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Exploring the Influences of Hegemonic and Complicit Masculinity on Lifestyle Risk Factors for Noncommunicable Diseases Among Adult Men in Maseru, Lesotho

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Abstract

Masculinity is an important health determinant and has been studied as a risk factor for communicable diseases in the African context. This paper explores how hegemonic and complicit masculinities influence the lifestyle risk factors for noncommunicable diseases among men. A qualitative research method was used, where eight focus group discussions were conducted among adult men in Maseru, Lesotho. The data were analyzed using a thematic analysis approach. Although the participants typically described taking responsibility as a key feature of what it meant to be a man in Lesotho, their reported behaviors and rationales indicated that men commonly abdicated responsibility for their health to women. Participants were aware of the negative effects of smoking on health and acknowledged the difficulty to stop smoking due to the addictive nature of the habit. The initiation of smoking was linked by participants to the need to be seen as a man, and then maintained as a way of distinguishing themselves from the feminine. Regarding harmful alcohol consumption, participants reported that stress, particularly in their relationships with women, were linked to the need to drink, as they reported limited outlets for emotional expression for men in Lesotho. On the subject of poor diet, the study found that most men were aware of the importance of vegetable consumption; the perceived lengthy preparation process meant they typically depended on women for such healthy food preparation. Almost all participants were aware of the increased susceptibility to diverse negative health effects from physical inactivity, but because of the physical nature of the work, those engaged in traditionally masculine occupations did not exercise. In the context of lifestyle risk factors for noncommunicable diseases, masculinity has positive and negative impacts. It is important to design health education programs targeting men to successfully mitigate the negative health impacts of masculinity.

Keywords

masculinity, risk factors for noncommunicable diseases, adult men, lifestyle, noncommunicable diseases

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Masculinity is socially and culturally constructed, and as such has different features depending on the context (Chesebro & Fuse, 2001; Evans *et al*., 2011; Ratele, 2008a; Ratele et al., 2010; Schrock and Schwalbe, 2009; Shefer et al., 2010; Vigoya, 2001). Masculinity is primarily founded on life events and activities in most societies (Evans et al., 2011; Ratele et al., 2010); therefore, the concept may be described as a set of role behaviors that men are socialized to perform (Sorrell & Raffaelli, 2005). As a result, definitions of what it means to be a man change from time to time, and in different circumstances (Mutunda, 2009).

Men's views of manhood are shaped by their upbringing and their social environment. The society in which men live encourages the attitudes, beliefs, and behaviors

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that are associated with increased health risks among men (Courtenay, 2011). These social support networks influence men's health choices positively and/or negatively. Positive role modelling in a family setting influences the way in which men construct their views of masculinity and men's health choices (Marsiglio, 2009). Previous studies have reported that men in healthy marriages are more likely to report health benefits from being married (Chung & Kim, 2015; Strohschein, 2016).

While a number of studies describe masculinity as a set of traits, behaviors, and roles generally associated with the male sex, it is noted that the concept is not exclusive to the male sex as some females demonstrate some masculine characteristics and behaviors as well (Connell, 1995; Ratele et al., 2010; Schrock & Schwalbe, 2009; Shefer et al., 2010; Sloan et al., 2015).

Similar to findings from the developed countries, traits associated with masculinity in African literature include ambition, analytical reasoning, assertiveness, invulnerability, competitiveness, virility, fearlessness, physical strength, independence, leadership, and control. Men are defined by their ability to endure pain, their self-reliance, being the decision-makers in their households, and essentially by avoiding anything that makes them look feminine (Moynihan, 1998; Mutunda, 2009; Ratele, 2008a). The willingness to take risks is also a trait typically included in scales developed to measure masculinity (Shefer et al., 2010).

Masculinity influences health-seeking behaviors. The relationship between masculinity and health-seeking behavior continues to manifest in men's utilization of health services (Courtenay, 2000). Even though contemporary masculine identities continue to change, beliefs and behaviors regarding health-seeking behaviors are adversely predisposed by masculinity constructions (Courtenay, 2000).

Critical scholars identify masculinity not only as a power relation between males and females on the subjects of dominance and subordination, but also as a power struggle between various facets of masculinity (Ratele, 2008a; Schrock & Schwalbe, 2009; Shefer et al., 2010). Different studies acknowledge four facets of masculinity: hegemonic, complicit, marginalized, and subordinate masculinities (Connell, 1995; Evans et al., 2011). This paper focuses on exploring how the characteristics of hegemonic masculinity impact the lifestyle risk factors for noncommunicable diseases (NCDs).

