Tanzania Journal of Health Research
Volume 25: Number 3, July 2024
https://dx.doi.org/10.4314/thrb.v25i319

Lived experiences of women who had hysterectomy for uterine prolapse in Southeast Nigeria

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Abstract

Background: Hysterectomy aims to relieve symptoms and improve patients' lives. Yet, the lived experiences of women who had a hysterectomy for uterine prolapse in sub-Saharan Africa have primarily been unexamined. This study explored their experiences after hysterectomy at a specialist hospital in Southeast Nigeria.

Objective: To explore the women's physical, psychological, social, and economic experiences after hysterectomy.

Method: Individual in-depth interviews were conducted on 21 women aged 31-72 at 3- 6-month check-ups after hysterectomy. The interview transcripts were subjected to hermeneutic phenomenological interpretation.

Results: Loss of the uterus was particularly distressing to the women. They questioned their womanhood at its loss. Some continued to experience body pains and symptoms of depression months after hysterectomy, making them limit their economic activities. Their narrations showed dissonant grieving: consoled by the relief of the prolapse but bothered by uncertainty about the surgery and poor empathy from their spouses. Expecting stigmatisation, they reduced their social relationships. They tried to cope by depending more on their children and parental family members, seeking guidance and support from other women who previously underwent hysterectomy, and increasing their spiritual relationship.

Conclusion: The findings suggest that pre- and post-surgery counselling, incorporating verbalization and problem sharing, and self-help groups can be helpful to women who have had hysterectomy.

Keywords: culture; hysterectomy; lived experiences; prolapse; uterus

Introduction

One of the goals of Health for All the World Health Organization (1997) is the improvement of well-being. Care provision is usually patient-centred, relating to enhancing their personal and social life. Therefore, surgical processes aim to relieve symptoms and improve the patient's well-being and life experiences. Uterine prolapse, the progressive loss of anatomic support for the uterus that causes the uterus to protrude out of the vagina gradually, occurs in both pre-and post-menopausal women and is usually accompanied by urinary, bowel, sexual or local symptoms

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(Desai et al., 2019; Li et al., 2023; Yakubu et al., 2017). Advanced uterine prolapse is often managed by hysterectomy, the surgical removal of the uterus. Hysterectomy is considered adequate and relatively safe (Omokanye et al., 2012; Usman et al., 2017), with almost all European women who had hysterectomy returning to work after 12 weeks (Dedden et al., 2022; Shehmar, 2016).

Hysterectomy, however, could change the physiological functions or wholeness of the body and therefore affect the sense of self and life experiences of the woman (Desai et al., 2019; Gün & Kömürcü, 2013; Uçar et al., 2016). It has also been linked to a sense of reduction in feminine properties, loss of creativity, emptiness and prolonged depression, especially among younger women (Azadeh-Ghamsari et al., 2002; Li et al., 2023). Most studies on personal experiences of women who had a hysterectomy for uterine prolapse were conducted in Western and Asian countries (e.g., Afiyah et al., 2020; Gün & Kömürcü, 2013; Li et al., 2023), with a few in Africa (Ntihabose & Twahirwa, 2021; Pilli et al., 2020). However, lips and Lawson (2019) note robust differences in women's life contexts across cultures. There was, therefore, the need for studies on the personal life experiences of women who had hysterectomy due to uterine prolapse in sub-Saharan Africa.

This study explored the subjective physical, psychological, social and economic life experiences of women who underwent hysterectomy due to uterine prolapse at the National Obstetric Fistula Centre (NOFIC), Abakaliki, Southeast Nigeria. NOFIC is the foremost specialist centre in Southeast Nigeria where women who have uterine prolapse undergo a hysterectomy. Gauging their experiences after hysterectomy can be helpful in matching professional care with their needs.

Method

Participants

The participants were 21 women who met the inclusion criteria out of 50 women who had hysterectomy for uterine prolapse at NOFIC between June and December 2022. The inclusion criteria were check-up attendance 3-6 months after the surgery, being without any co-morbidity, and willingness to participate in the study. The participants' demographics are presented in Table

Ethical Consideration

Ethical approval was obtained from the research and ethics committees of NOFIC and Alex-Ekwueme Federal University Teaching Hospital, Abakaliki, which is the teaching hospital to which NOFIC is affiliated (HREC approval number NHREC/16/05/22/200). Participants voluntarily signed a consent form and were informed that withdrawal at any research stage is permitted. They were assured that their information would be treated with utmost confidentiality.

