International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Ojajuna EO et al. Int J Reprod Contracept Obstet Gynecol. 2026 Oct;15(10):4217-4222
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20263478

Review Article

Activities of traditional birth attendants in a local council in Nigeria, menace and corrective measures

Eric O. Ojajuni[1], John O. Dirisu[2]*

[1]Department of Medical Microbiology, Faculty of Medical Laboratory Science, Ambrose Alli University, Ekpoma, Nigeria
[2]Department of Virology, UK Health Security Agency, England and Department of Medical Microbiology and Public Health, Faculty of Medical Laboratory Science, Nnamdi Azikiwe University, Nnewi Campus, Nigeria

Received: 27 May 2026
Accepted: 03 July 2026

***Correspondence:**
Dr. John O. Dirisu,
E-mail: dirisujohn@yahoo.com

ABSTRACT

Pregnancy and child-bearing remain key aspects of a woman's life and adequate health access is needed by the expectant mother to birth each child safely. Given the prevailing circumstances in certain localities in Nigeria, adequate health access for proper maternal care is lacking and absent in some cases. The result of this lack is the thriving presence of unskilled and untrained traditional birth attendants (TBAs) who in most cases reside locally and are easily assessable by expectant mothers. In particular, Ilaje a local council in Ondo state has a preponderance of unskilled and untrained TBAs which is increasing the scale of the problem and culminating in increased maternal and infant mortality. A number of other factors such as poverty, poor educational exposure, and primitive religious and cultural indoctrination have also been identified as causal factors in this regard. While steps have been taken to address this challenge by a previous state government, successive governments have not mounted similar interventionist responses. The 'Abiye' and 'Agbebiye' initiatives were home grown models to reduce the incessant proliferation of unskilled TBAs, reduce infant and maternal mortality, and to strengthen the coordination of referrals from the community health centres to the well-equipped hospitals, which led to Ondo State becoming the only state in Nigeria to achieve the millennium development goals (MDGs) of reducing maternal death, surpassing the 75% reduction goal. It is hoped that such initiatives will be sustained to continue to savour the gains.

Keywords: Pregnancy, Traditional birth attendant, Abiye, Agbebiye, Ilaje, Ondo state, Maternal mortality ratio, Millennium development goal

INTRODUCTION

Pregnancy is a vital stage of a woman's reproductive life leading to childbirth. The delicate nature of this stage makes close monitoring in the form of antenatal and postnatal care essential[1]. However, in underdeveloped and developing countries, due to different reasons such as poverty, poor educational exposure, primitive religious and cultural indoctrination, pregnant women may not be able to get adequate gestational care.[2-4]

Despite good progress, Africa still has the greatest burden of child and maternal deaths.[5]

In many African countries, there is a great dependence on the activities of TBAs, many of which rely only on crude experience and lack the necessary knowledge and skill to carry out safe antenatal, labour and postnatal services. The result of this is a high incidence in foetal and maternal complications and high mortality.[6] Nigeria, a developing country and 2018-2022 world poverty capital[7], has several activities of these TBAs with the highest incidence occurring in rural communities and among poor people.

According to the World Health Organization (WHO), a TBA is "a person who assists a mother during childbirth and who initially acquired her skills by delivering babies

herself or through apprenticeship to other TBAs".[8] A TBA is also called a traditional midwife, community midwife or lay midwife.[9] In addition to the alternate names above, in Nigeria TBA is called different names in different cultures; among the Yorubas they are called "Iya-Agbebi", in Hausa as "Mai-Haifuwa" or "Sarguwa" and known by Fulani as "Ungozoma".[10,11] Also, among the Bini speaking people of Edo State, they are called "Iye", "Obo-omo", "Owinna-ibiẹka", although no supporting article was found for this. These TBAs basically have no formal training in field of gynaecology and midwifery.[6] They are mostly middle-aged/older women and are highly respected in their roles as midwives to rural communities.[6] TBAs are different from skilled birth attendants (SBA) which ''exclusively refers to people with midwifery skills who have been trained to proficiency in skills necessary to manage normal deliveries and diagnose, manage/refer obstetric complications".[12] This include midwives, doctors and nurses, that have been specially trained to manage childbirths and perform immediate newborn care.[13] Trained and untrained TBAs not included in this category.

