The Quality of Life, Social Care and Family Relationships of Older Unmarried Saudi Women Living in Jeddah: A Qualitative Study

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Abstract

Changes in the Saudi family structure are having profound effects on the current cohort of older Saudi women. This is reflected in living arrangements whereby family patterns have been transformed from extended to nuclear ones. Previous social research has not examined the current situation of older Saudi women, with little known about their Quality of Life (QoL).

This study explores the QoL of older unmarried Saudi women by analysing their family relationships, social lives and daily activities. It examines how family relationships, social integration, health and financial aspects are influenced by social policies and gender-related issues.

The study is based on in-depth interviews with a purposive sample of 50 widowed, divorced and never-married women aged 60-75 in Jeddah, Saudi Arabia from a range of socio-economic classes; 25 lived alone and 25 lived in inter-generational households.

Gender segregation was a decisive factor that adversely affected the QoL of interviewees. They were dependent on their family or maids socially, instrumentally, and some financially on the ‘Goodwill’ of their children or relatives. Older divorced women were particularly likely to experience financial and social problems. Lower class and many middle class older women who lived alone were dissatisfied and suffered from depression, isolation and loneliness, whereas higher class women living alone demonstrated greater autonomy, independence and life satisfaction. Most interviewees had poor health and multiple chronic diseases, such as diabetes and high blood pressure, which are linked to their socially and geographically restricted lives. Also, urbanization and associated cultural changes have adversely affected their QoL.

Gender segregation driven by ultra-conservative patriarchy has resulted in the economic and social dependency and restricted lives of older unmarried Saudi women. State intervention is needed to improve the general situation of older women, such as establishing care homes, increasing social insurance income and providing medical insurance.
Declaration

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the text, bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification. I agree that the University has the right to submit my work to the plagiarism detection service TurnitinUK for originality checks. Whether or not drafts have been so-assessed, the University reserves the right to require an electronic version of the final document (as submitted) for assessment as above.

Seham Hassan Salamah

30th September 2017
For my beloved
husband and children
Acknowledgements

All praise and thanks to God for helping me overcome what seemed like insurmountable obstacles.

Since the beginning of my PhD program, especially when I started the interviews, I have found it difficult to hear the sad stories of older Saudi women. However, amazing people supported and strongly inspired me; they are the reason I was able to complete this work. Specifically, I would like to thank the following.

First, I would like to thank the participants for their time and honesty in providing the information I needed to complete this study. I would like to say to them: “Do not ever allow numbers (age) to break you. Instead, stay proud and be productive. You can do anything. Always put your trust and faith in God.”

My heartfelt thanks to my PhD supervisor, Professor Sara Arber, for her constant, diligent and patient guidance as she read every word of my drafts. She provided an effective direction for the success of this thesis and also created a code to encourage me with the words “you can do it.”

Special mention goes to my local supervisor, Dr. Nora al-moussed. I am grateful for her years of assistance. She did not hesitate to support me with constructive feedback.

An extraordinary gratitude goes to the most beautiful and beloved mother in the world. Thank you for your patience and support. I love you. God keep you long.

To my beloved husband, Hani: Your patience has been indescribable. You even played the role of mother to our children. You’ve supported me with all your possessions. Without you, this work would not have been possible. “You are an angel in human form.”
Thank you to my son Abdullah for spending your childhood years with the mentality of a man who feels a responsibility toward – and who supports – his mother. I love you, my beloved son.

To my sweetheart Tooli: You have suffered so much throughout my PhD study. You encouraged me in the most difficult of circumstances while you yourself needed help. I can only say that you inspired me to help these older women because I learned to understand their anguish even more from your suffering. I love you so much, my daughter, and I am very proud of you.

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Many thanks go to the staff of Social Insurance. I credit you with the success of the interviews I conducted in your department. You comforted me and provided private office space for some of the interviews.
Finally, but by no means least, thank you to the staff of the Ministry of Health for the information you gave me.
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# Glossary

## English and Organisation Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>CDSI</td>
<td>Central Department of Statistics and Information</td>
</tr>
<tr>
<td>CNDH</td>
<td>Comisión Nacional de los Derechos Humanos</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GAS</td>
<td>General Authority for Statistics</td>
</tr>
<tr>
<td>GCC</td>
<td>Gulf Cooperative Council</td>
</tr>
<tr>
<td>HRW</td>
<td>Human Rights Watch</td>
</tr>
<tr>
<td>KAU</td>
<td>King Abdullah University</td>
</tr>
<tr>
<td>KSA</td>
<td>Kingdom of Saudi Arabia</td>
</tr>
<tr>
<td>MDPS</td>
<td>Ministry of Development Planning and Statistics</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NCD’s</td>
<td>Non-Communicable Disease</td>
</tr>
<tr>
<td>QoL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>UAE</td>
<td>United Arab Emirates</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNESCO</td>
<td>The United Nations Educational, Scientific and Cultural</td>
</tr>
<tr>
<td></td>
<td>Organisation</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WREC</td>
<td>Women’s Right and Economic Change</td>
</tr>
<tr>
<td>Arabic words</td>
<td>Meaning</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Absher</td>
<td>Electronic portal issued by Ministry of Interior of Saudi Arabia</td>
</tr>
<tr>
<td>Abaya</td>
<td>A Muslim’s robe-like outer-garment</td>
</tr>
<tr>
<td>Alhamdulilelah</td>
<td>Thanks God</td>
</tr>
<tr>
<td>Allalah</td>
<td>Depend on God</td>
</tr>
<tr>
<td>Badia</td>
<td>Life of the Dessert</td>
</tr>
<tr>
<td>Benteh</td>
<td>Daughter</td>
</tr>
<tr>
<td>Esha</td>
<td>It is the night-time daily prayer</td>
</tr>
<tr>
<td>Fitna</td>
<td>Temptations to men</td>
</tr>
<tr>
<td>Hadiths</td>
<td>Noble teachings from the Prophet Mohamed (PBUH)</td>
</tr>
<tr>
<td>Haram</td>
<td>Sin</td>
</tr>
<tr>
<td>Irdd</td>
<td>Honour</td>
</tr>
<tr>
<td>Kuttab</td>
<td>A class of Qur’an recitation for children, which was usually attached to the local mosque</td>
</tr>
<tr>
<td>Maghreb</td>
<td>Prayer scheduled before sunset</td>
</tr>
<tr>
<td>Mahram</td>
<td>Male legal guardian</td>
</tr>
<tr>
<td>Mithaqan ghalithan</td>
<td>Solemn covenant</td>
</tr>
<tr>
<td>Mufti</td>
<td>Islamic Scholar</td>
</tr>
<tr>
<td>Nahda</td>
<td>Renaissance</td>
</tr>
<tr>
<td>Niqab</td>
<td>A face veil covering used by women</td>
</tr>
<tr>
<td>Shahadah</td>
<td>Testimony of Faith</td>
</tr>
<tr>
<td>Sharia Law</td>
<td>Religious law forming part of the Islamic tradition. It is derived from the religious precepts of Islam, particularly the Quran and the Hadith</td>
</tr>
<tr>
<td>Sultan</td>
<td>A Muslim Sovereign</td>
</tr>
<tr>
<td>Ulama</td>
<td>Religious Scholars</td>
</tr>
<tr>
<td>Wali</td>
<td>Legal guardian</td>
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</table>
Chapter 1: Introduction to the Research

1.1 Introduction
The main aim of this study is to investigate the everyday lives of older unmarried women in the western coastal city of Jeddah, Saudi Arabia. The implications of the process of ageing are explored among this subgroup of women who live in a very conservative society. Building on the knowledge of older women in my own family and their experiences, I took on this challenge and selected this topic. There were no previous research has been done on unmarried older women in Saudi Arabia in general, particularly in Jeddah.

The ageing process is a common experience. In later years, individuals can view life experiences either positively or negatively, and the factors and challenges encountered throughout the course of life may vary from person to person. Simultaneously, well-being and quality of life (QoL) can be harder to maintain later in life. The concept of QoL is described by Shin and Johnson (1978, cited in Gilhooly et al., 2005:14) as having access to resources for the “satisfaction of individual needs, and desires, [and] participation in social activities enabling personal development”. As such, the definition of ‘quality of life’ should be determined empirically and reflect an individual’s personal experiences. To date, knowledge of the situation faced by older women in Saudi society is limited; thus, my research study will investigate their lived realities and how circumstances throughout the course of their lives have influenced their later years.

The world population is rapidly growing older, as fertility rates have dropped to an exceptionally low level in most regions of the world; in addition, people tend to live longer (He, Goodkind and Kowal, 2016:1). The number of older people is rapidly growing, and many see this as a problem in society. Cheadle (2016) recently reported that total fertility rates, defined as the average number of children born to a woman who survives her reproductive years (aged 15-49), have
decreased globally by approximately half since 1960. The global fertility rate is just 2.5, roughly half of what it was 50 years ago. Cheadle argues that if the world has too many older adults who are dependent and not enough workers, the reduced working population is likely to find it challenging to support the increased health care and other costs of caring for the growing elderly population.

The World Health Organization (WHO) devoted its annual World Health Day in 2012 to ageing. The European Union designated 2012 as the Year of Active Ageing and Solidarity between Generations. The UN General Assembly conducted a high-level meeting in September 2011 about avoiding and controlling non-communicable diseases (NCDs), which are strongly related to ageing (Beard et al., 2011:4). These international organisations encourage older people to be active while ageing, including by funding activities and facilities that encourage them to interact with different generations and enrich their lives.

Several factors affect the QoL of older people; in particular, their health, financial capacity, autonomy, social activities, family or social support, and home environment. According to Galambos (1997), quality of life was associated with goodness of life which is related to an individual’s perceived psychological, spiritual, sociocultural, biological, and environmental well-being. Furthermore, Gabriel and Bowling (2004:675) stated that quality of life (QoL) reflects both macro-societal and socio-demographic influences on people and the personal characteristics and concerns of individuals. They add that one can argue for the existence of a common core of values within societies, and that the presence or absence of these values influences overall QoL. However, Kelley-Gillespie (2009:266) argues that many authors claim that quality of life is best represented by health-related characteristics. She also added that health-related quality of life reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. All of these factors affect the QoL of elderly people and are influenced by the cultural and religious traditions of each community.
Some Middle Eastern societies are addressing factors related to ageing aiming to promote a healthier QoL for older people in the Middle East region. For example, in Qatar, the Ministry of Development Planning and Statistics (MDPS) (2015:110) promotes the initiative of having family gatherings by encouraging the entire family (e.g., parents, sons, and daughters) to live in the same vicinity, by providing subsidised rentals from the state to create positive environments to benefit elderly people, especially older women. In the United Arab Emirates, elderly primary home care services are a vital source of healthcare for the ageing population, helping to maintain elderly patients in their own homes through a multi-disciplinary, team approach (AlShaali and Al Jaziri, 2015:18). In Tunisia, the Union of Social Solidarity deploys mobile teams to provide free home-based health services for elderly people and organises specialised government-funded rehabilitation and physical therapy services for older people for little or no fee (Hussein and Ismail, 2016). Thus, these Middle Eastern countries share a vision of improving the QoL of elderly people, albeit using different methods and strategies to reach their goal.

Later life is now numerically dominated by women and will continue to be so for the foreseeable future (Arber and Ginn, 1991; Bernard & Phillips, 2000). According to Dyson (2001:84), elderly women are at a higher risk of poor health. Although women consistently have a longer life expectancy than men, they also tend to have a higher probability of acquiring chronic illnesses and disability in later life. Dyson also argued that older women tend to have fewer resources than men, being more likely to live alone, be widowed, have a lower income, or live in social or rural isolation. Generally, older women are undervalued and neglected by the people surrounding them. The experiences of men and women in old age differ, and a large proportion of older people worldwide are women. According to the United Nations (UN) (2015:2), the population of older women 60 years and above around the world was 54% compared to 46% of older men, in 2015. In most societies, older women are more vulnerable to discrimination, including poor access to jobs and healthcare, abuse, denial of the right to own and inherit
property, and lack a minimum level of income and social security (United Nations Population Fund, UNFPA, 2012:13).

Although elderly women have some similarities in terms of their life experiences, differences particularly exist in relation to their culture and environment. In Turkey, Yirmibesoglu and Berkoz (2014:152) concluded that elderly women are satisfied with the residential and environmental conditions in which they live; however, the majority of them suffer from ill health. They are socially active, and their rate of participating in social activities is high, as it is in some other countries in the Middle East and North Africa (MENA) such as Egypt and Jordan. Whilst older women are satisfied with their social lives, they suffer from the consequences of poor health services in their countries. Nejati et al. (2008:25) stated that in Iran the QoL for older women is more problematic than it is for elderly men because of factors negatively affecting their lives, such as low finances, poor health, and especially their low level of education. Nejati and colleagues argue that the core problem in Iran is the high spending on foreign policies at the expense of domestic spending which has affected everything negatively, including the position of older people and, in particular, women.

In contrast to other MENA countries, Tamimi (2016:2) claims that no existing research has examined older people in terms of healthy ageing in Saudi Arabia. Therefore, the situation of elderly women is unclear due to a lack of data, particularly to the study of ageing which will help these older Saudi women have a better experience in their later life. Utz and Nordmeyer (2007), in the US, state that while feminists have done a good job of documenting the problems and disadvantages associated with old age, they rarely provide a critical discussion of how age, or, as they say, “age relations,” structure the opportunities and constraints that individuals accumulate throughout the course of their life. They argue that ’age relations’ is the system of inequality based on age that privileges the young at the expense of the old. This happens because we live in a world that values youth and regards old age as a period of decline. Consequently, Utz and
Nordmeyer add that scholars should assemble a series of well-written chapters that provide both theoretical justification and empirical examples of how age is a source of inequality throughout the life course and why it must be incorporated into the feminist theories. This would explicate the negative factors affecting their lives and create a clear plan to assist older women in securing a better QoL.

1.2 Focus of the Research
This study will explore the fundamental elements which affect the QoL of older Saudi women. In theory, Saudi Arabia is a wealthy country that has the resources to provide large budgets, specifically for elderly women, due to Saudi’s high economic wealth as compared to other developing countries. Bagader (1999:287-288) states that the Gulf Cooperative Council (GCC) communities have the ability to fund a ‘community of well-being’ of younger and older people and also to honour the aged. However, Bagader also reported in his recommendations in 1999 that there is a lack of sophisticated plans. Despite the progress made by health and medical schools and colleges in the countries of the GCC, little attention is given to the subject of older people, particularly aged women. Further, there is no curriculum on gerontology or ageing in the syllabus of medical schools or Departments of Sociology. In particular, until now, the situation of older Saudi women has been largely unknown and is characterised by a scarcity of relevant data. In this study, it is my aim, as a researcher, to build a foundation for future researchers and scholars, to increase the attention given to this age group of women in Saudi Arabia who may be at risk due to their poor QoL.

Saudi Arabia is a highly religious country, and it is important to consider the position of older people from an Islamic perspective. In Islam, older women have a privileged position, as they are included with older men in several hadith from the Prophet Mohammed (Peace be upon him, PBUH), which, narrated by Abu Musa Al-Ash‘ari, said: “It is out of reverence to Allah to respect the white-headed (aged) Muslim” (Abu Dawud; ranked Hasan by Al-Albani) (Yaqut, 2010). This hadith shows that giving respect to older people is a way of demonstrating how
Muslims obey God and apply the teachings of Islam. In Muslim societies, particularly Saudi Arabia, Muslim people once respected and honoured older women due to their desire that God would put them in the best place of paradise (heaven). According to traditional Saudi cultural norms, older women maintain one of the most fundamental places in their family members’ hearts, as older women’s siblings, children, and all relatives should heed their opinions in decision-making regarding such issues as marriage, education, and travel. It is a tradition that most Saudi families specify one family day at the weekends to visit their elderly women relatives. Accordingly, the elderly women are always the first guests on any occasion; even strangers in the public sphere are expected to show respect to them and offer assistance to help older women with their needs. Thus, the presence of older women is seen to demonstrate the solidarity of the Saudi family; it is important that older women are at the forefront of any occasion and they are considered the foundation of Saudi society.

Although these traditional values and expected behaviours are part of Saudi culture, they are insufficient to understand the real situation behind the walls towards older women within older women’s homes. In the past, I observed many cases in which older women were pretending to be happy, putting on a show to conceal the suffering of their experiences. Thus, I have chosen to explore older women’s lives in depth and to hear their own words instead of relying on traditional ideologies about elderly women and different or inconsistent statements from others. A qualitative approach is the appropriate way to discover what we do not know about older Saudi women; it will give me power as a researcher and provide Saudi citizens with previously unknown information about this topic, as well as identify the factors that affect their QoL. Addressing my research questions (see Section 1.4) will reveal an unknown reality for all Saudis in Saudi Arabia, particularly in Jeddah city. These research questions will address our lack of understanding of the social factors affecting the QoL of older Saudi women.
My own positive attachment to my mother and older female relatives has influenced my interest in older Saudi women, particularly my desire to understand their subjective life experiences and, more importantly, my desire to understand the emotional world of older women. I am aware that many elderly women among my extended family and friends’ families are suffering from a lack of care and support. As a woman, I want to understand what it is like to be an older woman in Saudi society and what influences their QoL. Studying older women’s issues is sociologically important, yet quite challenging. As a lecturer at King Abdulaziz University, Jeddah (Department of Sociology), I have aspired to explore these issues for more than 15 years. I wish to understand older Saudi women’s current situation and position within Saudi Arabian society. As Barkan stated (2011), understanding the elderly and the experience of ageing helps us understand a society. This knowledge will give me, as a sociologist, information about the factors affecting older Saudi women’s QoL. As mentioned in Section 1.1, information is lacking about the study of ageing in Saudi Arabia. It is my interest as a sociologist to improve the sociological understanding of older women in Saudi Arabia and to inform the broader society about the importance of studying older women.

A major motivation behind this study is to undertake new research in the Kingdom of Saudi Arabia (KSA) about the position of older women. It has also been noted in Saudi society that concerns have been expressed about the lack of daily interactions between elderly women and their sons and daughters, most notably throughout the last 20 years. Often young people leave their parents in the rural areas to go to the cities to find work or to continue their studies in universities or higher education institutions (Al-Shabani, 2005:51). The changes about contemporary issues and differences of opinion, in view of Islamic teachings about honouring older Saudi women, will be discussed in the following chapter.
On a personal note, I feel concerned about my mother (75 years old), the other elderly women in my family, and other elderly women in general. From my personal observations, many older women appear feeble, as though they were children. They are always waiting for occasions like weddings, which provide opportunities to see other people, but the rest of the time they live mainly in complete loneliness. This personal dissertation was an enormous incentive for me to undertake this study, as I hope to ensure that older Saudi women receive greater support and help in the future.

In the remainder of this chapter, I will discuss my research problem and research questions, as well as outlining the structure of this thesis.

1.3 Research problem

No previous research in Saudi Arabia has focused on the care or support of older Saudi women who are widowed, divorced or who have never married. My aims with respect to this research study are, firstly, to examine the QoL of unmarried (divorced, widowed or never-married) older Saudi women; secondly, to explore the ways in which older women’s QoL is related to ageism, their gender roles, and social activities in old age; and, thirdly, to better understand the impact of gender segregation in Saudi Arabian society and the consequences of changes in family structure for older women in later life.

The number of older people will continue to increase in the Kingdom of Saudi Arabia; it is expected that future growth in the proportion of individuals aged over 60 will result in significant challenges for the families of older people and the government. A 2010 survey by the Central Department of Statistics and Information (CDSI: 2010) showed that the age group of 65+ represented only 1.01% of women and 1.47% of men in the Kingdom of Saudi Arabia. Saudi Arabia is very unusual compared to other societies in having a greater number of older men than women; 59% of people over 65 years are men and 41% are
women (see Table 1.1). However, of people who are aged 65 and above in Saudi Arabia, there were more elderly, divorced women (3.8%) as compared to elderly divorced men (2.4%) and a substantially higher rate proportion of widowed among elderly women (53.7%) compared to elderly men (5.2%). Never-married elderly women account for only 0.73% of older women, and never-married elderly men accounted for 1.6% of older men. These figures show that 57.5% of older women are unmarried, compared to only 7.6% of older men in Saudi Arabia; this emphasises the need to study unmarried women (see Table 1.1).

Table 1.1: Marital status of Saudi men and women aged 65 years and older in 2010

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Men</th>
<th>Women</th>
<th>Total population of both genders and %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>Population</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>364926</td>
<td>115695</td>
<td>480621 (71%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>20898</td>
<td>148865</td>
<td>169763 (25%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>9465</td>
<td>10539</td>
<td>20004 (2.8%)</td>
</tr>
<tr>
<td>Never married</td>
<td>6311</td>
<td>2032</td>
<td>8343 (1.23%)</td>
</tr>
<tr>
<td>Total</td>
<td>401600</td>
<td>277131</td>
<td>678,731</td>
</tr>
</tbody>
</table>

Source: *CDSI, 2010: Table 3.6.*

When I originally began exploring this topic, I intended to select my participants from among unmarried older women who lived in care homes in Jeddah city to explore their situations, especially as they are living without any family members, and to determine what kind of QoL they are experiencing. Unfortunately, when I started to access the care homes, I found only one private care home in Jeddah city. Due to the lack of care homes in Jeddah, I changed my direction to obtain my sample from the community. Still, I learned a lot from my visit to the care home as I witnessed the situation of the women there. These care home residents
did indeed face difficulties, but at least their daily needs were being provided for inside the care homes. This made me consider: what about unmarried older women who have different types of living arrangements? How are they handling their financial and other needs? These questions pushed me to learn more about unmarried older women residing in the community in different types of living arrangements.

Through a literature review, I noted that most studies of older women have been conducted in the West, with remarkably few in the Middle Eastern region. This research study will provide a greater understanding of the experiences of living alone and of life in inter-generational households in the community, as well as how these living situations impact on the QoL of older unmarried women in Jeddah, Saudi Arabia. It will also start to build a picture of what policy measures might be developed to meet the support needs of older unmarried women in Saudi Arabia.

1.4 Aims of the study and Research Questions
The general aim of my research is to examine the QoL, social support, and family circumstances among older unmarried women living alone or living with other family members in Jeddah. There is no doubt that gradual change is occurring in Saudi society, and this is having a profound effect on the current population of ageing Saudi women. My study intends to highlight and examine the impact of ageism and socio-cultural norms on the well-being of older unmarried women and on the challenges they encounter in obtaining appropriate services within Saudi society. This research will provide recommendations for the planning of support services for older unmarried Saudi women as well as for the development of a seamless long-term care approach. In addition, it will draw greater attention to the situation of older unmarried women among their families, academics, policy makers, other organisations, and society in general. Overall, the study aims to
understand how older unmarried women are coping with ageing and how the quality of their lives may be improved.

Understanding the factors that affect the QoL of older unmarried women living alone and living with their children or other relatives will facilitate the development of social and health policy interventions for this group. Older women themselves can provide significant insights into what promotes their personal well-being. It is only by asking older women to describe what life is like for them that we will be able to understand what is required to create the necessary strategies to meet their social, economic, and health needs. This research study will also identify gaps in social services which need to be addressed. The absence of previous studies related to ageing Saudi women has led to a lack of comprehensive policies focused on the different needs of older unmarried women in society. Thus, a goal of this research is to develop recommendations and resources to improve the QoL of older unmarried Saudi women on the basis of my research findings.