Data collection

With information from the hospital's records, each participant was approached while waiting for the doctor when they came for a check-up. Adequate rapport was established before the participant was given the goal and instructions of the study. Data were collected through two stages of interviews for each participant. The first stage was for participant demographic data and assignment of number codes. The second stage was the in-depth interview on their experiences after the hysterectomy. The two stages of interviews were done on the same day for each participant at the Outpatient Department, anchored by one of the researchers (P.N.E.). The interview lasted for 3-6 months as the women visited for check till 21 participants were interviewed, and no new information emerged, reaching data saturation.

Data analysis

The interview transcripts were independently read and re-read, coding and identifying meaningful themes by an inductive approach, demanding themes be rooted in the data (Patton,

2002). Codes were used on the socio-demographic forms filled out by the participants, such that P1 and P21, for instance, represented the first and twenty-first participants, respectively. These codes were used to vivify the integrated narrative. Transcripts with identified themes were re-analyzed, aggregating themes to piece together the women's experiences.

Interpretive hermeneutics phenomenology was utilized for the thematic analysis, where there was continual review and analysis between the parts and the whole text (Polit & Beck, 2005). With the researchers applying their understanding and knowledge of the participants' cultural context and the subject under study, statements that were seen to illuminate the researched phenomenon were extracted. With the list of non-redundant units of meaning, clusters of themes were typically formed by grouping units of meaning together. Supporting verbatim quotes were lifted from the scripts to evidence the experiences.

Results

Participants' demographics

The participants were aged 31-72 (*M* = 50.43 years, *SD* = 11.38). Most (85.7%) were married, with an average of 5 children per woman. The majority (80.9%) were from the Igbo ethnic group, with the rest from the neighbouring Yala ethnic group. Farmers constituted the largest occupational group (Table 1).

Table 1: Socio-demographic characteristics of the participants

N	Age	Job	Marital Status	Number of Children	Edn	Type of Hysterectomy	Awareness of loss of womb
1	40	Trader	Married	7	None	total abdominal	Yes
2	39	Teacher	Married	7	HND	total abdominal	Yes
3	55	Farmer	Married	8	None	total abdominal	Yes
4	45	Baker	Married	5	FSLC	sub-total abdominal	Yes
5	62	Frying akara	Married	5	FSLC	total abdominal	Yes
6	69	Civil servant	Married	2	HND	sub-total abdominal	Yes
7	72	Farmer	Married	12	None	total vaginal	Vague
8	70	Farmer	Married	5	None	total vaginal	Yes
9	45	Civil servant	Married	2	BSc	sub-total abdominal	Yes
10	40	Farmer	Married	8	SSCE	total abdominal	Yes
11	31	Farmer	Married	6	SSCE	total abdominal	Yes
12	60	Farmer	Married	7	FSLC	total abdominal	Yes
13	59	Farmer	Married	8	FSLC	total vaginal	Yes
14	53	Farmer	Divorced	0	FSLC	total vaginal	Yes
15	39	Hair dresser	Single	9	FSLC	sub-total abdominal	Yes
16	40	Farmer	Married	3	FSLC	total vaginal	Yes
17	48	Farmer	Married	7	SSCE	total vaginal	Yes
18	50	Civil servant	Divorced	5	SSCE	total abdominal	Yes
19	50	Farmer	Married	6	SSCE	total abdominal	Yes
20	47	Trader	Married	2	SSCE	total abdominal	Yes
21	45	Radiographer	Married	4	BSc	sub-total abdominal	Yes

Note: *N:* Participant code number; Edn: Educational level; FSLC: First School Leaving Certificate; SSCE: Senior Secondary Certificate of Education; HND: Higher National Diploma; BSc: Bachelor of Science degree

Lived experiences after hysterectomy

The overarching theme in the women's post-hysterectomy experiences is the "experience of living with no uterus" due to its prominence in their responses. Figure 1 shows the subthemes.

