Original

Healthcare Providers' Reports of Encounters with women with Cryptic Pregnancies and HIV status of Acquired babies in Southeast Nigeria

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ABSTRACT

Background: Nigerian cryptic or false pregnancy is a scam that lures infertile women into believing they can conceive and give birth to their babies. Case reports have documented HIV-infected babies born to HIV-negative mothers via the Nigerian cryptic pregnancy. The study explored healthcare providers' encounters with women who had babies through the Nigerian cryptic pregnancy method and the health outcomes of the infants.

Methods: It was a cross-sectional observational study conducted among 388 healthcare providers who completed the questionnaires from two tertiary hospitals in Abakaliki. A structured e-questionnaire (Google Form) was sent to various specialties within the hospitals via their respective group WhatsApp platforms, and the necessary information was extracted from the completed questionnaires.

Results: A total of 185 (47.7%) of the 388 healthcare providers had encountered women who had babies through the Nigerian cryptic pregnancy scam. The majority of the healthcare providers were females (120/185, 64.9%), married (150/185, 81.1%), and medical doctors (135/185, 73.0%). More than half (57.3%) had practiced for 11 to 20 years, and 42.7% were within 40-49 years of age. A total of 36 (19.4%) of the healthcare providers reported HIV infections in children born through the Nigerian cryptic pregnancy. Of note was that the ascribed mothers were HIV-negative. There was a significant relationship between having an HIV-infected child and place of delivery of the cryptic pregnancy ($\chi^2 = 27.06$, p-value <0.001).

Conclusion: The frequent reports of HIV-infected babies from cryptic pregnancies are of great concern, highlighting the need for awareness and stronger health systems.

Keywords: Female infertility; HIV infection; Pregnancy; Scam

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INTRODUCTION

Cryptic pregnancy or denial of pregnancy is defined as a lack of subjective awareness of pregnancy until the final weeks of gestation or delivery.[1] Cryptic pregnancy has been classified into three subtypes: affective, psychotic, and pervasive.[2] The aetiology of this fascinating phenomenon has not been fully elucidated. False negative pregnancy test, none or minimal pregnancy symptoms, irregular periods, and psychosocial denial are some of the reasons for cryptic pregnancy.[3]

A report from a study in 2023 revealed that 1 in 475 pregnancies can be classified as a cryptic pregnancy, where pregnancy is not discovered until at least 20 weeks.[4] In contrast to the medical definition of cryptic pregnancy, the cryptic pregnancy scam is a misinformation in which an infertile woman is made to believe that she is pregnant when she is not pregnant.[5] This phenomenon is rampant in Nigeria because of the stigma associated with infertility, especially among women. This can lead them to go to great lengths to have babies; thus, they are vulnerable to scammers. Under this pressure, some women go to extreme lengths to make the dream of motherhood a reality. Also, because of societal norms and culture, adoption is not readily acceptable in the African society, hence the option of going to great lengths to prove pregnancy and biological birth.[6,7]

A comprehensive documentary by BBC Africa,[8] reveals that scammers impersonate medical fertility treatment" guaranteed to result in pregnancy. This so-called treatment can be administered as an injection, a beverage, or a herbal substance inserted vaginally. The exact composition of these treatments remains uncertain; however, there are speculations that they may contain steroids or hormones, given that many women report experiencing bodily changes such as swollen abdomen, breast tenderness, and pregnancy-like symptoms following these treatments.

The women are warned not to visit conventional hospitals to do scans or take pregnancy tests, as none of these can detect the baby. When it's time to "deliver" the baby, women are told labour will only begin once they are induced with a "rare and expensive drug". Accounts of how the "delivery" happens vary, but all are disturbing. Some are sedated only to wake up with a Caesarean-like incision mark. Others say they are given an injection that causes a drowsy, hallucinatory state in which they believe they're giving birth. Either way, the women end up with babies they are supposed to have given birth to.[8]

Cryptic pregnancy scams are a distinct and serious issue in Nigeria, contributing to human trafficking and maternal/fetal health risks. The ramifications of the cryptic pregnancy scam are extensive. Many questions arise that need addressing. For instance, where do the children involved come from? According to documentaries, many fake maternity homes collaborate with or function as 'baby factories. [8,9] These establishments may neglect to perform essential screening tests such as hepatitis B and C, haemoglobin genotype, and human immunodeficiency virus (HIV) testing on the teenagers who give birth in these facilities. Furthermore, Orji *et al*,[10] reported a case series where all the infants of the mothers tested positive for HIV, while the mothers themselves were negative. This observation underscores the deficiencies in antenatal screening and care for these 'baby-markers'. Consequently, there is a higher prevalence of mother-to-child transmission of diseases, particularly HIV, which could otherwise be prevented with proper medical intervention.

