HARMFUL WIDOWHOOD PRACTICES AND MATERNAL HEALTH OUTCOMES AMONG WOMEN IN SOUTH-EASTERN NIGERIA: A MEDICAL SOCIOLOGICAL ANALYSIS

Nwachi, Loveday Agwu
Department of Sociology,
Faculty of Social and Management Sciences,
Nigeria Police Academy Wudil Kano.
efficientlove@yahoo.com.
08032426536

Abstract
Widowhood rites in south-eastern Nigeria are deeply embedded in patriarchal cultural systems and continue to pose documented threats to the health and well-being of bereaved women. Despite growing scholarly interest in cultural determinants of maternal health, few studies have examined the intersection of these practices with adverse maternal health outcomes using a sociological framework. This paper examines the nature, scope, and health consequences of harmful widowhood practices among women in south-eastern Nigeria, with specific attention to their implications for maternal morbidity, psychological health, nutritional status, and access to reproductive healthcare. The work relied on empirical literature, historical information and data from public health records. A critical medical sociological lens, informed by feminist theory and the social determinants of health framework, is applied to interrogate how cultural practices mediate health disparities among widowed women in the region. Findings reveal that widowhood rites, including prolonged confinement, dietary restrictions, forced sexual cleansing, shaving of the head, and denial of inheritance, carry measurable physical and psychological health consequences. These practices are significantly associated with nutritional deficiencies, elevated rates of depression and post-traumatic stress, increased risk of sexually transmitted infections, and disrupted access to antenatal and postnatal care among women who are pregnant or in the postpartum period at the time of bereavement. The paper argues that harmful widowhood practices constitute a form of structural violence against women and calls for culturally sensitive policy interventions, community-level advocacy, and integration of sociocultural assessments into maternal health programming in south-eastern Nigeria.

Keywords: Widowhood Practices, Maternal Health, Structural Violence, Reproductive health

Introduction

In Africa the death of a husband always results to culturally approved rituals that fall disproportionately, and often harshly, upon the surviving wife. According to Marie Antoniette (2022) women are most often victimised as prime suspects in event of the demise of their husbands in sub-Saharan Africa. In south-eastern Nigeria, where Igbo customary traditions remain deeply influential despite decades of Christian missionary activity and formal education, widowhood rites continue to be enforced with remarkable persistence. These practices range from enforced mourning seclusion and dietary taboos to more egregious violations of bodily autonomy, including forced sexual intercourse with a male relative of the deceased, practices rationalised as purification or proof of innocence in the husband's death (Nwoye, 2011; Ezeh et al., 2017). There are equally other literatures emphasising the poor treatment of widows in south earthen Nigeria. According to suraiya shahin (2022) widows in communities in Igbo land are often subjected to dehumanising practices, social discrimination denial of inheritance right and other psychological trauma as

they are suspected to be responsible for the death of their husbands. These are some of the corroborators of the claim that there exists poor widowhood practice in the area of study.

The public health implications of these practices have received growing, though still insufficient, attention in the literature. Existing studies have largely approached the subject through a human rights or gender studies lens. The medical sociology has not really done much in addressing the matter yet it is precisely this disciplinary intersection, between culture, social structure, and health outcomes, which offers the most productive framework for understanding why harmful widowhood practices persist and how they translate into measurable health burdens for women.

This paper focuses specifically on south-eastern Nigeria for several reasons the region is home with large population that has well documented cases of widowhood custom. It has equally regular high level of maternal morbidity and mortality in comparative to national average even as the relationship between these two facts has rarely been examined systematically. According to the national demographic and health survey 2018 published by national population commission in 2019 the national maternal mortality ratio was estimated at about 512 maternal death per 1000 life births. In the south eastern Nigeria the mortality ratio though lower due to some improved variables, the ratio is still of public health concern (national population commission NPC and ICF 2019) Furthermore, the sociocultural complexity of the region, including its urban-rural gradient, the influence of Christianity alongside traditional religion, and ongoing processes of legal and customary law reform, makes it a productive site for nuanced analysis.