A classic example of a region where TBAs activities have greatly persisted is in Ilaje Local Government Area of Ondo State Nigeria. Hence this study discusses the menace of TBAs in Nigeria generally and Ilaje LGA specifically, as well as prescribe potential corrective measures at limiting or controlling TBAs activities. This review will also feature a brief description of the Abiye and Agbebiye initiatives developed by Ondo State government of Nigeria to curb TBAs activities.

MAGNITUDE OF THE PROBLEM

As at 2015, maternal mortality rate in sub-Saharan Africa was 546 per 100,000 live births, accounting for 66% of the global maternal deaths.[14] Only 56% of all births occur in health facility in sub-Saharan Africa.[15] In Nigeria, a sub-Saharan country, the situation is worse with less than 40% of delivery in 2013 occurring in health facilities by SBA, while others were performed by other attendants especially the TBAs.[16] A report by the World Bank in 2018 revealed that only 43% of Nigerian women had SBA during childbirth despite 64% of women seeing an SBA for prenatal care.[17]

In 2008, the Nigeria Demographic Health Survey (NDHS) put Ondo State as having the worst maternal and child health indices in the southwest of Nigeria, with a Maternal Mortality Ratio (MMR) of 745 per 100,000 live births far above the national average of 545 per 100,000 live births.[18] This was against the United Nation's Millennium Development Goal (MDG) to reduce world MMR by three-quarter or 75%, from 1990 to 2015.[19]

TBAS IN ILAJE LOCAL GOVERNMENT AREA, ONDO STATE

Ilaje is a Local Government Area in Ondo State, South West Nigeria. Its headquarters is in the town of Igbokoda. The local language of the people is Ilaje. It is predominantly an oil producing, riverine area, with the major occupation of the inhabitants being fishing.[20] The predominant religion in Ilaje is Christianity, although Islam and the traditional religion also coexist in the area.[21,22]

According to the National Population Commission's (NPC) census of 2006, the population of Ilaje LGA was estimated at 289,838 comprising of 145,859 males and 142,979 females.[23] The Nigeria Guardian newspaper reported that there are only seven doctors in the public service and two in private practice, while nurses and midwives were only twenty in Ilaje LGA.[24] These data imply that in Ilaje LGA, a single doctor serves 32,204 people (15,886 females) and a single nurse or midwife serve 14,491 people (7,149 women), which therefore equals a great burden on trained health practitioners in Ilaje. In addition, Gbadomosi while speaking to respondents in the area on behalf of the Nigerian Tribune, obtained that there was only one general hospital in the entire local government area with only three medical doctors at the hospital. Specifically, one respondent stated that, "There are no modern facilities or equipment in this hospital. The scanner machine at the hospital is old and not even functional. We travel as far as Ondo town and Okitipupa to receive medical attention".[20] More also, Ikulajolu, in investigating the deplorable state of healthcare in Ilaje LGA, gathered from a responding TBA that the health centres in Ilaje often refer pregnant women to his place (TBA home), because there are no midwives in the health centres.[25] All these information point to the fact that adequate healthcare facilities are absent in Ilaje LGA, hence, most of the residents generally, and pregnant women in particular, must seek alternative healthcare sources, mainly the TBAs.

MENACE OF TBAS IN ILAJE

The spectrum of activities carried out by TBAs range from the antenatal, labour and post-natal stages of pregnancy. While antenatal care is a means of identifying and remediating high risk pregnancies, as well as enlightening pregnant women on safe pregnancy habits, and is recommended to be performed by SBAs, sadly, TBAs in Ilaje also perform wacky antenatal care and sometimes end up messing things up.[26]

The detection of pregnancy by TBAs in Ilaje is by the abdominal palpation of foetal movement coupled with symptoms of maternal vomiting, rather than proper laboratory diagnosis and sonographic imaging. This method of abdominal palpation is an inaccurate method in pregnancy detection, since several other conditions such as gastrointestinal (GIT) upset may result in abdominal rumbling, and hence misdiagnosed by TBAs as the baby kicking. This will result in false positive results. Also, palpation cannot detect early pregnancy since the first set of foetal movement called 'quickening' only begins between the 16th to the 22nd week of pregnancy.[27] Hence,

before the 16th week most pregnancy result will appear negative based on this method. This will result in false negative results.