When aiming to understand the QoL of older unmarried women in Saudi Arabian society, the starting point will be to seek their own views and perspectives on their living situations and needs. The proposed research questions for this study are:

- Why and how do gender-related issues, socio-cultural norms, and family structure influence the well-being and QoL of older, unmarried Saudi women in Jeddah?

- What are the factors that support, or do not support, older unmarried women to maintain their QoL? How and why do these factors influence the everyday reality of their lives?
• What are the benefits and challenges facing older unmarried Saudi women aged 60 to 75 living alone compared with those living in inter-generational households? How and why do these two distinct living situations affect their support, care, and material well-being?

• How do social factors influence older unmarried women’s health and ability to function? What social factors are associated with social isolation, social loneliness, and depression among unmarried elderly women?

By addressing these questions, the factors that influence the well-being and QoL of older, unmarried Saudi women will be identified. It is hoped that such information will raise the awareness of this under-researched population, provide evidence about their needs for social and financial support, allow healthcare providers to improve personal health care plans.

It is essential to recognise the scope of this research study. Elderly Saudi women who are currently living with their spouse and women with medical conditions that are known to interfere with comprehension (e.g. serious illnesses like Parkinson’s disease, dementia, etc.) will not be included in this study. The study will be restricted to older women aged 60 to 75, living alone or in inter-generational households in Jeddah, Kingdom of Saudi Arabia.

1.5 Structure of the thesis
The research study comprises 10 chapters. A brief overview of the following nine chapters (2-10) is as follows:

Chapter 2– Saudi Arabian Society, Family Structure, and the Situation of Women
Chapter 2 provides a geographic and demographic overview of Saudi Arabia. Accordingly, it presents recent information about Saudi Arabia and describes
Jeddah City as the main setting of the research study. Middle Eastern literature will be discussed to provide a broader perspective on the life course, roles, and characteristics of Arab women. Most importantly, this chapter will explore women’s position within Saudi culture. It will provide information on how the existing family structure influences the Saudi woman’s social, psychological, and economic well-being; in particular, it will examine factors which have influenced and continue to affect the situation of older unmarried women in Saudi society. In addition, the chapter will discuss the impact of gender roles, gender segregation, and gender inequality and highlight the contribution of religion, socio-cultural norms, and traditions. It will focus on the social context and explore gender inequality both inside and outside the family, where women are positioned as a subordinate group.

Chapter 3 – Theoretical Background and Literature Review
In this chapter, relevant literature will be reviewed from available past studies as a background for the research study. Western and European literature will be covered to provide a wider, international perspective on ageing and older women. The chapter will provide a discussion of core concepts related to ageing, ageism, and intersectionality theory. It will explore the influence of gender-related issues, societal changes and socio-cultural norms on the QoL of older unmarried women. The literature discussed includes psychosocial theories of ageing, such as disengagement, activity, and continuity theory, and the context of Saudi Arabian society. The sociological theories of ageing that relate to older women in Saudi Arabian society include patriarchy, gender segregation, gendered cultural norms, and structured dependency. These sociological theories will be discussed to provide a framework for exploring the ageing experiences of older women in Saudi Arabia.

Chapter 4 – Research Methodology
This chapter discusses the research methodology used to achieve the aims of this thesis. The choice of qualitative research to meet these goals is justified along
with the selection of the research design. A target of 50 participants was set for this research on older unmarried women, comprising 25 living alone and 25 living with family members. The sampling strategy for the pilot and main study is described in this chapter. In addition, this chapter outlines the recruitment procedure and emphasises the role of gatekeepers in both the pilot and main study. Also, this chapter will discuss the importance of ethical considerations, including informed consent between the researcher and respondent, and the need for confidentiality and issues of risk in qualitative research for both the researcher and respondent. Finally, reflections on the 50 qualitative interviews will be discussed which include issues and difficulties that the researcher encountered while conducting the pilot and main study.

Chapter 5 – General Characteristics and Socioeconomic Resources of Older Women
This chapter provides an overview of the 50 older unmarried Saudi women aged 60-75 years old focusing on their socio-economic resources, educational status, and living arrangements. This chapter discusses, in detail, the present economic resources of older Saudi women which are an important element of their financial well-being and highlights the respondents’ financial dependency.

Chapter 6 – Social Support to Unmarried Saudi Older Women in Later Life
Social support is a physical and emotional comfort provided by the family, friends, and others. This chapter discusses the sources of support received by older Saudi women in times of illness, their daily social activities, financial matters, and their social relationships with their relatives and friends. The chapter examines the social relationships of Saudi women with their children, comparing older Saudi women who live alone with those living in inter-generational households.
Chapter 7 – Health Status and Health Care Access of Older Unmarried Women
This chapter discusses the background of the healthcare system existing in Saudi Arabia, the health status of older Saudi women, and their access to healthcare centres. It explores the causes of the poor health status of older Saudi women, despite the level of development in the country, the factors that influence their physical and social well-being, their lack of awareness regarding existing health care centres in their neighbourhoods, and how gender inequalities affect their access to the medical insurance and the healthcare system of Saudi Arabia.

Chapter 8 – Quality of Life of Older Unmarried Women
This chapter explores the concept of the QoL of older unmarried Saudi women. It examines the relationship of their educational level, economic position, living arrangements, health status, and life circumstances, in relation to their overall well-being and QoL. Additionally, the types of support received by them in their daily lives will be discussed and how these relate to their QoL.

Chapter 9 – Discussions of Findings
This chapter discusses the results of the research in relation to previous Western and Middle Eastern literature on older women. It discusses gender-related issues and socio-cultural norms in the lives of older unmarried women and how these influences their well-being and QoL. This chapter discusses, in particular, the impact of socioeconomic status and financial resources. The main themes in the four analysis chapters are integrated and explored in more detail. The ways in which these older women find meaning in their lives will be illustrated.

Chapter 10 – Conclusions and Recommendations
The conclusion chapter outlines the key conceptual findings and provides a summary of the study. It provides recommendations for current and future research. Based on my findings, suggestions will be presented to improve the QoL.
for older unmarried women in Saudi Arabia and to help them achieve positive experiences in their old age. Limitations of this study are also discussed.
Chapter Two

Saudi Arabian Society, Family Structure and Women’s Position

2.1 Introduction

This chapter provides a geographic and demographic overview of Saudi Arabia, with special emphasis on the city of Jeddah (21.2854° N, 39.2376° E) as the main setting of the research study. The issue of elderly women in the Middle Eastern Region, particularly in Saudi Arabia, has hitherto been neglected. Despite the strong influence of cultural and religious norms in Middle Eastern societies, many elderly women face a myriad of factors that affect their quality of life as they age. Relevant Middle Eastern literature will be discussed to provide a broader perspective on the life, conditions and characteristics of Arab women in the family and society. This chapter also presents recent information about Saudi Arabia and the social factors that have influenced the situation and role of older women in Saudi society.

2.2 Overview of the Kingdom of Saudi Arabia

The Kingdom of Saudi Arabia (KSA) is a monarchy, founded on 23 September 1932. Arabic is the official language and Islam is the official religion. Long (2005:1) considers Saudi Arabia as a ‘young nation with an ancient history’. He added that ‘previous communities have lived and worked in a symbiotic relationship with nomadic tribes for at least 6,000 years’. However, according to Mufti (2000:1), in the early part of the twentieth century, the number of nomads, commonly known as Bedouins in Saudi Arabia, have ‘diminished substantially’. The Bedouin population migrated to the city centres due to increased job opportunities, because of the developing oil industry.

The flag of Saudi Arabia is based on the symbol of the reform movement of late King Abdulaziz Ibn Al-Saud and his warriors. The green flag of Saudi Arabia is inscribed in white with the *shahadah* (testimony of faith) which means “There is
no god but God (Allah): Muhammad is the Messenger of God”. Below the letters, also in white, is a sword (Library of Congress, 2006). The sword was added to the flag in 1906 to symbolise the military success of Islam and Abdul Aziz Al-Saud who founded the kingdom of Saudi Arabia in 1932 (Zuhur 2011:2).

Metz (1992) states that Saudi Arabia is socially characterised as a religiously and conservative country and Al Lily (2011) adds that Saudi Arabia suffers from a lack of cultural diversity, and that cultural values are an amalgamation of tribal and Islamic principles. For this reason, it is difficult to differentiate between Islamic principles and Arabic customs. According to Montagu (2015:5), Saudi Arabia’s status as a religious and conservative society has its roots in the 18th-century alliance of religion and state between the first Al Saud king, Muhammad bin Saud, and the Muslim reformer Muhammad Abdul Wahhab. Perhaps 60–70 percent of the Saudi people are conservatives, who do not want the change or reforms that the government has been attempting to introduce. He also added that the continuing pact between the Ulema’ (clerics) and the government has provided a stable environment in which to practise the Islam that they have inherited, and adhere to the practices and rules to which they are committed.

Extensive migration of rural people to urban cities like Jeddah has affected the lives of Saudis in general. Bagader (2006: 74-77) states that at the beginning of the 1960s, the Hejazi people, especially from Mecca, came to the city of Jeddah as commuters who went back to their hometown after work every day (see map in Figure 2.1), while migrants from Medina settled in Jeddah, visiting their hometown on their day off. In the 1970s, migration to Jeddah increased as job opportunities increased. From the 1980s, migration to Jeddah entered another phase. At this time, uneducated migrants from Saudi villages entered domestic service and simple trade areas. This led to a significant increase in the number of migrants to Jeddah and created different social levels.
The rhythm of life in Jeddah became faster. The absence of the traditions that they were accustomed to in their villages, such as interdependence and social solidarity, communication with neighbours or caring for the elderly, meant that social relationships became more superficial and based on utilitarian values. These developments affected the formation of the Saudi family, as it changed from the extended family to the nuclear family. The migrants, who moved with their wives to Jeddah in the 1960s and the 1970s, left their extended families to form new families. Forty years after leaving the extended family, women became even more dependent on their husbands. Without an extended family, widows and divorced women often found themselves living alone after the death of their husbands or after divorce.

Figure 2.1 Map of Saudi Arabia.

Source: www.infoplease.com/atlas/saudi-arabia

2.2.1 Geography

The Kingdom of Saudi Arabia is positioned on the Arabian Peninsula in Southwestern Asia. It is north of Yemen and the north west of Oman and the United Arab Emirates (see Figure 2.1). It is located south of the Syrian and Iraqi deserts. Kuwait is located on the north-eastern and Jordan on the north-western
border, which runs from the Arabian Gulf to the Gulf of Aqaba for about 870 miles. The Red Sea is on its western border, and the Arabian Gulf to the east, along with Bahrain and Qatar. The size of the Kingdom of Saudi Arabia is about 2,217,949 km$^2$ (Zuhur, 2011:1).

The Kingdom of Saudi Arabia (KSA) is divided into four main regions and thirteen administrative districts with each of these divided into governorates. Each area is known for its geographic features, natural resources, history, and cultural traditions (Zuhur 2011:13). The central region, also known as the Najd Plateau, consists of the cities of Riyadh, Al-Qasim, and Al-Hail. The second region, found in the western part of KSA, is called Hijaz. This region lies down along the Red Sea coast, comprising Tabuk and the two holy cities of Makkah and Al-Madinah.

The western region includes the city of Jeddah, which is also known as the Bride of the Red Sea. The third region is named Asir and found in the southern part of the country. This area is comprised of the cities of Al-Baha and Jaizan (Janin and Besheer 2003: 9-10). The fourth and final region is the Eastern Province. This part includes the heart of the petroleum industry at Dhahran which is sited in the port of Ras Tanura to the north and Dammam to its south. It is home to the industrial city of Al-Jubail, the historic area of Al-Ahsa, and the oasis cities of Hofuf and Qatif (Zuhur, 2011:14).

### 2.2.2 The setting: Jeddah City

The city of Jeddah is located along the coast of the Red Sea and is the main urban centre of western Saudi Arabia. It is the primary gateway to Makkah and Al-Madinah, the holiest cities in Islam. According to Long (2005: 6), Jeddah is the second largest city in Saudi Arabia next to the City of Riyadh. Jeddah has been the principal seaport of the Kingdom since ancient times due to its proximity to the Red Sea, and the location itself is strategically important for trade routes.

Janin and Besheer (2003: 16) stated that Jeddah is an ancient commercial port that served as the trading hub and gateway for pilgrims coming to nearby Makkah.
They added that the city is ‘modern in every sense and yet retains its historic charm’. Long (2005) states that Jeddah was the first commercial centre in the Kingdom where the diplomatic community and foreign ministries were located. This all changed in the 1970s when Riyadh was opened to foreigners. As Jeddah is located by the sea, its boulevard coastline, also known as the Corniche, is occupied by restaurants, shops, and hotels, and has been a popular destination for many.

It is vital to understand what constitutes the physical and social environment and the cultural context of Jeddah. According to Al-Ansari (1982), the City of Jeddah has been described all through its history by two unique elements; by being an attractive port for trade and migration. The oil boom period experienced by the country during the 1970s increased the importance of Jeddah. Like other cities in Saudi, it expanded and became an attractive place of opportunity for employment, buoyancy of trade, and developed a presence of governmental and educational institutions. With an increase in internal migration of people from the surrounding villages and towns, Jeddah became a cosmopolitan city (Bagader and Alturki, 2006). Furthermore, Fadaak (2011: 152) states that the modern town of Jeddah comprises a mixture of different races and ethnicities that have shaped the multicultural identity of the city. The features of its class divisions can be seen in the poverty belt and the slum areas.

### 2.2.3 Population and life expectancy

The most recent report from the Central Department of Statistics and Information (CDIS, 2010) showed that the population of Saudi Arabia has more than tripled since the 1974 census, to 27,136,977, including Saudis and non-Saudis. Saudi citizens accounted for 68.9 percent (18,707,576) while non-Saudis comprised 31.1 percent (8,429,401). Male Saudi citizens were 9,527,137 (50.9%) while females were 9,180,403 (49.1%) (CDSI 2010: 1-14). However, since 2010, the General Authority for Statistics (GAS) of KSA has not provided a report about
the population in the KSA, but they estimate that the total population in KSA was 31,742,308 in 2016 (GAS, 2016).

By the end of the 1970s, the population of Jeddah was estimated to be close to one million, and in 1986 was 1.4 million. By the 2010 census, the population of Jeddah was 3,430,697 with 1,729,007 Saudis and 1,714,123 non-Saudis. It is notable that half the population of Jeddah are Saudis while the rest are non-Saudis. Among the Saudi population, there were 830,992 (48.1%) females and 898,015 (51.9%) males (CDSI 2010: 1-14). The CDSI (2010) has shown that the number of Saudi citizens aged below 15 years old was 5,550,117 (29.7%), the number aged 15-59 years old was 12,288,491 (65.7%) and the number aged 60 years old and over was 937,902 (5%). There are unsubstantially more older men (age 65+) 537,765 (57%) than older women 400,137 (43%) (CDSI 2010:2), which contrasts with the gender difference of more older women than older men in virtually all societies.

According to Nydell (2002: 1), ‘life expectancy in the Arab countries has risen dramatically’. He states that between 1955 and 1988, life expectancy rocketed from 43 to 67 years of age in Morocco, from 42 to 67 in Egypt, 34 to 71 in Saudi Arabia and from 55 to 77 in Kuwait. A 2009 study by the Ministry of Health, reported that Saudi Arabia had a relatively high life expectancy at 74.7 years old for women compared with 72.5 for men (KSA, Ministry of Health 2009:31).

2.3 Saudi Arabian society and Family structure
Islam values dominate Saudi Arabian society. Religion has a profound influence on day-to-day activities at all levels of society: social, cultural and political. All the laws in the Kingdom must adhere to Islamic principles, which are outlined in the Quran. According to Zuhur (2011: 180), ‘law is a matter of religion and vice versa’. As a result, the society is conservative in all aspects of life. According to Metz (1992), Saudis consider the family as the ‘basis of their identity’ and position in life. Additionally, Bagader (2003: 244) states that the family is
considered the ‘fundamental cornerstone’ in Saudi’s societal structure. To completely understand Saudi society, it is imperative to understand Islamic culture. Jawad (1998: 29) argues that Saudi Arabia is considered to be ‘traditional and ostensibly closer to Islamic cultural norms than the other Muslim countries’ since the two Holy regions (Makkah and Al-Madinah) are located in the country, which hence is considered the Centre of Islam.

Saudi Arabian family structure is patriarchal. According to Yackley-Franken (2007: 38), patriarchy has been part of Saudi culture since the early 1900s, and ‘male dominance’ over family affairs is undeniable. The oldest man in the family acts as the head of the family. This was highlighted in Islamic law which states ‘the family is the basic unit of Saudi society and the guardian (male) should be obeyed’ (Zuhur 2011: 218). In a study by Almosaed (2009: 39-41), she concludes that patriarchy gives men a dominant position in society, as well as the family. This system gives all the power and rights to men as men are seen as superior to women.

According to Abd Al-Ati (1995), family rights and obligations are assigned to family members who are enjoined to administer them privately, and are assigned according to sex and age (Almosaed, 2008:62). Additionally, the responsibilities of family members in Islamic societies are expected to be in accordance with socio-cultural norms and with Islamic values. This includes performing prayers, fasting and a most important value emphasised by the Qur’an is to respect elders and treat grandparents with kindness which is part of worshipping God. Georgas et al. (2006) stated that traditionally, the responsibility of the father in the Saudi family is to be the breadwinner and the mother to be the housekeeper. According to Sultana (2011), patriarchy influences the social customs, traditions and social roles in society. Hence, the male legal guardian, who guides the family, is solely responsible for providing instructions to his family members based on the religion and customs. Additionally, Abudabbeh (2005:426) stated that in Muslim society:
men are given specific duties which they should perform for their wives and children; wives are given instructions on how they should treat their husbands, and children are advised to honour their mothers. A man should provide an upright Islamic and ethical education to his wife because, as the maintainer of the children at home, it is her responsibility to guide her children towards righteousness.

Bedouins have represented a large proportion of the Saudi Arabia population since the establishment of Saudi Arabia in 1932 (see section 2.2). They came from the Arabian Peninsula and migrated to various parts of the Arabian world. They were the first local people before the Kingdom was founded by King Ibn Saud. Bedouins provided the bulk of the judiciary, most of the religious leaders and much of the Praetorian Guard that protects the King and his entourage from various potentially subversive forces (including elements of the Saudi military) (North and Tripp, 2009:72). According to Kark and Frantzman (2012:500), Bedouins left the nomadic life which they had followed for thousands of years and began settling into a new life which was previously unfamiliar to them. Bedouin families were part of traditional Saudi Arabian society from which they received their identity as Saudis and their religion, namely Islam.

Bedouin families were the first type of family that represented Saudi Arabian society. Culturally, Bedouins were an extended family with family members and relatives living in one household. Long (2003) stated that the extended family is the single most important unit of Saudi society, playing a pivotal role not only in Saudi social life but in its economic and political life as well. However, because of the impact of Western culture and the era of the oil boom, the culture of Saudi people has gradually changed. Long (2005: 28) emphasised that the rapid urbanisation of the Kingdom is one of the reasons behind the gradual loss of traditional cultural values, and the transformation of the extended family into a nuclear family. This was confirmed in a study by Bagader (2003: 249) on Jeddah about the issues and marital problems in the Gulf Cooperation Council (GCC)
countries. Most of the young people who planned to get married preferred to form nuclear families and set up an independent residence. Some would even set up a separate residence as a condition of their marriage contract. Although most young couples nowadays choose to live as a nuclear family because of the influence of Westernisation, the extended family remains relevant (Abudabbeh, 2005: 427). Additionally, it was stated by Rahaman (2015:2) that the Bedouin culture is “actively” preserved by the government. According to Wilson and Graham (1994: 246), the Saudi family has changed markedly in the 'space of two generations'. Nowadays, fewer Saudi women are willing to live with their in-laws than in the past. Because the extended family is declining, social support among family members may be weakening. Also, more women are becoming educated and participating in paid work than in the past.

2.4 Women’s position in Saudi society
Socio-historical studies of the Middle-East that discuss the position of women are limited compared with studies of women in other countries (Keddie, 2007: 203). According to Moghadam (2003: 65), the ‘women’s place’ in Saudi Arabia is in the home, and their lives are more restricted compared to other Middle Eastern countries. Their traditional position is as a wife, a mother and nurturer to their children, and being responsible for taking care of family members. In addition, Alhareth, Dighrir and Alhareth (2015: 122) state that the position of women in Saudi society, especially in the public domain, is complicated. Control of women by men is still a strong cultural norm in Saudi Arabia. However, a study by Elamin and Omair (2010), found that young, single, unemployed, and educated Saudi males report less traditional attitudes towards working females compared with old, married, employed, and less educated ones. Age was found to be the most important predictor of male attitudes towards women working. Thus, the position of women in Saudi Arabian society is strongly influenced by the attitudes and age of their male legal guardian. The differences between the perspective of the younger generation and the older generation of Saudi men affects the circumstances of Saudi women in society.
Education is essential for an individual to have a better position in society. In Saudi Arabia, the plan to spread education to girls throughout the country has developed rapidly since the 1960’s (Shukri, 1972). Before that time, women’s education in KSA was restricted to the house, where a sheikh would teach girls how to read the Qur’an and the basics of writing (AlMunajed, 2009:6). Additionally, traditional education in Saudi Arabia came from the two Holy Mosques in Makkah and Al-Madinah (Murtada, 1996:32), and private schools were established in 1941 by immigrants from Indonesia and Malawi (Alsweel, p. 6). Moreover, Kirdar (2004:27) said that the first modern girls’ school in Saudi Arabia was founded by King Faisal’s wife in 1956. However, even though opportunities for educating women in KSA became available at that time, the restriction of their male guardians often prevented them from partaking in school life; instead, they used to spend all their time undertaking household chores in preparation for married life, which is crucial to Muslim women.

Abu Shaqqa (1999:126) stated that Muslim women have the right to professional work if there is no conflict with their family responsibilities. There is no clear restriction which prevents a Muslim woman from participating in paid employment. However, there has been a misinterpretation of Islam in certain Muslim societies about this concept (Al-Jafari, 2000). For example, the Qur’an commands women to stay in their house to take care of family needs. However, this commandment does not signify that women cannot work outside of their domain. In the Holy Qur’an, there is evidence to prove that women can work outside of their homes, as the Almighty says” And when he arrived at the water of Midian (Madyan) he found there a group of men watering (their flocks), and beside them he found two women who were keeping back (their flocks)”. He said, "What is the matter with you?" They said "We cannot water (our flocks) until the shepherds take (their flocks). And our father is a very old man." (28:23). Additionally, Ullah, Mahmud and Yousuf (2013:45) stated that the Prophet Mohammad (PBUH) himself encouraged women to engage in various activities; trade and commerce was one of them; his own wife (Khadija) was a prominent
businesswoman at that time. Therefore, Islam did not explicitly prohibit women from working, but it emphasized their role as wives and mothers, ordering them not to go outside their house unless it is necessary such as going to the mosque or doctor (Khimish, 2014:139). In recent times, the attitudes and values that are related to female education and women who work outside the home or family property are becoming more positive and supportive because of industrialisation, urbanisation and education, and are clearly evident, especially in large cities (Georgas et al., 2006:443).

