


The Voices of Black South African Men on Renal Dialysis at a Tertiary Hospital: A Phenomenological Inquiry

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Abstract

The study explored the psychosocial experiences of rural black South African men undergoing renal dialysis in a tertiary hospital. Twenty men aged between 20 and 59 years ($Mean_{age} = 40.65$ yrs; $SD = 12.52$) participated in the study. Participants were recruited purposefully. Data were collected over a period of 4 months through in-depth face-to-face interviews and analyzed using the Interpretative Phenomenological Analytical method. The following three key themes were extracted from the interviews: (a) the emotional pain and fear of death following a diagnosis of ESRD; (b) living on dialysis interferes with the management and handling of “manly” responsibilities and duties and, (c) dialysis as a challenging yet life-saving measure. The findings further suggest that renal dialysis has an impact on men's sense of masculinity and has the potential to complicate the management of renal failure. The paper concludes by recommending that cultural and community factors be taken into account when considering interventions to manage the health of men living with renal conditions.

Keywords

renal dialysis, end stage renal disease (ESRD), masculinity, South Africa (SA)

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Chronic kidney disease (CKD) is a global public health problem that affects over 7.5 million people worldwide (Bikbov et al., 2018). In South Africa, it has been estimated that CKD affects about 10% of the population (Meyers, 2015), with 10,744 people reported to be on treatment for the disease in the country (Davids et al., 2019). A major complication associated with CKD is end-stage renal disease (ESRD) (Sadala et al., 2012). A form of treatment for people with ESRD is dialysis (Meyers, 2015), which is a medical procedure that entails the removal of excess toxins and water from the blood (Vadakedath & Kandi, 2017). A 2017 South African Renal Registry report suggested that over 9000 patients were on dialysis, with 2000 undergoing dialysis in public hospitals, and about 7000 in private health institutions (Davids et al., 2019). The South African health care system is comprised of two distinct health sectors that are characterized by inequalities—these are, the public and private sectors (Etheredge & Fabian, 2017). The former, which is under resourced, is government funded and services nearly 90% of the population especially the

historically oppressed and under-privileged blacks. In contrast, the well-resourced private sector, is accessed by the remaining 10% of the population, that is, the part of the population that do afford to buy medical aid insurances, and these are the middle class, the emerging political elite, and the historically privileged white populations (Etheredge & Fabian, 2017; Jardine & Davids, 2020). The low number of dialysis patients in South African public hospitals is attributed to the lack of human and renal dialysis resources when compared to private institutions (Davids et al., 2019). For people in disadvantaged rural communities, their access to renal dialysis is even more concerning owing to their poor socioeconomic

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status (Kilonzo et al., 2017). According to Jardine and Davids (2020), the lack of access to dialysis centers in such rural communities may result in some of the patients dying without being diagnosed. In spite of all of these reports, there's scarcity of empirical research with people on ESRD, especially black men from rural and disadvantaged areas.

There are two commonly used dialysis services, namely hemodialysis (HD) and peritoneal dialysis (PD). A patient on HD has to visit a dialysis center or hospital at least three times per week for four hours, which is an average of 12 hours per week (Malatji et al., 2019). Comparatively, patients on PD are required to self-dialyze at home for 30–45 min, four times per day. This means that a patient will spend on average 21 hours per week on dialysis. The eligibility criteria for HD or PD depends on numerous factors, including the level of knowledge about the disease, the patient's formal education, desire in life, place of residence, and distance from the dialysis unit (Sinnakirouchenan & Holley, 2011). Most people in rural areas lack knowledge of kidney disease and related services and thus often seek healthcare services late and when complications have already occurred (Kilonzo et al., 2017; Malatji et al., 2019; Meyers, 2015). When some of the highlighted challenges are taken together with the number of hours required to dialyze and the distance travelled to accessing dialysis services, rural patients often default on their treatment.