In addition to pregnancy diagnosis, abdominal palpation is also employed by TBAs in Ilaje to monitor all stages of gestation. During pregnancy, expectant mothers are made to drink loads of herbal concoctions under the pretext of "making the baby strong", with some resulting in miscarriages and other causing maternal and/or foetal complications. An earlier study has demonstrated that intake of concoctions in pregnancy may result in complications.[28] Similarly, TBAs in Ilaje generally lack the skill to diagnose certain disease and other conditions that may affect the new-borns and mothers in pregnancy such as human immunodeficiency virus, syphilis, hepatitis B, hepatitis C, rhesus incompatibility, etc. Also, the examination of maternal well-being through the use of routine tests such as packed cell volume (PCV), haemoglobin estimation, blood pressure and sugar levels are not done, rather only quack physical examination is performed.

TBAs in Ilaje perform their deliveries either at their homes or the homes of the expectant mothers. In some cases, where beds are not available, the TBAs in Ilaje perform deliveries on the bare floor. The stage of labour is grossly mismanaged among the TBAs and some of the unhygienic practices often lead to the transmission of infectious diseases. As a result of their crude techniques, the TBAs often cannot correctly predict when labour will start and these result in misuse of labour-initiating drugs such as misoprostol and oxytocin.[29] The result of this is that labour begins before term; hence there is a delivery of premature infants and with the lack of vital facilities such as incubators to support the premature infants, infants often die or have life-long complications. Also, in some cases these drugs may not be available and following incorrect time of labour prediction by the TBAs, the mother is told to bear down, against an undilated cervix, resulting in cervical laceration/tear.[30]

Following delivery, the TBAs in Ilaje also mismanage cord separation, cord tying and cord cleaning. Cord separation is done by them using unsterilized razor blade; while cord tying is by using thread; and cord cleaning is done using kerosene and palm oil or hot water in pawpaw, with most of these techniques having no scientific backing and carried out without observing aseptic techniques.

Post-delivery immunization of infants is non-existent. Post-delivery care in infants is by administration of concoctions. The TBA administers concoction even in some misunderstood physiological events such as beating of the anterior fontanelle. Also frequently, TBAs in Ilaje introduce religious and fetish practices into their service. Incantations are sometimes made with the aim of bringing about or remediating certain conditions in the post pregnancy.

COMPLICATIONS ARISING FROM TBA PRACTICES IN ILAJE

The crude practices employed by TBAs commonly results in some complications such as miscarriage, premature births, infection, maternal and foetal death as a result of the use of unsterilized equipment, inability to control bleeding during delivery, and the administration of teratogenic concoctions.[31,32] The result of these is a mother never carrying her baby or the baby never getting to know its mother or both, which is not a good reproductive health outcome.

PREFERENCE FOR TBAS IN RURAL ILAJE

While there have been a lot of efforts by individuals, organisations and the localised government itself to discourage the patronage of TBAs, a number of factors have continued to encourage their dominance particularly in rural settings such as traditional beliefs, religious fallacy, poor road conditions, limited access of women to decision making in the family and lack of adequate transportation system to reach the nearest health facility.[33] On a specific scale, it has also been reported across Nigeria that the preference of TBAs may be as a result of perceptions of higher efficacy of traditional medicines, cultural indoctrination ease of access and proximity to TBAs as compared to SBAs, higher costs of services in health facilities and more friendly attitude of TBAs.[2,35]

Traditional medication is preferred among many expectant mothers in Ilaje as well as persons with ailments as a result of the impersonal nature of orthodox nurses and doctors that often appear too officious, while the traditional midwives in contrary to the SBAs, speak local and familiar language and share same cultural experience with the expectant mothers, both of which build an interpersonal relation among the parties.[36]

CORRECTIVE MEASURE TO THE MENACE OF TBAS IN ILAJE

The persistence of the activities of TBAs in Ilaje isn't because the government hasn't done anything to curb this or streamline their activities for a better reproductive health output, but because there are a number of factors that have continued to militate against these strategies such as poverty, low educational level, religious and cultural factors, and interpersonal relationships with the TBAs.[36] A long-term goal at correcting TBAs activity will involve providing highly trained SBAs for all deliveries in poor communities (Ilaje included), but an intermediate solution is to identify, support, and train birth attendants who are already practising in local communities.[37]