Despite extensive searches, we were unable to find sufficient data on the medical implications of cryptic scam pregnancies, particularly concerning the transmission of blood-borne infections. This study aims to fill that gap, contributing to the existing body of knowledge and raising awareness about the issue of cryptic pregnancy scams in Nigeria.

METHODOLOGY

Study area

The study was a hospital-based cross-sectional study that was conducted in two tertiary Hospitals in Abakaliki metropolis: Alex Ekwueme Federal University Teaching Hospital Abakaliki (AEFUTHA) and the National Obstetrics and Fistula Centre (NOFIC).

The Alex Ekwueme Federal Teaching Hospital, first established in the 1930s as a general hospital by the British Colonial administration and upgraded to a tertiary hospital in 2011, is situated within the Abakaliki metropolis. The National Obstetrics and Fistula Center, which was established to manage women with vesicovaginal fistulas, was upgraded in 2018 to accommodate subspecialties such as Paediatrics, Obstetrics and Gynaecology, Internal Medicine, and

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Surgery. These two hospitals are major referral centers for other health institutions, including three general hospitals, two major missionary hospitals, and a host of private hospitals, all located within and around Abakaliki metropolis. It serves an estimated population of about three million people who are mainly farmers, civil servants, and small to medium-scale businesspeople. The AEFUTHA and NOFIC have healthcare professionals in different specialties; doctors of different cadres (Consultants, residents, and medical officers), Nurses, pharmacists, medical laboratory scientists, and other healthcare professionals such as dentists, radiographers, physiotherapists, etc. Among the medical practitioners, there are sub-specialties in various fields of medicine such as Paediatrics, Obstetrics and Gynaecology, Internal Medicine, and Surgery in the Tertiary hospitals in Abakaliki.

Study design was a cross-sectional study that involved healthcare professionals in two tertiary hospitals in Abakaliki. It was conducted between March 2024 and February 2025.

Sample size calculation

This was calculated using Cochran's formula for determining the prevalence of a condition in a single population.[11]

$$n = Z^2pq/_{e^2}$$

Where '*n*' = the minimum sample size, '*Z*' = the normal standard deviate, which equals 1.96.

'*P*' represents the proportion of students with the desired characteristics in the population, taken to be 50% (0.5). The letter 'q' represents 1-p (1-0.5=0.5).

The letter 'e' represents the desired level of precision, set at a 95% confidence interval, which equals 0.05.

$$n = Z^2pq/_{e^2}$$

$$n = (1.96)2(0.5)(0.5)/_{(0.05)2}$$

n = 384

Hence, the minimum sample size was 384

Data collection

The self-administered structured questionnaire was pretested on eight healthcare professionals (2%) of the calculated sample size to assess the reliability of the questionnaire. The feedback obtained from the pretest was used to refine the questionnaire in terms of clarity and comprehension. It was subsequently sent to the social media platforms of all the subspecialties in the two hospitals. The questionnaire sought information on the socio-demographics of the healthcare professionals and their experiences with women who had children through the Nigerian cryptic method. Healthcare professionals' experiences include where such encounters occurred, whether in the healthcare facility or outside, duration of the pregnancy, laboratory tests done in pregnancy, antenatal care, and place of delivery, the health status of their babies, and when and where the diagnosis of HIV was made on the infant.

An introductory aspect of the research and an informed consent form were attached to the questionnaire. All healthcare professionals working in the two tertiary hospitals in Abakaliki were included if they gave informed consent, filled out, and submitted the questionnaire.