To give importance to the position of women in Saudi Arabia, many feminists have fought to gain equality for women in the country. Alhareth, Dighrir and Alhareth (2015:122) argued that Islamic feminism attempts to work within the values of Islam, and not against them, by offering social benefits in a culturally satisfactory and sustainable way to families through enhanced opportunities for daughters, sisters, wives and mothers. This approach by the Islamic feminists aims at claiming rights for women in society so that they can educate themselves and the importance of women in the economic sector can be recognised. However, while women in Saudi Arabia have a pre-eminent position within the family, it would be improper to think that the role of women is confined to homemaking. Developments in the Kingdom have brought increasing opportunities for women in both education and employment. Bahry (1982: 502) states that the societal role of Saudi women is changing along with other social changes in Saudi Arabia. However, these modifications are still within the framework of Islamic values and social practices.

In Saudi Arabia, there are groups of elite women who have been able to work in specific gender-segregated jobs such as teachers in schools. The government have been promoting the employment of women, for example in 2005, the Saudi Minister of Labour announced a policy for staffing lingerie shops with female employees, a move that was eventually made mandatory in 2011 (Arab News, 2015); it creates more labour opportunities, especially for Saudi women who are
less educated. As part of the Saudisation process, in which there has been a progressive replacement of expatriate labour in the Kingdom, across all skill levels, with unemployed Saudis (Fakeeh, 2009:77), the Ministry of Labour of Saudi Arabia has identified several employment opportunities for women. These include occupations such as; beautician, receptionist, banquet-hall employee, tailor, photographer, nutritionist, governess, caterer, and hospitality or recreation industry worker; but Saudi women are only permitted to work in gender-segregated work settings (AlMunajed 2010:6). The working area must be consistent with sociocultural norms and must comply with the gender segregation that is strictly practised in Saudi society.

UNESCO (2006:191) reports that women’s literacy rates in Europe and Northern America are mostly well above 95%, with very few exceptions. However, a study by Al Masah (2010:2), reports that in Saudi Arabia, women (including expatriates) have a literacy rate of 79%. However, only about 65% of women who are employed are literate, and 78.3% of unemployed women are university graduates. Saudi Arabia had the lowest state female labour participation rate in 2009 (20.1%) compared to its fellow Arab countries, such as Qatar, UAE and Kuwait. According to Ismail, Neema, and Olney (2016:4-7), despite the rise in employment of Saudi women from around 450,000 in 2005 to around 800,000 in 2014, almost all these jobs were established in the retail, hospitality, and construction sectors. The retail and hospitality industries have been the focus of major government ‘Saudisation’ and feminisation campaigns, aimed at encouraging women to enter the workforce. Regardless of their increased employment in health and education, Saudi women continue to face challenges in entering other sectors like engineering and architecture. Within the Saudi context, it is evident that despite the increasing rate of Saudisation in general, the number of actual female jobs that have been created through Saudisation is still low compared to males.
The political participation of women in Saudi Arabian society has become a major issue and has been promoted since 2011, when King Abdullah approved that women have the right to suffrage and to vote (HRW, 2015). This late progress of women’s empowerment in Saudi Arabia has slowed the development of equal access and rights between men and women in the political sphere. While in other Muslim countries like Turkey, Bozkurt (2007), argues that Turkish women first obtained their voting and election rights in 1934, while New Zealand, was the first country to allow women to vote on September 19, 1893 (Pridgen, 2014). These countries promote gender equality between men and women from all sectors of society. Moreover, despite the late empowerment of women in Saudi Arabia, a reporter named Tasneem Nashrulla of the Buzz Feed News (2014) stated that Saudi Arabia has achieved an incredible feat by having 19.9 percent of its representative chamber as female members (30 out of 151 seats are held by women) which is higher compared with other parliaments located in the MENA area, such as Egypt.

In 1979, a historic event happened in Saudi Arabia that affected women’s position in society. This event decreased women’s freedom and mobility in Saudi society. Hegghammer and Lacroix (2007) argue that Juhayman Al-Utaybi, a former theology student, together with his fellow rebels, attacked the Mecca Grand Mosque. The reported reason for this act of Al-Utaybi was to stop Westernisation happening in the country. In 1978, a year before this historic event, the media, for example magazines and newspapers, published articles which were written by both men and women discussing women’s participation in the public sphere such as: education that was suitable for women, where women should work, and women’s right to drive (Doumato, 2000). Nonetheless, the attack on Mecca in 1979 affected the progress of women’s participation in the nation. For example, Hamdan (2005:47), stated that broadcasting by unveiled women on television was forbidden, and banned Saudi women from establishing their businesses without their male guardian's consent. Thus, these events essentially led to the formation of the women's movement in Saudi Arabia.
According to Carmichael (2015:28), the position of women in any given society is dependent on the cultural norms and associated institutional arrangements, sometimes dating back centuries. However, because of the events that marked the past decades, from the start of women’s education in the 1960’s until the proclamation of the participation of women in the political sector in 2011 by the late King Abdullah, the position of Saudi Arabian women in society has improved significantly.

2.5 The Position of Older Women

According to Calasanti and Slevin (2001: 41), although women in many Islamic societies remain secluded, elderly women also enjoy considerable power over younger women through controlling their ritual and occupational activities. As an example, in Pakistan, older women have more mobility, have greater access to household resources and have more decision-making power within the household in comparison with younger women. (Isran and Isran, 2012:842). An elderly woman is believed to have a certain position which enables her to play a vital role in the family. A study by the Agewell Foundation (2015) showed that elderly women in India had a very limited role in the decision-making process at all levels of family, societal and national. However, they enjoyed the traditionally exerted authority over younger women (McNay, 2003:10).

The male legal guardian in each Saudi Arabian family maintains and influences the young regarding the value of respect for age and seniority. According to Long (2003), the wisdom and authority of elders are seldom challenged, and younger men and women must wait their turn, often until their sixties or older, before they are accorded the role of family patriarchs and matriarchs. Additionally, older women also participate in family consultations, business and occasions where the family is involved. Georgas et al. (2006) state that as a grandparent, elderly women in the family are highly respected and play a major role in deciding about many family issues. Additionally, Long (2003) stated that older women are involved, even in politics - King Abd al-Aziz (Ibn Saud) regularly consulted with
his full sister, Nura, who was one of his closest advisors on matters of state; and with King Faisal’s wife, ‘Iffat, who was active in public affairs, particularly women’s education. She was universally called “the Queen” out of respect for her pioneering efforts, even though this title technically did not exist. Thus, older women’s position can influence the decisions of their male legal guardians because of his respect for them; their voice may be undeniably important within each Saudi Arabian family.

According to Gschwandtner and Studentin (2007:10), elderly women in Islamic societies are usually well respected in society and are often seen as the protector of traditions, religion and proper behaviour. However, because of globalisation, the value and importance of the elderly has gradually deteriorated. El-Haddad (2003:12) stated that because of modernisation, a mother or grandmother in the Gulf countries is no longer the main agent of raising children or of dealing with them. Regarding issues relating to socialisation, the youth prefer to gain knowledge from the television, radio and internet rather than socialise with their mother or grandmother, and to benefit from their knowledge.

Yahya El-Haddad (2003), in Saudi Arabia, argues that religious teachings and the traditional cultural value system urge youths to be loyal to older persons and to make sacrifices for their sake. In the past, caring for the elderly in Saudi Arabia did not need any special arrangements, except in rare cases, because the teachings of Islam are that the youth should take care of elderly relatives in their household. The daily lives of older people progressed according to the lives of those with whom they lived.

Regarding elderly women, particularly those who are mothers and grandmothers in Muslim societies, as the Prophet Mohammed (PBUH) said in his narration ‘Paradise lies at the feet of your mother’ (Hassan, 2006). Thus, honouring, respecting and giving the mothers and grandmothers their rightful position in society will lead you and direct you to paradise after death.
2.6 Gender roles

Analysing the position of older women, in their homes and society, indicates how culturally prescribed gender roles affect their lives. El-Sanabary (2003: 75) states that the primary role of Middle Eastern women is to care for their home, and working outside is justified only when it is necessary. Thus, the traditional Middle Eastern role of a woman is as a mother who cares for and teaches her children.

A study by the World Bank in the Middle East and North Africa (MENA) on gender and development, argues that traditional and sociocultural norms define gender roles and this may ‘affect women’s aspirations and their selection of jobs and professions that they believe to be acceptable, respectable, or appropriate’ (World Bank, 2004: 100). In the Saudi Arabian context, 'gender-role expectation' is seen as the main obstacle for women who are attempting to enter the labour force (El-Sanabary, 2003: 75). On the contrary, Khimish (2014) argues that there are many verses in the Qur’an that allow Muslim women to have different types of roles in society. Alhareth, Dighrir and Alhareth (2015:124) state that Muslim society in the Kingdom of Saudi Arabia, and around the world, has depreciated the accomplishments of Muslim women by practising cultural norms that illustrate male domination over women in general in society, including in education. For this reason, most Saudi women throughout their lives have focused on the values of domesticity, where their roles were restricted to being housewives, mothers and nurturers of their children. Even today, although more labour is needed in the Saudi Arabian economy, traditions and gender-based socio-cultural norms are still upheld.

Long (2005: 36) argues that gender roles in the Saudi context are changing due to rapid urbanisation. He also added that men and society in general, for economic reasons, are gradually acknowledging the participation of women in the labour market. As pointed out by Bagader (2003:259), working women have become financially independent, which improves their situation and position within the family and society. Therefore, changes that have happened in Saudi Arabia over
the past two to three decades have affected the role of women, particularly as they have entered jobs like teaching and nursing. However, women still have the primary role of being a mother or wife.

2.6.1 Gender segregation

Gender segregation is part of the Saudi socio-cultural norm, and is widely implemented in Saudi Arabian society. According to Buisson (2013:100), gender segregation, often termed as the prescriptive prohibition of free-mixing in Islam, is commonly presented as a means of individual and societal protection. The rules of segregation in Islam were to ensure the ‘cleanliness’ of both women and men. This was seen as ensuring that both genders do not give into the temptation of the opposite sex and to sin. However, in pre-Islam times, Abu Shaqqa (1999:71) stated that the Prophet Mohammed (PBUH) did not consider preventing the mixing of men and women as necessary to ensure modesty. Additionally, the Prophet did not see the mixing of genders as contrary to decency. Thus, mixing of men and women within the limits of decency should not be considered as haram (sin), or contrary to dignity. Additionally, some researchers point out that gender segregation was not a ‘traditional’ practice in Saudi Arabia, but it was relatively recent and linked to the discovery of oil, the development of the state, the process of urbanisation and conservative religious discourse (Al-Khateeb, 2007; Tonnessen, 2016).

According to an-Nabhani (1990:28), the system of gender segregation applied in Islam is to give protection against anything that may culminate in an illegal sexual relationship, or divert men and women from the specific system that Allah tasked them with to control sexual relationships. Applying gender segregation in society attempts to prevent unrelated women and men from committing a crime called khulwa. A reporter named Abeer Mishkhas of the Guardian (2007) stated that khulwa is a concept which describes a man and a woman being alone together in an enclosed space, which in the Islamic interpretation might lead to temptation. The mixing of unrelated men and women was commonly punished as the crime of
khulwa; however, in classical Islamic jurisprudence, there is no stipulation of punishment for gender mixing, but only for fornication and adultery (Tonnesen, 2016:11).

In the Middle Eastern region, some countries continue to implement gender segregation in schools and other public places (Doumato and Possusney 2003: 11a). Saudi Arabia enforces strict gender segregation, even on public transportation and in public facilities such as restaurants, beaches and amusement parks (Tamimi, 2012). Therefore, the position of Saudi women differs from other Islamic nations and signifies the more conservative society which has evolved in Saudi Arabia. In comparison, Barimo (2012:55) stated that in Turkey, social interaction between men and women, especially the youth, is no longer condemned.

Having to lead gender segregated lives results in an unequal distribution of women and men across occupations and educational establishments. According to CDSI (2010), women make up only 15% of the Saudi workforce because of preconceived notions about women’s inferiority. Moreover, gender segregation reinforces the discrimination and perceived inferiority of women in male-dominated societies in the Middle East. It is an essential contributor to the disparity between men and women regarding their level of education, income, and labour force participation (Doumato and Posussney 2003: 11b). As a result of strict gender segregation, Saudi women have limited access to the public sphere, which deprives them of complete freedom and independence. Gender segregation limits their social involvement and largely precludes them and keeps them out of life in the public sphere.

Most Saudi women and men consider that women’s nature is different from that of men, as they deem women to be physically weak. Saudi women also traditionally worked only in the domestic sphere. According to Baki (2004), certain jobs such as engineering and architecture are exclusively open for men,
while women are restricted and only allowed to study these fields at a theoretical level. Until recently, only certain jobs (e.g. teaching and nursing) were open for women, which is why women often specialise in education and healthcare (Hamdan, 2005). As discussed earlier, the cultural norm only allows women to work in segregated spheres where they cannot be seen by unrelated men. Hence, Saudi women have limited access to the public domain, which reduces their work opportunities, as well as their social opportunities since they are not allowed to mingle with anyone without the approval of their male guardian.

2.6.2 Salafism

Muhamad IbnAbd al-Wahhab (a religious scholar, and the father of Grand Mufti of Saudi Arabia) provided a doctrine which, in his strict theological interpretations, states that the kingdom of Saudi Arabia has one religion, Islam, of which there is only one dominant ideology that stresses a strict social adherence to Shari’a law, following of the Prophet, and the purge of ‘un-Islamic’ practices (International Center for Religion and Diplomacy, 2016:3; Blanchard, 2008). Additionally, Salafism is defined as the purest way of Islamic life, based on the understanding of the best generations of Muslims (Abdul Cader, 2015:167). Also, it was defined by Nielsen (2017:2) as a patriarchal movement with authority patterns dominated by men and a gender ideology that appears to leave little space for women’s authority. Abdul Wahhab’s purpose in establishing Salafism as a doctrine was to free the environment from all the “defilement and pollution”. Thus, in that view, people should abandon superstition and revive the preaching of Prophet Mohammed (PBUH); but this point of view is very conservative, especially regarding gender segregation. The doctrine of Muhamad IbnAbd al-Wahhab spread rapidly in the Arab peninsula, and was followed by many people (Nevo, 1998). Furthermore, Salafism was reintroduced by the Saudi state in the 20th century as the dominant school of Islamic law, education, and culture (Alqahtani, 2012:29).
The implementation of gender segregation in Saudi Arabia in the past was, to a large extent, influenced by the Salafist doctrine. According to Abdul Cader (2015:167), Saudi Arabia predominantly follows the Hanbali school of thought, while also considering the Malaki, Shafei, and Hanafi schools. Hence, the Hanbali school of thought is considered the most conservative school in the Islamic religion, and many Salafist scholars of Saudi Arabia follow this doctrine (Abdul Cader, 2015:170).

Thus, as part of the Saudi Arabian culture, gender segregation was practised all over Saudi Arabian society due to the strong influence of Salafism. As a result, Saudi families applied the dominant culture, which is a mixture of religious thought and tribal tradition referred to as the honour of women. Baki (2004:3) stated that the reason for such mobility restrictions on women is due to Saudi society's strong belief in family honour; the pride and honour of a woman's family are directly related to her chastity—known as ird (honour). Arab “sensitivity to ird is so great that an entire way of life has been built around it. Saudi society is structured to keep a woman within strictly defined limits that make it difficult, if not impossible, for her to lose her sexual virtue.” Thus, many restrictions were imposed on women because the tribe and family honour are connected strongly to ird (Alhazmi and Nyland, 2015:94). Therefore, to keep the chastity of the women in the family, many restrictions on education, paid work, and travelling alone were applied to women in the society in order to limit their interaction with unrelated men. This affects the mentality of the male legal guardian of each Saudi family—who were afraid of sending their daughters to educational institutes in the past, which created inequality for women, as ird is only connected to women, not men. In addition, the reason why guardians insist on gender segregation for their female members is because of the presumption in their patriarchal beliefs that women are temptations to men (fitna), and endanger men’s faith by sexually tantalising them with their appearance, their voice, and their presence (The Ex-Muslim, 2013).
Salafi movements tend to be quite literal in their interpretation of the Qur’an and Traditions (Hadiths), and impose a highly conservative vision upon women – opposing all mixed sex schooling, mixed sexes working together in the workplace (or women working outside the home at all), imposition of extreme dress codes, opposition to women’s suffrage (and often opposition to the concept of voting at all) (Fuller, 2003:38). Thus, Saudi women’s position in the society has been affected totally by the concept of Salafism that limits their capability to be part of or to contribute to Saudi Arabian society. Moreover, as mentioned in the previous section, although formal education for Saudi girls was started in the late 1950’s, and even though the Saudi state was advocating the importance of education for both men and women, the influence of the conservative groups who opposed the idea of education, particularly for girls, had a very strong impact on the mindset of Saudi society. Therefore, the Saudi state leaders required great wisdom to convince their own people of the importance of education (Alyami, 2016:869), especially for Saudi women.

2.6.3 Gender Inequality
Inglehart and Norris (2003, cited in Moghadam 2005: 98) state that on ‘the issues of gender and sexuality, Muslim nations have remained the most traditional societies in the world’. According to Okkenhaug and Flarkerud (2005:2), ‘Gender in the Middle East is certainly shaped by and works within a patriarchal society’. Moghadam (2005: 99) argues that gender inequalities in Muslim societies are a hindrance to economic growth and modernisation, and that the continued restriction of women’s participation in the economic and political aspects of society adversely affects the ongoing development of society, gender and social status in Muslim societies.

Gender inequality exists in Saudi society as women are considered 'vulnerable' owing to the 'power imbalance' caused by the patriarchal system in which men dominate women in all aspects of life (Mobarak and Soderfeldt, 2010: 114). Although Saudi society has gradually accepted the employment of women in
gender-segregated fields like teaching, banking, hospitals, social services, or jobs like receptionist, tailor, governess and other jobs available for women, gender inequality still exists. An example of gender inequality in Saudi society is reported in the study by Mobarak and Soderfeldt (2010: 115), wherein Saudi Arabian women experienced discrimination at higher levels of their work. In addition, if they had contact with male colleagues, male patients, or had long hours of work, these became negative issues for their future marriage prospects. When a Saudi woman demands her rights or opposes restrictions, this shows the strength of her character. However, Saudi society would consider her to be impolite, and some may even consider her immoral, and she would more than likely face disapproval and condemnation.

Gender plays an extremely significant role in the disadvantaged position of Saudi women. According to The Global Gender Gap Report (Hausmann, Tyson and Zahidi, 2011) presented at the World Economic Forum in 2011, women fare very poorly in Saudi Arabia compared with men and women in other nations, ranking 131 out of 135 countries in 2011. The Global Gender Gap was introduced by the World Economic Forum and aims to examine the difference between men and women in four important categories; normal economic participation and opportunity, educational attainment, health and survival, and political empowerment. In the study, Saudi Arabia was the only country that scored zero in the category of political empowerment. However, in 2011, King Abdullah acknowledged the rights of women to participate in the political sector (see Section 2.4).

Another inequality experienced by women in Saudi Arabia relates to their mobility. Women are not legally allowed to drive in Saudi Arabia (Rajkhan, 2014:24), which severely limits their movement in the public sphere. The male guardianship system holds back the mobility of women in every sector of society. Tonnesen (2016:9) argues that the male guardianship system means that a woman cannot participate in politics, gain an education, work, or travel without the
permission of her male guardian. The guardian could be her father, brother, grandfather, father’s brother, husband or son. If a woman wanted to go abroad, she would not be allowed to travel if she did not have approval from her male legal guardian. The Human Rights Watch organisation (HRW) (2016:22) stated that since 2011, the Ministry of Interior in Saudi Arabia set up an electronic portal called ‘Absher,’ where male legal guardians can approve passports for female wards and approve their travel. This site allows male guardians to provide permission for a single trip, multiple trips or until the woman’s passport expires.

Gender inequalities in Saudi Arabia still exist but starting from the era of the late King Abdullah in 2005, there has been progress, with some reforms, especially for enhancing and empowering women in Saudi Arabia, giving them the chance to have a somewhat more equal role in Saudi society. As the HRW (2016:2-3) stated, women can now work without requiring their guardian’s permission. They also report that Saudi Arabia has worked to improve women’s access to government services, including allowing women to obtain their own identity cards; distributing family cards to divorced and widowed women, which stipulate familial relationships and enable women themselves to independently conduct several government bureaucratic tasks; and eliminating the requirement that a woman has to bring a male relative to identify them in court. This identity card provides the divorced and widowed Saudi women with permission to let their children continue their education, as some women are punished by their ex-husbands who keep their children out of school. However, a woman still cannot travel with her children without the consent of her ex-husband, who is still the legal guardian of their children (HRW, 2016:60).

2.7 Violence against women in marriage

As written by Bell (1997:238), marriage is an institution through which men are provided with rights over women. The Qur’an defines marriage as a compassionate and peaceful relationship that is grounded in love (Qur’an 30:21). However, in Saudi Arabia, women have limited rights and authority within their
marriage. As Saudi Arabian society is largely influenced by a patriarchal system (see Section 2.3), it also influenced the system of marriage. Al-Hibri (2009:493a), states that in relation to marriage and divorce, the point of view of the Qur’an can be summarised as “staying together on equitable terms or separating with kindness”. Thus, the Qur’an gives an equal right for both men and women to live a happy life together or to be legally separated without harm to either of them.

The Qur’an defines the marriage contract as a ‘mithaqan ghahithan’, an Arabic term which means a ‘solemn covenant’ (4:21). In the Qur’an, Prophet Mohammad states that the marriage contract is the worthiest contract and divorce as the most hated acceptable act in the eyes of God. Al-Hibri (2009:493b), argues that the marriage contract has been used to specify the rights and demands of both husband and wife, and hence offers a unique vehicle for the protection of women. Regarding the legal rights of women in Muslim societies, women can ask for stipulations to be added to the marriage contract to protect women’s rights such as: the equal right to pledge divorce, remain monogamous, the right to continue their studies and work, equal division of domestic responsibilities and living conditions which is protected under Islamic law (Alkhateeb, 2012:17).

According to Islamic law, polygamy of up to four wives is legal, but only providing that all the wives are treated fairly. However, due to social change, Long (2005: 40) indicates that polygamy in Saudi Arabia is presently declining. Mobaraki and Soderfeldt (2010: 116) found that women in a polygynous marriage have a higher chance of having 'psychological distress' and face more problems in family roles, married life and satisfaction with life when compared to women in monogamous marriages. Western influence over Saudi society has contributed to the decline of the practice of polygamy, especially among the younger generation.

Arab nations have one of the highest rates of child marriage because of the culture and traditions, which has been passed down from generation to generation.
Alsaidi (2015:16) stated that in Saudi Arabia, tribal and cultural practices have a profound impact because they reinforce the idea that child marriage is not only allowed but expected by their culture. Moreover, illiteracy and poverty are strongly associated with child marriage in certain countries. Roudi-Fahimi and Ibrahim (2013:1) state that in Arab countries, the highest rates of child marriage are seen in the poorest countries such as Yemen, Sudan, Somalia, and South Sudan where, in 2011, the annual income was less than US$2,000. However, in Saudi Arabia, because there is no age restriction for marriage, women may be obliged by tradition to marry under the age of 16 years (Milaat and Floery 1992: 82-90). Shaky and Milaat (2000: 46-54), state that up to 27% of Saudi Arabian women in the year 2000 were married in their early teenage years (under 16 years old), and most of these women were illiterate (57.1%). In addition, as reported by Gulf News (2012), it was shown that there were more than 5,500 child brides below the age of 14 in 2012 in Saudi Arabia.