Empirical studies have reported on numerous challenges faced by men on either HD or PD. Apart from commonly reported challenges such as having to be dependent on dialysis, physical and psychological health problems, and financial constraints (Bruce et al., 2009; Hashemi et al., 2018), men have also been identified to also experience intimate relationship problems (Edey, 2017). Most reported are sexual problems ranging from low sex drive, erectile problems, orgasm difficulties, and infertility (Aleksaite et al., 2019; Kidney Health Australia, 2016). Some of the ensuing sexual problems could compromise the affected men's sense of manhood (Bailey et al., 2018), leading to a number of psychosocial problems (Courts & Boyette, 1998; Davison et al., 2015). Studies from some Africa countries such as Nigeria and Ghana have identified men on dialysis to experience poor social and psychological health (Agaba et al., 2017; Ganu et al., 2018). Poor mental health in particular, could impact on the disease management, and therefore, predispose the affected men to medical complications (Bruce et al., 2009; Hashemi et al., 2018; Neugarten & Golestaneh, 2019). In essence, understanding men with ESRD's mental health and socio-economic challenges and more importantly, their masculinities (Rees et al., 2018), becomes an important management issue for scrutiny.

Masculinities are understood as norms and expectations related to what men say and do to be men (Gutman in Ammann & Staudacher, 2021). Masculinities are amenable to change secondary to a dynamic interplay of several factors (Ammann & Staudacher, 2021); while with changes that may imply the loss of "manhood" and "sense of control" (Canham, 2009), a situation possible with men on ESDR, suffering is inevitable. Positive masculinity has been associated with high self-esteem and psychological well-being (Burns & Mahalik, 2008; Reilly et al., 2014). To enhance positive masculinity, men tend to assume social roles or responsibilities which are traditionally perceived to entrench a man's sense of manhood (Connell & Messerschmidt, 2005), that is, being in control, decisive, independent, and competitive. The conceptualization of masculinity is relative to culture (Griffith, 2015), thus for men in the current study, their notions of manhood might be shaped by their cultural beliefs and experiences. For instance, in traditional African communities a "real man" is one who is seen to be a capable provider, protector, able to satisfy the needs of a woman sexually, and contributes to the welfare of the community by participating in communal activities (Minga, 2016). Such a "manly identity" is highly regarded in African communities, as it leads to men feeling respected in their communities (Douglas & Maluleke, 2018; Siweya et al., 2018). Unfortunately, men who are on renal dialysis often struggle to live up to the cultural standards of a "real man" suggesting that mental health problems may ensue (Chironda & Bhengu, 2019). For instance, compromised masculinity secondary to poor sexual performance and diminished social roles are commonplace in men on ESDR (Burns & Mahalik, 2008; Diaz-Medina, & Mercado-Martinez, 2019; Kerklaan, et al., 2020; Rees et al., 2018). While there exists a number of studies on the impact of ESRD on African American men in the United States of America, including diminished masculinity (Burns & Mahalik, 2008; Evans et al., 2011; Golestaneh et al., 2021; Sanders, 2020), very few such investigations have been on men in the African continent (Agaba et al., 2017; Govender, 2012). Such a diminished sense of traditional masculinity creates shame and may lead to poor psychological adjustment (Govender, 2012). Another complication may come in the form of the affected men abandoning their much needed treatment once they feel that their "manly identities" are threatened (Chironda & Bhengu, 2016; Etheredge & Fabian, 2017; Khunou, 2013).

In the light of management challenges accompaniment threatened masculinities in ESDR, studies on the experiences of black South African men on renal dialysis, especially those focusing on their masculinities are generally lacking (Achempim-Ansong & Donkor, 2012; Chironda

& Bhengu, 2019). The present study sought to address this gap by exploring the lived experiences of rural black South African men on renal dialysis with a special focus on their “masculine identity.”

