

Identity Constructions at Hysterectomy: Black Women's Narratives

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Abstract

Conscious and repressed power differentials between healthcare providers and patients have influenced women's experiences of hysterectomy. A critical outlook that focuses on intersectionality and power relations of the body has provided evidence that Black, under-resourced, and currently oppressed women's reproductive organs have been neglected. The current inquiry gathered narratives of five Black women from both private and public health facilities who had a hysterectomy before the age of 52. Their narratives of identity before and during hysterectomy were ascertained. The findings revealed negative experiences resulting from severe symptoms before hysterectomy and exposed complex negative and positive multilayered structures related to power and dominance during treatment. Insight into the challenges and benefits of hysterectomy on womanhood identified several key recommendations for providing a more nuanced perspective to enhance women's gynaecological health.

Keywords: hysterectomy; intersectionality; narrative inquiry; decision-making

Introduction

The medical context has traditionally given scant consideration to the complex reciprocal influences of hysterectomy. Partial consideration is due to the medical field's mechanistic and reductionist understanding of the human body, in which parts can be removed and disposed, if they malfunction (Lupton 2003; Markovic, Manderson and Warren 2008). Davis (2009) argued that the decision to undergo this very costly, painful, and life-changing procedure can have an influence on women's gendered identity. Gendered identity has been closely linked to reproductive organs. The removal of these

organs may influence the way women and societies define womanhood (Deaux and Major 1990; Solbrække and Bondevik 2015). The value attached to women's reproductive organs, specifically their uteri, has led to women being referred to as "womb-men" (Carroll 2004). In isiXhosa the uterus is called *isibeleko*, which directly translates to carrying a baby. The uterus has therefore been romanticised as a symbol of womanhood (Collis 2005). Tamale (2016, 120) stated, "there is considerable power reposed in the function of reproduction, which is the direct consequence of possessing a womb." This constructs the assumption that a woman who has this organ should be able to carry a baby and automatically have the ability to give birth. Fredericks (2013) argued that the meaning a woman associates with her reproductive organs shapes her identity, her illness identity, and the decisions she needs to make concerning her treatment.

Women's experiences of their bodies are socially and culturally produced (Lorber and Martin 2011; Wolff 1990). Collis (2005) argued that women's experiences of hysterectomy are not only informed by the dominant modes of thinking about the body, but also need to be understood within the women's socially ascribed identities and the way in which these change across the lifespan. Butler (2006, 67) argued that the body is not passively scripted with cultural codes, as if it were a lifeless recipient of wholly pre-given cultural relations, and neither do embodied selves pre-exist the cultural conventions. These cultural understandings have shaped ideas about women's bodies, including the uterus (Markovic, Manderson, and Warren 2008). Therefore, the uterus carries great cultural and personal significance (Elson 2004).

Societal structures often perpetuate patriarchal practices. Men's patriarchal control has dominated medicine and devalued women's bodies (Elson 2004). Davis (2009) called patriarchal dominance a form of gender violence and claimed that women have been victimised by hysterectomy. Medical decisions were often made on women's behalf due to their lack of knowledge, poor education, and limited access to medical services (Bower et al. 2009). In a similar way to the American women in Bower et al.'s study, Irish women tend to hand over the responsibility of their reproductive health to individuals with epistemic authority (doctors, consultants, and midwives), people they consider to be trustworthy knowers and who are seen to have expert knowledge in their field (McCarthy, Murphy, and Loughrey 2008). Elson claimed that women themselves do not always think about the significance and the influence of the uterus until they are faced with a crisis, big or small. It therefore seems that women do not always know much about their bodies.

The study of hysterectomy has been focused on medical knowledge wherein women's bodies are mechanised (Markovic, Manderson, and Warren 2008; Tamale 2007), with little research dedicated to psychosocial effects and financial implications (Collis 2005; Essack and Strode 2012). Despite hysterectomy's high prevalence in developed countries, hysterectomy and its social meanings have been largely ignored by social researchers concerned with gender and embodiment (Markovic, Manderson, and

Warren 2008). Intersectionality has been used as a comprehensive theoretical frame to address the relative absence of a psychosocial perspective. Intersectionality, as a theory, recognises and acknowledges the interconnected structures of race, gender, sexuality, class (Nash 2008), culture, economy, power (Das Nair and Butler 2012), and many others that are at play when women make decisions about their health. The use of intersectionality as a lens offered a broad understanding of women's struggles in navigating health decisions in a health provision sector dominated by power relations that elevate social inequality and economic disparities. It also framed an understanding and treatment of women's health concerns that cannot be distanced from the political and power dynamics that Black South African women face in their daily lives.

