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To cite this article: Marisa Casale & Andrew Gibbs (2015) GENDER DIFFERENCES IN SOURCES AND AVAILABILITY OF SOCIAL SUPPORT AMONG SOUTH AFRICAN CAREGIVERS OF CHILDREN, South African Review of Sociology, 46:4, 100-125, DOI: [10.1080/21528586.2015.1109475](https://doi.org/10.1080/21528586.2015.1109475)

To link to this article: <http://dx.doi.org/10.1080/21528586.2015.1109475>



Published online: 08 Jan 2016.



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GENDER DIFFERENCES IN SOURCES AND AVAILABILITY OF SOCIAL SUPPORT AMONG SOUTH AFRICAN CAREGIVERS OF CHILDREN

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ABSTRACT

Research indicates that social support can have a protective effects on health, yet these effects may not be the same for men and women. Gender has been shown to predict the amount of social support available, the nature of social networks and effects of social support on health and quality of life. This analysis uses data from a mixed methods study, consisting of a quantitative survey (n=2477) and in-depth qualitative interviews (n=24), to explore the gendered nature of social support sources and availability among caregivers of children in HIV-endemic South African communities. Survey findings show how both child care and social support are provided disproportionately by women, who are receiving less support than their male counterparts; sources also differ, with women more likely to receive support from family members. Qualitative data highlight how gendered understandings of masculinities and femininities are drawn on to make sense of these differences. These results reinforce the usefulness of exploring social support by gender. They also point to the need both for more immediate interventions to support women in HIV-endemic communities, and longer run interventions to address gender inequalities and norms that position women as natural carers and men as unable to care.

Keywords: social support, gender, caregivers of children, HIV, South Africa



INTRODUCTION

It is to know that we are united; not only in my home, but also with my neighbourhood, so I know that if there is something that I need to do, but not able to do it right away there are people who are going to help me to do that thing... Things have never been easy in life, but the main thing is to feel free emotionally or to be free emotionally, so when I get advice or support, that helps me... (Male caregiver with non-HIV related chronic illness).

These are the words used by a chronically ill South African male caregiver of children – one of the participants from the qualitative study on which this paper is based – to explain the value of social support for his life. This caregiver spoke about feeling happier because of the knowledge that there would be people in his family or neighbourhood available to offer him support when he should need it. The quote above alludes to the importance of social support – from family, friends and the broader community – for coping, the achievement of practical goals and psychological well-being. However, there is also ample evidence of the protective role of social support for (mental and physical) health more broadly, described as ‘supportive relationships that directly provide something that people need to stay healthy or adapt to stress’ (House, Umberson & Landis 1988). This ‘something’ refers to the various types of support, which can comprise emotional support, such as love or care; instrumental support, tangible items such as information or practical assistance; and appraisal support, such as encouragement and constructive feedback (Heaney & Israel 1997; House & Khan 1985).

Alternatively, social support can be defined in terms of the sources of support or support providers. Key sources of support are to a large extent context-specific and may include a wide range of individuals and groups; however, the most commonly cited support providers in the literature are significant others, family members and friends (Taylor 2011; Zimet et al. 1988).

A large body of literature, from many parts of the world, has shown social support to be positively linked to better mental and physical health outcomes, quality of life and even the likelihood of survival (Holt-Lanstad, Smith & Layton 2010; House, Umberson & Landis 1988; Ke, Liu & Li 2010). However, this work also shows that positive effects of social support on coping and well-being are not the same for all population groups and settings, but can vary for different contexts, depending on the combination of stressors experienced, and provider and recipient characteristics (Casale et al. 2015; Kawachi and Berkman 2001; Li, Seltzer & Greenberg 1997). Moreover, while receiving support may have positive effects on human well-being, providing support also has a cost. This cost may be emotional (especially in the case of emotional support, care and comfort) or may consume ‘tangible’ resources (for example, time taken to listen and provide advice and/or financial resources used to provide money or other in-kind assistance) (Thomas 2006; Umberson & Montez 2010).

It is therefore important to identify and better understand factors associated with support availability and provision, and to identify key sources of support within a

specific community or population. Knowledge of differences in support access and sources can be useful in understanding vulnerability to health risks across populations, by identifying who is more or less able to draw on social resources to cope with stressors (Casale et al. 2009) and who is bearing the cost of providing them. This would be useful to inform health and social interventions targeting specific populations.

Previous empirical work has shown gender to be one of the key factors – together with age and socioeconomic status – to influence levels of social support, the nature of social networks, the cost of maintaining these networks, and the effects that social support can have on health and quality of life outcomes (Antonucci & Akiyama 1987; Kato Klebanov, Brooks-Gunn & Duncan 1994; Kawachi et al. 1997; Turner, Pearlin & Mullan 1989; Walen & Lachman 2000). For example, in some populations, differences have been found between men and women regarding the type or size of their networks, the ways in which they seek or utilise support to deal with stress and distress and the extent of the protective nature of social support for their health (Schraedley, Gotlib & Hayward 1999; Tamres, Janicki & Helgeson 2002; Wallen & Lachman 2000). Some studies indicate that women tend to have large and more diverse social networks (Antonucci & Akiyama 1987) but that these networks are more difficult to maintain (Wallen & Lachman 2000). Other studies have shown gender (being female) to be linked to less social support: for example, Kato Klebanov et al. (1994) found female headship to be associated with less social support for mothers of toddlers (Kato Klebanov, Brooks-Gunn & Duncan 1994). There is also evidence of differences in the way male and female caregivers seek or utilise support to deal with stress and distress: for example, a 2002 meta-analytic review examining sex differences in coping, found that women were more likely than men to seek both instrumental support and emotional support, through verbal expressions to others, in order to deal with stressors (Tamres, Janicki & Helgeson, 2002); they have, however, been shown to rely less heavily on their spouse than their male counterparts (Belle 1991). Studies have also shown social support to have a stronger protective role for mental health among women, especially for depression (Casale et al. 2015; Schraedley, Gotlib & Hayward 1999). Moreover, women have been found to provide more frequent and effective social support to others (Belle 1991).