Definition of Terms

Ascribed mother: The mother of a child who is a product of a cryptic pregnancy

Cryptic Pregnancy: is defined as a lack of subjective awareness of pregnancy until the final weeks of gestation or delivery

Cryptic pregnancy Scam: A pregnancy seen in a previously infertile woman not confirmed by a pregnancy test or ultrasound, and the duration of pregnancy cannot be explained by science

Healthcare providers: All levels of staff, skilled in their various health disciplines, who attend to patient care in a Tertiary hospital setting.

HIV infection: A diagnosis of HIV made in a hospital setting, either by DNA polymerase chain reaction in infancy or serology.

Female infertility: The inability to conceive after one year (or longer) of unprotected sex

Data analysis

All data collected were analyzed using the Statistical Package for Social Sciences (SPSS) version 26. Categorical data were represented in frequency tables and charts, while numerical variables were represented as mean or median, depending on their normality test. The difference in proportions between the two groups, as well as a test of association, was done using the Chi-squared test. The confidence interval was set at 95%, and a p-value of less than 0.05 was considered statistically significant.

Ethical Considerations

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Ethical approval was obtained from the Research and Ethics Committee of Alex Ekwueme Federal University Teaching Hospital, Abakaliki. Confidentiality and Privacy were maintained throughout data collection and management. The study strictly adhered to the ethical guidelines outlined in the Declaration of Helsinki. Confidentiality of participant information was maintained throughout the study.

RESULT

A total of 185 (47.7%) of the respondents had encountered women who had babies through the Nigerian cryptic method. A lot of the healthcare providers were within the 40-49 years age bracket 79/185, 42.7%). The majority of them were females (120/185, 64.9%), married (150/185, 81.1%), and are medical doctors (135/185, 73.0%). More than half had practiced their professions for 11 to 20 years (106/185, 57.3%). There were statistically significant differences in the relationships between sociodemographic characteristics of healthcare providers (HCPs) who had encountered Nigerian cryptic pregnancies and those who had not. [Table 1]

Table 1: Sociodemographic Variables of Study Participants

Variable	HCP encounters with cryptic pregnant women			FT	P value
	Yes (%)	**No (%)**	**Not sure (%)**		
Age					
20-29	17 (9.2)	54 (27.3)	2 (40.0)		
30-39	67 (36.2)	62 (31.3)	2 (40.0)	25.22	<0.001
40-49	79 (42.7)	60 (30.3)	1 (20.0)		
50-59	18 (9.7)	19 (9.6)	0 (0.0)		
≥60	4 (2.2)	3 (1.5)	0 (0.0)		
Gender					
Male	65 (35.1)	92 (46.5)	3 (60.0)	5.88	0.046
Female	120 (64.9)	106 (53.5)	2 (40.0)		
Marital status					
Married	150 (81.1)	126 (63.6)	2 (40.0)		
Single	31 (16.7)	68 (34.4)	3 (60.0)	21.70	0.001
Divorced	2 (1.1)	1 (0.5)	0 (0.0)		
Widow/widower	2 (1.1)	3 (1.5)	0 (0.0)		
Profession					
Doctors	135 (73.0)	143 (72.2)	4 (80.0)		
Nurses	9 (4.9)	7 (3.5)	0 (0.0)	5.21	0.690
Pharmacists	23 (12.4)	23 (11.6)	0 (0.0)		
Medical lab scientists	7 (3.8)	5 (2.5)	0 (0.0)		
Others	11 (5.9)	20 (10.1)	1 (20.0)		
Subspecialty in medicine					
Obstetrics and Gynaecology	23 (12.4)	28 (14.1)	0 (0.0)		
Paediatrics	74 (40.0)	59 (29.8)	0 (0.0)	12.69	0.078
Internal Medicine	15 (8.1)	17 (8.6)	0 (0.0)		
Surgery	11 (5.9)	27 (13.6)	1 (20.0)		
Others	62 (33.5)	67 (33.8)	4 (80.0)		
Years of Practice (in years)					
0-10	56 (30.3)	99 (50.0)	4 (80.0)		
11-20	106 (57.3)	74 (37.4)	1 (20.0)	19.70	<0.001
29-30 and above	23 (12.4)	25 (12.6)	0 (0.0)		