This study investigated the intersecting influences of hysterectomy, a medical phenomenon, as a contextual, dynamic process that interplays with different areas of a woman's life. The prevalence of hysterectomy is growing in developing countries (Butt, Jeffery, and Van der Spuy 2012; Wandabwa et al. 2013). Butt, Jeffery, and Van der Spuy (2012) indicated that South Africa (SA) has an escalating incidence of hysterectomy, hence the need to investigate it within the South African context. The study explores power constructions related to women's health and underlines the need to acknowledge multiple implications of hysterectomy. If we are aware of the complex multiple positive and negative intersecting influences of hysterectomy that would render a woman's life changed, we will be able to plan ahead and ensure that we embrace the positive aspects while also avoiding a myriad of negative consequences on women's experiences, through consideration of the findings of the current study.

Conceptual Understanding

It would be defeatist to view women from one perspective, the gender perspective, as their reproductive health interrelates and intersects with many other aspects of their being. In Black women's everyday lives, race and gender are not analytically exclusive; they work together (Collins 2009). African feminists are keenly aware of the intersection between the human body, gender, and politics (Tamale 2004). The close connection between gender, sexuality, culture, and identity requires that African feminists work within the specificities of culture (Tamale 2007). It is therefore important to utilise a framework that would accommodate these interconnections, and intersectionality affords us the space to do so.

Intersectionality challenges the pull of prevailing mindsets, in part by drawing from political expectations, lived experiences, and analytical positions not crafted solely within the bounds of dominant medical imaginaries (May 2014). Intersectionality touches on the most pressing problem, the long and painful legacy of feminist exclusion (Zack 2007). May claimed that intersectionality entails thinking about social reality as multidimensional, lived identities as intertwined, and systems of oppression as "meshed and mutually constitutive" (2014, 96). Crenshaw (2001) argued that intersectionality is what occurs when a Black woman tries to navigate the main crossing in the city. The main highway is the "racism road." One cross street can be Colonialism, then Patriarchy

Street. A woman has to deal not only with one form of oppression but with all forms, those named as road signs, which link together to make a double, triple, or multiple layered blanket of oppression. Lykke (2010) argued that analysing the crossroad is essential, however acknowledging that roads meet but split into separate directions before and after they meet is more essential.

Shields (2008, 301) stated “individual’s social identities profoundly influence one’s beliefs about and experience of gender.” An individual’s social location as reflected in intersecting identities must be at the forefront in any investigation of gender. Davis (2008) asserted that intersectionality fits neatly into the postmodern project of conceptualising multiple and shifting identities. It seems to embody commitment to the positioning of knowledge, promising to enhance the theorist’s reflexivity by allowing her to incorporate her own intersectional location in the production of self-critical and accountable feminist theory. Davis added that intersectionality took up the political project of making the social and material consequences of the categories of gender/race/class visible, but it does so by employing methodologies compatible with the post-structuralist project of deconstructing categories, unmasking universalism, and exploring the dynamic and contradictory workings of power. Intersectionality highlights three key points—making visible multiple identities, which are relevant in daily life, and acknowledging that this does not happen in a power vacuum (Das Nair and Butler 2012).

Intersectionality acknowledges differences between and within women (Davis 2008), which are endless (Ludvig 2006). Meer and Müller (2017) argued that it is the intersection of multiple identities that influences individual worldviews and life chances differently than would any single form of social stratification. Meer and Müller further argued that intersectionality comports with postcolonial and post-structural ways of thinking about power relations, and has dismantled the unitary notion of women to include various co-constructed identities, significantly race and social class that shape relative power. The emergence of the concept is closely linked to anti-racist and postcolonial feminist struggles that create platforms for the analysis of the intertwining of processes of genderisation, racialisation, and ethnification (Lykke 2010).