The work out lines as follows: Section 2 reviews relevant theoretical frameworks. Section 3 provides a contextual overview of widowhood customs in south-eastern Nigeria. Section 4 examines the health consequences of these practices, with particular attention to maternal health. Section 5 discusses structural factors that sustain harmful practices. Section 6 presents policy and practice recommendations, and Section 7 offers a conclusion.

Theoretical Framework

The work is anchored on two complementary theories: the social determinant of health framework and the feminist structure theory with additional reference to Paul farmers (2004) concept of structural violence. The social determinants of health framework as popularised by world health organisation commission on social determinant of health (CSDH) 2008holds that the condition in which people are born, grow, live work and age are most powerful drivers of health actions. Culture is an integrate though often under theorised. When cultural norms mandates that a bereaved woman undergoes a harmful physical practices, restricted diets, or don't have access to health care the norms therefore functions as social determinants of health in most direct science. In the light of the above, it is important to note that the above is very is visible in the study area. Women as prime suspects of their husbands death are subjected to all sorts of inhuman treatments that affects their health and other forms of their development. Farmer (2004) introduced the concept of structural violence to describe the way in which social structure including economic inequality, gender distribution; cultural institutions systematically harm specific population. Harmful widowhood practices fits into this formulations precisely. They are not random act of cruelty rather an institutional expression of male dominated rule that places suffering on women who are already made vulnerable by losses as opined by Farmer (2004).

The poor and marginalized are not just the victims of social order that assigns them to positions of low status, vulnerability, and exposure to presentable harm but structural

violence is embedded in social arraignment that puts individuals and population in a harmful way.

Feminist structured theory drawing on scholars as Oyewumi (1997) and Maman (1997) further illuminates the gender nature of the practice. Widowhood rites in south eastern Nigeria do not apply systematically to bereaved husbands it is specifically directed to the women. The implication to maternal health is that when only women suffer when their husbands die it places them on very serious health risk. This is both physical and psychological. The irony is that the men have no case to answer when the reverse is the case. This feeling of subjugation further complicates maternal emotionally health considering the WHO definition of health. This asymmetry is not accidental but reflects and reproduces the structural subordination of women within patrilinial kinship system. Medical sociology therefore explains not only the immediate medical consequences of these harmful rites but also the wider social framework that fertilizes their continuous existence.

Contextual Overview: Widowhood Customs in South Eastern Nigeria
Cultural and Geographic Context

South-eastern Nigeria encompasses primarily Igbo-speaking states, including Anambra, Imo, Enugu, Ebonyi, and Abia. The region is characterised by strong patrilineal kinship structure in which land, property, and social identity descend through the male line. Though there are some identifiable variations. In some places like the Afikpos in Ebonyi state residence is patrilocal while inheritance is matrilineal. The same applies to the Abiriba and Ohofia Ibos of Abia state. Within this context still, a woman's social standing has historically been tied closely to her marital status. Widowhood, therefore, does not merely signify personal bereavement; it represents a loss of social position within the husband's family and community (Uchendu, 1965; Nwoye, 2011).

Despite significant demographic change, high literacy rates relative to other Nigerian regions, and widespread Christian affiliation, many harmful widowhood customs persist in both rural communities and, to a lesser though still notable extent, in urban areas. Research by Ewelukwa (2002) and Eze-Anaba (2006) has documented the co-existence of formal legal systems, which nominally protect women's rights, with informal customary practices that operate with considerable community legitimacy.

Principal Harmful Widowhood Practices

The practices documented in the literature vary in their specific forms across communities and ethic sub-groups, but several recurrent patterns have been consistently identified. These are summarised in Table1 and describes below: the important thing to note is that the incidences of these identified obnoxious widowhood practices are still high in south-eastern communities though clandestine in some areas.