A better understanding of gender differences and dynamics related to both availability of support and the sources of this support would therefore be valuable in determining relative health risks and available resources among women and men in specific population groups.

Objectives and population

The analyses presented in this paper draw from quantitative (survey) and qualitative data collected through a mixed methods study with a sequential explanatory design, conducted with caregivers of children in two HIV-affected resource-deprived South African communities. The quantitative component of this mixed methods study consisted

of a household health survey with 2477 adults from two HIV-endemic communities (one urban and one rural) in KwaZulu-Natal, while the qualitative component consisted of follow-up in-depth interviews with 24 caregivers who had participated in the survey. The objective of this paper is to explore the gendered nature of social support sources and availability, by determining:

- Whether there are differences in the amount of social support available to male versus female caregivers (addressed through descriptive, bivariate and simple regression data from the quantitative survey);
- Whether there are gendered differences in the provision of support (addressed through descriptive survey data);
- Whether there are differences in the sources of support for male versus female caregivers (addressed through descriptive survey data);
- Possible explanations for these differences, based on the perceptions of male and female caregivers (addressed through thematic analysis of the qualitative data).

Social support may be especially important for this population of HIV-affected caregivers, given the greater mental and physical health risks among populations exposed to multiple social stressors such as HIV and caregiving (Catalan et al. 2011; Musil et al. 2009; Sheppard 1994; Sherr et al. 2001). Qualitative work from Southern Africa indicates that social support can help caregivers cope with hardship, in the context of generalised HIV (Campbell et al. 2008; Campbell et al. 2009; Casale 2011; Kiggundu & Oldewage-Theron 2009) and various studies with caregivers, deriving mainly from the developed world, show social support to be associated with less stress and better health (Bakasa 2007; Casale & Wild 2013; Pinquart & Sorensen 2007). Moreover, the gendered dimensions of social support may have particular relevance for this population of caregivers living in HIV-endemic South Africa. First, women most commonly take on the role of care provider in the home; a study estimated that women's daily unpaid care work was 13% compared to men's 5% in the South African home (Budlender 2008). Second, the prevalence and persistence of common mental health disorders, such as depression, have been shown to be higher among women (Herman et al. 2009; World Health Organisation 2012). In addition, women are also disproportionately affected by HIV, with women comprising 59% of all people living with HIV in South Africa (World Health Organisation 2011). The literature also points to the potential benefits that caregiver social support may have for the children in their care: more caregiver social support has been associated with better parenting and more positive child health and developmental outcomes (Oyserman et al. 2002; Sheppard 2009b; Simons et al. 1993).

Previous analyses from the survey data, on which this paper's analyses is based, in fact found more caregiver support to be associated with better caregiver mental health, and better overall general health and functioning (Casale et al. 2014; Casale et al. 2015; Casale et al. 2012b). In line with previous empirical studies, they also suggest

that social support may play a greater protective role for women (Schraedley, Gotlib & Hayward 1999), by protecting chronically ill female caregivers against depression (Casale et al. 2015). Previous analyses of the qualitative data suggested that this may be explained by the importance female caregivers place on communicating problems and receiving advice from members of their social networks, as well as the companionship and distraction deriving from social interaction, which could be preventing them from rumination (thinking repetitively and negatively about their illness and other stressors) (Casale, Wild & Kuo 2013).

Moreover, the qualitative data highlighted the importance attributed, by both male and female caregivers, to the identity and characteristics of support providers. It was suggested that the identity of the support provider, his/her relationship with the caregiver, and his/her previous experience with stressors faced by the caregiver, were important factors with regard to the effectiveness of social support as a resource for health, particularly for mental health (Casale & Wild in press; Casale, Wild & Kuo 2013).

The analyses in this paper further the mixed methods research described above, to provide insight on differences in support availability and sources for men and women and how women and men make sense of these differences. This is the first-known mixed methods study of this dimension conducted with caregivers of children in the Southern African region, to explore social support provision and availability from a gender perspective.

METHODS

The data presented in this paper derives from a broader mixed methods study with an explanatory sequential design: the quantitative and qualitative data were collected and analysed in two consecutive phases within this study and the second phase (qualitative component) was informed by and intended to provide further insight on findings of the first phase (quantitative component) (Ivankova, Creswell & Stick 2006). Ethics approval to conduct the survey research was obtained from the respective universities of KwaZulu-Natal and Oxford; ethics approval to conduct the qualitative research was obtained from the University of KwaZulu-Natal (UKZN) and the University of Cape Town (UCT). Approval was also sought and granted from the relevant South African national and provincial government departments and community representatives (e.g., councillors and tribal authorities).

Quantitative component data collection and analysis

The quantitative component of this study was a cross-sectional household health survey conducted in 2009 and 2010 with 2477 children aged 10–17, and their adult primary carers (18+), in two HIV-endemic resource-deprived communities in the KwaZulu-Natal province, South Africa.