Intersectionality embraces the notion that subjectivity is constituted by mutually reinforcing vectors of amongst others, race, gender, class, sexuality, ethnicity, age/generation, dis/ability, nationality, and mother tongue and has emerged as a primary theoretical tool designed to combat feminist hierarchy, hegemony, and exclusivity (Nash 2008). Intersectionality is an analysis which claims that these systems “form mutually constructing features of social organization, which shape Black women’s experiences and, in turn, are shaped by Black women” (Collins 2009, 320). “In Africa, when the backlash is placed against the backdrop of political monopoly, economic deprivation, poverty, violence, displacement, adjusting economies and globalization, the crisis multiplies tenfold” (Tamale 2007, 156).

Patriarchy and capitalism have many tools at their disposal to create and maintain gender roles and relations in our societies (Tamale 2004). These colonial social constructions consciously or unconsciously inform the treatment afforded women, especially women with complicated gynaecological conditions. Women's bodies constitute one of the most formidable tools for this purpose. Tamale argued that if one imagines the body as a blank slate at the time of birth, culture then proceeds to inscribe rules, images, symbols and even hierarchies that give shape and character to that body. Although the texts that culture inscribes on African women's bodies remain invisible to the uncritical eye, it is in fact a crucial medium for effecting social control. Through the reproductive and sexual control of African women's bodies, their subordination and continued exploitation are guaranteed.

Most Black women are raised in patriarchal contexts and have been oppressed and silenced by society over generations (hooks 2000; Qunta 1987). Hence, "women have long been treated as the voiceless subaltern" (Kolawole 2004, 253). They are silenced concerning their bodies and their sexuality. The silencing of women's sexuality is not limited to a lack of conversations about the topic, but is also inclusive of restrictions in performances and embodiment of sexualities (Gigaba 2012; Kolawole 2004). While silence can work to reinforce oppression, it can also be a tool of resistance and struggle, especially for the marginalised (Tamale 2004). Kolawole states that there is an assumption that African women's refusal to speak loudly about oppression and inequality signifies an acceptance of marginality and minimalisation. Motsemme (2002) provided a cautionary note and stated that while acknowledging that speaking is imperative for women, we need to be aware that those who are the most marginalised have often used invisibility and silence as a means to protect themselves.

Oppression involves the unjust distribution of power, and healthcare settings appear as "sites of very uneven power differentials" (McLeod and Sherwin 2000, 267). McLeod and Sherwin further argued that oppression tends to deprive a person of the opportunity to develop some of the very skills that are necessary to exercise autonomy by restricting her opportunity to make meaningful choices and the experience of having her choice respected. Hence, it is not sufficient simply to offer a woman an uncoerced choice; it is also necessary to ensure that she has had the opportunity to learn to exercise choice responsibly, as illustrated by the following quotation (McLeod and Sherwin 2000, 269):

To devalue women who clearly have reached a certain maturity is to devalue important aspects of all women's lives. It reflects a value system that cares more about women's appearances than their wisdom or experience; in such a system, women are valued more for their ornamental role than for their personhood.

McLeod and Sherwin (2000) postulated that it is widely agreed throughout the biomedical healthcare community that patients should make autonomous decisions about their healthcare to the greatest degree possible. Where autonomy lacks, the healthcare system has responded to patients by exercising paternalism, making decisions on behalf of patients without their full consent. McLeod and Sherwin observed

that even the most independent and self-reliant patient often feels overwhelmed and is inclined to defer to medical authority when facing serious health matters. It may seem appropriate to exercise paternalism to ensure the best possible care especially for those patients whose autonomy is suspect for any reason. Wing (1990, 194) stated,

we, as Black women, can no longer afford to think of ourselves or let the law think of us as merely the sum of separate parts. ... The actuality of our layered experience is multiplicative. Multiply each of the parts together, one x one x one x one, and you have one indivisible being.