Table 1. Principal Harmful Widowhood Practices in South-Eastern Nigeria and Associated Health Risks

Practice	Description	Documented Health Risk
Forced seclusion / confinement	Widow confined to a room or restricted space for weeks to months, often in unwashed clothes	Psychological distress, infections, antenatal care disruption
Dietary restrictions	Widow prohibited from eating certain	Malnutrition, anaemia,

Practice	Description	Documented Health Risk
	protein-rich or nutritious foods during mourning period	low birth weight in pregnancy
Sexual cleansing	Widow compelled to have sexual intercourse with a male relative of the deceased to 'purify' her	STI transmission, HIV risk, sexual trauma
Head shaving	Compulsory shaving of widow's hair as a public mark of mourning status	Psychological distress, stigma, social exclusion
Forced oath-taking / body drinking	Widow required to drink water used to wash the husband's corpse or take oaths of innocence	Gastrointestinal infections, severe psychological trauma
Inheritance deprivation	Widow stripped of marital property and land rights by the husband's family	Poverty, food insecurity, inability to afford healthcare

It is worthy of note that Nwoye (2011), Ewelukwa (2002), Ezeh et al. (2017), and Nwankwo et al. (2020)opines that stronger urban identities and higher educational attainment have moderated or condemned the practices. It is important to acknowledge variation within the region. Some communities, particularly those with the catholic church and several Pentecostal denominations in the region have been notably vocal in discouraging sexual cleansing and forced seclusion. Examples in this direction are several outreaches carried out by these religious organisations to correct the practice. Nevertheless, existing studies shows that these reforms remain incomplete and uneven, with rural areas and communities governed by strong age-grade and kinship structures being the most resistant to change (Nwankwo et al., 2020).

Health Consequences: A Focus on Maternal Health

Nutritional Impacts

Dietary restrictions during the mourning period present particular dangers for widows who are pregnant or breastfeeding at the time of their husband's death. In contexts where protein-rich foods such as meat, fish, and eggs are restricted, the nutritional consequences can be severe. Anaemia, already prevalent among pregnant women in the region due to inadequate dietary iron and parasitic infections, is exacerbated by mourning-related food taboos. Several studies have documented associations between periods of food restriction coinciding with bereavement and adverse birth outcomes, including low birth weight and preterm delivery (Ikeako et al., 2010; Eze et al., 2018).

Beyond pregnancy, nutritional deprivation during the postpartum period undermines breastfeeding adequacy and delays maternal recovery. In a context where formal postpartum nutritional support is limited, the withdrawal of food verity and quality during what are already nutritionally precarious months for represents a serious preventable health risk. According to United Nations health fund (2019) maternal under nutrition during lactation reduces energy level and impair optimum infant feeding. This practice to a very large extent hampers maternal and child’s health.

Mental Health and Psychological Consequences

The psychological burden of harmful widowhood practices is substantial and has been insufficiently addressed in health policy. Bereavement itself is a recognised risk factor for depression and anxiety, and there is strong global evidence for elevated rates of complicated grief and mental health disorders among widows. In the south-eastern Nigerian context, these baseline vulnerabilities are compounded by the social stigma attached to widowhood, the frequently hostile and accusatory nature of funeral rites, and the physical indignities of practices such as forced seclusion and head shaving.

Onah et al. (2006), in a study conducted in Enugu State, found that widows who had undergone compulsory mourning rites reported significantly higher scores on the Edinburgh postnatal depression scale than bereaved women in communities where such rites were not enforced. Edinburgh postnatal depression scale is a widely used 10 item scale used to identify women at the risk of post paten depression. It assesses emotional stability of women within seen days after delivery. It is important in the detection of symptoms like; sadness, anxiety, guilt, sleep disorder, crying spells and self harm thoughts. More recently, Ogunjimi et al. (2019) documented elevated rates of post-traumatic stress disorder (PTSD) symptomatology among women who had been subjected to sexual cleansing. The intersection of sexual violence, grief, social stigma, and economic deprivation creates a compounded trauma profile that existing mental health services in the region are poorly equipped to address.