Site selection and sampling

The urban site was a township approximately 20 kilometres south of the city of Durban in the eThekweni municipality; the rural site was located in the uMhlabuyalingana municipality, bordering Southern Mozambique. Criteria for site selection included high HIV prevalence rates ($\geq 30\%$ HIV prevalence among antenatal clinic attendees) (Department of Health 2008), high provincial health deprivation indices (Noble et al. 2006) and their respective urban and rural nature (based on Statistics South Africa 2001).

The rural site was characterised by a lack of road infrastructure and transport (most roads or pathways were sandy tracks), high levels of poverty, and limited service availability and communication. Nearly 50% of all residents were estimated to live in traditional dwellings, typically consisting of reed and/or thatch huts, and the large majority of residents in the area travelled by foot to reach schools, clinics and other destinations, as public transport were non-existent in many parts of the district (Umhlabuyalingana Local Municipality 2011). About 60% of the municipal area fell under traditional authority ownership, while the remaining 40% constituted commercial farms and conservation areas. Based on the most recent census data at the time of the survey, unemployment among the labour force was estimated to be around 70% (Umhlabuyalingana Local Municipality 2011). The rural field research was undertaken in collaboration with a well-established and respected community-based NGO (non-governmental organisation), whose activities included home-based care, life skills training and other capacity building.

The urban site was a township, consisting of both informal and formal urban dwellings, in the eThekweni municipality, approximately 20 kilometres south of the city of Durban. As with most South African townships, this area has a history of segregation linked to migrant labour and political violence under apartheid, and was also an important centre of political activism and resistance. Based on South African national household census it was estimated that in 2001 only approximately 40% of the labour force was employed and about 34% did not have formal housing (Statistics South Africa 2001).

Within research sites, random sampling of geographical areas representing the smallest political boundary (census enumeration areas in the urban site and designated tribal areas in the rural site) and door-to-door consecutive household sampling were conducted. Homes were eligible if there was one adult caregiver (18+) who was primary caregiver of a child between 10 and 17 years of age. Paired interviews were conducted with one adult caregiver and a randomly selected child between 10 and 17 in his/her care.

Data collection and analysis

Trained bilingual (English and isiZulu-speaking) field researchers went from home to home within each selected area to determine household eligibility, obtain informed consent and conduct the interviews. Caregivers completed face-to-face interviews

lasting about 45–60 minutes, based on a survey questionnaire. The questionnaire collected information on various dimensions of caregiver mental, physical and social health as well as key socio-demographic information. This included information on social support availability and key sources of support for different types of support received.

Perceived social support availability was measured through the survey using the Medical Outcomes Study Social Support Survey (MOS-SSS), a 19-item tool with 5-point answer scales. Respondents were asked to rate how often each type of support was available if they were to need it, and choose one of five options ranging from ‘none of the time’ (1) to ‘all of the time’ (5). These responses were scored together to derive a mean support index, ranging from 1 to 5, with higher scores representing higher levels of perceived support. This scale measured perceived availability of functional support, including emotional support, informational support, tangible support, positive social interaction and affection. The MOS-SSS has strong psychometric properties ($\alpha=0.97$; 1-year test-retest reliability = 0.78) (Sherbourne & Stewart 1991). Though it has not been validated in South Africa, it has been widely applied in the developing world and used multiple times in South Africa (see for example, Gaede et al. 2006, Westaway et al. 2005).

Data on sources of support were collected through questions asking the caregiver whether anyone had provided him/her with each of the following respective types of support over the past 12 months: (a) provided money or tangible items (instrumental support); (b) given good advice or information to help them make a decision or solve a problem (informational support); (c) comforted or cheered them up when they were sick or sad (emotional support); (d) told them that they were ‘doing a good job’ and gave advice on how to do things better (appraisal support) and (e) done enjoyable things with the carer when he/she wanted companionship (companionship support). In the case of an affirmative answer, caregivers were then asked who had been most important in providing them with each of the above-mentioned types of support. In the case of a negative response, caregivers were asked to indicate whether this was because they had not needed this type of support or whether they had needed it but it had not been provided. Where applicable, caregivers were also asked to identify the gender of the individual chosen. The key provider’s gender for each type of support is illustrated in Table 2.

Descriptive, bivariate and regression analyses were conducted in SPSS to determine gender differences in support availability, and in the key sources of support.

Qualitative component data collection and analysis

Participant selection and characteristics

In-depth semi-structured qualitative interviews were conducted with 24 caregivers as part of the broader qualitative study component, purposively chosen from the urban site

survey participants. The intention for the broader study was to include both male and female, as well as HIV-positive and HIV-negative caregivers in the sample (based on self-report of status). Moreover, since women represent the large majority of caregivers in this community (89% of community survey participants were female), they were also more strongly represented in our qualitative sample. The final sample consisted of eight male and 16 female participants, among which half the sample (12) was HIV-positive and the other half HIV-negative (based on self-reports); the split was equal across gender groups. All participants were Black African and isiZulu was their mother language. Participants' ages ranged from 31 to 74 years.