Hegemonic masculinity is the dominant type of masculinity with qualities including heterosexuality, whiteness, superiority, physical strength, and suppression of emotions (Connell, 1995; Scott-Samuel et al., 2009). Messerschmidt (2018) reports different and flexible expressions of hegemonic masculinities that are relational and exist as a pattern of hegemony rather than domination. Some men embody hybrid hegemonic masculinity, which incorporate subordinate masculinity (Messerschmidt, 2018).

Complicit masculinity is a relatively more passive expression of masculinity (Connell, 1995; Evans et al., 2011; Gómez, 2007), and individuals in this category do not fulfill all the characteristics of hegemonic masculinity. However, complicit masculinity subscribers are not doing much to challenge this form of masculinity either, and since they are not challenging the gender systems they are faced with in society, they receive the benefits of being male to some degree (Connell, 1995; Gómez, 2007).

Marginalized masculinity is a subculture of hegemonic masculinity. This category lacks some of the qualities of dominant masculinity, such as physical strength (Connell, 1995; Evans et al., 2011; Gómez, 2007). Individuals in this category such as disabled men often demonstrate similar traits as hegemonic masculinity (Connell, 1995; Evans et al., 2011; Gómez, 2007). The last category, subordinate masculinity, exhibits characteristics opposite from those of hegemonic masculinity. Individuals in this group demonstrate femininity traits including physical weakness, and they easily express their emotions (Connell, 1995).

Masculinity and Health

Masculinity is an important health determinant (Courtenay, 2011), as individuals who identify as masculine are more likely to adopt risk behaviors that are less likely to promote good health and longevity (Courtenay, 2000; Sloan et al., 2015). Research is currently paying improved attention to the implications of gendered expectations and gender roles on men's health (Griffith et al., 2012). The male disadvantage in health may then be understood by exploring the pressure placed on men to prove their masculinity by taking part in masculine practices that are often harmful to their health (Rosaleen, 2006).

In addition to ignorance in describing their health, masculine men are indifferent and resistant to suggested healthy living practices regardless of the negative consequences of risky living practices (Rosaleen, 2006). Masculine individuals disassociate themselves from health-promoting behaviors because they perceive these as feminine (Gordon et al., 2013). Research reports that masculine men would rather risk their health and well-being in avoidance of femininity (Garfield et al., 2008; Gordon et al., 2013; Griffith et al., 2012; Sloan et al., 2015).

Previous studies have established an association between risky health behavior and the characteristics associated with being a real man (Ratele, 2008b). In Africa, studies on masculinity and health have largely focused on HIV/AIDS and explored the impact of masculinity on HIV risk behaviors (Sikweyiya et al., 2014).

Methodology

The study was based on qualitative data from focus group discussions (FGDs). FGDs were chosen to collect interactive data that encourage participants to identify and clarify their views. The study was conducted in Maseru, the capital city of Lesotho. Maseru is 138 km² in size (Ramoya & Brown, 1999) with a population estimated at 519,186 (Ministry of Development Planning, 2018). There are many people from other districts in the country in Maseru because there are more life opportunities in this city compared to other cities/districts.

Sixty black adult Basotho men aged 18–65 years participated in eight FGDs exploring the risk factors for NCDs, such as cancer, respiratory illnesses, cardiovascular diseases, and diabetes between November 2016 and February 2017. The median age for all participants was 35 years and the majority (51.7%; $n = 60$) of the men had never married at the time of the study. The majority of the men (36.7%; $n = 60$) were high school graduates, and most participants claimed to be generally "healthy" at the time of the study.

Each focus group consisted of 6–10 men. During the last two FGDs, discussions reached saturation point because no new information was gathered. Smaller groups were more effective compared to the bigger groups. The bigger groups were often dominated by participants who appeared naturally talkative, while smaller groups allowed all the participants to effectively take part in the discussions.

Two strategies were used to recruit the study participants. First, purposive sampling, that is, selective sampling from existing social groups, was undertaken. Purposive sampling allowed the researchers to focus on particular characteristics of the population. This approach helped us gain greater insights into the risk factors for NCDs among adult men from different angles. It also helped researchers to identify common themes that were evident across the sample. The targeted social groups included religious groups, recreational and sports clubs and business cooperatives. Liaising with the leadership of each social group, researchers identified and invited adult men who were available, willing, and able to participate in the FGDs.