Tashkandi and Rasheed (2009: 1243) argue that violence against women is a significant public health problem worldwide, with serious implications for the woman’s physical and mental health, as well as for her children. In addition, Almosaed (2004: 72) mentions that UN statistics reveal that domestic violence, specifically violence by the husband against his wife, is the most widespread form of violence against women. Memon (2008) states that more than 20% of women are reported to have been abused by the men with whom they live in the Arab world. However, data on the occurrence of violence against women are scarce for the Arab world. The few studies that have been conducted show that wife abuse is a significant health and social problem within the region.

In Saudi Arabia, Almosaed (2009: 39-41) concluded that men abuse women by the use of force and violence as effective tools of power and control. As argued by Vatandoos (2012:107), men use violence as a way of securing and maintaining the relations of male dominance and female subordination, which are pivotal to the patriarchal social order. However, the marriage relationship cannot be
terminated without grave consequences for most women, especially non-employed women, women with children, and women who would receive little sympathy from society and formal agencies such as the police, the courts and social services. HRW (2016:3b), states that Saudi Arabia has taken steps to better respond to violence against women and to provide women with better access to government services. In 2013, it passed a law criminalising domestic abuse and, in 2016, established a centre specifically tasked with receiving and responding to reports of family violence. Saudi married women believe that they must exhibit traits of sacrifice, tolerance and obedience to their husband. So instead of leaving the relationship, many women decide to cope with abusive marriages to maintain their dignity.

2.8 Ageing in Saudi Arabian society

As women age, they face additional discrimination based on societal assumptions relating to their age, gender and social status. According to Khadr (2012: 141), the ‘feminisation of ageing’ in the Middle East is particularly influenced by the ‘culturally oriented tradition of son preference and gender bias practices throughout the life course that contributes to the vulnerability of women in their old age’. Ageism is defined by Younos (2011: 45) as inequality between different age groups, especially ‘discrimination against the elderly’. Also, Younos states that ageism is strictly opposed by Islam as older people are considered an important part of ‘life experience, learning and as the backbone of society’. However, elderly women in Saudi Arabia experience ageism due to the strict implementation of socio-cultural norms.

According to Younos (2011: 18), the focal principles of a Muslim society are to show ‘respect towards parents, compassion towards children, and care for the elderly’. However, because of the changing family structure due to urbanisation and the impact of globalisation, this tradition is slowly diminishing. A study by Bagader (2003: 325) in GCC revealed that the ‘disintegration’ of the extended family due to adult children being busy with their own lives is a reason why many
elderly people are more exposed to the risk of greater financial stress and social isolation than those living in extended family households.

There are a few early gerontological studies about Saudi Arabian older people, such as the work of Mansour and Laing (1994), but none take a gender perspective. According to Karlin, Weil and Felmban (2016:2), the traditional role of the extended family was to care for older persons as a society. The assumption was that, the quality of living of an elderly person in Saudi Arabia depends on the people who surround them, such as their families, who will provide health care assistance in their daily lives. However, in Saudi Arabia, the country still does not have specific programmes that offer services for older people.

2.9 Conclusion

By outlining the culture, tradition and history of Saudi Arabia, this chapter has offered background information about the past and present situation of women in Saudi Arabian society, with special emphasis on the city of Jeddah. It concludes that the main factors affecting women’s position in society are its culture and tradition rather than religion. Women in the kingdom have become accustomed to a patriarchal society and the influence of Salafism doctrine. However, the status of women is evolving mainly due to urbanisation and social reforms. The effects of this can be seen in the increase in the literacy rate of women in the kingdom, which has improved substantially in recent years. The primary role of women in Saudi society used to be that of a wife and a caregiver, but because of societal changes, women are now being educated which helps empower them to be financially independent, and societal attitudes towards women’s role are beginning to change.

There has always been a small number of feminists in Saudi Arabian society who have fought back against the ideology of controlling and restraining women. Feminists have helped women to have a voice, one heard primarily by the upper echelons of society. These voices finally yielded results as various reforms have
been introduced since 2005, during King Abdullah’s reign. During his era, women’s plight gained attention, and the government introduced various opportunities for women in the economic and political sectors, such as the Shoura Council of the country, and this period brought a radical change for Saudi Arabian women. In 2013, TIME magazine, reported (Baker. 2013) that a presenter named al-Khmali stated “This is the beginning of a new era for Saudi women,” also adding “It’s about time women have a say — we are 50% of Saudi society.” Now in recent times, women in Saudi Arabia treasure the reforms that the late King Abdullah created and approved for their empowerment in Saudi Arabia.

According to Islamic teachings, the elderly women in Saudi society should be given great respect. Such admiration is noticed mostly in large joint families, as older women are seen as the protectors of the culture and religion. However, among young people, the respect for elderly women is deteriorating, and this may be due to modernisation and societal changes.

Women in Saudi Arabia have faced considerable struggles due to barriers such as the country’s cultural norms and the strong domination of the patriarchy system, which will be discussed more fully in the next chapter. Although the Qur’an gives privileges to women, these rights have been influenced by various religious interpretations in Saudi society. However, the Islamic teaching has become altered by culture and tradition, which has been applied under the umbrella of religion. The structure of Saudi society gives men the power to control women rather than allowing women autonomy and the opportunity to prosper.
Chapter Three: Theoretical Background and Literature Review

3.1 Introduction
This chapter aims to explore the status of women from a global perspective and to examine the situation of older women based on previous Western and Middle-Eastern studies. This chapter will discuss core concepts related to ageing, in particular, research literature on the influence of gender-related issues, societal changes and socio-cultural norms which affect older women’s quality of life.

In general, existing social theories of ageing are based on Western societies. Therefore, it is challenging to decide which social theories are most relevant to understanding older women in a non-Western society like Saudi Arabia. For the purposes of this study, this chapter first discusses ageism, gendered ageism, intersectionality, and modernisation theory followed by a discussion about productive ageing, successful ageing, active ageing and its importance in older people’s lives. Third, psychosocial theories of ageing are discussed, such as disengagement, activity, and continuity theory. Fourth, other sociological theories that are most relevant to Saudi Arabia’s socio-cultural norms are discussed, namely patriarchy, gender segregation and gendered cultural norms, structured dependency, and the concepts of independence and autonomy. Finally, this chapter will discuss the context and rationale for selecting these theories, and clarify how they relate to this study.

3.2 Ageism and Gendered Ageism
According to Abrams et al. (2015:5), in 1968, Robert N. Butler first coined the term ‘ageism’ to describe unjustifiable preconceptions of and discrimination towards elderly people, which are manifested in the behavioural display of a negative attitude or judgment (Palmore et al., 2005). In addition, a study by a European organisation called Equinet (2012:7) states that ageism produces both discrimination towards and inequality for older people. Therefore, ageism is a
process whereby individuals, particularly those that are elderly, experience a variety of complications that hinder them from gaining more knowledge and experience in different aspects of society.

Arber and Ginn (1991: 35) state that the, “stereotyping of elderly people profoundly affects the way they are treated, both at the societal level and as individuals in everyday interactions,” and is partly attributed to negative images portrayed by popular culture. In a UK study, Age UK (2011:4) found that age discrimination of older people was very serious, particularly in the UK with 64%, second only to France with 68%, for those in the 50-64 age group. Moreover, in East Asian countries, particularly in Hong Kong, China, Japan, Taiwan, and Thailand, discrimination towards elderly people is reportedly even more severe (Cuddy, Norton, and Fiske 2005:271). Thus, irrespective of the gender or social position of elderly people in society, the underlying views of old age are still negative (Calasanti and Slevin, 2001:18).

Palmore, Branch and Harris (2005: 55) state that ageism is a “social construct that is institutionalized in the structures, practices, and organization of culture; and then internalized in the attitudes, beliefs, and behaviours of individuals.” Arber and Ginn (1991: 34) discuss ageism in terms of the process of “systematic stereotyping and discrimination against people because they are old,” which is not related to the attitudes held by individuals but is underpinned and influenced by culture and society.

The World Health Organization (2007: 42) states that ageism is a “matter of concern for both older men and women; however, it can be more problematic for ageing women.” Thus, as Butler (2006:2) states, older women in particular experience the impact of ageism. This process was first observed by Susan Sontag (1972) in American culture, when she coined the term ‘double standard of ageing’ or ‘double jeopardy’ (Macnicol, 2006:25), whereby older women are the ones who suffer the most. Men are appreciated for their accomplishments, which
increase as they age, while women are valued for their beauty, which diminishes as they get older.

Green (2003) commended research that would “challenge unhelpful discourse on women and age.” It has been made clear by a number of researchers that women encounter a double jeopardy from ageism and sexism combined, particularly in their later lives (Neill and Khan, 1999). Older women are subject to ‘negative stereotyping and discriminatory behaviour’ and combined ageism and sexism has a significant impact on them (Clarke, 2011: 30). Older women experience neglect, violence, both domestically and in society, and the insecurity related to their financial, medical, and housing needs, which cumulatively expose them to multiple forms of discrimination (Begum, 2012) due to the effects of ageism.

3.3 Intersectionality

Women globally are subjected to different forms of discrimination and inequalities in society because of characteristics such as their gender, age, colour, race, socio-economic class, sexuality, ability, education, culture and religion. This affects women’s behaviour and mental state negatively, causing them to become depressed and lose their morale and self-confidence. Feminist scholars, such as Jones, Misra, and McCurley (2013:1) have argued that gender, race, and class are interconnected as ‘intersecting oppressions,’ which was first highlighted in 1989 by Kimberle Crenshaw, who used the concept of intersectionality to denote various ways in which race and gender interact to shape the multiple dimensions of black women’s employment experiences (Crenshaw 1993:1244). She developed the image of an intersection as a concurrence of several ‘roads’ or ‘axes’ of discrimination (Crenshaw, 1989, 1994, 1997).

An organisation in Canada named Women’s Rights and Economic Change (WREC,2004) defines intersectionality as a “feminist theory, a methodology for research, and a springboard for a social justice action agenda. It starts from the premise that people live multiple, layered identities derived from social relations,
history and the operation of structures of power.” People are used to being associated with different environments such as family, school, neighbourhood and the workplace, simultaneously, and can experience inequality or discrimination and pleasure at the same time; for example, women may be respected and receive much attention at work, although she might experience suffering, violence, and oppression at home.

It is vital to relate the different categories of inequality rather than to simply add them together. WREC (2004:2) stated that intersectional analysis aims to reveal multiple identities, thus exposing the different types of discrimination and disadvantage that occur as a consequence of a combination of identities. Therefore, it aims to reveal what form of discriminatory system (e.g., racism, patriarchy, etc.) creates inequalities and structures the respective positions of women. Moreover, Hanskivsky and Cormier (2009:3) state that an intersectionality approach grounded in real-life experience provides a theoretical foundation for the pursuit of social justice. This approach will provide more accurate evidence for making changes; changes that ensure actions that will lessen poverty, social exclusion, and subordination, particularly for women subjected to discrimination.

3.4 Modernisation Theory
Modernisation theory is a significant theory in the social sciences. According to Ferrara et al. (2014:184), modernisation theory proposes a process-based explanation of the transformation from traditional or under-developed societies to modern societies. Ferrara et al. added that modernisation theory is concerned with economic growth within societies; agricultural mechanisation, industrialisation and the rapid shift towards services as ingredients in the process of economic growth. Additionally, modernisation theory claims that as the economy’s composition transitions from agrarian to industrial and then to post-industrial, citizens will increasingly embrace cosmopolitan and post-materialist values such
as environmental protection, self-expression and gender equality (Stockemer and Sundstrom, 2014:2).

In the 1970’s, modernisation scholar Daniel Bell (1974) explained the change from industrial society to a post-industrial economy, and its effect on the family structure and social values. Furthermore, Inglehart (1990) discussed the two subsequent steps involving the ways in which modernisation theory changed women’s role in society. First, the shift from agrarian to post-industrial societies caused a “gradual erosion of traditional gender roles that formerly severely inhibited political action by women” (p.337). Second, this theory proposed that women could achieve equality by assuming higher economic roles in management and by earning more money, which would lead to greater influence in civic life (Inglehart and Norris, 2000:68). Therefore, modernisation theory has continuously evolved in scholarly works, and elements of this theory are particularly important in relation to changes in the family and women’s role.

Inglehart and Baker (2000) discussed two schools of thought regarding research and theory related to socioeconomic development. One school emphasises the convergence of values as a result of “modernisation” – the overwhelming economic and political forces that drive cultural change (Inglehart and Baker, 2000:20a). This school assumes that modern values are replacing traditional values. Therefore, a society’s traditional values are seen as dependent on economic factors that influence cultural change in a society. The other school assumes that values are relatively independent of economic conditions (Inglehart and Baker, 2000:20b).

However, modernisation does not follow a linear path. The rise of the service sector and the transition to a knowledge society are linked to a different set of cultural changes from those that characterised industrialisation (Inglehart and Baker, 2000:49). Thus, modernisation may relate to the development of one aspect of society that is assumed to lead to changes in other societal sectors.
These developments depend primarily on the importation of technology as well as a number of other resultant political and social changes, including increased levels of education, the development of transport, communication and mass media, international trade, urbanization and the decline in importance of the extended family (Ferrara et al., 2014:184).

3.5 Productive Ageing
Globally, older people desire to have a better life experience in their later lives which includes having good health, financial security, an active social life and to become productive in their old age. In the 1980’s, in the US, a significant group of older US citizens expressed that they wanted something else besides leisure and family obligations after traditional retirement and ‘productive ageing’ became a rallying cry for elder advocates and others looking for a more positive approach to ageing (Walker, 2002:123). Thus, this event opened the eye of the researchers to focus and to realise the significant effect of human development as a good indicator of QoL.

According to Edwards (2011), ‘productive ageing’ is defined as any activity by an older adult that contributes to producing goods or services. Au (2015) stated that the example of the activities regarding productive ageing was volunteering, employment and caregiving. In the US, there are policies and programmes that support older adults as workers, volunteers, and caregivers (Morrow-Howell et al., 2015:6). Additionally, they said that there are public and private workforce development programmes specifically for older adults, and there is a growing trend toward career counselling for older adults. Furthermore, in Australia, one of their national strategies implies that older people must exhibit individual responsibility, take up training and employment opportunities, and keep themselves healthy (Davey and Glasgow, 2006:24). Therefore, in these countries (The US and Australia), the policy makers, researchers and even the private and public sectors help to provide better life experiences, develop older people’s productivity, and enhance their level of autonomy and independence.
3.6 Successful and Active Ageing

Different concepts have been proposed to define the notion of “ageing well”. However, according to Constanca, Ribeiro and Teixeira (2012), the most dominant terms employed in recent decades have been “successful ageing” in the United States and “active ageing” in Europe. While these terms are often used interchangeably, they are inherently different, and neither is without criticism (Foster and Walker, 2014). The term ‘successful ageing’ was introduced by Havighurst in 1961 and developed by Rowe and Kahn in 1998. According to Martin et al. (2015:11), Rowe defined successful ageing as being the opposite of ‘failure’, it is a rebuttal to some of the criticism that the term ‘successful ageing,’ as used by Rowe and Khan (1987), had received. Fernandez et al. (2011:94) state that successful ageing is a comparatively new concept, synonymous with others such as ‘healthy’, ‘productive’, ‘optimum’, or ‘positive’ ageing. Villar (2012:1087) argues that successful ageing is a positive perception of ageing which aims to focus on the aspects that help people ‘age well’, in turn allowing them to enjoy healthy ageing over a greater number of years with no severe illness or disability, including their mental well-being. This perspective would help elderly people to sustain their well-being and allow them to have a healthier QoL.

Katz (2013:20) criticises the successful ageing model, arguing that it pays scant attention to people whose lifestyles are challenged by having to manage dependency and live with disabilities. However, many researchers support the relevance of healthy ageing to the importance of the discussion about ‘successful’ old age. Valiant (2012:187) defines healthy ageing as a state of contentment and vigour. It is reliant on disease prevention factors such as chronic illnesses, a healthy lifestyle, independence, and QoL. The concept of successful ageing by Rowe and Khan (1987) was developed and organised owing to the overwhelming public health implications of healthy and successful ageing according to the MacArthur Foundation (2003). It is one of the most constant and popular areas of research in the history of the topic. The concept of successful ageing drawn in the MacArthur Foundation study (2003) suggested that variables relating to mental,
physical and emotional health are more important to successful ageing than ‘holding a winning ticket in the genetic lottery of heredity’ (Holmes, 2006:27a). Therefore, to achieve the greatest possible chronological age, successful ageing attempts to modify the factors that lead to disease and poor health through disease prevention and health promotion programmes (Holmes, 2006:27b). However, most writers do not characterise ‘successful ageing’ as simply achieving the oldest possible age.

The concept of "successful ageing” has highlighted clinical and health criteria, whereas “active ageing” has been defined as “continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force” (WHO, 2002: 12). Additionally, Foster and Walker (2012) state that “active ageing” is concerned with facilitating older people’s rights to remain healthy (reducing the costs of health and social care) and remain employed longer (reducing pension costs) while participating in community and political life. Thus, the concept of “active ageing” not only focuses on the social activeness of older people but also concerns their health and financial aspects to provide a better QoL. Therefore, while these two concepts (successful ageing and active ageing) emphasise different aspects of the importance of “ageing well”, they both aim for one unified goal, which is to ensure the best QoL in later life.

There has been a considerable amount of research over recent decades that has created and developed theories that describe the process of how to achieve successful ageing. A range of psychosocial theories will be discussed and explained in the next section of this chapter.

3.7 Psychosocial Theories of Ageing
This section presents a brief overview of the psychosocial theories of ageing. The psychosocial theories of ageing such as disengagement theory, activity theory,
and continuity theory have attempted to explain older adults’ behaviour in Western society. In discussing these theories, I will explore and describe whether they are relevant to the present situation of older unmarried women in Saudi society.

3.7.1 Disengagement Theory

Two sociologists, Cumming and Henry (1961, cited in Nay and Garrat, 2009: 84), proposed the theory of disengagement, which has had a significant influence in gerontology. This theory suggested that in the “normal course of ageing, people gradually withdraw or disengage from social roles as a natural response to lessened capabilities and diminished interest, and disincentives from the broader society to participate.” To some extent, Cumming and Henry (1961) believed that the biological deterioration of the body’s systems through ageing would normally result in inactivity and greater social isolation.

Bagader (1999) argues that although elderly people may abandon some of their previous roles from their pre-ageing phase, particularly concerning their careers and professions, they still play other roles, and their separation and disengagement from some social roles does not mean, in any way, their disengagement from other social relations. Additionally, Victor (2005:19) argues that disengagement theory is impossible to examine empirically. For example, if an elderly person disengages herself from an activity, there will still be other activities that can replace her past activity. According to Subramanien (2013), the gradual loss of older people’s social roles and relationships is a prerequisite of disengagement theory. Thus, this theory requires the full abandonment of all kinds of activities to achieve its core interpretation. Moreover, Tosse (2014:51) states that the idea of this theory for achieving successful ageing is that older people live in harmony and peace; they are satisfied with their lives, prepare themselves for death and let the younger generation take over. For example, when older people disengage from the workforce, it permits younger adults to enter it.
In disengagement theory, the ageing person voluntarily withdraws from social and community life, and contentedly pursues other solitary and passive activities. This theory also claims that ageing individuals, in anticipation of death, gradually withdraw from life physically, psychologically, and socially.

### 3.7.2 Activity Theory

Activity theory is a psychosocial theory of ageing that contrasts with disengagement theory and emphasises the active participation of older people in social activities. According to the activity theory, successful ageing is interpreted as undertaking an active social life (Nussbaum et al., 2000: 9). Miller (2009: 39) argues that an older person will become more socially and psychologically fit if they actively engage in life. Schultz (2006: 10) adds that activity theory assumes that activity produces successful ageing through the relationship between activity and life satisfaction or subjective well-being.

Morf and Weber (2000:81) state that “Activity theory is a conceptual framework based on the idea that activity is key, that doing precedes thinking, that goals, images, cognitive models, intentions, and abstract notions like ‘definition’ and ‘determinant’ grow out of people doing things.” In addition, Victor (2005:21) argues that activity theory is a prescriptive view of ageing in which activity and engagement are seen as offering the path to successful ageing. Therefore, the key element of this theory is for older people to involve themselves in continuous activity to ensure successful ageing.

The activities of older people in developing countries, particularly in India, are more likely to be linked to family activities such as grandparenting (WHO, 2011). However, El-Sobkey (2014:110) states that in Saudi Arabia both older men and women suffer from inactivity, although men are significantly more active than women because of cultural issues; for example, older Saudi men have opportunities to take part in sports activities unlike older women. It is evident that
culture, norms, and the environment play a vital role in enabling older people to engage in social activities that allow them to enhance their QoL.

According to Trevino (2014:154), activity theory reflects modern U.S. society and its cultural values of individualism and independence. Thus, activity theory has been applied primarily to Western societies, which have their own culture, one different from that of Saudi society. Therefore, this theory must be consistent with the culture of its community. Otherwise, it may not be applicable. The restrictive nature of the social environment in Saudi Arabia due to gender segregation and sociocultural norms limits older women’s social activities. One of the key issues for older Saudi women that will be examined in this thesis is how difficult it is for them to achieve successful ageing because of the structural barriers that affect their participation in many aspects of life.

3.7.3 Continuity Theory
According to Nussbaum et al. (2000: 9), the continuity theory of successful ageing helps to explain some of the contradictory evidence that supports both disengagement theory and activity theory. Schulz (2006: 266) states that this theory was formed from the observation that, despite the prevalent changes in health and social roles with ageing, the majority of older people perform the same pattern of activities as they did in their earlier lives.

According to Hooyman and Kiyak, (2000) and Quick and Moen (1998:44-64), continuity theory describes a linear series of life events that gradually lead to a logical career stage and a pleasant experience or transition without maladjustment or distress into retirement. Atchley (1988), and Hooyman and Kiyak (2000) state that the situation of elderly women does not change, but instead they maintain a common pattern of activities. Therefore, preserving the same activities is the most common approach of older people as they age.
According to Goldberg (2002:76), individuals should continue lifelong activities as they age and remain engaged socially and professionally, since high activity of a continuous nature correlates well with positive life satisfaction among older adults. Thus, this theory requires substantial energy from older people to continue to participate in the same activities that they did in their mid-lives. In addition, Becker (1993) argues that continuity theory has not undergone rigorous testing, but it has been criticised for its conceptualization of normal ageing as the absence of physical or mental disease. Thus, continuity theory has been critiqued by some experts because of the exclusion of certain criteria that are connected to elderly people such as their having mental conditions like Alzheimer’s, which means this theory is not suitable for all older people.

3.8 Sociological Theories of Ageing

Sociological theories of ageing are essential to understanding the status and position of elderly women in Western and Middle-Eastern societies, and will help this study to explore the ageing experiences of older, unmarried women in Saudi Arabia. A brief overview of the following theoretical ideas will be provided: Patriarchy, gender-segregated lives, gendered cultural norms, structured dependency, and the concepts of independence and autonomy, as these are likely to relate to the experiences of elderly unmarried women in the Saudi context. These theoretical ideas will help to provide this study with an understanding of how a range of social factors affect and influence the quality of older unmarried Saudi women’s lives.