Research Method

Study Setting and Design

The population of the study comprised participants with ESRD either on HD or PD drawn from the Pietersburg Tertiary Hospital—the only public institution in the Limpopo Province (South Africa) with a renal dialysis unit. Limpopo Province is predominantly rural, with an area of 1,25,755 km, and has an estimated population of 5.8 million people, which is served by 42 hospitals, including the Pietersburg Hospital (Statistics South Africa, 2016). All the other hospitals in the province lack renal facilities and refer their renal patients for treatment and care to the Pietersburg Tertiary Hospital. Patients have to be put on a waiting list before they can be scheduled for dialysis. At times, patients have to make a return trip of up to 500 kilometres from their homes three times per week to access renal services at Pietersburg Hospital. A phenomenological research design, and in particular, the hermeneutic design was adopted for the present study. The design was considered appropriate for the present study since the intention was to describe and interpret the experiences of rural African men on renal dialysis (Matua & van der Wal, 2015; Smith et al., 2009). Phenomenological studies, particularly the hermeneutic type, seek to illuminate the human experience as it is lived within a particular cultural, social and historical context. More importantly, the hermeneutic design derives knowledge through describing and interpreting meanings embedded in people’s lived experiences shaped by consciousness, language, cognition, preunderstanding, and assumptions (van Manen, & Adams, 2010). Data were collected through in-depth face-to-face semi-structured interviews. This method is considered suitable for collecting high-quality data (Mathers et al., 1998) and is in line with phenomenological inquiry, especially when the topic under discussion is sensitive. The interview schedule was adapted from Smith and Osborne’s (2003) interview guide on interviewing patients on dialysis. Here below are sample questions that were asked to the participants:

- Can you give me a brief history about how your kidney problem from when it started to your beginning of dialysis?
- How does dialysis affect your everyday life (*prompt*: work, interests, relationships)?
- Has having kidney disease and starting dialysis affected how you see yourself?

Sampling and Recruitment of Participants

The participants (see Table 1) were chosen through a purposive sampling method. This strategy is based on the judgment of the researcher, the purpose of the study, and the knowledge of the participants about the study at hand (Babbie & Mouton, 2001). Purposive sampling “allows the researcher to select study participants based on similar experiences and knowledge of the phenomenon being studied” (Brink et al., 2012, p. 141). Twenty male participants ($Mean_{age} = 40.65$ yrs; $SD = 12.52$) who had been on dialysis for more than a year ($Mean_{dialysis} = 4.70$ years, $SD = 2.36$) and coming from rural parts of the Limpopo province were sampled for participation. Ten participants were on PD while another ten were on HD. All participants were men above 18 years who were medically stable, and without a formal diagnosis of any psychiatric condition. The choice of men with more than 12 months on dialysis was informed by Gerogianni and Babatsikou’s (2014) suggestion that participants in similar research should have been dialyzing for more than 12 months. The reason advanced by the two authors is that such participants would have gone through the initial processes of frustration, coping and adaptation with dialysis. The participants were referred from five rural districts (see Table 1 for demographic variables) in Limpopo Province, and were attending weekly dialysis sessions at Pietersburg Tertiary Hospital. To enhance our understanding of the phenomenon studied (Omona, 2013), the researchers targeted four men per district, resulting in a total sample of 20 men.

Procedure

To access the participants, the first author who is an experienced clinical psychologist approached the renal unit manager at Pietersburg Tertiary Hospital. The manager introduced the lead researcher to the renal unit staff members, including the nephrologist, renal unit coordinator and shift managers. The senior management oriented the lead researcher to the unit, including familiarizing him with patients’ dialysis schedules. A brochure containing information about the study and the researchers’ contact information was left at the unit for recruitment purposes. The senior staff management assisted with the recruitment of some participants. The lead researcher visited the unit weekly, introduced himself to patients in the waiting area and requested them to participate in the study. Those who were interested were asked to indicate the dates and times that would suit them to be interviewed. All interviews were conducted in the unit, except two that were conducted in patients’ homes. Before each interview could be initiated, the researchers obtained participants’ written consent. Data were recorded on a digital audio recorder. The interviews spanned between 45 and 90 min.