The second recruitment strategy was the identification of well-known men from different communities who were asked for the names of adult men they knew who they thought would be willing to participate in the study. These prominent men comprised local school principals and small business owners who knew many men in their respective communities. Men recruited through this strategy were members of the general population in Maseru. This approach minimized possible biases from purposive sampling. The FGDs were exploratory in nature and were designed to have an atmosphere that encouraged open conversation and mutually beneficial interactions.

The FGDs lasted for approximately 1–1.5 hr each, excluding the time for refreshments after each FGD. Participants were given informed consent forms prior to each FGD. The signed consent forms were collected before conducting the FGDs and were later stored in a locked cabinet at the University of KwaZulu-Natal, accessible only to the authors. The meeting facilitators collected the participants' demographic information before the start of each FGD, and all FGDs were audio-recorded. The FGDs covered questions on smoking, harmful consumption of alcohol, poor diet and physical inactivity, and their impact on NCDs' prevalence. The study sought to explore the effect of masculinity on lifestyle risk factors for NCDs; therefore, during the FGDs, the men were asked to define a man in Lesotho's context. Extensive probing was used to gather more information based on the participants' responses. Facilitation was designed to keep the FGDs on topic, while also allowing participants the freedom to pursue avenues that they found particularly important.

We asked participants to keep everything discussed during the FGDs confidential; however, we acknowledge that this could not be guaranteed. Each participant was given a unique identifier to ensure their anonymity. Participation in the study was absolutely voluntary, and no reward was given to the participants. The FGDs were transcribed and translated from Sesotho into the English language. Thematic analysis was used for data analysis. Themes and/or statements relevant to the study emerging from the data were identified and coded in each text using NVIVO software. NVIVO is a software program used to organize, categorize themes arising from the data, and analyze qualitative data such as FGDs and interviews.

Ethics approval to conduct the study was obtained from the University of KwaZulu-Natal Ethics Committee (Protocol reference number: HSS/0697/015D). Participants in this study were ordinary members of society. Gatekeeper permission was sought from the local relevant authorities even though our participants did not belong to any specific institutions/organizations.

Results

Exploring Definitions of Masculinity Among Adult Males in Maseru

The participants' definition of a man generally portrayed a man as one who engaged in health-defeating behaviors. In general, participants did not define a man in a polarized fashion. Factors comprising sex, age, marital status, fatherhood, and taking responsibility were discussed with varying emphasis on each factor. Reflecting an extreme hegemonic masculinity, one participant alleged:

> For one to be considered a man, one should be having a wife and also some concubines or girlfriends outside his marriage. There is also this statement: 'Be a man', for you to be a man you should drink so many quarts [of beer] a day. The feminine type of a man who takes a good care of himself, respecting his family and wife is seen as not being man enough. A man is a sheep, he does not cry. Even if you go through hardship, don't cry, don't let people know. A man is expected to be resilient and able to stand the pain in any forms of it. A man should mask his emotions and emotional experiences he goes through and should always come out as strong. (Participant 2, FGD#2)

For some participants, by virtue of being born male, and being at least 18 years old, one would be referred to as a man in Lesotho:

> A man is a male individual who is 18 years old and can take responsibility, married or not married. As long as he is old enough to be trusted to take responsibility in the family, he is a man. (Participant 7, FGD #3)

Gender and age were not enough for some participants; they strongly believed that males had to be married in order to qualify to be men. Having a wife and children gave masculine men a sense of pride and recognition.

> A man is a married male person. When he is married, he is now having the responsibility of caring for other people, his wife and children which he did not have before getting married. (Participant 2, FGD #8)

Traditional masculinity ideology qualified males who attended traditional initiation school as men.

> [A man is] a male person who has gone for our Sesotho traditional initiation school (lebollo). When he gets back to the society, he is now referred to as a real man because we have now taught him how to be a man while he was in the mountain. He can even get married now. (Participant 3, FGD #7)

The teachings given at initiation school were believed to shape and equip young males to become responsible men. Contrary to this belief, some younger masculine males who were born and had grown up in urban areas did not subscribe to the traditional initiation school and its teachings:

> Those people are not turning into men just because they have gone to the mountain. They are just full of theory of what a man should be like. They are still boys until they get married like everybody else. Maybe they are referred to as men just to praise them for having been brave enough to go to the mountain. . . (Participant 2, FGD #6)

Brave deeds and good work were associated with being a man. Although less common for complicit masculine participants, males who performed good and acceptable deeds in their families and societies were defined as men, regardless of age and marital status. Referring to an individual as a *man* based on deeds was sometimes applied to both men and women. Women who performed duties that were expected to be carried out by men were commended as "men." For example, women who were bread winners were said to be "men" or acting like men:

> When one is a hard-worker and serious about his work, that person is usually called a man. So his hard work and good works leads others to refer to him as a man. (Participant 4, FGD#8)

> A man takes responsibility in his family. If he is married, he protects his wife and children. If he is not married, he protects and caters for his parents and family members. (Participant 5, FGD#5)

For traditional masculine subscribers, there was an underlying certainty that some actions were not sufficient for one to be deemed a man in the absence of marriage:

> One cannot become a father without bearing a child, at the same time; he cannot become a man unless he gets married. If he is not married, he can only be referred to as a man as praise if he has done some good works associated with men. (Participant 2, FGD#3)

Irrespective of other traits and behaviors associated with masculinity, heterosexual sexual orientation appeared to be a determining factor for one to be described a man. Hegemonic masculinity undermined homosexuality, and homosexual males were generally disqualified as men in most of the FGDs:

> Being born male does not necessarily mean that we are all men. There are [male] people who are 18 years old and above and responsible in their families but whose [social] behavior and the way they live does not say they are men. I have an example; the gay men were born males but the way they conduct their lives does not reflect the way a man should live. They are women . . . (Participant 5, FGD #1)

Smoking

Participants were aware of the negative health effects of smoking. However, cigarette smoking was prevalent, especially among working middle-class men and tertiary students. Smoking hand-rolled tobacco was more common among older men, especially those who were less educated and unemployed. Smoking cannabis was reported by younger adult men:

> I usually smoke a 'zolo' in the morning and in the evening. During the day on campus it depends on the day and with the

> company of friends I am with I have decreased my smoking to roughly four times a day. Before I came here I had nothing to do for almost the whole day so I smoked a lot. (Participant 8, FGD #2)

Smoking is addictive in nature, and once initiated, it becomes difficult to stop:

> If I go for two or three days without smoking, I feel good. I usually would get back to it because of the strong cravings I get, but health wise it is not good to smoke. (Participant 4, FGD #2)

Social support networks in men's lives play an important role in men's health decisions. Peer pressure, desire to be accepted, too much leisure time, and proof of masculinity were cited as the reasons why smoking was initiated:

> I was in secondary school when I started smoking and it was out of peer pressure and also wanting to be regarded as cool and as a man. (Participant 1, FGD #4)

Subscribers to hegemonic masculinity linked smoking to manliness and the quote below illustrates that it was a behavior used to clearly identify a man as masculine by essentially avoiding anything that made them look feminine.

> I cannot smell like a woman, smoking gives me that smell, different from a woman. There should be a difference between a man and a woman. We cannot smell the same. (Participant 3, FGD #5)

Harmful Alcohol Consumption

Participants in the study reported periodic heavy drinking, prevalent on weekends and at social events. Consumption of traditional alcohol was common among older men particularly those who were unemployed. Beer consumption, especially of the local brand "maluti" was prevalent among younger and working middle-class men. Masculinity prominence played a major role in men's binge drinking:

> A man drinks beer. He drinks quarts. That's a common practice. You should drink quarts to show that you are a man. (Participant 4, FGD#7)

Binge drinking was further reported as a celebration for achievements:

> I usually drink to reward myself. For instance, if I manage to achieve a goal I had planned for a week or for a month, I reward myself. So I would meet up with my friends and enjoy ourselves. (Participant 7, FGD #2)

Some men described drinking as therapeutic in light with the fact that masculine men were typically expected to suppress their emotions:

> We drink and talk about life; I mean everything from our hurts and joys maybe from the family or girlfriends. It is funny that when we are sober it is difficult to talk about some stuff. I for one cannot openly talk about family issues to my friends when I am sober, but when I am tipsy anything goes. I don't know why this happens so for me that is one of the reasons why I drink, I become free. . . (Participant 7, FGD #3)

Other men blamed their female partners for their harmful alcohol consumption. Heavy drinking helped them to deal with pain and disappointments:

> Men usually cannot stand pain. Not physical pain as such, this emotional pain. For example, a man who has a wife who is always shouting at him would rather be in a bar and get home drunk and care free. Unfortunately some women do not realise that they are the source of their husbands' bad drinking habits. (Participant 2, FGD #8)

The environment in which some men lived contributed to their harmful alcohol consumption.