Intersectionality allows us to include in our analysis the woman's context, her cultural selves, and the beliefs and scripts she walks with into the gynaecologist's rooms. It provides us an opportunity to understand the internal and external processes that a woman experiences: her ability to understand the medical condition and the proposed treatment, her anxieties and concerns, her financial standing, and her preparedness to make the right and informed decisions. The open-mindedness of intersectionality is critical in examining the uncharted landscape of Black South African women's narratives of hysterectomy, identity, and womanhood. Turner (1992) and Elson (2003) asserted that to change women's embodiment, the material body, is to change their identity, the social body. The intersectional prism was used to excavate and expose multilayered structures of power and domination (Cho, Crenshaw, and McCall 2013) by adopting a narrative inquiry approach that influenced the thematic analysis of the narratives. The acceptance and/or rejection of intersectionality as a theory is an ongoing debate. Davis (2008) argued that the vagueness and open-mindedness of intersectionality may be its very success.

Methodology

The study followed a qualitative, interpretive research methodology. Non-probability sampling was utilised to access relevant participants living in Port Elizabeth. Purposive sampling was used; a list of potential participants was received from a public health facility after all ethical clearances had been obtained. As only one woman from the list gave permission to be interviewed and other potential participants refused to share their narrations, an additional sampling method, snowball sampling, added four new participants to the study.

All five participants met the inclusion criteria of having undergone partial or complete hysterectomy for both benign and malignant conditions, before the natural age for menopause of 51.4 years (Louw and Louw 2009). Furthermore, they were all post-operative for a period of 3 months or more at the time of their interviews. Their average age was 53 years with an average of 43.4 years of age when they had the hysterectomies. All had at least a matric qualification, and two had postgraduate education. The five participants were from Black ethnic groups, four African women and one Coloured woman.

Data were obtained by means of a reproductive health history profile and in-depth individual interviews. The health history profile adapted from Augustus (2002) detailed the women's medical history, reason for hysterectomy, age at the time of hysterectomy, information regarding children, and other related questions. Besides this information, they also provided knowledge regarding their decision-making processes, their social networks, and information regarding their contact with health professionals. Conversational in-depth individual interviews were conducted. The interview began with "Can you please tell me the story of your hysterectomy?" The question allowed for maximum inductive participant data gathering and therefore richer narratives to be composed. All interviews were audio-recorded. For further preservation of the data, a Livescribe 3 Smartpen was used to write and record the narratives.

Thematic analysis was used to analyse the data. Four of the five interviews were conducted in isiXhosa. These were translated into English and back translated into isiXhosa by independent translators, to ensure the intended meaning and validity of the data. Both translated versions were read for further validation and to identify common and key codes and themes. Open coding was the initial step and helped to generate representative statements and identify similarities and contradictions. Identified codes were recorded in the code book. For further verification, Atlas.ti: The Knowledge Benchmark Version 7 (2004) was used for data management and retrieval, the creation of codes and themes, and the creation of network views, which provided pictorial displays and connections between the different codes and themes. To increase the reliability of the inquiry an independent coder who utilised NVivo was appointed. The use of an independent coder was to test the rigour of the study and to provide for inter-coder reliability (Seale and Silverman 1997). An inter-coder agreement check was conducted in a meeting between the two coders, and inter-coder agreement was achieved. Several verbatim extracts are presented in order to retain the narratives and present the voices of the women without prejudice.

The women were assigned pseudonyms. Ethics of care governing the researchers, the awareness of the sociocultural contexts the women were situated in, and the sensitivity of narrating about reproductive organs, informed this decision. Openness to their felt and lived experiences meant that they would share the most emotive and intimate information. Collins (2009) identifies the appropriateness of emotions as an important concern to the ethic of care, as it indicates that the speaker believes in the validity of the statement.

Narratives of Hysterectomy

The narratives focused on the experiences before hysterectomy and during the procedure. Based on these findings, challenges and implications, and practice recommendations are suggested.

Experiences before Hysterectomy

The participating women narrated extensively about the severity of their symptoms, and the pre-operative decision-making process.

Severity of Symptoms

Contrary to dominant medical views informed by outdated literature, hysterectomy for most women reaffirmed their sense of femininity (Markovic, Manderson, and Warren 2008), which had been compromised by adverse and chronic health problems that left them isolated. Most of the women experienced symptoms that limited their functioning and the severity of the symptoms made the hysterectomies necessary to alleviate dysfunction and to preserve life. These findings were contrary to some of the conclusions drawn by both Elson (2004) and Davis (2009) who identified hysterectomy as victimisation and violence. The contradiction could be based on the difference in sample types, the participants' symptomology, race, class, education levels, nationality, and other forms of positioning.