Data collection

Qualitative interviews were between one and two hours in duration and were conducted in participants' mother language (in most cases isiZulu). Interviews with male caregivers were conducted by a bilingual (English – isiZulu) male interviewer, while interviews with female caregivers were conducted by a bilingual female interviewer. The qualitative instrument was designed as a topic guide for face-to-face in-depth semi-structured interviews. Broad themes and related open questions were included to cover key topics to be addressed during the interview. However, themes were probed and explored through follow-up questions, based on participants' responses, in order to obtain a better understanding of their meaning (Ritchie & Lewis 2006). The application of the topic guide was flexible, in order to permit topics to be covered in a different order if appropriate, maintain the logical flow of the conversation, and allow for discussion of unforeseen emergent topics that could be relevant to the research questions (Ritchie & Lewis 2006). As part of the qualitative interview, participants were asked questions (as per the topic guide) that served to better qualify and understand the survey findings relating to the gendered nature of support provision and receipt (described in the results section below). They were informed of these key survey findings showing differences in support availability and sources of support among male versus female caregivers, and asked to offer their explanations for these.

Qualitative data analysis

Data was transcribed, translated and analysed thematically, through a combination of framework and inductive approaches (Corbin & Strauss 1990; Miles & Huberman 1984; Neuman 2006; Ritchie & Spencer 1994). As part of a broader qualitative study, themes were identified from the transcript content and attention was paid to the way the themes were treated and presented and the frequency of their occurrence (Berelson 1952; Ritchie & Lewis 2006). Dominant and less dominant themes, areas of agreement and disagreement were also sought in the data. The data for this particular paper was analysed collaboratively by both authors (one female and one male). NVivo software was used to support the coding and management of the data. This paper presents and discusses

only data from the qualitative interviews of relevance in providing explanations for quantitative findings highlighting gender differences in support availability and sources of support. The themes of interest for this analysis are presented below, based on the questions they aimed to provide further insight on.

The results section below therefore discusses both quantitative and qualitative findings that address the following themes: the gendered nature of care provision; the gendered nature of support availability, and the gendered nature of support provision.

RESULTS

(a) The gendered nature of care provision

The descriptive survey data highlight how in this community, as in most Southern African communities and globally (Peacock & Weston 2008), care responsibilities for children are disproportionately taken on by women; this includes care responsibilities for orphaned children. The large majority of primary child caregivers in this sample was female (89%) and the average age of caregivers was 44. It should also be noted that in most of these households with children between 10 and 17 years of age (71%), at least one orphaned child was also in the household members' care; this statistic reflects the high levels of orphanhood in these communities. As indicated in Table 1, households with female caregivers were more likely to be caring for orphaned children (73% versus 61%).

Table 1: Socio-demographic, health and social support characteristics for whole sample and by gender.

Variables	Total sample (n = 2477)	Females (n=2199)	Males (n = 278)	Chi-square value	t-value	p value for differences between males and females
Socio-demographic variables						
Age (mean, SD)*	44.2 (13.9)	44.3 (13.8)	43.4 (14.4)		1	ns
Completed high school (%)**	18.1	16.9	27.5	18.8		<.001
Two highest socio-economic quintiles (%)	40	39.4	44.6	2.8		ns
Orphaned children in household (%)	71.3	72.7	60.8	17.0		<.001
Social support score (mean, SD)	3.6 (1.3)	3.6 (1.3)	3.8 (1.2)		-2.9	< .01

Notes: * n = 274 for male caregivers for this variable, due to 4 missing values; ** n = 2183 for female caregivers for this variable, due to 16 missing values.

(b) The gendered nature of social support availability

Survey findings: more support available for male caregivers

The survey data showed that male caregivers in our sample were receiving more social support than female caregivers. Bivariate analyses (T-tests) showed that being male was associated with receiving more support ($p < .01$). This association still remained significant after controlling for age, household socio-economic status and education in a linear regression ($p < 0.05$) (Casale et al. 2012a).

Qualitative study findings: explanations for gender differences in support availability

There was overall consensus among male and female participants that male caregivers were receiving more support because it was considered unusual or 'rare' for a man to take on the role of primary child carer. As a result, when a man was seen to be taking on these care responsibilities, this would invoke greater compassion for the (male) caregiver and concern for the children under his care, especially among female community members.

It's not an everyday thing to see men caring for a child. That's why they are supported. (Healthy female caregiver).

Caring for children is mainly done by women, so now if men are now able to do that, it's something that is amazing and to be happy about, because it's rare (Healthy male caregiver).

Linked to this perspective was the assumption that male caregivers were more likely to experience difficulty caring for the children as they were less knowledgeable and/or capable in their role as caregiver than their female counterparts. This perspective was advanced by female caregivers:

It is known that women are the ones who are always caring, so this man doesn't have a clue how to put a baby's nappy on properly, and how to make a formula for his child and when the child is crying. He won't know what to do. So that's why they [male caregivers] receive more support, because they don't know how to care for a child. (HIV-positive female caregiver).

It could be the fact that men are known to be lacking in the ability towards caring for children, especially in the absence of the women. That is why men taking care of children receive more support. (HIV-positive female caregiver).

The perceptions of caregivers interviewed in the qualitative study was thus that survey findings of greater available support for male caregivers could be explained primarily by the fact that they were male *and* caring for children, versus simply being male. Several male and female caregivers said that they did not feel these men would be receiving more support from individuals in the community if they weren't doing anything to 'deserve' this support, such as caring for children. Once again, the assumption was that women were more naturally supportive of others and should be the primary caregivers

of children. As such, if a man was seen to be providing care not only would he be considered exceptional, but also lacking the innate skills and ability to care. He would therefore be considered deserving of support, whereas women were seen to be naturally able to undertake this role without additional support.

The support only goes to men caring for children, even here in the neighbourhood. If there is a man who takes care of his children, he receives massive support from the neighbours ... You only receive support for something you are committed to. (Female caregiver with non-HIV-related illness).