3.8.1 Patriarchy

Kendall (2011: 322) argues that ‘sexism is interwoven with patriarchy’ – a system of social organisations in which men control the political and economic structure, and in which the man is the usual head of the household. Walby (1997: 5) states that patriarchy is conceptualised as a “system of social structures and practices in which men dominate, oppress and exploit women.” Thus, patriarchy is a system
in which men are assigned to controlling positions and women are subordinate to men. For Ritzer and Ryan (2011:441) patriarchy is a theory that attempts to explain that extensive gender stratification is a result of social organisation rather than the result of some natural or biological fact. Therefore, the concept of patriarchy does not consider the biological differences of the body structure between males and females. However, in a study by Sultana (2012:4), she discusses the origins of patriarchy, whereby men are considered superior and women are inferior, and the assumed biological inferiority of a woman makes her inferior in her capacities and ability to make decisions. As men are born with greater physical strength than women, this ideology affects women in every aspect of their lives, including the concept of being ruled by and being dependent on men.

Hooks (2004:1), defines “patriarchy as a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence.” This reflects what is happening in most Muslim countries, as most parents there subscribe to the ideology of the patriarchy, which is passed down between generations and to their children. Wrenn (2010:10) states that the apparent subordination of women exists because some women unconsciously see themselves as weak and have accepted this inferiority without question. In summary, Walby (1990:20), in relation to patriarchy, states that “In this system women’s labour power, women’s reproduction, women’s sexuality, women’s mobility and property and other economic resources – are under patriarchal control.”

The rapid economic development and modernization in MENA societies, particularly in Saudi Arabia (see Chapter 2), has not changed the ideology of patriarchy, but these societies can be seen to be divided into two forms of patriarchy, ‘traditional patriarchy’ and ‘neo-patriarchy’ (Sharabi, 1988). The
‘traditional patriarchy’ is the old concept of patriarchy, in which the role of the man is to provide financially and to be responsible for the security and protection of women and children (Monagan, 2010:161). ‘Neo-patriarchy’ was first used by Sharabi (1988), meaning a ‘new form of governance.’ He coined this term from the concrete structures of ‘modernity’ and ‘patriarchy’ (p.1), whereby a new form of power and control structure is created that is followed by women, but supervised by men in the family (Habiba, Ali and Ashfaq, 2016:216). Sharabi (1988:4) emphasises that in Arab societies, “the Arab awakening or Renaissance (nahda) of the nineteenth century not only failed to break down the inner relations and forms of patriarchalism but, by initiating what is called the modern awakening, also provided the ground for producing a new, hybrid sort of society or culture the neo-patriarchal society or the culture we see before us today.”

According to Altorki (2000: 223), Saudi Arabia “remains highly patriarchal at the national, provincial, regional, district, at the family levels and the functional level of the workplace.” A prominent example of patriarchy in Saudi Arabia is that all women, regardless of age, must have a male legal guardian (mahram), who limits and makes the decisions about their employment, education, and social activities such as attending family occasions. The oldest man in the family, whether he is the father or brother, acts as the head of household and mahram. Janin and Basheer (2003: 77) argue that “he is the court of the last appeal and decides what other family members should do to promote the interests of the family as a whole.” Women cannot marry without the final consent of their father. If a woman is unmarried, she is still under her father’s control. As the messenger of Allah (PBUH) said, “There is no marriage except with a guardian.” According to the hadith of Aishah: “And the ruler is the guardian of the one who does not have a guardian” (Sahih). This hadith explains that in a Muslim marriage ceremony, women who do not have a legal guardian (wali) can take the sultan (a Muslim sovereign) as her wali to assist her and be a witness at her wedding. Thus, women

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1 See Vol. 3 Book 9, Hadith 1880
cannot get married without a man who will represent her as her *wali*. Therefore, women of all ages tend to be dependent on their male legal guardian at all times, thus the domination of men affects women’s situation in society, particularly within the family.

Doumato (2000:93) states that “girls were taught enough to buy into an assigned role, a role in which they were subordinate to men, but not enough to challenge it.” We find that women in Saudi society yielded a long time ago to the patriarchal authority represented by their father, husband, or brother, and this became an intrinsic part of her life; she would take no action without referring to that authority. In addition, Alhaidari (2003:369) argues that the current law on personal affairs, based on patriarchal authority, has made the woman an incomplete entity, inefficient, and a burden in any circumstances where she is unable to control her fate, despite her crucial role as a direct and indirect participant with men in all aspects of life.

The patriarchal ideology is fundamental to gender inequality and the subordination of women in Saudi society, which exists on a society-wide basis. The government sector supports the concept of patriarchy, which means restrictions on women, especially the application of gender segregation that will be discussed in the next section.

3.8.2 Gender-Segregated Lives

Gender-segregated lives are ‘reflected in daily living patterns’ of Saudi society (Zuhur 2011: 218) and are ‘legally required’ (Moghadam, 2003: 4). The result of gender segregation is a “significant disparity between men and women regarding their level of education, income, and labour force participation” (Doumato and Posusney, 2003a: 11). Long (2005: 36) emphasises that the segregation of women and the ‘restriction of their mobility in public’ are key socio-cultural norms in Saudi Arabian society.
According to Pilcher and Whelehan (2004:64), gender segregation occurs when women and men are placed separately from one another, while otherwise joining in a largely similar set of activities. For example, in education, boys and girls have the right to be educated and to be taught by an institution that will provide them with knowledge and experiences that will enhance their being together. However, the application of gender segregation has resulted in the two genders being educated separately, particularly in ‘single-sex’ schools or universities. Martin and Lapidus (2008:12) conclude that “what sex segregation does is create inequality and deprive all students of the benefits of a diverse classroom.” Thus, sex segregation in education denies the additional knowledge and experiences within a mixed-gender class that will let the “men know about women and the women know about men.”

There are many countries in the Middle East that apply gender segregation in paid work (see Chapter 2). Hartmann (1976) defines gender segregation in the workplace as the “primary mechanism in a capitalist society that maintains the superiority of men over women.” The effect of this segregation results in inequalities between the genders, especially for women who are employed workers. Moreover, Pilcher and Whelehan (2004) state that before capitalism was established the patriarchal system was recognised in that men manipulated the labour power of women and children in the family. In this way, men learned the techniques of hierarchical organisation and control, which were later drawn upon to create a “sex-ordered division of labour in the wage labour system” of capitalism (Pilcher and Whelehan, 2004:65).

In the Saudi Arabian context, a common example of strict gender segregation is in the Saudi household, where many homes have separate designated entrances for women and men. Gender segregation is strictly enforced in restaurants, where there are separate sections designated for ‘families’ and for ‘bachelors,’ where the latter are men without their family, and ‘family’ means women accompanied by their male guardian, children, or relatives. Gender segregation is also
implemented on public transport, in schools, and in working areas which separate women from men. Janin and Besheer (2003: 75) state that if women want to work, the permitted jobs for them are considered to be in hospitals, banking, teaching, and social services, but “only with women or girls as their patients, clients, or students.” In addition, women’s working areas must comply with strictly gender-segregated work settings. All of these, according to Metz (1992), are part of Saudi tradition and socio-cultural norms as a way to maintain ‘sexual modesty.’ As a result, women remain dependent on men (Metz, 1992) and gender segregation has contributed to their “social and psychological problems as they are unable to share the social life with all members of the family” (Fatany, 2007: 19).

3.8.3 Gendered Cultural Norms

According to Slattery (2003: 113), a significant issue when discussing gender is “whether the behaviour of men and women in society is determined by biology or by culture.” Kornblum (2012: 121) discusses how gender socialisation refers to how we understand our gender identity according to cultural norms of ‘masculinity’ and ‘femininity.’ In feminist studies, Jarviluoma et al. (2003: 11) state that it has always been “understood that the social construction of a woman and femininity takes place in the frame of the gender order, thus, within the gender system in which different genders negotiate and struggle for power.” Moreover, Volpp (2001:1198) emphasises that “the fusing of gender with culture and tradition continues when the space of the ‘home’ and practices within it provide an oasis of secure identity for communities experiencing dislocation or subordination.” In addition, she says that a culture should be judged according to how it treats its women (p.1196). Thus, the identity of a nation relies on women’s representation of themselves (e.g., dress, behaviour, practices, and role) in society.

The traditional cultural norms regarding gender roles are that Saudi women should limit their activities primarily to inside the home and restrict their active
participation in the public sphere. For example, Janin and Besheer (2003: 75a) state that women are “not allowed to go to school with men, to work with men, and to drive cars, whereby they are strongly encouraged to be wives, mothers and homemakers.” Doumato (2003: 241b) adds that Saudi women are not allowed to undertake domestic or foreign travel alone or “check into a hotel or undergo surgery in a hospital without written permission from a father or husband.” In public, Keddie (2007: 150) states that “women have to wear an abaya (a black garment that covers the entire body) and must cover their head and hair.” Janin and Besheer (2003: 75b) point out that “Saudi women have been brought up to accept this way of life as entirely normal.” They also argue that the consequences of nonconformity can be damaging to their family’s honour.

Therefore, the position of Saudi women in the private and public spheres is restricted by the socio-cultural norms which are strengthened by the patriarchal system and gender segregation, which allow discrimination, disempowerment, inequality and the oppression of women in all aspects of society.

3.8.4 Structured Dependency
According to Harris and Tanner (2008: 34), structured dependency refers to social and economic situations that create a condition of dependency in older people. Bury (1995: 18) states that structured dependency highlights important issues, especially the ‘rules and resources’ that influence the daily reality of older people. However, a number of authors have argued that the society is “structured in a way that makes older people dependent, that leads some older people to be considerably more dependent than others” (Timonen, 2008: 11a). According to Townsend (2012: 209), the experiences of older people related to their “retirement, poverty, institutionalisation and restriction of domestic and community roles” would help to explain how “dependency of older people came to be artificially structured.” Thus, the degree of structured dependency of older
people may vary from many factors related to their experiences and the structural system of the society.

Estes (1979) states that dependency theory offers enlightenment about the facilities and services for older people which are most disempowering and stigmatising. She claims that ageism is one of the key factors that determines how society neglects older people. In the labour force, older people are often viewed as being less productive (Wilson, 1997), and in their social lives older people can be classified as ‘weak,’ and as needing a guardian to protect them and give them what they need (Dunleavy and O’Leary 1987). Carney (2009:16a) discusses the dependent status of older people due to their lack of political power, and that a multi-dimensional model allows us to begin to understand how a complex set of political interests and social processes conspire to produce ‘structured dependency’ in old age. Thus, the dependency of older people depends on the culture, the norms, the state, and the people who surround them.

Structured dependency theory argues that the experiences of older people in later life are the result of social and economic conditions and are due to “restricted access to a wide range of social resources particularly income” (Vincent, 1995: 165), and “lack of opportunities for paid work and institutional care that make older people powerless and dependent” (Timonen, 2008: 11b). These perspectives have been developed to “emphasize structural factors affecting the lives of older women” (Cattan, 2009: 67).

Plath (2009:210) argues that in modern industrialised society, old age has become associated with dependency. Carney (2009:16b) argues that in Ireland older people suffer resource effects from their dependency on paltry pensions. Giridhar et al. (2012:24) state that in India elderly women are fully dependent financially on their male relatives. In Saudi Arabia, all women, and particularly older women, face various factors that demonstrate their dependency; for example, they are dependent on their husband or male-legal guardian in their financial and decision
making (Bacchus 2005:24), and they rely on men for public transport (e.g. taxis) because they are not allowed to drive cars (Al Alhareth et al., 2015:121). However, middle-aged women in Saudi Arabia have become more independent and may have greater autonomy than older women because of their education and the modernisation that has taken place in recent years (see Section 2.4). Thus, older women, particularly in Saudi Arabia, demonstrate to the fullest extent how they are constrained by their country’s norms and dependence on male relatives; both these factors reduce their autonomy and prevent them from being independent.

3.8.5 Independence and Autonomy

In the Western context, independence is considered to be the most important factor for maintaining the self-identity and self-respect of an individual (Wilson 1997: 47). According to Fry (1989: 87), in old age, a person often struggles to keep their autonomy, ‘willfulness and independence’ because of their failing body associated with ageing. She adds “how older people respond to these physical changes reflects their sense of autonomy and self-determination developed over the life course.” Home is the private domain of most older people in which they can generally act as they wish, that is, with autonomy (Arber and Evandrou 1993: 21).

Independence is widely accepted as being positive by older people, government, and service providers (Plath, 2008). In Denmark, although promoting independence is not specifically referred to in policies, a related belief is that assistance should be provided as ‘help to recipients to help themselves’ (Schulz, 2010). However, in India the notion of independence for older people is contrary to the strong family bonds valued in their society, which promotes the importance of choice, participation in decision-making, and opportunities for older people to lead active and satisfying lives (Plath 2009:216b). Therefore, the notion of independence in Western culture helps older people to live their lives as their
own; although for older people living in a more conservative culture such as India, the notion of independence for them may not be suitable and might lead to conflict between themselves and their family members.

Beauchamp and Childress (1994:58) state that “autonomy typically refers to what makes a life one’s own; that it is shaped by personal preferences and choices.” It is a characteristic of an individual who is independently free to choose and able to dictate his or her own life. For Dryden (2010), autonomy is an individual’s capacity for self-determination or self-governance. However, the concept of autonomy has been challenged depending on the kind of environment in which a person lives. The WHO (2015:219) argues that autonomy can be enhanced regardless of an older person’s level of physiological capacity. This may be accomplished by changing the environment that a person inhabits or providing assistive devices that help them manage limitations in their capacity. Thus, the autonomy of older people could be improved depending on the restrictions that might hinder them (e.g., culture, norms, family, physical mobility, etc.). Moreover, in Saudi Arabia, women’s autonomy is often prevented by the patriarchal ideology. Aquil (2011:24) argues that women living in a male-dominated society find it difficult to have autonomy. This is the case for Saudi women, who are dependent and cannot manage their affairs without the existence of their father or male guardian, who has to approve their decisions, and can prohibit these decisions if he does not like them.

Arber and Ginn (1995a: 12) state that loss of autonomy is more obvious for people living in a residential institution, where staff have control over most aspects of the older people’s existence compared with older people living at home. The independence and autonomy of older women can be compromised by deteriorating health, loss of support from their family and friends, and no longer living in their own home. Thus, the concepts of independence and autonomy are important for understanding to what extent older Saudi women are able to attain QoL.
3.9 Conclusion

This chapter provided an overview of the theoretical perspectives related to ageing. The literature reveals that socio-cultural norms may contribute to the ageism that older women experience within the family, especially in the Saudi Arabian context. The chapter discussed psychosocial and sociological theories to provide a broad understanding of the social lives of older women in both Western and Middle-Eastern contexts.

Intersectionality is a comprehensive theory, and its use as a conceptual framework in this study. This theory was very helpful because it addresses the multiple characteristics of older Saudi women that affect their situation. Another way in which this concept is valuable to this study lies in the fact that it provides a clear interpretation of the factors that are interconnected with and that contribute to the poor QoL of older Saudi women.

Successful ageing is regarded as the enjoyment of positive experiences that enhance older individuals’ ability to adopt healthy lifestyles by engaging in activities and exercise, thereby boosting their QoL. Additionally, active ageing is a concept suggesting that older people can acquire better QoL by being active socially, and engaging in activities such as employment, education, social works, etc. However, in Saudi Arabia, particularly for older women, cultural norms and a patriarchal system limit the mobility and decisions that could allow them to move around freely according to their needs.

Disengagement theory emphasises that to achieve successful ageing, older people have to refrain from all kinds of activities. This study will examine to what degree disengagement theory applies to the lives of older Saudi women as they only engage in limited activities, and due to the patriarchal system, their geographical mobility is curtailed. Activity theory emphasises the importance of social activity in later life. Arguably, older people must remain active as this promotes life satisfaction. However, this theory assumes that older people have complete
control over their social situations. A key issue is to what extent activity theory is relevant to the situation of older Saudi women, as their social participation may be restricted due to gender inequalities and socio-cultural norms. Continuity theory argues that older adults make the adaptive choice to maintain and preserve the connection with their past experiences. The concept of continuity assumes that older people maintain the same activities, roles, and relationships as in the past in order to achieve successful ageing.

The concept of patriarchy describes the power relationships between men and women. In essence, it defines the system in which the father or a male member of the family is considered to be the head and controls the decisions of other family members. It relates to male dominance and control over women in society. Using patriarchy as part of my theoretical framework will play a significant role in my study. It will help to explain and better understand the situation and subordination of Saudi women in the family and Saudi Arabian society, and enable me to examine the influence of male dominance on the quality of older unmarried Saudi women’s lives. The concept of gender-segregated lives is relevant to the situation of all women in Saudi Arabian society. In the Saudi Arabian context, gender segregation is assumed to be necessary to maintain women’s sexual modesty and decency. Using the concept of gender-segregated lives as part of my theoretical framework is vital, as this will help to explore how it influences the well-being and quality of older women’s lives. The concept of gendered cultural norms focuses on how gender roles are defined by culture and society, and how gendered cultural norms result in unequal opportunities between genders. Adopting gendered cultural norms as a part of my theoretical framework will clarify how older women construct their gender identities through traditional family and societal roles and allow examination of the negative implications of gender norms for the quality of older unmarried Saudi women’s lives.

The concept of structured dependency provides a useful framework for my research study since it highlights the socially constructed situation of many older
Saudi women. Analysing the structured dependency of older Saudi women focuses attention on economic restrictions and lack of access to social resources, as well as how social policies affect the experience of ageing women. Independence and autonomy are essential to older women. Maintaining independence and autonomy in later life in relation to health, social life, and mobility are the elements of successful ageing for older women. This study will examine the independence of older women by investigating their physical and personal autonomy throughout their lives, as well as studying how older women promote and maintain their health and physical independence in later life.

To conclude, in order to assess the life-long experience and quality of older unmarried Saudi women’s lives, intersectionality theory and the sociological theories which are patriarchy, gender-segregated lives, gendered cultural norms and structured dependency are the theoretical approaches adopted in this research study. In general, all these theories are relevant in helping to understand the present situation of older unmarried women in Saudi Arabian society, including the challenges and inequalities they face in later life.
Chapter 4: Research Methodology

4.1 Introduction
The methodology used to achieve the research objectives will be presented in this chapter. Aiming to have a clear conceptual understanding of the issues and challenges faced by ageing Saudi women, it is appropriate to use qualitative research methods to explore their position and experiences. Victor, Westerhof and Bond (2007:97) highlight that the common element of qualitative methods is to “represent reality as seen by the study participants rather than imposing on the study the reality of the researcher.” Adopting the same principles, qualitative interviews are used in this study to reveal the circumstances of older unmarried Saudi women from their own perspective. The chapter begins with the rationale for choosing qualitative research methods, the study sample, the pilot and the main study. The potential harm, risk, and role of both the researcher and participants will be discussed. Ethical considerations and data analysis used in this study will also be described.

4.2 Rationale for Using Qualitative Research
I chose qualitative research to achieve my aim of understanding what factors influence the quality of life of elderly Saudi women who live alone, with their children or with other relatives. Qualitative research methods were appropriate to better appreciate the position and experiences of the interviewees. Oral interviews were used to obtain in-depth information from the respondents, communicating with them in their different vernaculars and accents and aiming to understand their world by ‘stepping into their mind in a logical manner’ (McCracken, 1988:9). This in-depth focus aims to disclose the reality of the lives of participants, determine what is happening to them in their daily lives, and show how different factors influence their QoL.
In my study, unstructured in-depth interviews will provide the most appropriate way for respondents to express their experiences and tell their stories. Lindlof and Taylor (2011:172) recognised qualitative interviewing as a successful research approach, providing a greater understanding of subjective realities. Victor, Westerhof and Bond (2007: 96-97) state that, “the importance of qualitative approaches in ageing research is to analyse the other’s perspective through words, actions, concepts and meanings”. Mack et al. (2005:1) stated that qualitative methods are effective in comprehending elusive issues, such as socio-economic circumstances, gender roles, ethnicity, and religion. Qualitative research provides a good way to understand social human behaviours, principles, attitudes, emotions, and relationships with others. Therefore, this method was optimal in exploring the wide range of critical issues that affect older unmarried Saudi women.

King and Horrocks (2010:1) argue the qualitative research interview “differs in significant ways from other forms of interviews to which people will be more accustomed”. Lindlof and Taylor (2011:172) state that the distinction between in-depth interviewing and other types of interviews is that the “answers given continually inform the evolving conversation”. The in-depth interview provided an opportunity to examine the innermost attitudes and values of the interviewees and emotional depth through detailed conversation. Hatch (2002:109) emphasises that ‘probing questions’ are vital to encourage respondents to provide more in-depth explanations on the subject.

Qualitative interviewing provides a greater understanding of subjective realities and a highly efficient method of collecting information on the ‘real’ experiences of every individual. According to Boyce and Neale (2006:3), “In-depth interviews are useful when you want detailed information about a person’s thoughts and behaviour or want to explore new issues in-depth.” In my research, this approach allowed respondents to have complete freedom of expression. This technique was deemed successful in obtaining information from my sample of elderly women in
Jeddah. The unstructured interview is particularly valuable for elderly illiterate women, who may require elaborate explanations and repetition, and where some questions are not clear to them. Zhang and Wildemuth (2009:308) state that in the unstructured interviews, the questions and answers cannot be predicted; instead, the interview relies on the fluid interaction between the researcher and the interviewee. Adopting an unstructured interview technique with my respondents during the interview made them more receptive to expressing their own opinions, which is a key advantage of unstructured interviews over the more inflexible structured interviews.

Older unmarried Saudi women are highly sensitive about admitting being neglected by the younger generation. According to Bagader (2003:466), there is a potential sense of alienation between the older and younger members of Saudi Arabian society, caused by the generation gap. A structured interview would not have been mitigated against the effects of such sensitivities. For instance, such an inflexible method would have resulted in a lack of rapport built between me as a younger woman and participants. Smith and Osborn (2003:58) state that the structured interview purposively limits the talk of the interviewee.

In my study, open-ended responses provided by participants were the primary source of my data. The participants felt the freedom to use their own words when answering the questions. According to Handy and Ross (2005), open-ended questions allow the participants to request elaboration from the researcher if they fail to understand the question posed to them. A virtue of my interviews was that participants were allowed to refrain from discussing any issues. My role was critical in conducting the interviews and collecting the data. According to Padgett (1998:18), if qualitative research is a “voyage of discovery, then the researcher is the captain and navigator of the ship”. Mason (2002:67) adds, a qualitative interviewer must be ready “to make on-the-spot decisions on the content and sequence of the interview as it progresses and to keep everything running smoothly”. From the participant’s viewpoint, this method encourages them to
describe and express their answers using their own words, while feeling more relaxed during the interview. Lindlof and Taylor (2011:111) state “no qualitative project can capture every aspect of a scene as it unfolds” and despite the in-depth knowledge the interviewing process provides, there will undoubtedly be unknowns. This qualitative research has revealed the most important factors that may hinder the interviewee’s QoL.

Little is understood regarding the QoL of older Saudi women. Therefore, the objective of using qualitative methods in my research study is to identify the factors affecting Saudi older women in order to understand their current reality. This method offers the most effective approach to uncover the experiences of the study participants, especially for those who are not familiar with talking to a stranger. Using qualitative in-depth interviews allows the researcher to talk at length with the respondent, regarding their social and personal issues. It also facilitates a discussion of potential sources of stress, without imposing the constraints of closed questions.