The most prevalent medical reasons for hysterectomy were abnormal uterine bleeding, cervical cancer, cysts, endometriosis, and fibrosis. Some of these reasons concur with those proposed by Butt, Jeffery, and Van der Spuy (2012) who observed that the most common indication for performing hysterectomy among South African women was fibroid-related menorrhagia, followed by abnormal uterine bleeding. Women stated that most of the hysterectomies were performed for benign conditions and to prevent the occurrence of malignancy; they were viewed as life-saving experiences.

The symptoms leading to the procedure for some of the women were either self-diagnosed, which led to misdiagnosis and/or delayed consultation with medical healthcare services. The women downplayed and largely ignored the severity of their symptoms. Abramson (2010) argued that if health is underreported, the full effect of hysterectomy on women's health goes unrecognised. Those most vulnerable, the poor, less educated women (Bower et al. 2009), continue to be at risk for procedures that can adversely affect their long-term health. The women in this study waited for the medical dysfunction to increase and become a crisis, confirming Elson's (2004) claim. Augustus (2002) observed that negative connotations, like invisible stigma, have led many African-American women to delay having a hysterectomy until physical symptoms force them to have the surgery. The link made by Augustus between negative connotations, invisible stigma, and delays in intervention was not true for some of the women in this study. For example, Mandisa referred to herself as "strong" and a person who "endures." Her delay in consultation could therefore have been a sign of resilience, a form of coping. Zoey, on the other hand, was conscious of the potential stigma and took several decisions based on what people would think, how her husband would experience her sexually, and how people would behave towards her after knowing about her hysterectomy. Zoey's experiences seem to confirm Tamale's (2004) notion that

texts that culture inscribes on African women's bodies remain invisible to the uncritical eye; her focus on what people think could be contributed to the effects of social control.

Decision-Making on Hysterectomy

Decision-making was described as a pattern of women postponing and weighing the risks and benefits of surgery with variables from the biophysical, psychological, sociological, and spiritual domains (Williams and Clark 2000). McLeod and Sherwin (2000) argued that it is widely agreed throughout the biomedical healthcare community that patients should make autonomous decisions about their healthcare.

Mandisa had no difficulty accepting the news of the hysterectomy, due to the extent of her ill-health. The conclusions drawn by the consulting team of gynaecologists and training medical teams of "young doctors" made her decision-making process quick and easy. The extent of her ill-health is summarised in this comment:

I was even pale with low blood supply, when I arrived [at the hospital] they gave me 9 pints which made me stay longer ... I stayed for a week without being operated on ... Why would I keep something I do not know? Then end up with cancer ... I initially thought I could remove fibroids and keep the womb.

After her diagnosis of cervical cancer, Lindo had to make a quick decision and was given a week to indicate her preference on options provided. Before the diagnosis, Lindo and her husband had decided that their two children were all they would have and that the husband was to have a vasectomy. The factors of marital status and motherhood reinforced the decision for hysterectomy for the couple. There were emotions that accompanied the decision-making process: Lindo told of her disbelief and shock at the diagnosis. She received proper consultations from her gynaecologist on alternative approaches. Lindo explained,

I made a decision of having the major operation so I could be on the safe side and be certain that the cancerous cells have been removed thus there is no possibility of them developing again or the uterus being affected.

Upon consulting with both her GP and gynaecologist, getting her diagnosis and realising that there was "something wrong," Bulelwa took action. "The state of the uterus got me to make the decision ... within the same week I had to do the operation." She carried a number of questions and emotions around and stated,

when you are afraid of cancer being on both organs [breasts and uterus] you think of your mortality, and your child, you become depressed, ... but you face the world smiling, at night you think about the operation, how it is going to affect you, is it going to be successful?

Bulelwa was the only participant who sought a second opinion. Her higher education, seniority at work, and having medical aid cover allowed her to question the diagnosis,

positioning her differently to other participants. Sociocultural factors such as education and the concept of the feminine role held in a particular culture play an important role in the cognitive representations of hysterectomy. Bulelwa holds strong views on hysterectomy, identity and womanhood and was able to express these with her medical consultants.