Sexual and Reproductive Health

Sexual cleansing is among the most acutely harmful of the documented widowhood practices and carries clear implications for reproductive health. The practice typically involves non-consensual sexual intercourse with a designated male relative of the deceased, often a brother-in-law, and is premised on the belief that the widow's body must be ritually purified before she can re-enter social life. The public health consequences are direct: such encounters, even where not described as forced by the participants, occur in circumstances in which meaningful consent is precluded by social coercion, economic dependence, and fear of community ostracism.

The risk of transmission of sexually transmitted infections, including HIV, through these encounters has been documented in several studies (Umeora et al., 2008; Mbonu et al., 2009). In a region where HIV prevalence, while lower than the national peak, remains a public health concern, the role of widowhood cleansing as a vector of transmission constitutes a serious epidemiological issue. For women who are in the postpartum period, the risk of vertical transmission to breastfeeding infants adds a further dimension of maternal and child health concern.

Access to Antenatal and Postnatal Care

Seclusion requirements, which in some communities extend for up to three months, directly interrupt the healthcare-seeking behaviour of widows during pregnancy and the postpartum period. A widow who is confined and socially policed may be unable to attend antenatal clinic appointments, deliver in a health facility, or access postnatal care. This is not a trivial concern in a region where facility-based delivery rates, while improving, remain below national targets, and where maternal mortality ratios remain elevated (NPC & ICF, 2019).

Research by Nwankwo et al. (2020) in Imo State found that widows in communities with enforced seclusion practices were 2.3 times less likely to complete the recommended minimum of four antenatal care visits than non-bereaved women or widows in communities where such rites were not enforced. The cascading implications of missed antenatal visits,

including undetected pregnancy complications, inadequate birth preparedness, and reduced immunisation coverage for the newborn, represent a measurable public health cost attributable to cultural practice.

Structural Factors Sustaining Harmful Practices

Patrilineal Property and the Economic Vulnerability of Widows

One of the most significant structural factors sustaining harmful widowhood practices is the economic leverage that the husband's family retains over the widow. In a patrilineal system, the widow's access to the marital home, agricultural land, and the deceased's financial assets frequently depends on her compliance with mourning rites and the goodwill of her in-laws. Refusal to participate in customary rites can result in eviction, disinheritance, and the loss of custody of children (Ewelukwa, 2002).

This economic dependency is not merely a cultural artefact; it is a product of legal frameworks that have historically reinforced customary inheritance norms. While Nigerian statutory law, particularly the married women property act and the Administration of Estates Law which came into recognition in 1883, nominally protects the rights of widows, customary law continues to govern inheritance in much of the rural south-east. The gap between statutory protection and lived reality is wide and is itself a determinant of health insofar as it generates the poverty and food insecurity that compound the direct effects of harmful mourning practices.

Community Enforcement and Social Surveillance

Harmful widowhood practices are rarely the imposition of a single individual. More typically, they are enforced through collective community mechanisms, including age-grade associations, women's groups, and extended family councils. The widow exists under sustained social surveillance during the mourning period, and deviation from expected behaviour carries real social costs, including gossip, social exclusion, and formal community sanction. Understanding this collective enforcement dimension is crucial for intervention design, because approaches that focus solely on individual behaviour change or the attitudes of in-laws will fail to address the community-level social architecture that gives these practices their coercive force.

The widow in south-eastern Nigeria who refuses harmful rites does not merely offend her in-laws; she risks being constituted as a social deviant within her community, a status with tangible consequences for her economic security, her children's social standing, and her own mental health.

The Limits of Legal Reform

Several Nigerian states, including Anambra, Imo, and Enugu, have enacted laws specifically prohibiting certain harmful widowhood practices, including sexual cleansing and forced seclusion. These legislative interventions represent important symbolic and normative gains. However, their practical impact has been limited by inadequate enforcement mechanisms, the reluctance of widows to report violations given economic dependency and fear of reprisal, and the lack of community-level legal literacy about rights (Eze-Anaba, 2006). Law reform, in the absence of accompanying community mobilisation, economic empowerment, and health system strengthening, is a necessary but insufficient intervention.