4.3 Criteria for Sample Selection

Fifty elderly Saudi women were interviewed, aged 60 to 75 years. The selection criteria were that participants were living alone or living with their family or relatives in Jeddah. Excluded from the sample were elderly women currently living with their spouses or with medical conditions known to affect cognition (serious illness such as Parkinson’s disease or Dementia). The respondents were recruited according to the following criteria:

a) Twenty-five (25) elderly Saudi women, who were never-married, or are widowed or divorced, and are living alone or living only with a housekeeper and/or driver.

b) Twenty-five (25) elderly Saudi women, who were never-married, or are widowed or divorced, and are living with their children or other immediate relatives.
I purposely divided unmarried older women equally into two groups according to their living arrangements to have a clear comparison and distinguish factors that affect their lifestyle, how they socially interact with the people surrounding them and their QoL.

The age group 60 to 75 years was selected, as this group may be particularly affected by inequalities due to gender issues and Saudi cultural norms. Since most women in this age group are unmarried, primarily widowed and divorced, this age group will highlight the impact of changing family structures on older women’s roles within the family and Saudi society and how this influences their QoL. Women in this age group, who are not married, become more vulnerable as they age and may be socially excluded in various ways that influence their well-being. Women over 75 years old were not included in my sample criteria. The researcher decided to avoid this age group, because many people 75 years and above may have potential problems related to their memory, such as forgetfulness, dementia, and Alzheimer’s, as well as potentially serious ill health or frailty.

4.4 Sampling Strategy
According to King and Horrocks (2010:27), qualitative research is “interested in how people differ in relation to a particular phenomenon, as much as it is in what they have in common”. My initial sampling criteria were (see Section 4.3) to provide a balanced comparison between older Saudi women living alone and those living with adult children or other relatives.

Within qualitative research, purposive sampling is frequently employed. Devers and Frankel (2000:264) state that purposive sampling strategies enhance the understanding of selected individuals or groups’ experience and are ideal for developing theories and concepts. In addition, Neill (2007) states that purposive sampling is where the researcher “starts the study with a sample where the phenomenon occurs” and ‘information-rich’ cases are sought that fit the focus of the research. As sample members that fit my criteria were not easily accessible in
public areas, the role of gatekeepers in collecting my purposive sample was crucial (see Sections 4.5.1 and 4.6.1).

To achieve the criteria of living alone and living with others, I initially used snowball sampling to select interviewees. Snowball sampling was applied in my research study; after finishing every interview with an older unmarried woman, they were asked to recommend some of their friends or neighbours that might fit my criteria and be a participant. According to Arber (2001), snowball sampling can only be utilised when the target sample members are involved in a network with others, who share the same features or interests. Jupp (2006:282) stated that snowball sampling works well when members of a population are acquainted with each other. As some of my participants helped me to recruit additional older women that fulfilled my sample criteria, some became my gatekeepers. In particular, I benefited from the snowball sampling approach to identify women in the poor class, as these older women assisted me through their connections to contact other poor women.

After conducting 20 interviews, I realised the importance of my respondent’s income level and how their socio-economic circumstances influenced their QoL. I identified three classes of older women: high income, middle income, and poor income women with distinct characteristics; therefore, I subsequently included the criterion of income level in selecting older women to ensure a sufficient representation of women from each class. I therefore altered my selection of gatekeepers to try to ensure an equal representation of women from each class. In summary, my research work relied particularly on snowball sampling to fulfil my sampling criteria of living alone and living with other relatives, which was supplemented later by the additional criteria of social class.

4.5 Pilot Study
The pilot study interview of 10 unmarried elderly Saudi women was conducted from February to September 2012. According to Bloor and Wood (2006:131),
pilot work helps the researcher test their ability to perform the interview, check the interview guide, evaluate the proposed allotted time, check for possible problems that might hinder the interview process, and adjust or settle them if necessary. It also provides the researcher with the knowledge to develop techniques, prepare for possible ethical issues, and determine ways to ensure the research succeeds.

It was originally anticipated that recruiting participants for the pilot study would take approximately five months. However, due to accessibility constraints, the pilot interviews were extended by three months beyond the projected date. Finding potential participants for the research study was difficult. For this age group of women to share their life experiences is a private matter, especially in the context of Saudi socio-cultural norms. Although the purpose of my research was explained to them, some of the potential participants thought I came to assist them with their current health conditions or financial requirements. I presented potential participants with the letter from the Vice-President for the Graduate Studies and Research – King Abdulaziz University (Appendix 2), the letter of informed consent (Appendix 4a), and my University identification card to confirm that I am a Lecturer at KAU in Jeddah, conducting a research study.

A key issue was the emotional challenge I faced after asking the elderly interviewees relatively probing questions. My sympathy towards elderly unmarried women motivated me to want to contribute to their well-being and QoL. During my initial pilot interviews, I experienced mixed emotions and confusion between my duty to follow the scientific technique of pursuing all answers for my study and my inability to control my emotions, such as sadness. This was especially experienced during the interviews with my first five participants. I gave my participants additional time to elaborate and to make them feel more relaxed and comfortable, which led to additional stories and resulted in each interview lasting over six hours. Therefore, as a result I experienced mental, emotional and physical stress, which made me think about giving up my PhD on
this subject, as I could not endure hearing their sad and shocking stories. Although I am a Saudi woman, I did not expect to be told such emotional stories, which overwhelmed me. In addition, because of the long time I spent conducting each interview, it cost me the time of being with my seven-year-old daughter who was then diagnosed with Type One Diabetes. However, when I expressed my feelings and situation to my supervisor, she encouraged me and helped me realise that my study was the only way to help older unmarried women and allow their voices to reach the officials. She encouraged me to continue to explore their stories in order to help them to improve their QoL. I changed my mind and became more determined to help them by revealing a portrayal of their real situation.

The experience from my pilot interviews was the cornerstone of my research. These interviews were very challenging due to the unfamiliarity of the Saudi community with face-to-face interviews, particularly with the elderly people, which meant the guardians of senior citizens hesitated to permit me to meet the interviewees. Despite this, after the first five interviews, I ensured that my subsequent interviews would be shorter because of the experience and knowledge I had obtained during the first five interviews; additionally, the moral support from my supervisor gave me greater confidence and motivation to finish this research study.

4.5.1 Pilot Study Gatekeepers

King and Horrocks (2010:31) define a gatekeeper as someone who can provide or obtain permission to attain potential participants or those with the ability to manage such access. In the pilot study, gatekeepers were used, and later, they served as mediators for recruiting participants for the main study. Hennink, Hutter and Bailey (2011: 93) emphasise that a gatekeeper can act as “intermediary between the researcher and the study community”. The gatekeepers played a vital role in recruiting and accessing potential participants. There were three gatekeepers for the pilot study:
Gatekeeper 1:
Prof. Zawawi: the first pivotal gatekeeper. He is a Professor of Endocrinology at King Abdulaziz University (KAU) and a former member of the Shura Council (Consultative Council), who is also involved in social work. Dr Zawawi, played a great role in facilitating interviews with patients from both public and private hospitals. Many of his patients have been in touch with him professionally for two or three decades and have trusting relations, which helped me a great deal in recruiting from his own group of patients.

Gatekeeper 2
My niece, who is an undergraduate trainee dentist and has a large circle of patients from whom she could identify potential participants.

Gatekeeper 3
One of my sisters, a Business Administration graduate who is working for the Local Faysaleyah Community, with an immense group of elderly acquaintances.

4.6 Main Study
The main study was conducted from July 2013 to March 2015 and involved interviews with 40 older Saudi unmarried women. I still encountered a range of problems, even though the pilot study gave me a lot of familiarity with challenging issues, such as transportation and the interference of their daughters, which caused more time and sometimes caused the interview to be cancelled. Even though I adjusted my approach, the obstacles were easier to overcome than those previously mentioned in the pilot studies section.

4.6.1 Main Study Gatekeepers
In addition to the first three gatekeepers from the pilot study, who remained with me to the end, I also recruited eight gatekeepers to access potential participants for the main study:
Gatekeepers 4, 5 and 6
Three interviewed participants became gatekeepers. Their personal connections with other elderly Saudi women allowed them to encourage their friends to participate in my study.

Gatekeepers 7 and 8
I purposely recruited two gatekeepers from the Social Insurance Department, which is the department responsible for identifying persons in need of financial aid in KSA. To qualify for financial aid, a person must not have an income above SR2000/month. These two gatekeepers assisted me by identifying five suitable low-income participants and advising on the best time to conduct interviews. Further assistance was provided by the office of the Department of Social Insurance, such as providing me with a suitable private office to conduct the interviews, and hospitality was included, which aided the interview process for participants.

Gatekeeper 9
The researcher’s younger sister, who graduated from the Department of Psychology and was employed in a private care home in Jeddah city. With the help of personal connections, she was able to recruit participants for the study.

Gatekeeper 10
Employed as a cardiologist, owning his own professional clinic, he connected the researcher with some of his patients, who agreed to be interviewed for the investigation.

Gatekeeper 11
A driver employed by the researcher. His expansive social circle allowed him to connect the researcher with several older Saudi women with higher income, through their own drivers.
4.6.2 Recruitment Strategy and Arrangements for the Main Study

In the pilot and main study, participants were recruited with the help of my gatekeepers. The gatekeepers used the participant information sheet (Appendix 4a) for the recruitment process by informing potential participants about the motivations for the research study. The participant information sheet was explained and then a copy was given to them. Potential participants were asked by the gatekeeper if they would like to participate in my research study and if they would like to speak with the researcher.

If the potential interviewee was not interested, the gatekeeper thanked them for their time. If they were unsure, the mobile contact numbers of the gatekeeper and researcher were provided. If the potential participants expressed their interest in participating, the gatekeeper obtained their contact numbers and informed the researcher accordingly. Contact details of the researcher and gatekeeper are mentioned in the participant information sheet in case participants wished to call for any clarification. Once I received names of interested potential participants, I telephoned them to explain the purpose of my research study, reassuring them about the protection of their privacy and anonymity and informing them that the entire process of the interview would be audio-recorded. If they were still interested in participating, I asked them to suggest a convenient date, time, and venue for the meeting. If a woman indicated she was no longer interested in participating, I would politely thank her for her time.

Gatekeepers were crucial in recruiting potential participants and giving them background information about the study and my motivations for conducting the study. Most potential respondents were unsure, because they were living with guardians, and they took the time to consult their guardians. In the pilot study, I said I would meet with participants and their guardians to explain the study personally, but in the main study, I initially phoned their guardians to explain the purpose of the interview to save time and resources, such as transportation, and then showed their guardians the official documents from the start of the interview.
The recruitment process was very complicated and difficult in the deeply conservative community of Saudi Arabia.

Based on my pilot study experiences and Saudi cultural customs, some daughters and relatives who lived with elderly potential participants were doubtful about providing consent for the interview. Therefore, for the main study, I provided participants and their immediate relatives with a copy of the informed consent and attached the letter from the Vice-President of KAU (Appendix 2a) for their reference and information. For participants who could not read the participant information sheet, I would read it to them to ensure their understanding. Once verbal informed consent had been obtained, I would begin my interview.

As mentioned in Section 4.5, issues faced in the pilot study were the presence of a participant’s relatives and the length of the interview. Therefore, for the main study, I informed their relatives I would need privacy during the interview process. In my interviews, the expected time for each interview was one-and-a-half hours, but the actual conversation usually lasted three to four hours due to a wide range of irrelevant topics being introduced and discussed. Whenever possible, I diverted the discussion of irrelevant issues by redirecting the conversation to the main questions to ensure interviews would finish within the allotted time.

4.6.3 Development of the Interview Guide

In developing the interview guide, I considered the age and possible medical conditions of the respondents; thus, my research questions should be easy to understand by elderly Saudi women. Following Patton (2002: 342), the interview guide served as a checklist to the researcher during the interview to ensure the flow of conversation followed the research objectives.
A pilot study was undertaken before conducting the main study to identify any potential difficulties, estimate the time and cost of work, identify additional relevant questions, and delete irrelevant questions in the interview guide. In the pilot study, particularly during my first five interviews, the interview guideline was in my possession. When necessary, I used it to refresh my memory of certain questions, as well as to be more precise. However, my conversation with an older woman in my family revealed to me the understanding that older people prefer to converse with someone who focuses on them while they are talking. Therefore, I sought to familiarise myself with the interview guideline’s content to ensure that I became more focused on listening to participants’ statements. After my first five pilot interviews, I was much more confident and comfortable because, during these interviews, I had familiarised myself with the questions. Therefore, I did not need to use my interview guidelines while interviewing the remaining participants.

After the pilot study, the interview guideline was revised, and I added questions that were important regarding the health of older women; for example, participant’s awareness of health care centres which are in every neighbourhood in the community, their knowledge of the services they offer, and the work times of these health centres. The questions in my interview guide were originally developed in English (Appendix 1a); however, as the interview guide was administered in Arabic, I translated the questions into Arabic (Appendix 1b). I double-checked the verbal equivalence between the Arabic and English versions to ensure the compatibility of the meaning of the two versions. To ensure the greatest possible clarity, slight modifications were made to questions to ensure a clearer understanding during the interviews. These changes centred on the wording and sequence of the questions to clarify any ambiguity.

4.7 Characteristics of Actual Interviewed Sample
A total of 50 older women were interviewed: 15 from the poor class, 24 from the middle class and 11 from the high class. Table 4.1 shows codes for participants’
living arrangements, marital status and socioeconomic status which are used in chapters 5-8 after data extracts. For instance, the participant codes of A2, 75M, W mean that the participant lives alone with two maids or one maid or a driver, 75 years old, middle-class, and a widowed older Saudi woman. Table 4.2 provides details of the final sample, which included the pilot and main interviews. This table provides information about whether each interviewee is living alone or living with others, their marital status, age, and socio-economic level.

**Table 4.1: Explanation of Participant Codes.**
(Used in Table 4.2 and data extracts in Chapters 5-8)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
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</tr>
<tr>
<td>Living Alone</td>
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</tr>
<tr>
<td>Living with others</td>
<td>LO</td>
</tr>
<tr>
<td>Socio-Economic Class</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>P</td>
</tr>
<tr>
<td>Middle</td>
<td>M</td>
</tr>
<tr>
<td>High</td>
<td>H</td>
</tr>
<tr>
<td>Marital Status</td>
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</tr>
<tr>
<td>Widow</td>
<td>W</td>
</tr>
<tr>
<td>Divorced</td>
<td>D</td>
</tr>
<tr>
<td>Never married</td>
<td>N</td>
</tr>
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</table>
Table 4.2: Sample characteristics by Age Group, Living Arrangements, Marital Status and Socio-Economic Group.

*P = Pilot Study Participants*

*O = Indicator of age group of the participants*

*X = Indicator of marital status of the participants*

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Age</th>
<th>60-64 group</th>
<th>65-69 group</th>
<th>70-75 group</th>
<th>Marital Status</th>
<th>Living Arrangements</th>
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<tr>
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<td></td>
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<td>Layla</td>
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</tbody>
</table>
Table 4.2 shows that equal numbers of older women who live alone (n=25) and live with others (n=25) were interviewed. However, more high-class women lived alone (9 out of 11) than in the other classes. In terms of age, half of the interviewees were 70-75 (n=25), with 13 aged 60-64 and 12 aged 65-69. In relation to marital status, over half were widowed (n=28), 20 were divorced, and only two were unmarried.

### 4.7.1 Failed or Excluded Participants

Of the 50 interviews conducted, 11 other potential participants (two from the pilot, and nine from the main study) were not interviewed or excluded from my research study for the following reasons, see Table 4.3.

1. Lied about key information.
2. Interference of the next of kin or immediate relatives.
3. Refusal to be interviewed with an audiotape recorder.
4. Refusal occurred after seeing my interview guidelines.
5. Transportation problems.
Table 4.3: Excluded and Failed Interviews in the Research Study

F = Failed Participants indicator

<table>
<thead>
<tr>
<th>No. of participants</th>
<th>Reasons for Excluded or Failed Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Refused audio recording</td>
</tr>
<tr>
<td>1-P</td>
<td>F</td>
</tr>
<tr>
<td>2-P</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
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<tr>
<td>5</td>
<td>F</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
</tr>
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<td>7</td>
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<td>9</td>
<td></td>
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<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 4.3 shows there were failed participants (who could not be interviewed). These (7) participants, did not agree to be interviewed for the following reasons:

- Participants 7 and 11 had interference from their immediate relatives
- Participants 3, 4, 9 and 10 refused to be interviewed after reviewing my interview guidelines
- Participant 1 had transportation issues

On the other hand, (4) participants were excluded (conducted interviews) for the following reasons:

- Participants 2, 5 and 6 refused to be interviewed with an audio-recorder
- Participant 8 was dishonest about her information

4.8 Ethical Considerations

Maintaining ethical responsibility towards participants is a vital aspect of the researcher’s role. Therefore, ethical considerations, such as consent,
confidentiality, and anonymity, were considered throughout my research. The modus-operandi of this research was to avoid any harm to participants and provide freedom from coercion. Whenever participants appeared distressed or uneasy, I avoided asking related questions. According to Lindlof and Taylor (2011: 119), the ethical issues of qualitative research are ‘not different in most respects from those in other social-scientific approaches’. King and Horrocks (2010: 103) emphasise that the “ethical practice of social research with human participants” requires ample attention and concern throughout the research process as “ethical issues will exist and emerge – often raising moral dilemmas that are not easily resolved”. In this research study, I have followed the ethical codes proposed by King and Horrocks (2010) for my qualitative interviews. I also subscribed to all aspects of the British Sociological Association Statement of Ethical Practice (BSA, 2002). Additionally, the research did follow the ethical good practice principles of the University of Surrey.

4.8.1 Informed consent

It was essential for participants to know the purpose of the research study, how the study would be carried out, and the benefits of participating in the study. King and Horrocks (2010:110) emphasise the “importance of getting the informed consent of participants before taking part in the research”. Prior to conducting the pilot study, I obtained two authorization letters; one from the Vice-President for Graduate Studies and Research of KAU (see Appendix 2a and 2b), and one from the Ministry of Social Affairs in Jeddah. This letter was obtained when I originally planned to interview older women in care homes (see Appendix 3a and 3b). Despite my decision not to undertake research with participants from care homes, I still used this letter from the Ministry of Social Affairs and showed it to my potential participants to provide them with additional information about my research study.

Since the subjects of my research study were women aged 60–75 years, I had to consider their educational status and any present impairment associated with
ageing processes, such as diminished eyesight and hearing. I was aware that written consent might be difficult to obtain in research with older adults in Saudi Arabia who are illiterate. I was particularly careful to ensure that vulnerable participants were not exploited. As such, potential participants were given a participation information sheet (Appendix 4a), which was translated into the Arabic language (Appendix 4b) and presented in large print (big font capitalised when needed and italicised). In cases where potential participants were unable to read, I read it aloud for their understanding. Additionally, I constantly checked that participants could hear and understand my explanations about the research.

The purpose of the participant information sheet was to give potential participants enough information and knowledge with which they could decide whether or not to take part in my research interviews. The information sheet also outlined the aims and objectives of the research, the participants’ rights and roles, their right to withdraw at any time, and it informed them that the entire process of my interview would be audio-recorded. The researcher’s contact details were also given should the women wish to ask additional questions at any time. Written or signed consent was not obtained because approximately half of the sample was illiterate. Therefore, consent was sought verbally.

Within the Saudi culture, regardless of age, all women are required to have a male legal guardian (mahram), whose consent was necessary to obtain before the women could decide to participate in the interviews. The consent of their guardians was taken verbally. In the absence of a male guardian, adult daughters are often placed in the role of caretaker for elderly parents, whereas older women living alone could make the decision freely about whether or not to agree to be interviewed. Furthermore, it is unacceptable in Saudi Arabia to engage in conversation unless the person has been formally introduced to their male legal guardian or daughter. Associated with this convention is the Saudi cultural attitude of being suspicious; hence, participants and their relatives typically asked to see the researcher before agreeing to participate in the research study.
4.8.2 Confidentiality and anonymity

Confidentiality and anonymity were ethical issues that I considered before conducting the interviews. According to King and Horrocks (2010:117), “confidentiality is defined as the equivalent to the principle of privacy while; anonymity refers to concealing the identity of the participants in all documents resulting from the research. Therefore, actively protecting the identity of research participants”.

In my research study, confidentiality of a respondent’s identity was guaranteed. I gave assurances that no one else except the researcher and the research supervisor would have access to the audiotapes, which would always be stored securely. Furthermore, complete anonymity was promised to all participants. I told them that pseudonyms would be used throughout the research process and that this measure would ensure that respondents would not be identifiable in any publication about the results of the study.

4.9 Reflections on Conducting Interviews

An important element of the success of this research was I originate from the holy city of Al-Madinah Munawwara, the participants trusted me. All Muslims love people from Al-Madinah and particularly love The Prophet Mohammad (PBUH).

The research interviews were conducted in Arabic to allow the free flow of discussion and because almost all participants were only able to communicate in Arabic. Using their mother-tongue enabled participants to provide detailed accounts of their experiences, which would not have been possible if they had to use English. The length of interviews varied because it depended on the course of the interview and the medical conditions of the participant at the time of the interview, as well as any reluctance to disclose personal information or uneasiness to express their true feelings. During the interviews, aside from audio tape recording, I noted other issues about the interviewee such as expressions and body language when I asked the women some sensitive questions that related to their
bad experiences. These notes were set aside for future reference. I also reminded participants that breaks from the interview were permitted if needed.

Conducting interviews with elderly Saudi women proved quite challenging. I have captured the stories of older women who are no longer married from the perspective of the women themselves. This information has given me insight into their daily needs and helped me to understand what gives meaning to their lives, while often dealing with a lack of proper caring attention and inadequate social and welfare support from their children and relatives. Some older women’s interviews took a considerable length of time while others discussed information that was irrelevant to the study. In the latter cases, I had to divert them gently back to the main topic. In the case of interrupted conversations, I noted the last words of the conversation and later reminded the participants. Almost all questions in my interviews were open-ended, and efforts were made to ensure that the central topics were covered in each interview; the manner in which these questions unfolded varied from participant to participant.

I imposed no constraints on the participants to answer any question that they felt was too personal or if they felt uncomfortable giving answers. Since some of the questions pertained to things that happened in the past, I gave participants ample time to respond because I understood that it is often difficult for them to remember their experiences. Instead, I asked them to do their best to give me an accurate answer.

At the conclusion of the initial interviews, I discussed the results of my interviews with my supervisors to smooth out any issues related to my interview technique. In summary, challenging factors that influenced the process of the interviews included the following:

- The timing and date of the interviews were not easy to arrange. This issue was not under the control of the participants but of their relatives due to socio-cultural
norms that require relatives to know the researcher before allowing their elderly family member to take part in the research study.

- Daughters and/or immediate relatives stayed during the interview and were sometimes reluctant to leave during the interview process.
- The desired length of interview time of one-and-a-half hours was insufficient due to irrelevant topics introduced and discussed by the participants.
- Access to transportation and location of residence.

These issues will be discussed in more detail in the following sections. Throughout the study, I was reflexive on the issues and concerns that arose from every interview. Moreover, as I became more experienced, my interviews became more successful.