When men are caring for children, he should receive support, because they are very few men that are providing for their families, so that is why they receive more support ... Yes, because people get excited when they see a man care for his family, because for women, it is normal for them to take care of the family. (Male caregiver with non-HIV-related illness).

It should be noted that, while there was overall consensus on the above explanations among female caregivers, several male caregivers were not able to answer the question regarding reasons for the apparent gender differences in support availability: they either said they did not know or did not appear to be able to answer the question(s) directly.

(c) The gendered nature of support provision

Survey findings on the gendered nature of support provision

Since the large majority of support, sources indicated fitted into one of the expected 'family', 'friends or neighbours' or 'significant others' categories, for each of the five types of support responses were collapsed into these three categories, an 'other' category, and categories indicating that the caregiver had not needed support or had not been given support (see Table 2).

The survey descriptive data on sources of support also suggested that women in this community were providing more social support, to both male and other female caregivers. For a breakdown of the gender of key support providers, for male versus female caregivers and by types of support, see Table 3. As indicated in Table 3, a much larger proportion of both male and female caregivers identified women as their key support providers. This was the case for all types of support. For example, 67% of female caregivers and 71% of male caregivers indicated that their key provider of emotional support was a woman (versus the 33% female and 29% male caregivers who identified males as their key support providers). The more detailed descriptive data on sources of support (from which the indicators in Tables 2 and 3 were condensed) showed that the most frequently indicated providers of social support were, for example, female partners, sisters, daughters, mothers and female friends/neighbours.¹

Reported sources of support differed for male and female caregivers. As illustrated in Table 2, a considerably higher proportion of female caregivers identified individuals

Table 2: Key providers of support to female and male caregivers respectively.

Main support provider	Types of support									
	Tangible support (‘lent you money’)		Advice (‘gave you good advice’)		Emotional support (‘cheered you up’)		Appraisal support (‘told you that you were doing a good job’)		Companionship (‘did enjoyable activities with you’)	
	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
Family	33.5%	25.2%	44.3%	34.5%	46.6%	27.7%	44.4%	29.2%	41.6%	22.6%
Friends or neighbours	22.2%	21.9%	22.2%	21.8%	21.5%	18.5%	20.3%	20.6%	21.4%	22.6%
Significant other	13.3%	14.5%	14.8%	24.6%	18.2%	38.2%	19.2%	32.8%	21.3%	37.7%
Other	0.6%	0.4%	2.0%	2.0%	0.9%	2.0%	0.7%	2.0%	0.5%	0.4%
No-one	8.5%	12.8%	3.7%	5.6%	3.2%	4.0%	14.1%	13.8%	4.2%	3.9%
Did not need help	21.9%	25.2%	12.9%	11.5%	9.6%	9.6%	1.2%	1.6%	10.9%	12.8%

Table 3: Gender of main support providers for female and male caregivers respectively

SOURCES	Tangible support (‘lent you money’)		Advice (‘gave you good advice’)		Emotional support (‘cheered you up’)		Appraisal support (‘told you that you were doing a good job’)		Companionship (‘did enjoyable activities with you’)	
	RECIPIENTS		RECIPIENTS		RECIPIENTS		RECIPIENTS		RECIPIENTS	
	Females (n=1399*)	Males (n=150)	Females (n=1684)	Males (n=207)	Females (n=1794)	Males (n=212)	Females (1741)	Males (211)	Females (1751)	Males (213)
Male		36.7%	28.7%	32.9%	32.9%	28.8%	33.9%	29.9%	35.5%	29.6%
Female		63.3%	71.3%	67.1%	67.1%	71.2%	66.1%	70.1%	64.5%	70.4%

Note: *Numbers of valid cases for these responses are lower than the total respective male and female subsamples, and differ across questions. This is primarily due to the number of cases for which these questions were not applicable, where, for example, respondents indicated that they had not needed or received support; this ranged between 13 and 33% of the respective male and female samples.

within their family as their most important source of support. This was the case for all types of support, but differences were largest for emotional support (47 versus 28%), appraisal support (44 versus 29%) and companionship (42 versus 23%). On the other hand, larger portions of male caregivers reported their partner or 'significant other' as their key source of support; while the difference in the percentage of male versus female sources was negligible for tangible support (e.g., lending money or material goods: 14.5% for males versus 13.3% for females), differences were marked for all the other types of support, which represented the more emotional and informational types of support (e.g., advice, encouragement and companionship: for example, 38% of males versus only 18% of females had received emotional support from their significant other and 33% of males versus 19% of females had received appraisal support from their significant other). This suggests that male caregivers in particular were likely to turn to their partners (in the large majority of cases, female) for emotional support and advice. It should be noted that a similar proportion of male and female caregivers indicated friends or neighbours as their primary source of (all types of) support (these proportions were quite consistent across gender and types of support, with between 18 and 22% of male and female caregivers turning having received each of the five types of support from friends or neighbours). Also, there were no notable differences in the percentage of male versus female caregivers who reported not needing help (see the last row of Table 2).

Qualitative findings: Explanations given for observed gender differences in support provision

Qualitative interviews with both male and female caregivers provided possible explanations as to why women may be providing more social support to (both male and female) caregivers. One theme that emerged was that women were perceived to be generally more loving and empathetic, more likely to listen to the concerns of others and try to help out.

It because women are compassionate and sensitive, and they are the ones closest to their children and play their role as mothers. (Healthy male caregiver).