https://dx.doi.org/10.4314/thrb.v25i319

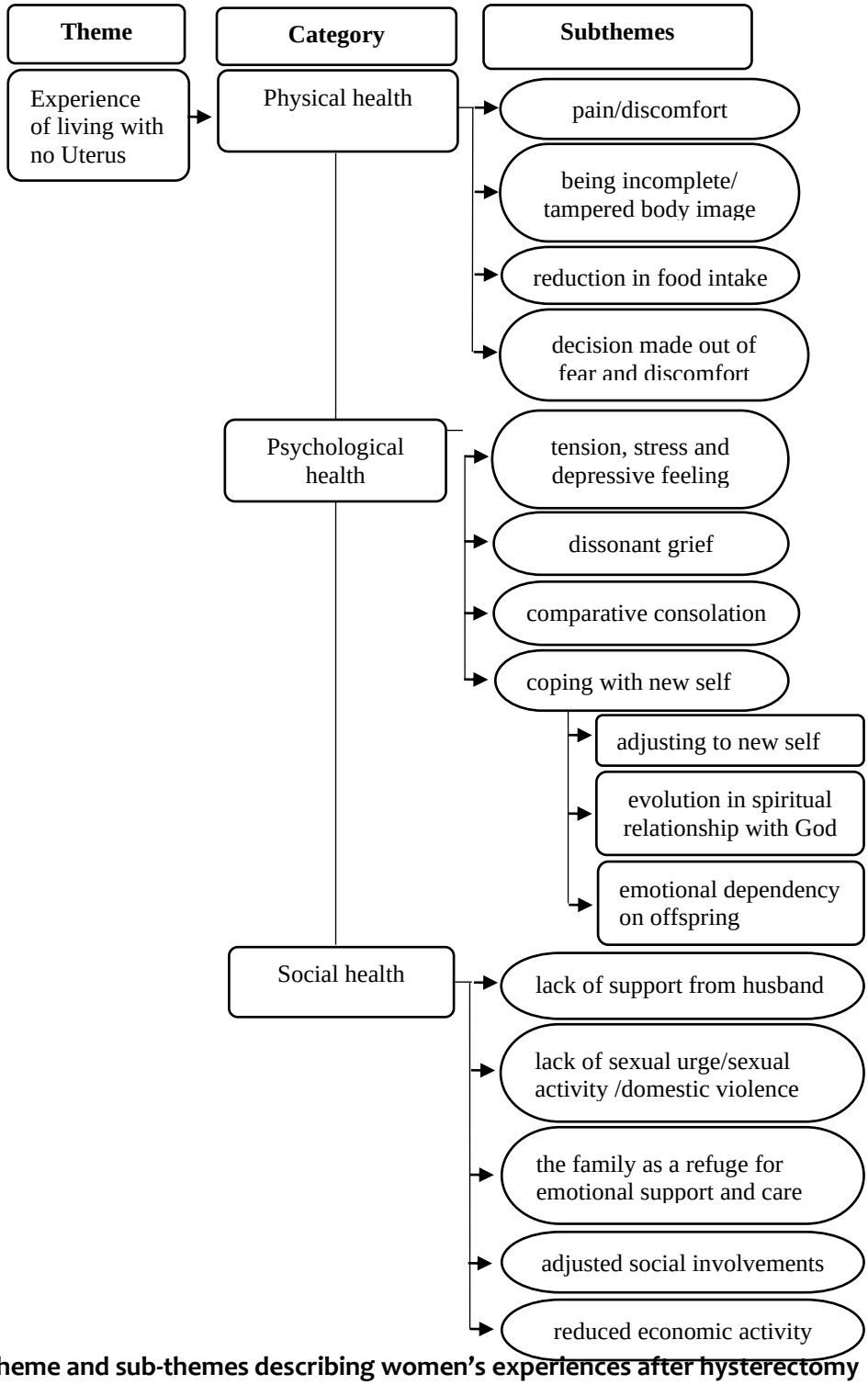

Figure 1: Theme and sub-themes describing women's experiences after hysterectomy

Their narratives fit into three categories: physical health, psychological health, and social health. These categories are reflected in subthemes, as shown in Figure 1. Economic issues emerged as outcomes of experiences in the physical, psychological, and social domains.