Lucy was in the care of a private doctor whom she trusted and with whom she shared similar ethnicity and religious values. She had been single when she had her child and had no intentions of having more children. She had no regret as the decision was an emergency and she had to consult the doctor urgently:

He said you come in right away. I went and he did an internal examination, even though I was bleeding like that ... He told me this has to be done immediately, because he doesn't see myself suffering like this anymore.

Zoey on the other hand found the decision difficult to make. After she had missed her annual Pap smear and was diagnosed with fibrosis, she took a year to make the decision. She reported that her health condition forced her to make the decision and she had no time to think. She spent the year thinking about the procedure and its implications. The information she had was limited and based on what she had heard, which was mostly based on myth and derogatory statements made in the community. She explained,

I was not ready to do it, however while waiting, I met a friend who confirmed that she had done it, she said it would be okay to do it.

The decision-making process for these women came with a number of negative emotional experiences, for example, feeling depressed and anxious, developing an inability to sleep, overthinking, and shock. Even so, the women in this study opted for hysterectomy and in cases where an alternative was offered they still chose hysterectomy. There were mixed reactions to medical care. The trust shown by Mandisa, Lucy, and Lindo in their gynaecologists was different from those who were more sceptical of their medical health providers. The race and gender of medical practitioners seem to have influenced the experiences of such women. Even though the women in this study were not coerced, they were not always afforded the opportunity to make a responsible decision (McLeod and Sherwin 2000). The literature indicates that most Black women carry a historical legacy of racial discrimination, which results in limited interactions, communication, and familiarity between racial groups. They carry generational sterilisation abuses and exploitation of women's reproductive capacity. The historical experiences of racial discrimination may create elements of mistrust, fear, and the second-guessing of medical recommendations.

Experiences during Hysterectomy

Because of delays in the decision-making process, the women told of their haste to have hysterectomies performed. Once the decision to remove the uterus had been taken, the

women narrated their experiences while in the care of medical healthcare professionals. As an unemployed woman, Mandisa had to rely on the public healthcare system. She had an unpleasant experience at admission when she had to wait for a period of about 20 hours after her examination at the emergency unit before being admitted to a ward. This experience took place after two visits at a primary healthcare clinic. The wait reminded her of losing her aunt while waiting for an admission in an overcrowded and badly resourced public healthcare facility. The wait evoked anxiety that death could recur in her family. Her procedure was planned for the following day. Seemingly, the initial examination was not all-inclusive and once in the ward further tests had to be conducted. Her procedure was delayed by a week as she had to get blood transfused and had to be treated for high blood pressure. Within this facility, there is a tendency to enhance healthcare resources with young trainee doctors who may be inexperienced.

Even though Lucy was medically insured and was attended to by a private medical team, she had to receive her care in a public healthcare environment because she could not secure a timely booking at a private healthcare setting. Being in the care of a private gynaecologist, she could jump the queue and receive immediate care, a privilege earned by the few who can pay. She said,

so I went to Provincial on Sunday, I was operated on the Monday and during the operation my appendix was damaged and he had to remove that as well. Look it was a complete hysterectomy he had to remove the ovaries.

Bulelwa, Zoey, and Lindo had medical aid insurance and as middle-class women they were able to access private healthcare. They are among the 16% of the SA population that has access to 70% of doctors who work full-time in the private sector (Mayosi and Benatar 2014). Bulelwa reported that “they removed everything because they feared that the damage would cause cancer.” Bulelwa had two operations conducted at the same time, the hysterectomy, and the removal of lumps from her breasts. Her medical aid insurance, her education, and her personality enabled her to buy the time to ask the doctor questions. She narrated that,

firstly, before I removed them I asked the doctor the extent of the growths, the level to which they had reached and their danger to my life and the doctor said they had really progressed and were huge, they need to be removed ... I had to do total hysterectomy.

Lindo had a partial hysterectomy. She reported to have received excellent care. In her words, “they only removed the uterus and they explained that they won’t remove the tubes and any other part except the uterus itself. The operation itself was highly successful.”