Sometime he [a man] responds in a bad way, saying I have my own problems, while a woman will listen and she will share with other people that would be able to help you. (HIV-positive male caregiver).

This was linked to their role and the pain they experienced as child-bearers:

A woman knows the labour pains or how painful it is to give birth to a child ... Because we can help as well because we are more compassionate and empathetic. (HIV-positive female caregiver).

It is mainly women who provide support since they carry children and are raised to be caregivers; therefore they are better able than men to understand children and children's needs. (Healthy male caregiver).

It was also argued that women were more likely to prioritise household needs, including supporting caregivers. Men, on the other hand, were considered to be less attentive to the family's needs and to engage more frequently in risky behaviour (e.g., use of drugs and alcohol), essentially stereotypical male behaviours closely linked to assumptions around men being more interested in drinking with friends rather than providing for their family:

Men can't take care of the children because when they have money they spend it on liquor. While women, when they have money they know that they have to buy food for the family. (HIV-positive female caregiver).

The first thing is a woman is not created like us men. We were created to get drunk and do bad things and we have hard hearts. (HIV-positive male caregiver).

Women are always closer to their homes than men. (Male caregiver with non-HIV-related illness).

Similarly, it was argued that men were often absent from their households and were less involved in or concerned with the challenges their households and families were facing and as such did not provide support. Often, women in the household would be left to deal with these challenges, such as the child care responsibilities and trying to make ends meet.

As for men they are always away from their homes. They don't pay attention to the problems concerning their households. They visit for a short period then go back to where they are coming from. (Healthy female caregiver).

Them, they are long gone, only a few men are real men, the rest ... For example like the father of my children, he is on drugs ... he doesn't even bother himself as I have to buy my children bread or I have to clothe my children and I have to get my children to school. And he doesn't worry himself about that. (HIV-positive female caregiver).

Once again, men's lack of responsibility for their children and providing support to caregivers and families was associated with the fact that they were not the child-bearers:

It's because they don't bring life, they leave you like that and their life continues while you are stuck and you have to face what you have brought into life. You understand that? (HIV-positive female caregiver).

A further argument that emerged was that women were more likely to provide tangible and emotional support in the community because they were emotionally and psychologically stronger than men. Women were also seen as more united, proactive

and solution-focused than men and more likely to collaborate in order to find solutions. This argument was advanced by female caregivers.

It's because we are very strong, stronger than men. (HIV-positive female caregiver).

Women are able to do things and they are united. They also have empathy and they help when you are in trouble ... When you tell a man about your problem, he will first just keep quiet and thinks, then he says he doesn't have what you are looking for. (Healthy female caregiver).

With more specific reference to support with child care, the theme of 'traditional' expected gender roles came up once again. It was perceived to be more appropriate for a woman to raise a child, and women were considered more competent in this regard. As such they would be more likely to provide support to other women and men in caregiving roles.

I think it's the way we were raised and we can't change it, and I think everyone knows that it's not easy for a man to raise a child, but the right person is a woman... (Male caregiver with non-HIV related chronic illness).

There was also an isolated reference to abuse and the risks of asking men for support and assistance, particularly with regard to child care. One female participant spoke about the fear women had of leaving their children with men, because of their perceived inability to care for them, but also because of fear of abusive behaviour. As a result women preferred to look after children themselves or seek assistance from other women.

Because we are the ones who look after the children. If a man is caring for a child, it does not look right. We are scared to leave our children with men, especially girl-children. We are the ones carrying the burdens. (Female caregiver with other illness).

Qualitative findings: explanations given for gender differences in sources of support

It was argued that women received more support from their families, because they in turn gave more support and care to their families. It was instead conversely argued that men don't pay enough attention to their families and in some cases are even abusive:

As I have said it before, women are able to help others. Men are abusive in their homes. (HIV-positive female caregiver).

It's because it is well known that women can look after their families while men don't make it their business to take care of their families. They will say there is someone who should take that responsibility since he doesn't have a child at home and the children are not his. But we, women give birth out of wedlock mostly and we rely on the Child Support Grant. And men will eat food which belongs to the children which has been bought through the Child Support Grant. And when a child complains about that, they will give children a hiding for their food. (HIV-positive female caregiver).

It was also argued, by female caregivers, that men dedicated more time and attention to people outside their own households, for example their friends.

Most of the time they don't care about the family, what they care about are friends. (HIV-positive female caregiver).

It's because men do not help in their homes when they have money, they only help people from outside. A woman doesn't forget her home. (HIV-positive female caregiver).

Women receive more support from family because they spend more time with their family and give more support to their family. Men are often out drinking and talking to their friends. (Healthy male caregiver).

Several female caregivers argued that expected gender behaviours and roles also played a part in men not seeking and/or receiving support in their homes. For example, they spoke about the notion that having to seek help or support within the family may make a man may feel 'less of a man' as it contradicted his role as the 'head of the family'.

We as women are not shy to talk about our problems, but men are ashamed when they have problems, maybe he will feel less of a man if he is asking for help. But we as women, we do not feel ashamed when we need help, it is easy for us to humble ourselves. (HIV-positive female caregiver).

There was also reference to men having greater difficulty than women in communicating their problems and concerns. It was argued that men had more difficulty than women in externalising/talking about their problems with members of their family, and that they often preferred to go to their friends for advice or assistance, to deal with adversity or adverse situations.

A man hides his feelings when something happened, they prefer to go to their friends and their friends are able to support them. (Healthy female caregiver).

Women talk and men don't. (Healthy female caregiver).