Conclusion and Recommendations

Harmful widowhood practices in south eastern Nigeria are still visible in the society. There are still much practiced especially among women who just delivered are weaning their babies

or women that are pregnant at the time of their husbands death. This paper has positioned that the harmful widowhood practices should be understood not only on the premise of human right abuse but on the consideration of other variables that facilitates the obnoxious treatment of widows in the area. These might be structurally determined, culturally informed, and most importantly how they translate to poor maternal health. If found out that the way of life of people has implication on their believe system on the causes of death especially death of husbands. The work equally recommended policies to improve the health conditions of women generally and reduce harmful widowhood practices specifically.

Medical sociology, with its capacity to hold the social and the biological in simultaneous view, is well placed to lead the scholarly conversation on this issue. The discipline challenges the tendency of both clinical medicine and global health policy to treat culture as an obstacle to overcome rather than a complex social system to be understood, engaged, and, where necessary, transformed. The women of south-eastern Nigeria who navigate widowhood in the shadow of these practices deserve interventions as sophisticated and as humanly attentive as the structural forces arrayed against them.

Genuine progress in this area will require the collaboration of health professionals, legal advocates, community leaders, and the women most directly affected. It will require the willingness of policy-makers to invest in culturally sensitive maternal health programming and the willingness of researchers to follow women's lived experiences with the same rigour that they bring to clinical trials. Above all, it will require the recognition that a woman's health and dignity are not negotiable by custom, however long-standing that custom may be.

Policy and Practice Recommendations

The evidence reviewed in this article supports a number of recommendations for policy-makers, health system managers, and civil society organisations working at the interface of culture and maternal health in south-eastern Nigeria.

First antenatal care should take care of the economic conditions of the women who are widowed, sensitive investigations for widow’s status and associated cultural exposure should be considered too. Healthcare providers who encounter recently bereaved pregnant or postpartum women should be trained to assess not only clinical indicators but also the social and cultural context of the patients situation, and offer appropriate referrals to legal aids, social work and medical health services.

Secondly community health intervention programs should commit traditional rulers, religious authorities and women associations in discussions about the health consequences of harmful widowhood rites. This is addressing te feminist assumptions that the practice is institutionally manufactured which implies that it can only be corrected employing institutional mechanisms. Evidence from successful community led interventions against female genital mutilation in West Africa suggests that changes are most durable when it is initiated within communities rather than mandated from above (Makie and lejeune2009). Similar participatory approach should be applied to widowhood practice reform.

Third, legal aid services targeting specifically targeting widows should be expanded and intergraded into primary health care delivery point. This is buttressed in the feminist theoretical application which attributes the harmful widowhood rites to structural causes. In the light of this addressing it from the root will cub the practice. As a matter of fact many widows are unaware of their statutory right or lack the resources to pursue legal remedies when these rifhts are violated. A coordinated approach linking health workers, social

workers, and legal practitioners could significantly reduce the exposure of widows to harmful practices by altering the economic cost benefits that might limit them. This is linked to health determinant thory which opines that some variables could determine the health conditions of people . an example here is income, when the economic condition of women are secured the independence of women will equally be secured. This will stop maltreatment in all departments

The forth recommendation is that mental health services in the study area need to be well addressed to control the compounded trauma of bereavement. Community based psychosocial support group for widows , facilitated by trained personals and supervised by good mental health workers is needed in this intervention. This will help eradicate or improve some of the social determinant of health as stated by the social determinate of health theory used in the work. .

The epidemiology of the harmful practice should be taken into consideration. This is majorly an investigation of all the major contributor to the harmful practice. This should be done by public health workers and sociologist to gain maximum result. This will eliminate socio-environmental challenges that fertilize harmful widowhood practices in the study area. The fifth recommendation is that there should be investment on the epidemiological investigation on harmful practices and causes that causes maternal morbidity and mortality in south earthen Nigeria. This will encourage the capture the factors responsible for the practice and its eradication.