Physical health

The women's physical health experiences appeared under the subthemes of pain/discomfort, incomplete/ tampered body image, reduction in food intake, and decisions made of fear and discomfort.

Pain /discomfort

Pain was mainly reported as backache, lower abdominal pain, burning sensation at the surgery site, and general body pain. The pain made it difficult for some of them to perform daily activities. Many of them experienced delays in the achievement of pre-morbid capacities. A 40-year-old woman with a third-degree prolapse who had a hysterectomy described her experience as:

> *I think that after the operation, the pain that comes with that thing coming out from my body will stop. Pain came over my body; I was disturbed and thought of how I would be without a womb.* (P1)

The women used different coping mechanisms to reduce the pain. P2, a 39-year-old teacher, married with 7 children, explained:

> *I feel tired; sometimes I feel dizzy, and everything becomes dark. I wash my face and sit, then get myself.* (P2)

P5, P8, and P16 reported unexplained fatigue, soreness, and pain months after the surgery. Each of them observed that the first three months were particularly difficult for them. They indicated that the area of incision had continued to hurt, even at the time of the interview. P1, P12, P15, and P17 noted that their sleep patterns were disrupted and that they lost the desire to eat anything, even to swallow food.

Being incomplete/ tampered body image

Many of the participants recalled how they were initially distressed at the recommendation of a hysterectomy and struggled to come to terms with the implications of being without a uterus. Some of them seemed to find it difficult to align their pre- and post-surgery self-image and believed that their body had been essentially tampered with. P9, a 45-year-old married with 2 children, showed her awe*:*

> *I did not believe that a woman could stay with no womb. Now that I have no womb, I am not complete as a woman and just there … (sighs).*
>
> *I feel as if I lack something in my body. I see myself as someone lacking a big thing, and it disturbs me a lot.*

P6, a 69-year-old married with 2 children, was more definite in her concern:

> *I have started infertility in my lineage, as any child that is my reincarnate will come to the world without a womb since I removed it in my first world.* (P6)

Reduction in food intake

It seems that because of the stress they experienced after the surgery, most of the women reported a decreased appetite. Reduced food intake and anxiety may partly account for their complaint of persistent physical weakness. One of the women indicated that trying to eat puts pressure on the stomach muscles and hurts her tummy.

Decisions made from fear and discomfort

The women were afraid of developing cancer and complications after hysterectomy. Fear of the invasiveness and removal of the uterus was a matter of stress for the women.

Psychological health

How hysterectomy affected the women's psychological health is summarized under the sub-themes of tension, stress and depressive feeling, dissonant grief, comparative consolation, and coping with a new self.

Tension, stress and depressive feelings

Many of the women were tensed months after hysterectomy. Some felt depressed and guilty and blamed themselves and their fate for suffering uterine prolapse. They recounted sadness, fatigue and loss of interest in everyday living. Their responses also show that even after the surgery, the women were concerned about the limited information they had about hysterectomy and its implications. They seemed to lack professional social support beyond medical care. P19 presented the issues thus:

> *I worry about other problems coming up. I have no peace of mind due to what I am seeing in my body: heat all over my body, weakness in my bones, night heat, etc.* (P19)

Dissonant grief and comparative consolation

Some of the women narrated the inner pain and anguish that they were experiencing. They were torn between a justification of the hysterectomy and a perceived perpetual loss of reproductive viability. They compared themselves with others who had cancer in terms of how much money and years they had spent awaiting a cure or death. They considered that their disease had a cure, although they did not like the cure.

Coping with the new self

Most of the participants reported experiencing a sense of loss after the hysterectomy that affected their emotional state and changed their relationship with significant others. These changes ranged from increasing to decreasing relationships with persons. Some of them explained that a new self in capacity, social reputation and rating emerged after the surgery, which they were adjusting to. Coping with a new self-appeared in three domains: adjusting to a new self, evolution in spiritual relation, and emotional dependency on offspring.