Table 1. Demographic Characteristics of Participants ($N = 20$).

	<i>N</i>	Mean	<i>SD</i>	Min	Max
Age	20	40.65	12.52	20	59
Duration on dialysis	20	4.7	2.36	1	9
Marital status					
<i>Single</i>	10				
<i>Married</i>	8				
<i>Divorced</i>	2				
Education levels					
<i>No formal education</i>	1				
<i>Junior certificate</i>	4				
<i>Senior certificate</i>	3				
<i>College certificate</i>	3				
<i>Under-graduate certificate</i>	3				
<i>Post-graduate certificate</i>	3				
<i>University/College student</i>	3				
Denominations					
<i>Pentecostal churches</i>	3				
<i>Missionary churches</i>	8				
<i>African independent churches</i>	5				
<i>African traditional religion</i>	4				
Employment status					
<i>Never been employed</i>	9				
<i>Employed</i>	2				
<i>Retrenched secondary to GMC complications</i>	9				
Type of dialysis					
<i>PD</i>	10				
<i>HD</i>	10				
Districts in the province					
<i>Capricorn</i>	4				
<i>Mopani</i>	4				
<i>Sekhukhune</i>	4				
<i>Waterberg</i>	4				
<i>Vhembe</i>	4				

The interaction with the study participants was emotionally draining for the first author who has also gone through dialysis. The author was reminded of his own emotional trauma, side effects and the negative impact of dialysis on his body. The first author managed the processes of interviews by developing and following an interview guide to avoid leading questions. He also used a journal to record his experiences of the interview process. When visiting the renal unit, the researcher notably observed that a high level of cohesiveness among participants and good social support given to the participants by the nursing staff. Some participants found the interview experience useful since they did not have an opportunity to share their experience of dialysis with anyone. On two occasions when the first author visited the renal unit, he was informed that some renal patients had passed on. This experience was experienced by fellow patients and staff members as painful.

Data Analysis

Audio-generated recordings were later transcribed and manually analysed using Interpretative Phenomenological Analysis (IPA), (Pietkiewicz & Smith, 2014). IPA follows four flexible yet rigorous guidelines in the sense making process. More importantly, IPA allows researchers to engage in a double hermeneutic process (Smith, 2011), that is, by going through the audio interviews and transcripts, the researcher tries to make sense of the participants' lived experiences while participants themselves are also trying to make sense of the same reality being investigated by the researcher (Tuffour, 2017). To make this process possible, four IPA guidelines were followed in the present study. Firstly, the 1st author repeatedly listened and read through each participant's transcript while taking notes. On each transcript, on the far right side, a text box was created which enabled the researcher to

capture his initial thoughts, observations and reflections during the initial phases of the analysis. Furthermore, the notes taken by the first author during the interviews, together with the reflections during team discussions, assisted in getting closer to participants' lived meaning making process relative to living with ESRD. The analyst ensured that he was careful and sensitive to the expressions of the participants when engaging in the analytical process to avoid misinterpretations of the data (Cassidy et al., 2011; Kacprzak, 2017). Furthermore, after gaining a general understanding of each participant's world including the noted impressions, the first author started a process of transforming the notes into emergent themes for each participant transcript. During this phase, the researchers analyzed key expressions associated with salient parts of the participants' lived experiences (Kacprzak, 2017; Pietkiewicz & Smith, 2014; Smith & Osborne, 2003). After this phase, emergent themes were then checked against each other while noting similarities and differences. The themes that were derived together with their related quotations were shared with the co-authors to review and refine. After the authors independently checked and reviewed the material, the authors had a virtual meeting to discuss the final themes while also considering comments and suggestions from secondary reviewers. The virtual meeting was intended to achieve common ground about the final themes generated from the analysis. The final themes adopted were revised about three times in order to capture the very essence of the participants' lived experiences with ESRD.