The role of various actors at the primary, secondary and tertiary levels of healthcare cannot be side lined in identifying the measures of correcting the activities of TBAs in Ilaje. Previously, under the Dr. Olusegun Mimiko led government of Ondo State, the 'Abiye' (Yoruba-safe

motherhood) and 'Agbebiye' (Yoruba-safe birth attendant) were implemented chiefly to help reduce the incessant proliferation of unskilled TBAs, reduce infant and maternal mortality, and to strengthen the coordination of referrals from the community health centres to the well-equipped hospitals.[38] Established in 2009, the 'Abiye'-safe motherhood initiative became a home grown model designed to confront four principal delays contributing to maternal mortality and morbidity: delay in deciding to seek care, delay in reaching care, delay in receiving appropriate care on arrival and delay in referral, which led to the Ondo State becoming the only state in Nigeria to achieve the MDGs of reducing maternal death, surpassing the 75% reduction goal.[39] By 2016, the Ondo State Government had reduced maternal mortality rate (MMR) by 84.9 per cent; from 745 per 100,000 live births in 2009 to 112 per 100,000 live births in 2016 through the Abiye initiative.[39,40]

While the Abiye initiative was developed to initially exclude the TBAs, a "Confidential Enquiries into Maternal Deaths in Ondo State (CEMDOS)" carried out to appraise the cause of about 80% of maternal deaths revealed that these were as a result of complications from late referrals and or mismanagement of labour cases by TBAs- the result was the Agbebiye initiative, with the main goal of eradicating TBA-related maternal mortality in Ondo state.[38] The pre-registered TBAs, the Abiye vanguards (volunteers recommended by members of community development committees), health rangers (re-trained community health extension workers), the medical officers of health in the LGAs, prominent traditional and religious leaders, civil society activists as well as law enforcement agents were all actors in this program. Supervision was done by the Ondo State Ministry of Health (MOH), Hospitals' Management Board (overseeing healthcare activities in secondary and specialist facilities), and the Primary Health Care Development Board (overseeing activities in LGAs and the field operations of the program).[38]

This initiative involved the registration of all TBAs in the state and establishing an incentive-based system for the referral of women in labour to hospitals before complications set in.[41] At term, prior to any pregnancy or labour-related complications, TBAs refer or physically accompany parturient to the nearest state-run maternity centre for safe delivery at no cost. At intervals skill acquisition workshops were organized by the Ondo State Primary Health Care Development Board (OSPHCDB), and interest free start-up capital for each category of TBAs after their training workshop certifications were given, and all TBAs were prohibited from taking deliveries at the risk of prosecution, fines, jail time, and sealing of their premises.[38]