**FT: Fisher's Exact Test

The majority of the healthcare providers (112/185, 60.5%) reported pregnancies lasting for more than 10 months to even 2 years in women who had the Nigerian cryptic pregnancies. Nearly half (90/185, 48.7%) confessed that no investigation was done to confirm pregnancy and screen for any transmissible infections. The majority of the healthcare providers

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(HCPs) did not know where the antenatal care (ANC) and delivery of the babies were conducted, but a quarter (53/185, 28.6%) reported non-hospital settings. More than half (103/185, 55.7%) of the HCPs reported that non-healthcare providers were involved in the organization of the cryptic pregnancies for the women. [Table 2]

Table 2: Observations made by healthcare providers from encounters with women who had Cryptic pregnancies

Observations	Frequency (n= 185)	Percentage
Place of encounter		
Within the hospital of practice	48	25.9
Outside the hospital of practice	137	74.1
Duration of pregnancy		
Less than 9 months	19	10.3
9-10 months	37	20.0
More than 10 months to greater than 2 years	112	60.5
Not sure	17	9.2
Carried out laboratory tests and an obstetric scan		
Yes	53	28.6
No	90	48.7
Not sure	42	22.7
ANC and delivery of the cryptic pregnancy		
Hospital setting (Government and private)	13	7.0
Non-hospital setting (Maternity homes and others)	53	28.6
Don't know	119	64.3
People who organize the Nigerian Cryptic pregnancy		
Doctors and nurses	38	20.5
Non-healthcare providers	103	55.7
Don't know	44	23.8

**ANC Antenatal Care

A total of 36 (19.4%) health care providers (HCPs) reported HIV infection in children born through cryptic pregnancy. Of note was that the ascribed mothers to these babies were HIV negative. About half of them (93/185, 50.5%) gave birth to healthy babies, while the remaining 56 (30.3%) were not sure of the outcome of the cryptic pregnancies. [Figure 2]

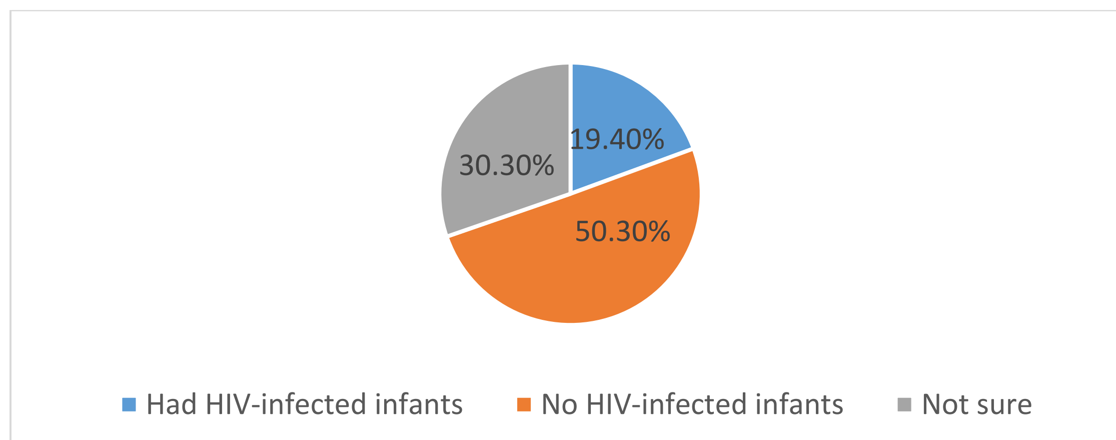

Figure 2: Reported cases of HIV infection among infants born to cryptic pregnant mothers

Table 3 showed that the majority of the HIV-infected infants were seen among Nigeria cryptic pregnant women whose pregnancies lasted for more than 10 months to greater than 2 years (28/36, 77.7%), did not carry out any laboratory tests during the pregnancies (22/36, 61/1%), were delivered in non-hospital setting (22/36, 61.1%) and were managed by non-

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healthcare professional (27/36, 75.0%). There was a significant relationship between having an HIV-infected infant and place of delivery by the Nigerian Cryptic pregnant women (χ^2 =27.06, p <0.001)

Table 3: Relationships between the observations of HCPs from women (HIV-negative) who reported to have had a Cryptic pregnancy and HIV infection in their babies