Trustworthiness of Findings

For quality purposes, central themes that were generated and interpreted by the first author were reviewed by the other two authors who are also clinical psychologists and experienced qualitative researchers. Secondary reviewers also strengthened the study through some of the analytically suggestions offered. The meetings held between the authors also helped in improving the study quality (Alase, 2017). Another quality factor was that the interviews were conducted by an experienced clinical psychologist who is also a researcher. Interviews were conducted in either English or the locally spoken languages (namely Sepedi, Xitsonga, and Tshivenda), depending on the preference of the participant. The transcripts that were in the local languages were later translated into English by an English language expert before data analysis. To ensure dependability, the second and third authors conducted a review to validate initial findings made by the first author. After this rigorous process, final themes were adopted. To strengthen the credibility of the study, participants' original quotations have been integrated in the report here below.

Findings

The following themes were drawn from data analysis namely: (a) The emotional pain and fear of death following a diagnosis of ESRD, (b) Living with ESRD interferes with handling of "manly" responsibilities and duties, and (c) Dialysis as a challenging yet life-saving measure. The results are presented and discussed below.

The Emotional Pain and Fear of Death Following a Diagnosis of ESRD

For the participating men, having been diagnosed with ESRD was described as an emotionally painful experience. The pain was described as mentally distressful, and was associated with feelings of anxiety, irritability, anger and sadness. Participant 20 who was 53 years of age on HD said "*it disturbed me mentally - I was not well mentally since I was diagnosed with renal failure.*" A similar sentiment is shared by participant 16 in saying that, "*sometimes I became short-tempered*" [54 years, on HD]. The two participants are revealing the emotional pain of being diagnosed with renal failure. For some men, the diagnosis reminded them of the dreadful and fatal nature of the disease:

. . . "*It was painful when I was told that I had kidney disease because this reminded me of my big brother who died of kidney failure*" [Participant 17, 28 years, HD].

. . . "*I know many people have died due to kidney failure! I thought to myself that what is important to me is to make sure that I follow the process of dialysis as per the prescription by the doctors and nurses here in the hospital*" [Participant 19, 38 years, HD].

The latter extract illuminates further on the fear of death experienced by this particular participant who perceived adherence to dialysis as his only refuge. Some men went on to retort that "*as a man, it [the disease] can change your sex life. You are no longer performing sexually because of stress. You are no longer able to perform, I feel like I am losing my mind*" [Participant 12, 48 years, HD]. The disease ends up being a source of "*conflicts in the house, because of my [men's] sexual frustrations, and as a result, when I am [men are] frustrated I [they] become short-tempered*" [Participant 11, 59 years, HD]. No wonder, men who realized that the disease and its associated mental distress were interfering with their sexual performance, described their situation as frustrating, helpless and hopeless. It is at this point that; these men start suffering from an existential crisis as illuminated by the following participants:

"You can't cope, you are always thinking and at times you even ask, why am I still alive?" [Participant 12, 48 years, HD].

"I ask myself, what is it that I have done to end up this way?"
[Participant 5, 33 years, PD].

This particular theme expresses the mental health impact, sexual performance problems, and existential crisis following a diagnosis of ESRD in rural black men. The affected men experience their "beingness" in the world as painful, horrific, and threatened by the condition. Phenomenologically, these men sound emasculated because the stress of the disease diminishes their sex drives. Also, discernible is the covert 'death wish' in some men, as a consequent of the apparent identity shift.

Living with ESRD Interferes with Handling of "Manly" Responsibilities and Duties

Another theme extracted from the data was that living with ESRD in this population was experienced as a source of interference in several important areas of these men's lives. The subthemes to capture this essence are presented here below:

Loss of income, productivity, and career prospects. For some men, the nature of the condition and the demanding dialysis render them unproductive and in some instance, having to give up on their studies or jobs. A consequent of the latter was the loss of income and failure to care and provide for their families. A 48-year-old participant on HD, said that *"you're no longer able to work; I lost my job. You cannot take your children to school. At the same time, you cannot support your family with a social grant."* In contrast, another 49-year-old participant also on HD said that *"I ended up dropping out from the university because I was not coping with the dialysis and the academic work"* [Participant 13].