> *I see myself as someone who has come to the end of my womanhood. It means that I am inferior to other women because I can no longer do what they can do as a woman, like bearing children.* (P6, 69-year-old, married, 2 children)

P4, a 45-year-old married with 5 children, cried while stating:

> *I am nothing but an empty sack. I can't feel like a woman any longer. Look, now. Look at me. What use am I for?* P4

Evolution in spiritual relation and emotional dependency on offspring

Most of the women experienced fear and uncertainty after hysterectomy and sought refuge in their spiritual relationship with God as absolute power. P19, a 50-year-old married with 6 children, was an exception. She instead reduced her spiritual relationship. Hysterectomy also made them more sensitive and emotionally attached to their children and increased their dependence on them.

Social health

Social health experiences included four sub-themes on how hysterectomy affected the women's spousal relationship, seeking emotional support and care, adjusted social involvements, and economic activity.

Spousal relationship

Some of the participants stated that hysterectomy introduced fresh problems in their relationship with their spouse. The loss of the uterus made them feel deficient, and they were

concerned about their spouse's reaction to their condition. They lacked sexual urges. Some women concluded that they did not receive enough support from their husbands after hysterectomy. They felt lonely and abandoned. Lack of support from their spouses harmed the women's emotional relationships with them. They were, therefore, reluctant to discuss their issues or have sexual intercourse with their spouses and did not accompany them in work and leisure. Their spouses became aggressive.

> *The only relationship problem is my husband because I refuse sex with him. I am afraid the sperm will enter my stomach and may cause a problem.* (P3)

> *The operation has affected my husband seriously. He now beats me. He is easily angry towards me and threatens to get another wife.* (P8)

P18, a 50-year-old with five children, was subsequently divorced:

> *There is division in my family, and he tells my children that I am trying to kill him. Our children are against me, seeing that he only caters to their needs. This operation has changed the peace we used to enjoy; my husband is always irritated. I also feel bad; I feel guilty that I caused all the problems, and even my children are affected. With time, I hope we will make up.* (P18)

Seeking emotional support and care from parental family and adjusted social involvement

The parental family served as a refuge for emotional support and care for most participants, especially when they felt lonely and found their spouse non-supportive. They trusted to receive support from their family. They were reluctant to attend public gatherings but attended family gatherings. They sometimes received emotional support and care from friends, especially those who have had hysterectomy. Many of the women reported reduced social involvement, with some basing their decision on fear of being the subject of gossip, and some feared being stigmatized and accused of envying other women with intact wombs.

Economic activity

The women reported economic deprivation and reduced ability to contribute to the financial needs of their families due to their poor health. Farming constituted a significant activity for a large proportion of the participants. Despite their dissatisfaction with their health condition after surgery, they still needed to go to the farm. Some had to change their economic engagements:

> *I had to change to a zobo (a local beverage) business, but it was not like my farm work, which produces food for me and my children, and most times, I sell the extra for money. I lacked food because Zobo's money was not enough for our upkeep.* (P2)

Discussion

The findings of this study show that although the women were aware that the surgery would involve the removal of their uterus, the loss of the uterus was particularly distressing to them due to the significance they attached to the uterus as a symbol of womanhood. Their recovery periods seem to be longer than were reported for European women (Dedden et al., 2022; Shehmar, 2016). Their post-surgery experiences were marked by tension and loss. The women in this study still complained about pain and fatigue months after the surgery. The pre-and post-surgery tension experienced by the women probably exacerbated their physical symptoms and delayed recovery.

Their apprehension about the loss of the womb seems to be peculiar and rarely observed in studies in other cultures (e.g., Li et al., 2023; Shehmar, 2016), although a more general concern with reproduction for those still seeking a child and resumption of sexual activity has been reported among European, Asian and African women (Afiyah et al., 2020; Alshawish et al., 2020;

Li et al., 2023; Pilli et al., 2020; Schmidt et al., 2019; Solbrække & Bondevik, 2015). They feared that the removal of their uterus would introduce infertility into their lineage by reincarnation.