4.9.1 Timing and location of interviews

The main logistical challenges I faced were timing and the respondents’ residential locations. These problems arose when I began to arrange appointments with the respondents. As a university academic lecturer, I was teaching two mornings each week, and it was difficult to arrange interviews with participants during the day. However, I managed to conduct some interviews in the morning despite the nocturnal nature of life in Saudi Arabia. In practice, most of the participants preferred to be interviewed in the evening to conform with local climate conditions. This practice is supported by Long (2005:64), who argues that in Saudi Arabia, “most social life begins after Maghreb (Sunset prayers) and can last until well after midnight”. Therefore, most of my appointments were scheduled after the two evening prayers (Maghreb and Esha), which fall between 6:30 and 9:00 pm; thus, most of my interviews were conducted during the late evening (after 9:30 pm).

King and Horrocks (2010: 43) recommend using a ‘location that is relatively quiet’. They state that the ethical procedure is to first ask the participants where they would like to conduct the interview, and usually they will choose their own ‘territory’ such as an office or their home. Additionally, Hoffman (2005:6) states
that the location of the interview should be considered carefully before proceeding. It is vital that the meeting place is quiet, tranquil and interruption free to gain a higher chance of ensuring interview success. Particularly for older women, a quiet place is very important for conducting interviews. Corbetta (2003:284) argues that ‘appointments’ must be discussed to agree on the time and place where the conversation can take place in tranquillity. Therefore, the participants selected the environments where the interviews took place. Just one participant chose a restaurant as the meeting location for two reasons. First, her house was located far away from the city, and second, she preferred to be away from her daughter’s house and wanted to be relaxed to express her views freely during the interview. Although it was held in a restaurant, no disruptions occurred during the process of the interview, and the audio recording was of good quality. Additionally, five participants were interviewed inside a private office in the Department of Social Insurance. The remaining forty-four interviewees preferred to conduct the interview at their homes, thereby ensuring they were in a familiar and comfortable environment. Additionally, conducting the interviews in their own dwellings provided me with the opportunity to obtain a comprehensive idea about which social class each participant belonged to by observing the type of housing, furniture, curtains, and any automobile/s the family had.

Another major benefit of conducting the interview in the participants’ homes was that the interviewees were not wearing their veils. This factor helped me distinguish their emotions as they told me their stories in detail. These older unmarried Saudi women loved to have visitors in their homes, which is why they were jubilant to welcome me and most treated me as their daughter.

4.9.2 Privacy and family permission

It was important to consider the status of older adults, particularly older women, in Saudi Arabia because they were not able to make any decisions for themselves and had to obtain approval from their male legal guardian. Therefore, meeting older women was incredibly challenging because it is a socio-cultural norm that a
close relative (for example, a son, daughter, or sibling) must be present when entering another person's house. My presence in participants’ homes caused interest and curiosity among the family members. In most cases during my pilot interviews, the respondent's daughter/s or immediate relative was always involved. In general, the daughters or other relatives wanted to talk to me first for at least 15 minutes to discuss my research, and most were unwilling to leave during the interview process even though I had given information about my identity and fully explained the purpose of the interview. In one case, the daughter of a pilot respondent asked to see the authorization letter from the Ministry of Social Affairs (see Appendix 3a) to verify the authenticity of my research study.

The participants did not find the topics within the interview difficult to discuss. Although they were open about discussing topics related to public issues, they were initially quite reluctant to talk about their personal lives, which was due to socio-cultural norms. I reduced the communication barrier by using techniques to establish rapport with them. Their love of talking contributed to the success of my interviews because the conversations flowed freely. However, most of the older adults I interviewed were afraid and uneasy talking in front of their relatives. This fear was confirmed during one of my pilot interviews when the participant’s daughter suddenly came into the room while I was conducting the interview. She stayed with us for about 15 minutes, but I did not terminate the audio recording. I noticed that the participant was uncomfortable and less forthcoming in the presence of her daughter. Hence, I politely told the daughter that the interview should be conducted in privacy to which she agreed and left. I restarted the interview from my first question to validate the participant’s answers.

It is noteworthy that the older women had no authority to ask their relatives to leave us to ensure privacy. Hence, in subsequent pilot interviews and the main interviews, I personally and politely requested the respondents’ daughters or immediate relatives to give us privacy for the purpose of the interview. It was evident that their relatives’ presence influenced the quality of interview data;
participants who had initially been quite unwilling to disclose their experiences and problems spoke openly and freely without any restrictions while in privacy.

4.9.3 Audio Recording
Although the arrangement of audiotape recording was agreed upon at the time of discussion of the participant information sheet (Appendix 4a), some of the research participants were still suspicious and doubtful about audio recording once the interview started. It should be noted that within Saudi culture, older women are unacquainted with any kind of interview. Thus, I again thoroughly explained the purpose and objective of my research study as well as the importance of audio recording.

I initially believed that audio recording might result in the respondent feeling uncomfortable, which would inhibit them and, as a result, may affect their responses. Several participants raised the question of what would happen with the recorded voice, and in response, I told them that the interview tapes would be coded and stored securely to maintain confidentiality. I was able to explain the importance of audio recording to potential respondents so that they co-operated willingly. This step was done to prevent issues whereby the participant would claim that she was not aware that the interviews were audio recorded. Moreover, it is unethical to undertake a recording if the participants have not given informed consent. At the end of the conversations, the participants were asked if they had questions regarding any aspect of the interview.

4.9.4 Non-Verbal Communication and Saudi Customs
According to Hatch (2002:108), it is the ‘researcher’s responsibility’ to encourage respondents to express their in-depth answers and anecdotes by constantly encouraging them both verbally and non-verbally. The researcher’s “body language, facial expressions, and verbal techniques” help to promote the participant’s cooperation in giving the interview. The inability of participants to understand some research terminology caused difficulties in some interviews.
Therefore, I continued to explain and interpret a plethora of issues for participants using the simplest terms that they could understand. It is important to note that over a third of my participants had limited or no educational background (see Chapter 5).

The seating arrangement in my interviews also contributed to participants opening up. When I first saw that respondents were not comfortable sitting on a standard sofa or settee, I asked them constantly if they wanted to sit on the floor. Within Arabic culture, people often sit on a low Arabic sofa laid directly on the floor. Such small actions were not necessary technically, but they improved the ability of the researcher to gain trust, build a good relationship and to be warm and approachable with participants in the research study.

As part of Saudi socio-cultural norms, women are not permitted to divulge any private matters to strangers and are expected by family members not to reveal any information that may prove to be embarrassing to the family. The dress code also made a difference because the age group of the participants was older. Contrary to the culture of wearing a niqab—a face veil covering used by women—I preferred not to cover my face during the interview process. These actions enabled me to gain other women’s trust wherein they felt safe to open up to me and allowed me to gain an understanding of what life is like for them as they deal with living with their problems. As a result, the interviewees called me benteh (daughter), meaning they accepted and treated me as part of their family. In response, I called them ‘Auntie’, which is conventional in Saudi culture.

Another challenge I faced in the initial piloting of my qualitative interviews was hospitality customs, which led to disruptions in the interview process. The participant and/or housekeeper constantly offered me sweets and drinks. Warmth and hospitality was displayed even by the poorest participant through the provision of food, tea, Arabic coffee, and a sofa to sit on, which all further exemplified the sincere generosity that participants showed towards me as a guest.
It made me uncomfortable, yet refusing hospitality in Arabic culture is considered offensive to the host/hostess, so I was continuously aware of my actions. It is understood in Arabic culture that guests must receive at least a small quantity of drink (usually tea or coffee), offered as a sign of respect and acceptance. In the absence of a housekeeper, the participant usually prepared the Arabic coffee by herself. Therefore, I made a remark in my field notes to consider preparing the coffee myself. After the initial pilot interviews, I informed the next participants and all main study participants that it was not required to prepare anything to eat/drink because I would bring coffee to drink.

The participants were delighted to be interviewed because they were pleased to see new faces and had an enjoyable time interacting with the researcher. However, during the process of my interviews, I saw sadness and dejection at times in my respondents’ eyes when they started to tell their stories. Sad expressions were displayed on their faces when their responses touched on their emotional feelings. When I was affected by the participants’ stories, I started to cry, but I tried to hide my emotions from them by keeping my head down and pretending that I was writing. When they noticed my emotional reactions, I discovered that they felt more comfortable in sharing their stories. This natural behaviour broke down any barriers between the researcher and respondents. When a respondent started to cry, I paused until she regained her composure.

4.9.5 Transportation issues
It is very hard in Saudi Arabia for women to access transportation services in the public sphere, particularly if they have no permanent driver. As a Saudi woman, I have experienced this situation, especially when one of my prospective participants was ready to have an interview, but it was not easy for me to arrange immediate transportation that would allow me to go directly to my participant’s house. Nowadays, transportation agencies such as Uber and Careem have arrived in the region, which can provide transportation at any time. However, during my research, I was obliged to hire an Egyptian driver who was reliable and
understood the Saudi situation. He was able to accompany me to each interview destination and played the role of a bodyguard in case of any potential issues.

4.10 Harm and Risk in Qualitative Research
According to Hadjistavropoulos and Smythe (2001:164), the “main ethical problems of qualitative research are a function of both its open-ended methodology and the nature of the questions posed to participants”. I considered ethical issues to avoid any risk to both the participant and the researcher (see section 4.8). When conducting the pilot and main study, I tried to prevent or minimise the risks discussed below while attempting to maximise the quality of information obtained.

4.10.1 Risks to the participants
Although physical harm rarely happens to participants in qualitative research, Rubin and Babbie (2011: 78) state that “research participants can be harmed psychologically in the course of a study and by revealing information that may make them at least uncomfortable”. In addition to this risk, they also emphasise that social research is often frustrating to participants because they may recall traumatic or stressful events that occurred in the past. When I realised that some participants were becoming distressed during the interview, I was emotionally supportive and suspended the interview for a while. In order to minimise the participants’ feelings of distress and intense emotions, I attempted to vary the topic temporarily to avoid causing unnecessary stress.

Another potential risk to participants is exploitation. “Exploitation refers to research that will not produce meaningful results and needlessly exposes participants to risk and inconvenience” (Boeije 2010: 50). Boeije emphasises that to avoid exploitation, the researcher must enhance the ‘well-being and knowledge’ of participants. Thus, the researcher must have the ability to adapt the situation during the conversation. The researcher must be conscious of what the
participants feel during the interview and not just think about what benefits he/she will receive.

While it was recognised that this study could involve potential harm to participants, serious consideration was given to various aspects such as confidentiality and anonymity procedures as outlined in section 4.8.2. To ensure that participants were not likely to be negatively affected by issues expressed, appreciation of participants’ statements was carefully monitored. It is essential to ensure that participants do not feel embarrassed to share personal information because of concern that their sensitive statements will be revealed to the public or immediate relatives.

4.10.2 Risks to the researcher

According to Boeije (2010:52), undertaking qualitative research may be 'stressful' for the researcher. Padgett (1998:41) argues that although the most serious concern is protecting the respondent from harm, the researcher may also be exposed to 'emotional and other risks’ that need to be considered. Padgett states that the ‘most immediate concern for the researcher is emotional’. During the interviews, I experienced emotional stress when respondents shared their stories because many recounted unfortunate and distressing experiences. Although the interviews were emotionally draining and, at times, upsetting to undertake, this experience gave me strength because the study will play a vital role in bringing the situation of older Saudi women to greater attention among academics, policy makers, other organisations, and society.

To deal with and minimise the risks to the researcher, it was beneficial to consider applying ‘bracketing’ (Padgett 1998: 41a). According to Padgett, bracketing refers to the conscious effort of the researcher to suspend their own assumptions, beliefs, and feelings in order to understand the experiences of the respondents.
Padgett (1998: 41b) states that ‘emotional stress is not the only risk’ that a researcher may encounter when conducting qualitative research, but a threat to the researcher’s physical safety may come from respondents if the latter has a violent history. These issues were potentially problematic because the interviews usually took place in the respondent’s home where the researcher could feel vulnerable. Since I did not know the participants, I usually checked their background through their respective gatekeepers. Additionally, I asked my driver to remain close and attentive outside a participant’s house while I was conducting the interview.

4.11 Analysing the Interview Data
Qualitative data was examined and thematically coded to analyse the stories that were gathered from the pilot and main study interviews. According to Dey (1993:31), the core of qualitative data analysis lies in the processes of describing phenomena, classifying it, and discovering how concepts interconnect. Thematic analysis is defined by Boyatzis (1998:4) as a “process for encoding qualitative information that may require an explicit ‘code’, wherein this may be a set of themes; a compound model with themes, indicators and qualifications that are indifferently related; or something in between these two forms”. According to Boeije (2010: 96), themes are “discerned in the data that represent repetitive responses or a subtle pattern in the data”.

The transcription of the data was undertaken firstly in Arabic in order to quote data extracts, and then relevant parts of the transcript were translated into English, transcribing verbatim. The interviews of each participant took more than two days to transcribe for many reasons, such as the participants talking about unrelated topics. To secure the confidentiality of the interview data, I conducted the transcription in a private room.

For the purpose of data analysis, I read through my field notes and listened to the audiotapes of each interview several times so that I could transcribe the women’s speech precisely and to make a full verbatim transcript of the interviews in Arabic.
and then translated into English. By repeatedly listening to the tapes, I was able to derive themes that I could classify the data against, looking for repetitive words and topics used by each older woman. By immersing myself in the transcripts, I became deeply familiar with the nuances and social context of each participant. To ensure that I kept the essence of this study, I constantly went back to the research questions and aims to ground myself as to what the study had set out to achieve. This process allowed me to become familiar with the data and note important information when I was transcribing the interviews. As I listened to the tapes, I noted comments and issues as they occurred and organised them into recurring themes from more than one participant. These common themes meant that a pictorial image began to emerge of what factors elderly Saudi women found both enhanced and decreased their QoL on a day-to-day basis.

I used thematic analysis as my analytical approach, which allowed me to obtain an understanding of the QoL of older unmarried Saudi women by using codes and themes and to progressively refine these codes and themes by continuously comparing them through the data until I reached data saturation. Coding was divided into several stages:

1. During and after the interviews, I noted all important factors related to the interview, such as the participant’s body language and facial expressions, and added these to the transcribed interviews in Arabic.
2. I listened to the audio-recorded interview and read all written notes to become familiar with the data obtained during the interview. While I listened to the recorded interviews, I highlighted the words that all participants frequently used to get a more accurate perception of what affected them from their past experiences.
3. Data analysis for this research study commenced with a preliminary set of codes based on the research questions, aims, and objectives of the study and the main factors discussed in the literature review. From my preliminary set of
codes, I analysed and compared these codes to construct more substantial themes to combine similar concepts that produced my main themes. According to Saldana (2009:3), a code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of data. These codes were selected through the data to provide a description from the categories I had selected, and focused on what affects older unmarried Saudi women in their everyday lives. Miles and Huberman (1994:56) state that reviewing a set of field notes, differentiating, combining, analysing and reflecting on the data is ‘the stuff of analysis’. The inferential or pattern coding approach was used to determine the conceptual coding and analysis of the interviews. These codes were produced through words used by the interviewees and acted as my reference point of their experiences. I constructed tables (Appendix 6b, 6c and 6d) to show each interviewee’s responses according to these codes and themes. Each row of the table represents the name of an interviewee, and the columns represent the codes or brief information about the key characteristics of the 50 interviewees, including their age, marital status and history, educational level, sources of financial support, living arrangements, medical insurance indicators, social engagement, primary activities, and chronic illnesses. For example, the table in Appendix 6b provides information about the participant’s age, marital status/history, number of children, and living arrangement. The table in Appendix 6c provides information about participants’ educational level, previous work experience, income satisfaction and financial support, and socioeconomic status. Finally, Appendix 6d provides information about participants’ medical insurance or services received for chronic illnesses, as well as about social engagements, primary activities, relationships, contacts and visits with family members, and personal evaluation of their QoL. The creation of these appendix tables made it easier to compare and review the collated data.
4. After collecting and revising the data, the main themes from the collated data were produced. According to Miles and Huberman (1994: 69), inferential or pattern codes “identify an emerging theme, configuration, or explanation and pull together extensive material into more meaningful units of analysis”. These central themes included the living arrangements of the participants, their educational level and socio-economic status, their health, their social activities, their family relationships and their QoL. At this stage, it was essential to read and re-read the interview data to determine whether my current themes were relevant throughout the data set.

5. Punch (2005:195) states that the methods for the analysis of data need to be systematic and clearly described. Therefore, I re-examined and re-evaluated the data consistently to refine the themes as the analysis progressed in order to evaluate the significance and validity of the themes. I had to go back and review the verbatim transcripts through the themes, which allowed me to explore the data carefully to provide a grounded empirical and theoretical understanding.

According to Chapman, Hadfield and Chapman (2015:203), in the final stage of analysis, themes emerging from the coded data are used to shape a theoretical structure, which itself is checked against any new data. Continuing a constant comparison of the emerging themes to the collated codes and the raw data allowed me to have a greater understanding of the phenomena and to construct the final themes (general characteristics and socioeconomic resources of older women, social support of older unmarried women in later life, health status and health care access of older unmarried women, and overall QoL of older unmarried women), which will be analysed in subsequent chapters as the factors that affect the QoL of older unmarried women in Jeddah (see Appendix 5 for the annotated transcript of the analytical process).
My thematic analysis offers a systematic approach to the analysis of qualitative interview data to understand the lives of older, unmarried Saudi women. Continuous comparison and re-examination of the main themes from the collected data provides a detailed picture of their everyday lives. The following four interrelated analysis chapters will examine the factors affecting these older unmarried Saudi women to provide a fuller understanding of their real-life experiences.

4.12 Conclusion
The research methodology used to conduct the study was described in detail. Qualitative methods using interviews were considered to maximise the possibility of achieving the aims of this research. The research design, sample selection methods, ethical considerations, data collection, and analysis procedures were explained. The pilot and main study of the research were described in detail. Although it was emotionally draining and at times distressing, conducting 50 interviews was a rewarding and encouraging experience overall. As a result of the pilot study, minor corrections and adjustments were made to the methods and the research design, and these changes were incorporated into the main study. The pilot study increased my experience of interviewing, developed my interpersonal skills and familiarised me with qualitative data collection, which guided me in conducting the interviews for the main study. Additionally, the researcher gained more knowledge of how to approach participants with sensitivity, open-mindedness, and reflexivity.

Prior to starting the interview, the respondents asked me first about personal information such as my place of birth, my parents’ names and family history. I answered all of their questions because I understood that this would help me build trust and rapport with respondents and reduce possible barriers between the researcher and the participant.
It was not easy to conduct qualitative research in a conservative society such as Saudi Arabia, especially on such a delicate subject. It was challenging, particularly when interviewing older women who were very sensitive about family and personal issues compared to the younger generation. Despite the various difficulties faced, I enjoyed the company of these older women and their simple and traditional ways. Learning about their realities and the difficulties they encounter in their daily lives, as well as their remarkable stories and has been very enlightening and a fulfilling experience as I would have never encountered their realities otherwise.
Chapter 5
General Characteristics and Socioeconomic Resources of Older Women

This chapter presents an overview of the socioeconomic characteristics of older unmarried Saudi women in my sample in order to create a profile of the research participants. This thesis specifically focuses on 50 older unmarried women aged 60-75 years old who are either living alone or with their relatives in the community. The researcher used purposive sampling with the sample designed as half (25) older unmarried Saudi women lived alone (i.e. only with maids/drivers) and half lived with family members. The aim was to provide insight about the well-being and experiences of older unmarried women in these two types of living arrangements. The chapter also describes the common factors that influence the socio-economic status, educational status, and living arrangements of the participants.

5.1 General Characteristics
Initially, the characteristics of the respondents will be described according to their age, marital status, educational level, living arrangements and conditions, and socioeconomic status and resources.
Table 5.1: Socio-demographic Characteristics of the Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 – 64</td>
<td>13</td>
<td>26%</td>
</tr>
<tr>
<td>65 – 69</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>70 – 75</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single / Never Married</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Divorced</td>
<td>20</td>
<td>40%</td>
</tr>
<tr>
<td>Widowed</td>
<td>28</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literate</td>
<td>34</td>
<td>68%</td>
</tr>
<tr>
<td>Illiterate</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td><strong>Living Arrangement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Alone</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td>Living with children or with relatives</td>
<td>25</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Paid Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>Never Worked</td>
<td>34</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Economic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Class</td>
<td>15</td>
<td>30%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>24</td>
<td>48%</td>
</tr>
<tr>
<td>High Class</td>
<td>11</td>
<td>22%</td>
</tr>
</tbody>
</table>

5.1.1 Age Group and Marital Status

Of the total sample of 50 older unmarried Saudi women, 13 (26%) were aged between 60-64 years old, 12 (24%) were aged 65-69 years old, and half (25) aged 70-75 years old (Table 5.1). According to marital status, only two respondents were single, 20 (40%) were divorced, and the majority 28 (56%) were widowed. The high percentage of widowed women in this research relates to the greater longevity of older unmarried Saudi women, and the tendency for women to marry men older than themselves.
5.1.2 Self-assigned Economic Status

The economic status and well-being of older unmarried Saudi women in later life depend on what they accumulated during the course of their life, as well as the income they currently receive. Their present income and assets are very important in considering older women’s own economic status. The levels of economic status of the respondents were self-assessed by rating themselves into one of 3 categories, namely poor class, middle class, and high class, based on self-evaluation of their own present financial situation. In this study, the economic status of the respondents was classified as poor class (15), middle class (24), and high class (11) (see Table 5.1).

5.2 Educational Resources

Female education was formally introduced in Saudi Arabia only in 1960 (Doumato, 2003: 245). According to Zuhur (2011: 233), ‘boys’ education had been established prior to the creation of Saudi Arabia in 1901’, but Saudi girls were excluded from formal education until 1960. Prior to this, there was only an informal educational system called *kuttab* (a class of Quran recitation for children, which was usually attached to the local mosque) in Saudi Arabia (Hamdan, 2003: 47). The goal of informal education was mainly focused on the memorization of the Qur'an and reading and writing Arabic. The opening of the first school for girls faced strong opposition from conservative groups in Saudi Arabia. This opposition only stopped when the ‘government pledged that female education would be in line with Saudi customs, especially that of rigid gender segregation’ (Rao and Latha, 2004: 265). However, Al Munajjed (1997: 59) emphasizes that education ‘gave Saudi women knowledge, skills, and a way of recognizing, but not necessarily exercising, their own social and economic power in society.’

Two-thirds (34) of participants were literate, and a third (16) were illiterate (Table 5.1). The respondents were asked about the highest level of education they had received, and the responses ranged from ‘never went to school’ (32%) to having a
graduate degree or having a PhD degree (22%). Table 5.2 shows that among the literate respondents, there was a wide range of educational levels.