In contrast some of the male caregivers provided alternative explanations about why they got support from outside the home. One male caregiver argued that they would go to their friends (versus family) for support because their friends showed more compassion and understanding:

Friends are quick to be compassionate, unlike the family who don't care. They [family] will say you are being stubborn and ignore you, but friends do help you and say 'This is our brother.' (HIV-positive male caregiver).

Another male caregiver advanced a rather different explanation, saying that women were 'weak' and 'like children', in that they are obedient and did as they were told. The implication was that family members preferred giving advice and help to women, who

were more likely to listen to and follow it. Men on the other hand, did not like to be told what to do and were not likely to follow advice given.

I think when a person is growing up, there is a stage where men don't take advice from the family, but a woman, she listens to everything she is told. She is not different from a child most of the time. So if you are a type of person who doesn't listen so it's not easy to be trusted, and a lot of things that come from men, they don't need to be told. So the family trusts the person who always listens, because if they tell the person who listens then everything will be ok; unlike telling men who don't want to be told. (Male caregiver living with other non-HIV-related illness).

Another explanation put forward to explain why women were receiving more support than men from their families was that men spent more time away from their homes, and so were often closer to their friends than their own families.

It's because they don't stay at home often, they are always on the road, you know. They prefer their friends than their own families. (HIV-positive female caregiver).

Most of men have a lot of friends where they meet in taverns and drink, and when they drink, they don't have special time or care with their families... (Healthy male caregiver).

DISCUSSION

Both quantitative and qualitative findings from this analysis highlight gender differences in the availability of social support and its provision. Survey data indicate that male caregivers in these communities are receiving more support than female caregivers, while women appear to be providing more support than men. Descriptive survey data also indicate that women are proportionately receiving more support from their families and men from significant others (mainly female wives or partners).

In making sense of these gendered differences, caregivers' perspectives reflected dominant understandings of masculinities and femininities circulating in South Africa and how this patterned the forms and extent of social support. Broadly these dominant configurations of masculinities and femininities asserted that the gendered differences of who provided care, the support they received and from whom, could be understood by deeply entrenched social and economic gendered patterns. This reflects what writers on feminist ethics of care have previously highlighted: that patterns and assumptions about the naturalness of care for women enable significant costs and burden to be transferred from the state and men to women, further reinforcing women's subordination (Gouws & van Zyl 2014). Moreover, these distinctions were binary, with very little overlap between explanations for women and for men in terms of care, reinforcing the ways in which gender is fixed categorically in people's worldviews (Connell 2009).

Women were positioned as 'natural' caregivers throughout interviews (Morrell & Jewkes 2011). Justification for this emerged in terms of biological essentialism: women are good caregivers because they have borne children and can therefore relate to the

challenges of providing care. This was used to explain why women overall provided more care for children and were more likely to support other caregivers. The dominance of biological essentialism in explaining highly unequal gendered relationships is clearly recognised in the literature (Connell 2009).

There was also recognition in the data that women were more focused on their homes and providing support and care within their homes, in the absence of male partner involvement. While this was partly linked to gendered assumptions of women as innate carers and in turn men's lack of caring skills (Gouws & van Zyl 2014), there was an underlying current of anxiety about men and specifically men's violence and alcohol use. This emerged in three particular ways. First, the reality of women shouldering the burden of care for children reflected the situation of many women in South Africa who, because of long-term economic and gendered historical determinants do not live with a male partner – indeed one study estimated that 54% of men were absent fathers (Mavungu Eddy, Thomson-de Boor & Mphaka 2013). Second, women's main networks and sources of support were within the household; this may reflect the real ongoing fear of violence that many women, particularly those in historically 'black' spaces, continue to face outside of their homes.² Hallman et al. (2014) for instance show how, as young women enter puberty, their ability to move around in public spaces becomes radically restricted. This may limit where and from whom women seek support. The third way was in women's anxieties about letting men provide them with support and care. The high levels of violence against women and children perpetrated by men in South Africa has been clearly recognised, particularly in highly marginalised communities such as those in which this research was conducted (Jewkes et al. 2014; Jewkes et al. 2011). Women's very real anxieties about the potential for men to be violent towards them or their children can be a real barrier to supporting male involvement in caregiving.

In explaining the particular patterns of support men received as caregivers, participants drew on gendered assumptions about men. Broadly this positioned men as unable to provide adequate care to children, therefore requiring additional support from women. Men's reported support from peers outside their family may be understood in two interlinked ways. First, dominant assumptions about men outlined by participants emphasise how they look 'outside' the family for support, communication and friendship (Gibbs, Sikweyiya & Jewkes 2014). Second, although not directly articulated in interviews, others alluded to the community perception that men who provide care are 'not real men' (Gibbs, Sikweyiya & Jewkes 2014; Mavungu Eddy, Thomson-de Boor & Mphaka 2013; Morrell & Jewkes 2011). Men's continued seeking of support from their male peers may thus be understood as an attempt to continue to position themselves in ostensibly masculine networks, thus overcoming any issues that may have emerged about their masculinity for being carers. This reflects somewhat Morrell and Jewkes' (2011) point that men typically do not become carers because they want to, but rather are forced into this role through circumstances such as unemployment, and are trying to retain a semblance of masculine respect.

We note that this study has a number of limitations. As indicated above, the analysis presented in this paper draws from data pertaining to a broader mixed methods study, which was not designed to solely address the specific gender-related questions guiding this paper. As for similar qualitative work of this nature, the qualitative findings of this analysis cannot be generalised to larger populations. Moreover, the larger number of female, versus male, caregivers in this sample provides more space for the perspectives of female caregivers, and risks giving greater weight to these.