CONCLUSION

While the Abiye and Agbebeyi initiatives were fit for purpose, result oriented, largely studied and replicated in other locations, their sudden end in 2017 cast a shadow over the brilliant results which had been received from these home-grown initiatives. It is instructive to state that home grown approaches to solving problems appear to provide better results, especially when they are properly implemented. It is hoped that the government would legislate a replacement for these initiatives which ended abruptly because the visionary had left the seat of power-this is mostly the case with most policies particularly in Nigeria, where these are centred on the political class.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Lu Y, Barrett, LA, Lin RZ, Amith M, Tao C, He Z. Understanding Information Needs and Barriers to Accessing Health Information Across All Stages of Pregnancy: Systematic Review. JMIR. 2022;5(1):e32235.
2. Ntoimo LFC, Okonofua FE, Ekwo C, Solanke TO, Igboin B, Imongan W, Yaya S. Why women utilize traditional rather than skilled birth attendants for maternity care in rural Nigeria: implications for policies and programs. Midwifery. 2022;104:103158.
3. Johnson OE, Obidike PC, Eroh MU, Okpon AA, Bassey EI, Patrick PC, et al. Choices and determinants of delivery location among mothers attending a primary health facility in southern Nigeria. Nig Post Med J. 2020;27(1):42
4. Sarker BK, Rahman M, Rahman T, Hossain J, Reichenbach L, Mitra DK. Reasons for preference of home delivery with traditional birth attendants (TBAs) in aural Bangladesh: a qualitative exploration. PloS One. 2016;11(1):e0146161.
5. African Development Bank Group. Goal 4 and 5: reduce child mortality and improve maternal health. 2022 Available at: https://www.afdb.org/en/topics-and-sectors/topics/millennium-development-goals-mdgs/goal-4-and-5-reduce-child-mortality-and-improve-maternal-health. Accessed on 25 June 2026.
6. Amutah-Onukagha N, Rodriguez M, Opara I, Gardner M., Assan MA, Hammond R, Plata J, Pierre K, Farag E. Progresses and challenges of utilizing traditional birth attendants in maternal and child health in Nigeria. Int J MCH AIDS. 2017;6(2):130-8.
7. The Cable, 2022. Available at: https://www.thecable.ng/india-overtakes-nigeria-as-worlds-poverty-capital/. Accessed on 25 June 2026.
8. World Health Organization, 1992. Traditional birth attendants: a joint WHO/UNFPA/UNICEF statement. Geneva, Switzerland Available at: https://apps.who.int/iris/bitstream/handle/10665/38994/9241561505.pdf.?sequence=1. Accessed on 25 June 2026.
9. Kavinya T. Opinions on directives by authorities to ban traditional birth attendants: should Malawi be

done with traditional birth attendants? Malawi Med J. 2012;24(2):45.
10. Oke RO. Iya-agbebi, traditional birth attendant in Yoruba setting and the issues on HIV and AIDS. Lumina. 2009;20(1):1-1.
11. Abdulhamid Z Lawal US, Tahir AM, Harande MM, Usman H, Nuhu A. Perceptions of Hausa and Fulani tribes on traditional birth attendants in Zaria local government area, Kaduna state, Nigeria. J Compl Alter Med Res. 2017;2(2):1-7.
12. Adegoke AA, Van Den Broek N. Skilled birth attendance-lessons learnt. BJOG: an Int J Obste Gynae. 2009;116:33-40.
13. Ljungblad LW, Sandvik SO, Lyberg A. The impact of skilled birth attendants trained on newborn resuscitation in Tanzania: a literature review. Int J Afr Nur Sci. 2019;11:100168.
14. World Health Organization. Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015 Available at: https://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf. Accessed on 12 June 2026.
15. Adedokun ST, Uthman OA. Women who have not utilized health service for delivery in Nigeria: who are they and where do they live? BMC Preg Childbirth. 2019;19(1):1-14.
16. Austin A, Fapohunda B, Langer A, Orobaton, N. Trends in delivery with no one present in Nigeria between 2003 and 2013. Int J Women's Health. 2015;7:345-56.
17. Eluobaju D, Okonofua F, Weine S, Goba G. Understanding birthing preferences of women in Benin City, Nigeria: a qualitative study. BMJ Open. 2023;13(5):e054603.
18. Ajayi AI, Akpan, W. Maternal health care services utilisation in the context of 'abiye' (safe motherhood) programme in Ondo state, Nigeria. BMC Pub Health, 2020;20(1):1-9.
19. World Health Organization. Millennium development goals, 2018. Available at https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs). Assessed 19 February 2018.
20. Gbadamosi H. 'We have 600 communities, one general hospital, no electricity'. Nigerian Tribune. 2018. Available at: https://tribuneonlineng.com/we-have-600-communities-one-general-hospital-no-electricity/. Accessed on 25 June 2026.
21. Olagunju O. Impact of rural transportation networks on farmers' income in Ilaje local government area of Ondo State, Nigeria. Agri Trop et Subtrop. 2022;55(1):9-18.
22. Adeleke ML. Socioeconomic characteristics of the artisanal fisherfolks in the coastal region of Ondo state, Nigeria. J Econ and Sust Develop. 2013;4(2):133-9.
23. Department of Research and Statistics, Ministry of Economic Planning and Budget. Facts and Figures on Ondo State; Department of Research and Statistics, Ministry of Economic Planning and Budget: Akure, Nigeria. 2010.
24. Tomoloju B. Delivering healthcare in Ilaje riverine communities. The Guardian: Nig Edit, 2020. Available at: https://guardian.ng/art/literature/delivering-healthcare-in-ilaje-riverine-communities/. Accessed on 25 June 2026.
25. Ikulajolu A. Investigation: untold story of Ondo oil producing communities battling poor health system. Rip Nig, 2022. Available at: https://www.ripplesnigeria.com/investigation-untold-story-of-ondo-oil-producing-communities-battling-poor-health-system/. Accessed on 28 June 2026.
26. McNellan CR, Dansereau E, Wallace MC, Colombara DV, Palmisano EB, Johanns CK, et al. Antenatal care as a means to increase participation in the continuum of maternal and child healthcare: an analysis of the poorest regions of four Mesoamérican countries. BMC Preg and Childbirth. 2019;19(1):1-11.
27. Bryant J, Jamil RT, Thistle J. Fetal movement. In StatPearls. StatPearls Publishing. 2021.
28. Kekana LS, Sebitloane MH. Ingestion of herbal medication during pregnancy and adverse perinatal outcomes. South Afri J Obste and Gynae. 2020;26(2):71-5.
29. Acharya T, Devkota R, Bhattarai B, Acharya R. Outcome of misoprostol and oxytocin in induction of labour. SAGE Open Med. 2017;5:1-7.
30. Zivaljevic J, Jovandaric MZ, Babic S, Raus M. Complications of Preterm Birth-The Importance of Care for the Outcome: A Narrative Review. Medicina (Kaunas, Lithuania). 2024;60(6):1014.
31. Ibama AS, Unamba BC, Jaja E. Traditional Birth Attendant in the Maternal and Child Health Space in Nigeria: Ancient Practices and Modern Recommendations. Gynecol Reprod Health. 2023;7(4):1-7.
32. Mamun MAA, Chowdhury AR, Khan MN, Shah MF, Uddin MB, Yasmin L, Ahsan MT. Knowledge, Attitudes, and Practices of Traditional Birth Attendants in Bangladesh: A Qualitative Study on Maternal and Newborn Healthcare in Local Community. Health Sci Rep. 2025;8(12):e71618.
33. Sarker BK, Rahman M, Rahman T, Hossain J, Reichenbach L, Mitra DK. Reasons for preference of home delivery with traditional birth attendants (TBAs) in aural Bangladesh: a aualitative exploration. PloS One. 2016;11(1):e0146161.
34. Johnson OE, Obidike PC, Eroh MU, Okpon AA, Bassey EI, Patrick PC, et al. Choices and determinants of delivery location among mothers attending a primary health facility in southern Nigeria. Nig Postgrad Med J. 2020;27(1):42.
35. Ehinmore OM, Ogunode SA. Fish in indigenous healing practices among the Ilaje of coastal Yorubaland of Nigeria: a historical perspective. Euro Sci J. 2013;9(14):192-206.