African women seem to highly value childbearing and attach much importance to the uterus as a symbol of viability. The efficacy of the womb seemed to persist beyond menopause. The experience of body pain and discomfort related to the surgery, feeling incomplete due to the loss of the uterus, perceived poor spousal support and depressive feelings seem to have contributed to their aversion to the resumption of sexual intercourse with their spouses (one of them was apprehensive about where the sperm from her spouse would enter). After the surgery, these women seem to have suffered from low self-esteem and fear of losing their femininity and charm in front of their husbands due to their loss of fertility.

The women seemed to attempt to cope with the physical changes in their bodies and the pain/discomfort they experienced by avoiding friends and refusing to participate in social activities. They may have considered that being unable to relate or work as usual would elicit concern and inquisitiveness from others. Thus, the women preferred to keep their condition to themselves and limited their social interactions because they expected stigmatization.

Hysterectomy affected the women's economic lives, although this was not as prominent as their physical, psychological and social life experiences. It seems that their economic difficulties can be accounted for by their physical, psychological and social life experiences and that their economic problems would be significantly reduced if their challenges in these other domains are addressed. Most of the women were married, and the cultural norm in the area of the present study places the burden of responsibility for the economic maintenance of the family on the male spouse (Onwuatuegwu, 2020).

Hysterectomy seems to be situated in a culture of contradictions. It is almost impossible to shield the women who had hysterectomies from observing and comparing themselves to other women either within or outside the hospital who they assume have intact wombs. Many of the participants were also concerned about the limited information they had on hysterectomy and its complications. Professional support in providing critical information to enlighten them on their concerns might help. This seemed to be lacking, inadequate or ineffective.

Previous studies (e.g., Hoga et al., 2012; Richter et al., 2000) reported that women who had hysterectomies believed that most husbands lacked basic knowledge or even had negative perceptions of hysterectomy and were unable to provide adequate emotional support to their spouses. The women in the present study also complained that they did not receive adequate information about hysterectomy and that their spouses did not provide adequate emotional support and care. Some of the women sought assistance from other women who had previously had a hysterectomy. This context portrays the tension the women experienced. Psychological intervention could reduce the length of stay and anxiety among women who underwent surgery (Xie et al., 2022).

The concern for healing and improvement of the life experiences of women who underwent hysterectomy for uterine prolapse, at least in Southeast Nigeria, seems to require both medical and psychological care that would impact their peculiar care needs. The psychological care component seems to be lacking among the participants in this study. This could be a deficiency in the management of patients who had hysterectomy. Further research is therefore required in this area, and the attention of concerned medical teams is also drawn to this.

Notwithstanding the findings, this study has probable limitations. The percentage of potential participants who did not meet the inclusion criteria for this study is extensive. They might differ in yet unknown ways from those who participated. In addition, the interviews in this study were conducted some months after the women had the surgery. It is possible that time-related changes in their post-surgery experiences were missed in this study. Future studies may consider a longitudinal design.

Conclusion

Removal of the uterus to manage uterine prolapse was very problematic among women in Southeast Nigeria. They considered the uterus to be central to womanhood. The women expected more empathy from their spouses about hysterectomy, although the women themselves had limited knowledge about the treatment. Clinical nurses and other health team members, therefore, need to provide more apparent knowledge about hysterectomy to the patients and include psychologists to target psychological care guidance that personalizes health education based on the women's individual needs and concerns and work with their families to help them cope with life without a uterus. Pre- and post-hysterectomy counselling by competent professionals would be beneficial to them. There is also a need to create self-help groups for women who underwent hysterectomy and improve public awareness about hysterectomy.

Availability of data and materials

The study dataset is available from the corresponding author following institutional approval.

Funding

This work did not receive funding beyond the contributions of the authors.

Conflict of interest

The authors report no potential conflict of interest.

Acknowledgements

We are grateful to the participants for sharing personal information and their time for this study. We also thank the NOFIC staff and management for facilitating this study.

Authors' contributions

PNE, ILO, **JEO**, **PNI**, and **JEE** designed the study; **JEO** selected the participants; **PNE** interviewed them; ILO, PNI, CHU, and AOA interpreted the interview transcripts; PNE, JEE, and EWO analyzed the data; and PNE, ILO, JEO, PNI, JEE, and **CHU** prepared the initial draft of the manuscript.

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