> For some, the reason is family problems faced. They are running away from a nagging wife. They would rather arrive home drunk because they are not respected in their houses anyway. They are treated like children. (Participant 3, FGD #2)

Another participant highlighted the difference between men and women, but he, like others, ascribed this difference to the competitive nature of the hegemonic masculine identity:

> Yeah, there is a huge difference. Men drink more alcohol than women. Men like showing off what they can do. Somebody mentioned the issue of competition that it is one of the reasons. Men enjoy competition almost in everything they do. (Participant 1, FGD #6)

Unlike smoking, men did not immediately associate harmful alcohol consumption with negative health effects but were able to instantly relate harmful alcohol consumption to social issues. Participants reported negative behaviors that often lead to increased violence and unnecessary fights with friends and family members, road accidents, and deaths, which could be avoided.

Poor Diet

Poor dietary patterns prevailed among most of the study participants owing to the men's dependency on their female counterparts for food preparation. Hegemonic masculine men considered food preparation feminine. When asked to

share their views on eating fruits, salads, and vegetables, almost all the men considered these as healthy options in a meal. The only complaint from most men was that salads were not filling. With regard to vegetables, most men complained about the long process associated with preparing vegetables, that is, cleaning/washing vegetables and chopping before the actual cooking.

> I do not know much about food stuff and preparation. The truth is that I am not interested. As long as my stomach is full I am okay. (Participant 3, FGD #4)

The stereotype of femininizing food preparation led to many men's poor dietary patterns, which were health defeating and exposed men to chronic diseases. The married men who were not living with their wives reported healthy eating only when their wives were around. Some unmarried men who lived with their families during the study depended on female family members for healthy food preparation. Those who were single and not living with their family members reported failing to prepare healthy meals for themselves. Convenient meals in the form of "fast foods" were a common alternative. This behavior describes complicit masculinity. These men could prepare their own healthy meals; however, they chose to abdicate that responsibility to women:

> I am not staying with my wife here, so I always go for meals that are easy to get at work and even at home except if my wife is around. The only time when I eat healthy food is when my wife is around. On my own, I always go for fast foods. Proper cooking is a mission. (Participant 3, FGD #6)

Cooking was deemed a women's responsibility even when both male and female partners were working. The quote below illustrates that there was an underlying acknowledgement of unfairness. It further indicates that the participant perceived working women to have undertaken men' roles:

> The fact that women are also working these days, they are doing men a huge favour. They should be staying at home nurturing babies and making sure that there is cooked food for the kids, men and the family at large while men are out at work. Strange enough when we get back home, both from work, I sit down and expect her to give me some food and even start complaining that she is too slow to prepare me some food. (Participant 3, FGD #3)

Contemporary masculinity is dynamic. Among unemployed men, there was more willingness to share responsibility for household chores that were previously seen as women's duties:

> It is not only women who should cook in the house. We should assist and share whatever house chore we have. Even doing laundry is one of the activities that I personally help with. I really do not mind. (Participant 1, FGD #5)

Physical Inactivity

Some participants lacked an understanding of what physical activity implied. Most participants were aware of their increased vulnerability to diverse negative health effects from physical inactivity. However, some men associated participation in physical activities with the middle-class and sports men. These participants were men who were unemployed or blue-collar workers. The latter felt that the physical nature of their jobs meant that additional physical activity was not necessary:

> It [physical activity] is mostly done by the middle-class people who are usually using cars as their mode of transport most of the time. They do jogging as a physical activity to keep healthy. From there it would be those people who are actively participating in sports who go jogging to get their bodies ready for games. I am a construction worker, when I get home; all I need is to rest for the next day. My job takes all my energy away. (Participant 2, FGD #6)

> I am a farmer; I am always busy in my garden. I also feed my chickens and pigs and clean their shelters on daily basis. In doing so, I believe I am engaging in physical activities that keep me healthy and active. What do you think? (Participant 4, FGD #6)

Some men did not partake in any physical activities claiming to be busy:

> To be honest with you, for me there is no sport or games that I play. I don't have the time. (Participant 1, FGD #5)

One of the benefits associated with consistent physical activities is maintenance of normal body weight. Participants were asked to explain the meaning attached to a man's weight. Some reported places in Lesotho where a man's body weight used to be associated with wealth. However, participants reported that they currently knew that being "fat" was not necessarily healthy and not an indication of wealth. Some participants confirmed awareness that being overweight was associated with avoidable diseases. They further stated that being overweight was a hindrance to many physical activities, but were particularly concerned about sexual performance as a reflection of their virility, which was highly valued as a symbol of hegemonic masculinity:

> I work with women. When they see a fat man, they would always comment that they doubt that fat [man] is doing well in his sexual life because of the weight he is carrying. So when women see fat men, they get too curious about their sexual performance. You cannot satisfy your woman in bed

> if you are fat my man. These women talk chief. I don't think this relate to sexual life alone. I mean, being fat must be heavy. I am sure any physical work is a challenge for a fat man. (Participant 3, FGD #3)

Discussion and Conclusion

While it has been noted that not all aspects of masculinity are associated with negative health behavior (Sloan et al., 2015), this study established that a dominant masculine identity could be problematic. Masculinity contributed to smoking initiation, harmful alcohol use, and a lack of motivation to engage in the activities required to maintain a healthy diet. On the other hand, masculinity could be protective as there was motivation to maintain a normal body weight. Moreover, this study established that the elements of masculinity conveyed by adult men in Maseru, Lesotho, were similar to the elements of masculinity conveyed by other populations from elsewhere and reported in previous studies.

Although men in Maseru were aware of the negative health effects from lifestyle risk factors for NCDs, their attitude and lifestyle did not seem to match their knowledge. Given that they had the knowledge, and that the ability to take responsibility for others was a key feature of being defined as a man, this finding may be considered unexpected. This study established that men, especially those who subscribed to hegemonic masculinity, commonly abdicated responsibility for their health to women.

Being masculine was associated with not caring too much about food and what to eat. For men possessing especially hegemonic masculinity traits, preparing and cooking their own meals was optional (Roos et al., 2001). In a study that explored how Finnish men from different occupational groups described food in their everyday lives, food was described as mainly feminine in nature (Roos et al., 2001). Based on this study, purchasing of food, preparation, and presentation were perceived as a woman/feminine partner's responsibility (Roos et al., 2001). Furthermore, there were foodstuffs from different studies that were labelled as masculine.

The current study established that most participants still considered food preparation a women's duty. This finding coincided with previous studies that revealed food preparation as a feminine task (Liebman et al., 2001; Tepper et al., 1997). This traditional belief has led to health-defeating dietary patterns in men (Wong and Lam, 1999), especially in the absence of spouses/partners or mothers/sisters who are expected to prepare food for men. Men who uphold traditional characteristics of masculinity are, therefore, exposed more than women to the risk of developing chronic NCDs associated with poor diet.

Similar to the findings of a study conducted in England among men of different ages, the current study revealed that some men believed drinking too much alcohol made them appear masculine (Harnett et al., 2000). This belief has contributed to increased harmful alcohol consumption rates among men (Iwamoto et al., 2011; Sloan et al., 2015). The masculine ideals of being a risk-taker has previously been cited in literature as associated with heavy drinking (Iwamoto et al., 2011; Landrine et al., 1988).

In respect of the importance of maintaining a healthy weight, this study found masculinity to be protective. Among the characteristics previously found to be considered important to masculinity are physical strength and competitiveness. These two traits are usually shaped and natured through participation in rigorous physical activities. Individuals who aspire and subscribe to hegemonic masculinity are expected to participate more in physical activities. Previous research has identified that physical activity is more prevalent among masculine individuals than it is among feminine persons (Azevedo et al., 2007; Oliffe et al., 2009; Sloan et al., 2015). Engaging in some form of physical activity gives masculine individuals a chance to compete with others, although in this study emphasis was placed on the type of work a man was engaged in. Individuals who are interested in looking muscular usually engage in more rigorous physical activities in order to build strong visible muscles (Verdonk et al., 2010), and this was related to occupational activity in the current study.

Limitations in the present study included that the current study data were collected in FGDs, which increased the probability of socially desirable responses from participants. The sample was relatively small. To address this limitation, purposive sampling was one of the recruitment strategies used to ensure quality data. The current study was dependent on self-reported information. It was possible that some participants provided inaccurate information in their responses to questions asked out of embarrassment or because they wanted to impress other participants. Moreover, some participants in the current study might have had trouble remembering their engagement in risky behaviors.

In conclusion, our study established that masculinity contributes to the prevalence of risk factors for NCDs among adult men in Maseru, Lesotho. Some findings in this study provide important directions for future research. For example, social environment plays a critical role in men's health especially where masculinity interferes with good health. We recommend future studies in an African context to contribute to the understanding of the role of the family in men's health decisions. We suggest that leveraging the masculine identity as one who takes responsibility should be expanded to include self-care, rather than abdicating responsibility to female partners in the case of healthy dietary practices, or worse still blaming females for harmful alcohol consumption.

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Disclaimer

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