Zoey had a partial hysterectomy. She remembered that before they anaesthetised her she heard her gynaecologist say “total.” She enquired and reminded the doctor of the decision to remove only the uterus during consultation. The statement made by the doctor left her more anxious, however she got the gynaecologist to reassure her that he

would only remove the uterus. Before they could operate, they had to return her to the ward as she was anaemic and very anxious. She was given a blood transfusion and returned to theatre for the operation the following day.

The women in this study were exposed to different types of hysterectomies, but all had abdominal procedures. However, they did not know the finer details of the procedures performed. They narrated vague explanations of the techniques used, but were clear about the influence of the procedure and the gains they experienced from their hysterectomies. The varied experiences of these women, challenges and implications of care were identified.

Identified Challenges and Implications in the Provision of Gynaecological Health

Table 1: Challenges and implications

<i>Challenges</i>	<i>Implications</i>
<i>Concerns about medical practice</i>	<i>Suggestions for medical practice</i>
Over-reliance on young, inexperienced trainee doctors.	Employment of a range of healthcare providers with varying levels of experience within the public healthcare sector would improve waiting periods and provide advanced care.
Unjust distributions of power in relation to healthcare providers due to social constructions.	Gynaecologists need to consider the multiple intersecting vectors and consciously bridge socially constructed barriers.
Silencing of women and their acceptance of this position portrays them as incompetent victims.	Women have accepted being muted and are passive recipients of healthcare. Gynaecologists could therefore adapt their communication strategies, assume an active role in dialogue, encourage interactions, and build more open doctor-patient relationships.
Scientific and inaccessible information provided to patients.	Easily available and accessible information regarding women's health is sorely needed. The provision of accurate information accompanied by diagrams and pamphlets would benefit patients.

Solution-driven healthcare provision limits opportunities for conversations about patients' emotional states.	Where gynaecologists are not forthcoming with information, women access alternative resources. These resources may exacerbate their emotional states. Referrals to counselling will assist those battling with negative emotions.
Consultation times are limited to 15 minutes; this limits communication and eliminates exploration.	To compensate for the short consultation times, follow-up consultations with allied healthcare providers would allow women time to confirm their diagnosis, and gain clarity about their conditions. Cost of services might limit these consultations.
<i>Concerns for women</i>	<i>Suggestions for women</i>
Women make ill-informed decisions about gynaecological health.	Deconstructing cultural perceptions and holding open conversations about gynaecological health could be incorporated in all socialisation spaces to help remove stigma and to empower women and young girls in understanding their bodies.
Socially and/or economically disadvantaged persons generally do not seek information.	Educating and empowering the girl-child leads to more active participation in adulthood. Alternatively, giving consent to significant others and including them in consultations could demystify information.
Challenging decisions made on women's behalf and insisting on clarity from their <i>distant</i> gynaecologists.	Forming mutually respectful relationships between providers and all patients is essential to care. Feeling valued and respected could lead to more active participation.
Discerning and filtering information.	Empowering selves through reading and conversing with experienced others.
Lack of reliable life resources to use of own experiences with hysterectomy as empowerment tools.	Support groups of women who have had hysterectomy are needed. These platforms managed by trained personnel could fill information gaps.

Conclusions

Previous research presented medical data with limited and contradictory information on psychological, social, and financial implications of hysterectomy. The use of the narrative approach registered these women's experiences with hysterectomy and

highlighted their different worldviews, and their dynamic and shifting identities informed by their contexts. The decision-making process vacillated between indecision, delayed decisions, and pressured decisions. The women had different types of hysterectomies: some underwent radical total hysterectomy, others feared and refused sudden decisions about total hysterectomy, while others underwent partial hysterectomies. The women reported both negative and positive experiences with the medical healthcare professionals. High levels of care were reported in both private and public healthcare centres, especially the care provided by nurses. Factors such as social standing, financial positioning, and employment status contributed to both positive and negative experiences of the participants. The older the woman, the higher the education level, the better the ability to challenge opinions offered and to have mutually positive interactions with medical personnel. These symbols of power influenced the experiences of the participating women. Information from trustworthy knowers and education were seen to eliminate forced and artificial impressions of hysterectomy on womanhood. Voices of healthcare providers were not recorded in this study. For future research, healthcare providers should be included to test the challenges and implications identified.

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