Observations	HIV infection diagnosed in infancy at HCF among HIV-negative mothers			χ^2	P value
	Yes (%)	No (%)	Don't know (%)		
Duration of pregnancy					
Less than 9 months	2 (5.6)	6 (6.4)	11 (19.6)		
9-10 months	4 (11.1)	25 (26.9)	8 (14.3)	11.44	0.140
More than 10 months to greater than 2 years	28 (77.7)	53 (57.0)	31 (55.4)		
Not sure	2 (5.6)	9 (9.7)	6 (10.7)		
Carried out laboratory investigations and an obstetric scan					
Yes	8 (22.2)	29 (31.2)	16 (28.6)		
No	22 (61.1)	44 (47.3)	24 (42.8)	3.78	0.436
Not sure	6 (16.7)	20 (21.5)	16 (28.6)		
ANC and the Place of delivery of the cryptic pregnancy					
Hospital setting	3 (8.3)	9 (9.7)	1 (1.8)		
Non-hospital setting	22 (61.1)	21 (22.6)	10 (17.9)	27.06	<0.001
Don't know	11 (30.6)	63 (67.7)	45 (80.3)		
People who organize the Nigerian Cryptic pregnancy					
Doctors and nurses	6 (16.7)	22 (23.7)	10 (17.9)		
Non-healthcare providers	27 (75.0)	48 (51.6)	28 (50.0)	9.37	0.051
Don't know	3 (8.3)	23 (24.7)	18 (32.1)		

**ANC= Antenatal Care, HCPs= Healthcare professionals, HCF= Healthcare facility

DISCUSSION

A total of 388 healthcare workers participated in this study, out of which 185 had encountered women who had babies through the Nigerian cryptic method. This shows the increased number of women struggling with infertility, who are desperate to have their dream babies by all/possible means, and the magnitude of the noxious activities of the perpetrators of cryptic pregnancy who prey on the vulnerability of these desperate women. Which, consequently, would increase the possibility of the attendant ugly experiences.

The majority of the healthcare workers who had encounters with the cryptic pregnant women were mostly married females. This could be explained by the fact that those who are mostly affected emotionally, psychologically by sociocultural pressures of infertility are the women. These women may have had female friends, may have sought help/ solace, or even confided in their fellow women, who happens to be a health care worker. Moreover, some of the female healthcare workers may also be struggling with infertility, seeking help and solutions from different sources, particularly from those who had finally succeeded with theirs, without proper scrutiny of the process involved. Thereby making the supposedly successful one's conduits of the scam network

This index study noted that a total of 36 (19.4%) health care professionals (HCPs) reported HIV infection in children born through cryptic pregnancy, 50.5% had healthy babies, while in the remaining 30.3% of cases, the outcome of the cryptic pregnancy was not known. The high rate of HIV-positive diagnoses among infants suggests a failure of prevention of mother-to-child transmission (PMTCT). It is plausible that the birth mothers (mostly teenagers) were not aware of their HIV status, as about 40% of people living with HIV in Nigeria are unaware of their HIV status. [12] The target of

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95-95-95 (95% HIV case detection, 95% enrollment into care and 95% viral suppression) by UNAIDS may not be achieved if adolescents living with HIV have poor access to HIV testing services and treatment. [13]As part of the National HIV scale-up, to prevent mother-to-child transmission of HIV, all pregnant women are routinely screened for HIV during antenatal care in health care facilities.[14] Unfortunately, these birth mothers of cryptic pregnant women evade proper maternal HIV screening, proper perinatal care, and prompt initiation of antiretroviral therapy because their pregnancies are concealed by the child traffickers. This finding corroborates the reports of Orji *et al*, [10] in a case series of HIV infected infants that were claimed to be born to HIV negative mothers who had cryptic pregnancy.