Participant 13, like many other participants, captures the essence of a forced choice, that is, having to abandon one's career prospects or employ in order to cope with the demanding dialysis. It appears that the forced abandonment, especially for the working population threatens these men's position of being a provider in the family.

ESRD as source of interference to sexual performance and enjoyment. A further analysis revealed that ESRD was responsible for men's low-sex drive, lack of stamina, experience of pain during sex and erection problems. These sexual problems are experienced as threatening to their manhood while making them vulnerable to being cheated or abandoned by their intimate partners. Participant 12 and 3 captured this respectively in saying that *"Sometimes a week or two can pass without desiring to engage in sexual intercourse. Some women will have affairs because you have lost your manhood. Those affairs will stress you"* [48 years, HD] and *"I am very*

weak, I could not have an erection, I no longer have a girlfriend as a result of this" [20 years, PD].

This finding on the disease impact on man's virility is a transparent 'gem' about threatened masculinities. When taken together with the affected men's awareness that the mental distress because of the disease also impacts on sexual performance. Consequently, for those defining their masculinities on the basis of virility, their "manly identities" are threatened.

ESRD as source of intimate relationship problems. Although the young and older men experienced common sexual problems, they had unique intimate relationship worries. For the younger population, one of their battles was that, *"it is difficult to explain to your partner that you're having such a problem [the renal disease]. At some point when you explain your situation to your partner, they might reject you, so I am just keeping this to myself as this is my personal problem"* [Participant 1, 24 years, PD]. To support further on this subtheme, Participant 2 said that *"I usually tell a lady in the beginning of the relationship, if they don't want to stay with me or not. For example, another lady left me and never returned back to me after I told her about the fact that I am on dialysis. I sometimes try to phone her and she does not even want to pick up her phone"* [Participant 2, 33 years, PD].

The essence ESRD is experienced as a potentially shameful or stigmatised condition in younger men. They then fear being rejected or abandoned once their 'disease secrecy' is discovered. No wonder, there's an apparent disease secrecy discernible from the data set. In contrast, the major concern affecting older men apart from abandonment issues, was constant worry regarding spousal fidelity perhaps secondary to virility issues: *"This dialysis has created serious challenges in my relationship. My wife ended up cheating on me with my friend. We nearly got divorced; we ended up consulting a psychologist for psychological help"* [Participant 7, 56 years, PD]. A consequence of which are marital conflicts and, for some, being abandoned, *"my wife was not at home when I came back home from the hospital after two months. I have since tried to call, she is not answering my calls"* [Participant 16, 54 years, HD]. To cope, some men avoided confronting their wives about suspicions of extra-marital affairs, others became self-absorbed while others contemplated divorcing their wives.

From this finding, it appears that the disease impacts on sexual performance and intimate relationships; and this appears to be a constant mental battle for these men. Younger men are aware of their distorted body image owing it to ESDR, thus, fear being rejected or forming meaningful intimate relationships. Their counterparts largely struggle with insecurities owing to virility issues. To cope, younger men rely on secrecy and avoidance of

intimate relationships while their counterparts become self-withdrawn or distances themselves by opting for a divorce.

ESRD as the basis for failure to be a family provider and resourceful community member. One significant meaning generated was that ESRD limited men's role of being a family provider and contributing meaningfully to their communities. Participant 7 remarked that *"it is painful to me because I am not able to provide for my family as I used to. It is true that my wife is working but I need to give her something as a man even if she did not ask anything from me"* [56 years, PD]. To say, **"as a man"** this participant magnifies the importance of the role of being a provider for his family; a role which has since been assumed by his wife. It is this regard that, affected men felt emasculated and frustrated for they failed to partake in this meaningful manly role secondary to ESRD. The disease management protocol, meant that *"you [men] cannot travel. You [men] cannot even attend family funerals because we are supposed to come for dialysis even on Saturdays"* [Participant 12, 48 years, HD]. This finding further reveals the impact of the disease on men's diminishing sense of selves as family providers and significant community members.