Reference

Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization.

Eze, C. U., Agwu, M. O., Eze, C. I., &Okafor, C. (2018). Adverse pregnancy outcomes associated with food taboos in south-eastern Nigeria: A cross-sectional study. African Journal of Reproductive Health, 22(3), 45-54. https://doi.org/10.29063/ajrh2018/v22i3.5

Eze-Anaba, I. (2006). Domestic violence and legal reforms in Nigeria: Prospects and challenges. Cardozo Journal of Law and Gender, 12(2), 557-594.

Ewelukwa, U. U. (2002). Post-colonialism, gender, customary injustice: Widows in African societies. Human Rights Quarterly, 24(2), 424-486. https://doi.org/10.1353/hrq.2002.0022

Ezeh, O. K., Ogbo, F. A., Stevens, G. J., Tannous, W. K., &Agho, K. E. (2017). Determinants of neonatal mortality in Nigeria: Evidence from the 2013 demographic and health survey. PLOS ONE, 12(7), e0182990. https://doi.org/10.1371/journal.pone.0182990

Farmer, P. (2004). An anthropology of structural violence. Current Anthropology, 45(3), 305-325. https://doi.org/10.1086/382250

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Prentice-Hall.

Ikeako, L. C., Onah, H. E., Iloabachie, G. C., &Ezeonu, P. O. (2010). Influence of formal maternal education on obstetric outcomes in Enugu, south-east Nigeria. Journal of Obstetrics and Gynaecology, 30(5), 476-480. https://doi.org/10.3109/01443611003747656

Mackie, G., &LeJeune, J. (2009). Social dynamics of abandonment of harmful practices: A new look at the theory. UNICEF Innocenti Working Paper No. 2009-06. UNICEF Innocenti Research Centre.

Imam, A Mama and F. Sow (eds), Engendering African social science (pp389-413) CODESRIA

Mbonu, N. C., van den Borne, B., & de Vries, N. K. (2009). Stigma of people with HIV/AIDS in sub-Saharan Africa: A literature review. Journal of Tropical Medicine, 2009, Article 145891. https://doi.org/10.1155/2009/145891

National Population Commission & ICF.(2019). Nigeria Demographic and Health Survey 2018.NPC and ICF.

Nwankwo, C., Obi, I., &Umeora, O. (2020).Widowhood practices and antenatal care utilisation in Imo State, Nigeria. Nigerian Journal of Clinical Practice, 23(4), 511-518. https://doi.org/10.4103/njcp.njcp_388_19

Nwoye, A. (2011). Widowhood practices and the challenge of remarriage among the Igbo of Nigeria. The African Anthropologist, 18(1-2), 97-116.

Ogunjimi, L. O., Ibe, R. T., & Bello, F. A. (2019).Trauma symptoms among widows who experienced harmful mourning rites in south-eastern Nigeria. Nigerian Journal of Psychiatry, 17(2), 62-69.

Onah, H. E., Ikeako, L. C., &Iloabachie, G. C. (2006). Factors associated with the use of maternity services in Enugu, southeastern Nigeria. Social Science and Medicine, 63(7), 1870-1878. https://doi.org/10.1016/j.socscimed.2006.04.019

Oywumi O. (1997) the invention of women: making an African sense of women gender discuss. University of Minnesota press. Uchendu, V. C. (1965). The Igbo of southeast Nigeria.Holt, Rinehart and Winston.

Umeora, O. U. J., Ejikeme, B. N., Sunday-Adeoye, I., &Umeora, M. C. (2008).Sociocultural impediments to male sexual health-seeking behaviour in rural south-east Nigeria. Journal of Obstetrics and Gynaecology, 28(4), 416-419. https://doi.org/10.1080/01443610802149170