The fact that many of the cryptic pregnant women were discouraged from accessing antenatal services or undergoing ultrasound scans suggests deliberate concealment aimed at evading medical scrutiny.
The finding of this index study is supported by the comprehensive report BBC Africa,[8] of the dubious ways employed by scammers to secure babies from possibly trafficked babies or baby factories without proper screening of the baby factories mother. Furthermore, this could also prove that these gullible women were not the real mothers of the babies claimed to be delivered by them, and the findings of their status could be an incidental finding.[8]

The majority of the HIV infected infants were seen among Nigerian cryptic pregnant women whose pregnancies lasted more than 10 months to >2 years and did not undergo any laboratory tests during pregnancy. This is similar to the BBC report of a case interviewed in one of the South East states in Nigeria, whose pregnancy lasted for 15 months. This is truly absurd, as 42 weeks of gestation is already a post-term pregnancy and has its attendant complications from placental insufficiency; 65 weeks or more is not only biologically implausible but dangerously misleading, likely used as a cover while scammers procure a child elsewhere. Cryptic pregnancy scam is indeed a harmful practice rooted in the desperation of women facing infertility, where scammers exploit them through deception, extortion, and criminal acts. [8]

This present study noted that nearly half (90/185, 48.7%) confessed that no investigation was done to confirm pregnancy and screen for any transmissible infections. The majority of the healthcare professionals (HCPs) did not know where the antenatal care (ANC) and delivery of the babies were conducted, but a quarter (53/185, 28.6%) reported non-hospital settings. More than half (103/185, 55.7%) of the HCPs reported that non-healthcare professionals were involved in the organization of the cryptic pregnancy in these women. These findings were consistent with investigative journalism of BBC Africa,[8] which exposed networks involved in child trafficking and fraudulent delivery setups, often referred to as "baby factories."
The index study documented a statistically significant relationship between having an HIV infected infant and place of delivery by Nigerian cryptic pregnant women. This practice undermines the efforts of both the Nigerian government and the Joint United Nations Programme on HIV/AIDS (UNAIDS), the current target of HIV testing and treatment called the 95-95-95 targets, which is supposed to be reached by 2025 to end AIDS by 2030. [13]It hampers early diagnosis of maternal HIV, delays the initiation of antiretroviral therapy (HAART) for infected mothers, and prevents timely administration of post-exposure prophylaxis (PEP) to exposed infants.

In conclusion, Cryptic and false pregnancies are practiced in Nigeria, with about one-fifth of healthcare providers reporting HIV infections among infants born through this scam. Public awareness is needed to expose "miracle baby" schemes and to promote care in accredited hospitals, where genuine options such as in vitro fertilization and proper antenatal services are available. Simplifying adoption processes will reduce barriers for couples seeking children, while comprehensive and mandatory birth and death registration will help curb child trafficking and ensure traceable records.

Strengths and limitations

The direct reporting from healthcare providers who should be knowledgeable about cryptic/false pregnancies and HIV infection, provides an invaluable insights to the rising number and possible outcomes of undocumented cases of cryptic/false pregnancy scams in the Southeast, Nigeria Additionally, the high percentage of healthcare providers reporting HIV

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infection in acquired infants highlights the seriousness of the issue and underscores the urgent need for improved healthcare services and interventions to prevent mother-to-child transmission of HIV in Southeast Nigeria

The study was, however, limited by the fact that healthcare providers may not accurately remember the encounters they had with women who had cryptic/false pregnancies, leading to potential inaccuracies in reporting. Also, healthcare providers may be reluctant to report negative encounters or experiences, potentially skewing the results of the study

Implications of the study

The high rate of HIV infection in acquired infants reported by healthcare providers may indicate potential gaps in healthcare services, such as inadequate prenatal care, lack of access to HIV testing and treatment for pregnant women, or insufficient prevention of mother-to-child transmission services. It also highlights the need for targeted interventions to prevent mother-to-child transmission of HIV. This may include increasing access to HIV testing and treatment for pregnant women, improving prenatal care services, and promoting safe infant feeding practices

Declarations

Authors' contributions: MCO, study concept, and manuscript original drafting; ESA and NBO, data analysis, and interpretation; OCO, literature review and manuscript writing; KYO, statistical analyses, histological examination, MOO, and ACN, contribution to manuscript writing and editing. All the authors read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Ethical consideration: Ethical approval was obtained from the Research and Ethics Committee of Alex Ekwueme Federal University Teaching Hospital, Abakaliki.

Availability of data and materials: The datasets used and/or analyzed during the current study are available upon reasonable request from the corresponding author.

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