Dialysis as a Challenging yet Life-saving Measure

Participant 1 offered this description *"I felt alive within two hours after being placed on the dialysis machine and it seemed as if my life was restored"* [24 years, PD, initially on HD], to demonstrate that dialysis improved his quality of health. Painful as it is to live on dialysis including its restrictions to being a fully functioning 'men', ultimately the affected men are left with no choice but to accept that dialysis is the only measure to save their lives:

"I have accepted that, because life was difficult for me. I am no longer coughing like before. The pain I used to experience before is not the same. I had more water in my lungs before. Therefore, my life is now better for me" [Participant 6, 36 years, PD].

Another participant expressed his feelings of ambivalence and discomforts with dialysis as follows:

"It helps me even though it disturbs my work schedule but the problem is this big-big pipe in my belly"; I am not comfortable" [Participant 8, 32 years, PD].

In the light of all challenges accompanying a renal disease diagnosis and its management, the affected men still perceived renal dialysis as the only solution to manage

their ill-health while preventing their demise. Dialysis was appraised to be a lifesaving intervention that improved their quality of life.

Overall, the findings have helped illuminate lived experience of rural black-man's 'being in the world' with ESRD. Their being in the world or masculinity is characterized as being distressed, unproductive, inadequate, and emasculated. This identity or existential crisis consequently appears to be interfering with their developing or maintaining meaningful intimate relationships.

Discussion

This study sought to explore the lived experiences of rural African men with ESRD with special reference to their masculinity. In the main, we established that living with ESRD is a mentally taxing experience associated with emotional pain and a decreased quality of life. The distress is complicated by some of the personal, occupational, and social difficulties that follow a diagnosis of ESRD including having to dialyse on a regular basis (Bruce et al., 2009; Hashemi et al., 2018). For instance, living with the condition interferes with the handling of manly responsibilities and duties such as providing for their families, satisfying their intimate partners sexually, and participating meaningfully in communal activities. Being hindered to discharge activities associated with real-men (Bailey et al., 2018; Bruce et al., 2009; Reilly et al., 2014) seem to impact negatively on their self-esteem and mental wellbeing (Gregg & Hedayati, 2021; Griva et al., 2020; Hamilton et al., 2019; Lew & Centron, 2021). For younger men, future sustainability of their identities and livelihoods is equally not promising because some of them are forced out of school or work (Sauvé et al., 2016). Considerably, the condition appears to impact negatively on a majority of the affected men's virility (Achempim-Ansong & Donkor, 2012; Kerklaan et al., 2020; Lin et al., 2005; Reid et al., 2016). Loss of virility taken together with failure to be a provider diminish affected men's sense of manhood, therefore, triggering an existential crisis (Bailey et al., 2018; Douglas & Maluleke, 2018; Khunou, 2013; Siweya et al., 2018).

The existential crisis is secondary to threatened masculinity (Higuera, 2018), expresses itself in intimate relationships. For young men in particular, it appears that they struggle with self-image (Bailey et al., 2018; Kerklaan et al., 2020) when compared to older men. This is because the disease impacts on the integrity of their physical health and bodies (Kerklaan et al., 2020). To protect their threatened or troubled selves including the fear of rejection, ridicule or even stigmatization (Coyne et al., 2019), some young men opt to keep the illness a secret while others become self-absorbed and avoid intimate relationships (Diaz-Medina & Mercado-Martinez,

