery are explained as well as those of planned SC [27,54].

CS and CTS on maternal request must be available also in the absence of contraindications for vaginal delivery. This pertains to RF, where CS is generally not performed on a maternal request [56]. In earlier publications, experts reported that they had performed CS on maternal request and that CS was used more frequently when the procedure was paid by patients [57]. Others insisted that SC must be performed only according to clinical indications. The latter stance is prevailing today as the government of RF stimulates fertility.

Discussion

The access to sterilization is of particular importance in conditions where women are not sufficiently protected against sexual and reproductive coercion. The latter is not always defined as such by victims; in particular, IPV may prevent a woman from naming certain behaviors as coercive [58]. In RF, women are not sufficiently protected against IPV [59]. According to some estimates, the prevalence of family violence in RF during last decades has been 45-70 times higher than, for example, in England and France [60].

In this connection, battered woman syndrome and learned helplessness must be timely recognized. The authorities should handle both neglectful and intentional contraception sabotage as offenses with bodily harm, if an abortion, unintended pregnancy, sexually transmitted or genetic disease has been knowingly inflicted.

Some sons of military and other functionaries have enjoyed far-reaching impunity in the Soviet and post-Soviet society, becoming involved in immoral and illegal activities, sexual coercion, etc. High social positions held by perpetrators or their relatives prevented reporting. The contraceptive sabotage, often by negligence under the impact of alcohol, was not uncommon; more references are in [61]. Admittedly, this aspect is overshadowed today by migration-related problems. Sexual and reproductive coercion are used for the purpose of migration, to cement a relationship or marriage, to obtain a residence permit and lodging, or to spread a certain genotype sometimes with geopolitical motives. According to a monograph published in 2012, ~50% of rapes in Moscow were committed by foreigners; while ethnic non-Russian residents of RF are not counted as foreigners. At that, many crimes remain unreported or unsolved [62]. Analogous data are difficult to find in the recent literature; the topic seems to be avoided these days.

A more frequent use of surgical sterilization would be favorable especially for overpopulated regions with gender imbalance. Availability of high-quality service is important, including mobile teams to offer sterilization in rural communities [13]. For ethical reasons, being a less invasive procedure, vasectomy is generally preferable to the female surgical sterilization (apart from CTS, which is performed without additional trauma). Even in a busy family planning clinic, vasectomy may suffer because of predominant orientation toward women. Female services, sterilization in particular, tend to be more complex and require more personnel, time and other resources. Vasectomy is learned and performed by general practitioners, gynecologists and surgeons, not necessarily specialist urologists. Paramedical personnel have been successfully trained to perform vasectomy in some countries with shortage of doctors. However, a physician must be available in case problems are encountered [13]. As for RF, the surgical sterilization is not widespread in this country. Apropos, according to the author's experience, the vasectomy specimens in Europe were around 0.5 cm long, while in RF - usually more than 1.5 cm, which might

imply pulling of vas deferens from the surgical wound. The voluntary sterilization is allowed only to individuals older than 35 years or those having at least two children (Ordinance No. 303 of the Health Ministry of RF, dated December 28, 1993). Admittedly, some private clinics would perform vasectomy for any adult.

There is a variation in the CS rates between ~44.3% across Latin America and the Caribbean vs. 4.1% in central and West Africa [26]. In private institutions of Brazil, the cesarean rates are high, reaching $\geq 80\%$ in the Southeastern region [28]. Around 84% of CS deliveries in Brazil are performed before the onset of labor, most likely for non-medical reasons [34]. This level should be strived for in overpopulated regions. In Sub-Saharan Africa, the low CS rate has contributed to the relatively high maternal and fetal mortality [63]. Admittedly, CS is more costly than vaginal delivery, and implicates more risks in conditions of limited medical facilities [64]. For that and other reasons, more international cooperation and guidance by developed nations is needed instead of rivalries and warmongering.

Conclusion

The worldwide increasing CS rates have resulted in the lowering of neonatal morbidity and mortality rates. Planned CS is associated with lower rates of complications such as the birth trauma, tube feeding, and hypotonia, when compared to planned vaginal delivery. The tubal sterilization and vasectomy are reliable methods of permanent contraception. Being a less invasive procedure, vasectomy is generally preferable to the surgical operations in women, apart from the CTS, which is performed without additional trauma. Bilateral salpingectomy at the time of cesarean delivery is safe; reportedly, it reduces the risk of ovarian cancer. According to surveys, a majority of women are pleased with their decision to be sterilized. A systematic performance of tubal sterilization could be an efficient birth control method, counteracting both the overpopulation and gender imbalance.

Birth control has been obfuscated in some countries by presumed national interests. The military needs young people. In RF, some professional and popular publications are biased, exaggerating or inventing adverse effects of contraception and abortions. The mass misinformation can be seen as reproductive coercion sanctioned by the state, which may lead to unwanted pregnancies, impaired mothering, child abuse and neglect, psychiatric and other derangements in children.

Declarations

Conflict of interest

The author declares that there is no conflict of interest.

Data Availability

All data generated or analyzed during this study are included within the manuscript.

Funding

This study received no specific grant from any funding Agency.

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Abbreviations

CS – Cesarean Section

CTS – Cesarean Tubal Sterilization

RF – Russian Federation

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Citation: Sergei V. Jargin, Luís Carlos Machado Júnior. "Permanent contraception with special reference to neonatology and pediatrics" *J Neonatol Pediat Care* (2026):104 DOI: [10.59462/JNPC.3.1.104](https://doi.org/10.59462/JNPC.3.1.104).