CONCLUSION

Findings of this mixed-methods study highlight the gendered nature of support and care provision in this community. Both childcare and social support are provided disproportionately by women, who, at the same time, are receiving less support than their male counterparts. Importantly, findings also highlight how gendered understandings of masculinities and femininities are drawn on in everyday settings to make sense of and naturalise these differences (Gouws & van Zyl 2014). These findings reinforce the usefulness of exploring social support provision and availability by gender, as these may differ for men and women. Gender may influence not only support availability, but also the types of support networks and key sources of support.

This is important to take into account, given evidence (from this study and more broadly) of positive associations between more social support and outcomes such as coping, better health, less stress and higher quality of life. This has been shown to be the case for adults in general and caregivers more specifically (Bakasa 2007; Campbell et al. 2008; Campbell et al. 2009; Casale 2011; Casale & Wild 2013; Holt-Lanstad, Smith & Layton 2010; House, Umberson & Landis 1988; Ke, Liu & Li 2010; Kiggundu & Oldewage-Theron 2009; Pinquart & Sorensen 2007). As indicated above, there is also evidence, across various populations, of links between more caregiver social support, better parenting and more favourable child health and developmental outcomes (Oyserman et al. 2002; Sheppard 2009b; Simons et al. 1993). If women in this community are disproportionately providing care for children and support to other caregivers, while receiving less support than their male counterparts, their well-being may be particularly at risk, as may be that of their children. Not only are they more exposed to the stressors and health risks linked to caring for multiple biological and foster children, they are also less able than their male counterparts to access support as a resource for coping, buffering effects of stressors and promoting health and wellbeing (House, Umberson & Landis 1988). Moreover, they are bearing greater physical and psychological costs of providing support to other – male and female – caregivers. This points to greater health risks among a population group more at risk for mental health and HIV in the first place (World Health Organisation 2011, 2012), and possibly greater risks for the health and development of their children (Sheppard 2009a)

Implications for interventions aimed at protecting the well-being of caregivers and children are twofold. First, there is a more immediate need to support women in similar HIV-endemic communities, who are bearing the brunt of caregiving and providing support and yet receiving less support than their male counterparts. There may, however, also be a need for more specific targeted support for male caregivers who are a minority and perceived to be more challenged in caring for children. They may well be receiving more social support because of the loss of a spouse or partner, absence of women in the home and greater difficulties in fulfilling caregiving responsibilities.

Types of useful support would comprise tangible assistance (e.g., grants), but also psychosocial support and practical support with activities such as caregiving, healthcare and transport to health facilities and government offices. Interventions could include initiatives such as support groups linked to health services, counselling, health education, parenting programmes and home-based care for caregivers and children.

However, in the longer run it would be important to work with both men and women to address gender inequalities and norms that position women as natural carers and men as unable to care. As indicated in the literature, gender norms and identities are not static, but are dynamic and changing, albeit embedded within long historical trajectories and more immediate economic and social contexts (Gibbs, Sikweyiya & Jewkes 2014; Jewkes & Morrell 2010). It is therefore possible to change, challenge and reformulate these gender constructs and relations (Connell 2009; Gibbs et al. 2014). Elements of successful approaches to transform gender norms and identities to promote greater male involvement in caregiving and democratise social support would include the provision of safe spaces for open dialogue around gender – where male and female caregivers are able to discuss common and differing ideas, in order to challenge stereotypes and gender inequities (Gibbs et al. 2014; Jewkes & Morrell 2010). Our findings also reinforce the importance of working with men around masculinities to increase men's involvement in caregiving (Morrell & Jewkes 2011; Van den Berg et al. 2013). Examples of these approaches include Sonke Gender Justice's 'One Man Can' intervention, that showed an increase in male engagement around caregiving (Van den Berg et al. 2013), as well as the 'Stepping Stones and Creating Futures' intervention, that also showed men's increased focus on their children and willingness to support them (Gibbs et al. 2014). More widely, there is also now greater recognition of the need for wide-scale structural change to enable greater male participation in caregiving, including policy reform, in particular around factors such as paternity leave (Peacock & Weston 2008). Without these wider reforms, gender transformative interventions are less likely to be successful at promoting greater male involvement in care.

ACKNOWLEDGEMENTS

We would like to acknowledge the important contribution of the entire Young Carers KwaZulu-Natal research team and our NGO partner the rural site, Tholulwazi Uzivikele,

to the quantitative component of the research. We are also very grateful to the caregivers who agreed to participate in this study.

FUNDING

This work was largely funded by the Health Economics and HIV and AIDS Research Division at the University of KwaZulu-Natal, South Africa. This broader Young Carers study was also funded by the Economic and Social Research Council (UK), the National Research Foundation (SA), the National Department of Social Development (SA), the Claude Leon Foundation and the John Fell Fund.

NOTES

1. It should be noted that the gender of support providers, illustrated in Table 3, refers to the key support providers indicated in the first four rows of Table 1 (family, friends or neighbours, significant others and – where applicable – the ‘other’ group).
2. We recognise that the major form of violence women face is intimate partner violence (IPV) and that this occurs within the home.

Please note that this study did not include key informant interviews. The participant interviews are either part of a health survey or qualitative study for which participants were assigned an identifying number to ensure anonymity. Given research ethics requirements, participant identifying information cannot be disclosed.

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