2019). Perhaps, young men avoid intimate relationships for fear of exposing their different, deficient or unattractive body-image (The Body Project, 2021). One could argue further that, since young men are undergoing the process of identity formation, the presence of ESRD negatively impacts on their self-image, self-esteem and self-confidence, hence some tend to resort to maladaptive coping strategies (Bailey et al., 2018; Diaz-Medina & Mercado-Martinez, 2019; Kerklaan et al., 2020). Unlike younger men, older married men's identity issues appear to be center around the construct of "I am not a man enough." One explanation for this might be that older men are more matured to worry about self-image. Hence, in their case the findings suggested that they worried about providing for their families and being unable to satisfy their wives sexually. The former also made them suspicious of their wives' fidelity in marriage. Despite this, some men seem to be suffering in silence as they were not able to vocalize their suspicions. This finding is consistent with the results of studies by Edey (2017) and Riazuelo (2021) who also reported that most men who are on ESRD have poor relationships with their intimate partners which resulted in marital conflicts and threats of divorce. As was evident in this study, for those who opt for divorce, this could also be seen as another ego-defense against the pain of feeling emasculated. Some researchers (e.g., Gregg & Hedayati, 2021; Lew & Centron, 2021), have suggested that these kind of maladaptive coping strategies deprive men of the necessary social support, making them vulnerable to depression. Generally, the challenges associated with ESRD for both younger and older men predispose them to poor mental health outcomes while jeopardizing the disease management process (Courts & Boyette, 1998; Davison et al., 2015; Hamilton et al., 2019). In a worst case scenario, some men might contemplate or commit suicide.

The impact of ESRD on men calls for community education programmes about renal disease and its management so as to raise awareness on the disease. In the same vein, the existing social constructs surrounding the role of a man or what it takes to be a man, also need to be debunked and revised to accommodate men who might become victims of ESRD. Intimate partners may also need to be involved in the treatment process of their affected partners. This could help to mitigate men's silences and mental pressures they have to endure. Support groups, including the provision of psychological services, may need to be prioritized in the management of men on dialysis. Considering the long distances that people in rural areas have to travel to access renal services, governments may need to prioritize availing renal dialysis services also in rural. Ease of access to renal health care services could perhaps be another important factor contributing to improved disease management.

Theofilou et al. (2013) suggest continuous assessment and tailored intervention for men in an effort to address and enhance their psychological wellbeing and quality of life. It is against this background that men's personal and cultural identities may need to be considered in the conceptualization of care and support of patients on renal dialysis. This is consistent with Khunou's (2013) assertion that men's reluctance to seek assistance is linked to feelings of shame and the perception of being weak. Particular attention needs to be paid on the special needs of men with diminished masculinities in ESRD care.

Strength and Limitations of the Study

The current study has contributed to the literature by providing cultural insights into experiences of black South African men on renal dialysis. The strength of the paper is its focus on rural black men's experience of dialysis. However, a number of limitations related to the study were identified. For example, the voices of their partners could not be heard. This suggests that there is a need for future studies to also explore the experiences of the men's intimate partners. Another limitation is that data were transcribed and translated before data analysis. It is possible that some original meanings in the data may have been lost through this transformational process. There are challenges in qualitative analysis when more than one researchers are involved especially when it comes to achieving common ground with the analysis, however, this was also a strength in the study as it enhanced the credibility of the study. Finally, since the study focused only on a small group of black South African men on renal dialysis, the study may not necessarily be generalizable other settings in Africa and the rest of the world. However, it is hoped that the findings of the study will provide some insights that may help in future investigations.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Ethical Considerations

Ethical approval for the study was obtained from the Research Committee of the University of Limpopo (TREC/321/2017:112). Furthermore, permission to conduct the study was sought and

obtained from the Limpopo Provincial Department of Health (Ref 4/2/2 on 27/12/2017). Gatekeeper's permission from the Pietersburg-Mankweng Research Ethics Committee (PMREC) was also obtained (PMREC 25 April UL2018/B) to gain access to the hospital. Participants were assured of the confidentiality of the study, and that they were free to withdraw from the study at any time. Debriefing and counselling services were made available in the Psychology Department within the hospital and at the respective referring hospitals where participants would feel comfortable.

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