36. Buowari OY. Traditional birth attendants issue: a menace in developing countries. Nig J Med. 2012;21(4):466-8.
37. Oyeneyin L, Osunmakinwa O, Olagbuji Y. Incorporating traditional birth attendants into the mainstream maternal health system in Nigeria-an evaluation of the Ondo State Agbebiye program. Afri J Repro Health. 2021;25(4):82-8.
38. Muanya C. Ondo records 75% reduction in maternal deaths. The Guardian: Nig Edit, 2016. Available at: https://guardian.ng/news/ondo-records-75-reduction-in-maternal-deaths/. Accessed on 25 June 2026.
39. Oladimeji OJ, Fatusi AO. Realist Evaluation of the "Abiye" Safe Motherhood Initiative in Nigeria: Unveiling the Black-Box of Program Implementation and Health System Strengthening. Front Health Serv. 2022;2:779130.
40. Oyeneyin L, van den Akker T, Durojaiye O, Obaado O, Akanbiemu F, Olagbuji Y, et al. Confidential enquiries into maternal deaths in Ondo State, Nigeria-a comparative analysis. BMC Preg Childbirth. 2019;19(1):1-8.

Cite this article as: Ojajuni EO, Dirisu JO. Activities of traditional birth attendants in a local council in Nigeria, menace and corrective measures. Int J Reprod Contracept Obstet Gynecol 2026;15:4217-22.