Table 5.2: Educational Status of the Participants

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never went to school</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>Studied through informal education</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Dropout from primary school</td>
<td>14</td>
<td>28%</td>
</tr>
<tr>
<td>Dropout from secondary school</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Dropout from college</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Primary school graduate</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Secondary school graduate</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>University graduate</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Two-thirds (32) of the sample had either no formal education or only minimal education; 16 never went to school, 14 dropped out from primary level, and two only received informal education because of socio-cultural norms, and the late introduction of education for girls in Saudi Arabia. Table 5.3 shows that half (14) of the 25 respondents from the 70–75 age groups were illiterate, only two finished their college degree, and the remaining nine dropped out from primary or secondary school, or became literate through informal education.
Table 5.3: Educational Status by Age Group of the Participants

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>60 – 64</th>
<th>65 – 69</th>
<th>70 – 75</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never went to school</td>
<td>-</td>
<td>2</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Studied through informal education</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dropout from primary school</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Dropout from secondary school</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dropout from college</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Primary school graduate</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Secondary school graduate</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>University graduate</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>12</strong></td>
<td><strong>25</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

The older participants in this study were born before any schools for girls were opened; the first school for girls in Saudi Arabia was established in 1956 (Janin and Besheer, 2003: 71). Two participants from the 70-75 age groups said:

* I was ten years old when the government first opened the school for girls in Saudi Arabia, especially in Jeddah. It was too late for me to enrol. It is true that I did not get any formal education, but nowadays I consider myself an educated woman, as I got all my knowledge and awareness from watching television.*

(Fatima A2, 74M, never went to school)²³

² See Chapter 4, Section 8, pg.96 for the guide how the codes were used
³ See Table 5.6 pg. 130 for the list of the codes based on their living arrangements
I never went to school as there was no school in those days and we were just living in the desert. Education was not in our mind before. (Wadha B, 72P, never went to school)

Al Munajjed (1997: 60) argues that middle class families were the first to enrol their daughters abroad in boarding schools in Egypt and Lebanon. Fayza, a middle-class woman who studied in Egypt said:

I was fortunate that my father encouraged me to continue my college education in one of the famous Universities in Egypt. He wanted me to obtain a Master degree, but I refused as there was a job-hiring in the Ministry of Education, and I preferred to start working as a lecturer. (Fayza A2, 75M, university level)

According to Hamdan (2005: 51), since ‘women’s education in Saudi Arabia officially began, educational levels have increased rapidly’; the number of women’s educational institutions grew from ‘15 in the 1960’s to 155 in the 1970’s.’ As shown in Table 5.3, of the 12 respondents from the 65–69 age groups, three were university graduates, two completed primary level, and the others dropped out from college level (1), or from primary school (4), or never went to school (2). The participants from the 65-69 age groups who completed college level said:

I am a university graduate and also obtained a Master’s Degree in Canada. I wished to continue and get my PhD, but my work occupied all my time. Five years ago, I thought of going back to complete my studies, but the work and family responsibilities stood in the way. (Tala UD, 68M, university level)
My parents were broad-minded and supported me to continue my studies. I am a university graduate and also obtained a PhD Degree. (Sarah A, 65M, university level)

The remaining respondents from the 65–69 age groups who dropped out from primary school or college, or never went to school were mainly influenced by their personal decision, socio-cultural norms and their previous residential location. Two of the participants from this age group said:

My family was not concerned about education and they were focused to find me a good man and have children. Also, I was not concerned at that time and I thought that completing college education would be only for taking a position only in my work. Honestly, I don’t like to work, because we have enough properties which provide sources of income. (Fadiya A, 65H, drop out from college level)

I never went to school because we were a nomad’s people in the past. We used to live in a desert area. I remember, when there were rains, we used to move to another location. That’s one of the reasons why education was not in my heart. (Fattomah A, 68M, illiterate)

In the younger age group (60–64), six of the respondents had a Bachelor or a Master’s degree (Table 5.3). Participants who completed their education up to university level and obtained a Master’s Degree said:

I graduated in one of the universities in the United States of America, where I spent four years there living in a nice home in Indiana. However, I wished I continued my education in America or here in Saudi Arabia. (Hessa A1, 63H, university level)
I am a university graduate and obtained a Master’s Degree in Canada. My husband was a doctor in King Abdulaziz Hospital and was supportive of my study. (Nisreen A2, 60H, university level)

The remaining respondents from the 60–64 age group dropped out from primary school because of socio-cultural norms such as early marriage, beliefs about keeping women inside the house, or not obtaining consent from their husband to pursue her education. Two of the participants said:

*I did not continue my primary education because of my early marriage. My family brought a man whom they said was a good man from their opinion and they asked me to marry and not lose him.* (Hedayah UC, 60M, drop out from primary level)

*I dropped out from primary school because our tradition pushed the girls to take care of their families only or marry at an early stage. If I had a good education, my life would be better and I would be like another human being.* (Muzna R, 62P, drop out from primary level)

There are different cultural and socioeconomic issues that prevented older Saudi women from having adequate access to education in the past. In this study, issues such as late opening of schools for girls, cultural norms, and economic status are the key factors that influenced the educational attainment of older unmarried Saudi women.

A prominent example of cultural norms that influenced the access of older Saudi women to education was the belief that it is better for a woman to stay at home and do the household chores for her family instead of attending school. Doumato (2000, cited in Hamdan 2005: 45) states that ‘girls were taught into an assigned role, a role in which they were subordinate to men’. According to Hamdan (2005: 45), ‘gender inequalities’ in Saudi Arabia’s education system are ‘institutionalised
and difficult to dislodge through individual action’ as women’s inequality is ‘traditionally structured’ in Saudi Arabian society. Further, Rao and Latha (2004: 266) argue that school in the past taught girls only to elementary level, and the ‘most suitable’ courses for them were in accordance with their traditional role in Saudi society. These courses emphasized mainly ‘Arabic language, home economics, child caring, and religious instruction’ (p. 266).

Other cultural norms that influenced the educational attainment of older Saudi women are the supremacy of the male legal guardian. Hamdan (2005: 59) emphasizes that the high drop-out rates among girls after primary level in the past were because ‘young girls are forced to marry at a very young age, and there is no law to prevent the parents or a guardian’ from requiring this. According to Al Munajjed (1997: 104), ‘early marriage often prevents a girl from continuing her education’, and schools in Saudi Arabia are ‘perceived as the primary institutional means of socialisation to prepare young girls to assume their role as mothers and housewives.’

Table 5.4 shows the educational attainment of the participants by their current economic status. The majority of the poor class women (nine) never went to school, while most other older women from this socio-economic group had basic education only. In contrast, six out of 24 middle class and five out of 11 high class women completed education up to college education or a university degree.
Table 5.4: Educational Status of the Participants by Economic Status

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Poor Class</th>
<th>Middle Class</th>
<th>High Class</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never went to school</td>
<td>9</td>
<td>6</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Studied through informal education</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dropout from primary school</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Dropout from secondary school</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Dropout from college</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Primary school graduate</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Secondary school graduate</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>University graduate</td>
<td>-</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>24</strong></td>
<td><strong>11</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Table 5.5 shows the highest educational degree attained by the (11) participants who had higher education. Five (5) of these participants were sent abroad by their fathers in order to complete their formal education, while six obtained all their formal education in Saudi Arabia.
### Table 5.5 Participants who finished their formal education

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Age</th>
<th>Socio Economic Class</th>
<th>Marital Status</th>
<th>Where did they finish their study?</th>
<th>Degree of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanabel</td>
<td>63</td>
<td>High</td>
<td>Widowed</td>
<td>Inside the Kingdom</td>
<td>Master</td>
</tr>
<tr>
<td>Hessa</td>
<td>63</td>
<td>High</td>
<td>Divorced</td>
<td>Abroad</td>
<td>College</td>
</tr>
<tr>
<td>Sarah</td>
<td>65</td>
<td>Middle</td>
<td>Widowed</td>
<td>Abroad</td>
<td>PhD</td>
</tr>
<tr>
<td>Fayza</td>
<td>75</td>
<td>Middle</td>
<td>Widowed</td>
<td>Abroad</td>
<td>Master</td>
</tr>
<tr>
<td>Asma</td>
<td>63</td>
<td>Middle</td>
<td>Divorced</td>
<td>Inside the Kingdom</td>
<td>Master</td>
</tr>
<tr>
<td>Nora</td>
<td>70</td>
<td>High</td>
<td>Widowed</td>
<td>Inside the Kingdom</td>
<td>College</td>
</tr>
<tr>
<td>Nisreen</td>
<td>60</td>
<td>High</td>
<td>Widowed</td>
<td>Abroad</td>
<td>Master</td>
</tr>
<tr>
<td>Eman</td>
<td>62</td>
<td>Middle</td>
<td>Widowed</td>
<td>Inside the Kingdom</td>
<td>Master</td>
</tr>
<tr>
<td>Fafi</td>
<td>62</td>
<td>Middle</td>
<td>Widowed</td>
<td>Inside the Kingdom</td>
<td>Master</td>
</tr>
<tr>
<td>Tala</td>
<td>68</td>
<td>Middle</td>
<td>Widowed</td>
<td>Abroad</td>
<td>College</td>
</tr>
<tr>
<td>Faerouze</td>
<td>65</td>
<td>High</td>
<td>Divorced</td>
<td>Inside the Kingdom</td>
<td>College</td>
</tr>
</tbody>
</table>

Five out of eleven highly educated participants obtained their education abroad which was linked to their guardians working or living outside of Saudi Arabia.

Two participants said:

*I was born in Saudi Arabia, but my father raised me in Lebanon because of his business affairs in Lebanon. I came back to Saudi Arabia when I was 24 years old. After, I obtained my college degree and my PhD in KSA.*

(Sarah A, 65M).
My father took me to Cairo when I was seven years old. He loves to read books although he was not educated. A friend of his who was working with the Ministry of Education helped him to get a job when King Faisal allowed the education of boys abroad. The strange thing is that my father wished to take my cousins (boys and girls) to obtain their education, but my uncle refused and allowed only his son to be sent with us to Egypt, and he apologised for not being able to send his daughters outside the KSA, and he said to my father, “it is shameful to send my daughters outside even with you”. (Fayza A2, 75M)

Therefore, socioeconomic status and getting an opportunity to travel abroad was associated with older Saudi women’s access to and success in higher education. According to Arebi (1994, cited in Hamdan 2005: 51), many upper-class families in the past had sent their daughters to ‘private interior schools in Egypt, Lebanon, Jordan, and Syria’ for formal schooling prior to the opening of Saudi universities. Most of these families belonged to the ‘first generation of Saudi bureaucrats and merchants’ (Al-Rasheed, 2013: 86). However, they were the minority of the older women in my sample; two-thirds had little or no formal education.

5.3 Living Arrangements and Housing
The family structure in Saudi Arabia usually consists of the ‘husband, the wife, and the children, living in an apartment, or a separate home near their extended families’ (Ashy, 2008). Therefore, it is very common in Saudi Arabian society to find parents living with, or close to, at least one of their children and siblings in the community. Regardless of economic status, Zuhur (2011: 230) emphasizes that the Saudi family usually ‘employ servants or household help more frequently than the West’ to take care of their home and sometimes their children.

Table 5.6 shows the living arrangements of the 50 respondents. Among those living alone, 13 were widowed and 11 were divorced. Only a minority of those living with others were living in the traditional situation of living with a married
son and daughter-in-law (10), the others were living with older unmarried daughters, an older mentally impaired son, younger children, siblings, and other relatives. In this research study, the ‘mentally impaired’ refers to the 39-year-old son of one participant who has Down’s syndrome.

Table 5.6: Living Arrangements by Marital Status of the Participants

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Single / Never Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Alone (A)</td>
<td>1</td>
<td>11</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Living with son &amp; daughter-in-law (with grandchildren) (S)</td>
<td>-</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Living with older unmarried daughter(s) (UD)</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Living with older unmarried “mentally impaired” son (US)</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Living with younger children (or non-problematic) children (UC)</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Living with brother (&amp; wife) (B)</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Living with other relatives (R)</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>20</strong></td>
<td><strong>28</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Divorced participants who were living alone had divergent views about whether they would prefer to live alone. For example, two participants said:

_I am living alone with my housemaid and driver. However, if I would get a chance to live with anyone, I would not object or refuse. I cannot endure loneliness and I feel that it is killing me. Alhamdullelah, I learnt how to deal with my loneliness._ (Fatima A2, 74M)

_I am living alone in an apartment and my children are helping me to pay the monthly rent. I have been living here for almost 17 years. I had a_
chance to live with my son, but I refused as I preferred to live alone.
(Majda A, 60P)

A participant who has been widowed for ten years reported that she wished to live with her family, but the family circumstances prevented her. She said:

*After my husband passed away, my husband’s son treated me badly. He asked me to leave the house as he did not like me to live with them. My husband’s son was supposed to take care of me as I always treated him well and raised him as if he were my son. After that incident, I did not get any chance to live with anyone again.* (Aiza A1, 75P)

On the other hand, a participant who was widowed for 16 years and living with her son, daughter in-law and granddaughter said that she would prefer to live independently.

*In the end, I feel that this is my son’s house and not mine. I wish I had my own house instead of living with my son. I prefer to live in a private and independent house of my own.* (Maria S, 70M)

However, the majority of the participants who were living with their married sons or their brother were satisfied with their living situation, for example:

*I am very satisfied and contented living with them. The best thing, they are really nice and good to me. I am happy now and I do not see anything bad living with them.* (Fafi B, 62M)

*After my divorce, I started living with my brother. I don’t have children because I am sterile. I have a good relationship with my brother, and my*
nephews and nieces. They are the dearest people to my heart, and I feel safe living with them. (Zana B, 75M)

In contrast, living with a married son and his family was problematic for an older Saudi woman who has been widowed for 14 years. She said:

*I have been living in this apartment with my son, daughter in-law, and grandchildren since my husband died. I never had a chance to live on my own, but I hope to have my own house to play the lady’s role, where I can bring visitors and invite people whenever I want. My son is poor and I am the one thinking of our daily expenses.* (Nadia S, 73P)

Based on the participant’s response about their self-assigned economic status (see section 5.1.2), the study sample consists of 15 poor class, 24 middle class, and 11 high class women. Table 5.7 shows the living arrangements by the self-assigned economic status of the participants. The data show that economic status influenced the living arrangements of older unmarried Saudi women as the majority of high class women (nine out of 11) lived alone compared with a minority of both poor class (six out of 15) and middle class (10 out of 24).

**Table 5.7: Living Arrangements by Self-Assigned Economic Status**

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Poor Class</th>
<th>Middle Class</th>
<th>High Class</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Alone</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Living with son (S), brother (B), or other relatives (R)</td>
<td>7</td>
<td>7</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Living with Unmarried Children (UC)</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>24</strong></td>
<td><strong>11</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Many of the respondents are living alone not necessarily because they have been abandoned by their children or relatives, but some chose to live on their own to
have a more independent life, especially high class women, or live in a separate house/apartment located close to their children. On the other hand, living with children does not necessarily mean the economic dependence of older unmarried women on their children; rather, it could also mean the dependence of their younger children on them.

5.3.1 Housing Situation of the Participants

According to Sugar et al. (2014: 115), in the Western countries the living situation of older people ‘has a great impact on the quality of his or her life.’ Further, Sugar et al. state that ‘the type and condition of a person’s living unit’ are important to their overall well-being, including physical and psychological health (p. 115). Table 5.8 shows that the majority (19) of the 28 widows are living in their own houses. This contrasts with divorced older women, among whom the majority are living in an apartment either paid for by their relatives (seven) or paid by themselves (five).

Table 5.8: Ownership or Rental of Place of Residence by Marital Status of the Participants

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Rented Apartment (Paid by herself)</th>
<th>Rented Apartment (Paid by Relatives)</th>
<th>Rented Apartment (Owned by NGO)</th>
<th>Owned House</th>
<th>House Owned by Relatives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single / Never Married</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>19</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>11</strong></td>
<td><strong>1</strong></td>
<td><strong>25</strong></td>
<td><strong>4</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Two of the high class participants who are living in their owned houses said:

*I moved into this house five years after my husband's death. My husband had planned and designed this house so that we could move and live here*
after the marriage of our children. I am happy and contented living alone in my own house, and I can always change the situation if I want to. (Nora A2, 70H, own house)

I am single and never been married. I never had a chance to live with other relatives. I have been living in my own house for 30 years, which is good for my financial situation. (Farrah A2, 74H, own house)

While just under half of the older women in my sample own their own house, housing is one of the important resources for older women, as illustrated by the following participants who wished to have their own houses.

Our house is too small and I hope to have a new house, even a simple house but not here, because it is a slum area. (Nadia S, 73P, lives in an apartment)

I need a place to stay, financial support, medical support and psychological support. Yes, I feel comfortable living with my brother and his wives, but this does not mean that I can do everything comfortably. The only thing that makes me feel fine is my medical insurance provided by my brother. (Wadha B, 72P, lives in brother’s house)

Paying for the monthly rent of the apartment was brought up as a vital problem affecting the financial well-being of older Saudi women who rented. A divorced participant said:

My monthly income comes from my social insurance and regular financial support from my sons. But, this is not enough to pay my apartment rental monthly. I never had a chance to live with my children, but I wished to live with any of them. However, my oldest son is living now in Dammam
The living situation of older women, in general, is critical to their lives during later life. Most of the older unmarried Saudi women in this research study who are living in their own home expressed satisfaction about their living circumstances. The majority of older widows living in an owned house are from the middle and high class, while most of the divorced women are residing in a rented apartment. Thus, this provides a clear indication that the present personal economic status of respondents influences their housing situation in later life. In addition, the apartment rental cost remains a financial burden for many respondents who do not have their own house, especially for low income older women.

5.4 Paid work participation

One of the main reasons behind the limited present income of many older unmarried Saudi women is that the majority had never engaged in paid work. According to Al-Munajeed (2010), women’s participation rate in the Saudi Arabia labour force in 1992 was 14.4%, and had only increased to 18% in 2013 (World Bank, 2013). Al-Munajeed (2010) argues that Saudi Arabia still has one of the lowest rates of female labour force participation in the region compared to the national female participation rate in the UAE (59%), Kuwait (42.5%), Qatar (36.4%), and Bahrain (34.3%). Al-Munajeed (2010) further states that over 90% of Saudi women actively participating in the workforce hold a secondary school qualification or a university degree, but she argues that getting a degree does not guarantee employment in the Saudi labour market as 78.3% of unemployed women are university graduates.

Table 5.1 shows that 34 (68%) of the respondents had never worked and only 16 (32%) had ever undertaken paid work. Three sample members were still carrying on some type of productive work, namely as a lecturer in the University (Fafi), as
a seamstress (Nadia), and as a security guard (Dania) in the airport. Traditional gender roles and socio-cultural norms play a part in explaining why most of the participants never participated in paid work (Altamimi, 2016). Due to the impact of socio-cultural norms and the low level of educational attainment, older women had limited employment opportunities, which affected their ability to work and have an independent income. Thus, the majority of respondents in this study were only engaged in unpaid household work throughout their lives. Table 5.9 shows that the youngest age group of women were most likely to have undertaken paid work (eight out of 13) compared with only three out of 25 women aged 70–75.

Table 5.9: Previous Paid Work Status by Age Group of the Participants

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Engaged in Paid Work</th>
<th>Currently Working</th>
<th>Never Worked</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 – 64</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>65 – 69</td>
<td>5</td>
<td>-</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>70 – 75</td>
<td>2</td>
<td>1</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>3</td>
<td>34</td>
<td>50</td>
</tr>
</tbody>
</table>

Two of the poor participants who had never engaged in paid work in the past said:

*When I was young, I used to visit a woman and I asked her to teach me how to wash, iron and sew clothes. When I got married, I worked at home with the aid of my father in-law in washing and ironing my husband’s family’s clothes for free.* (Manal A1, 74P)

*I never worked because my family used to say that women should not go out of the house.* (Aiza A1, 75P)

Due to socio-cultural norms, and the gender-segregated labour market, the employment of the first generation of educated Saudi women was limited to the education sector as teachers and in administration work (Al-Rasheed, 2013: 22).
The teaching of girls at school or universities is considered the desirable career choice for Saudi women. Two participants who had worked as a lecturer at the University said:

_I am presently working as a Lecturer at King Abdulaziz University. I retired two years ago but I approached the University to work again. My monthly income from retirement pension, salary as contractual Lecturer and income out of some properties of my deceased husband in Jordan are almost enough to support my needs. And since I am living with my oldest brother, I have no financial responsibilities for housing rent or maids._ (Fafi B, 62M)

_I retired from my previous work as a lecturer at the University and am now enjoying my retirement._ (Asma A2, 63M)

Unusually, Dania is presently working as a security guard at the airport, a job that is not considered an appropriate career for a Saudi woman. She said:

_I started to work as a security guard after my divorce. Although I am receiving a salary of 4,500 riyals monthly, still it is not enough to support my financial needs._ (Dania A1, 63M)

In general, women’s employment in Saudi Arabia is a major challenge. In a local newspaper article by Al-Munajeed (2010), regarding the participation of women in the Saudi labour market, she emphasized that the main reasons that prevent women’s participation are the ‘legislative, social, educational and occupational constraints.’ Most of the older Saudi women in this study, throughout their lives, subscribed to the values of domesticity, where their roles were restricted to being a housewife, mother and nurturer of their children. Even today, although more labour is needed in the Saudi Arabian economy, the traditions and socio-cultural norms that restrict women’s paid employment are still largely upheld.
5.5 Sources of Personal Income

Most older Saudi women are challenged with limited income due to the social inequalities they have faced throughout the course of their lives. In this study, current economic resources of older women are one of the important indicators of financial well-being and financial dependency. It is expected that the income of older women will mainly come from: retirement pensions, for the small minority who have engaged in paid work; for widows, from their husband’s pensions or inheritance; as well as from social insurance; and financial support from children and other relatives. However, the situation for divorced Saudi women is less well-known.

In this study, most of older Saudi women have multiple sources of income (see Appendix 5c). The data in Table 5.10 is drawn from Appendix 5c and shows that among the respondents, more than half (52%) receive financial support from their children, followed by 42% from social insurance. About a quarter of respondents are receiving monthly income from inheritance from their late husbands (26%), their own retirement pension (22%), and/or a husband’s pension (20%). Minority sources of monthly income include from siblings and other relatives, inheritance from their father, present paid work income, money from charities, father’s pension, income from business and properties, and one respondent had financial support from her neighbour.

Social insurance is the most important source of income for older women who have limited financial support. The government of Saudi Arabia provides a regular sum of money through the Social Security System, to persons who are eligible to receive it, namely: orphans, the disabled, senior citizens who do not have a retirement pension, women with no provider, and families with no provider (Fadaak, 2011: 111). According to a local newspaper in Saudi Arabia (Arab News, 2010), the estimated beneficiaries of the social security programme in 2010 were around 2.5 million Saudi citizens who are paid a flat rate of ‘860 Saudi Riyals monthly (nearly US $ 8 a day), which is more than three times the
international standard of poverty.’ Recently the government of Saudi Arabia has revised the amount to 1000 riyals (Ssa.gov, 2017).

Table 5.10: Percentage of participants receiving each Source of Income

<table>
<thead>
<tr>
<th>Sources</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goodwill Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>26</td>
<td>52%</td>
</tr>
<tr>
<td>Siblings / Relatives</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Charities</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Welfare Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Insurance</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Acquired Right</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inheritance from husband</td>
<td>13</td>
<td>26%</td>
</tr>
<tr>
<td>Retirement Pension</td>
<td>11</td>
<td>22%</td>
</tr>
<tr>
<td>Husband’s pension</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td>Inheritance from father</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>Paid work Income</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>Father's pension</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Income from business/properties</td>
<td>4</td>
<td>8%</td>
</tr>
</tbody>
</table>

Table 5.10 categorises the present income received by respondents into three types of financial support, namely: goodwill income, welfare benefit, and acquired right. ‘Goodwill income’ includes income from their children, siblings, relatives, neighbours, and charities. However, dependence on this type of income is vulnerable as there is never a guarantee that an older woman will regularly receive sufficient financial support. For example, payment may be affected if the parties have a problematic relationship. Welfare benefit comprises income from social insurance or social welfare. This type of income is at a low level, and the respondents barely survive by stretching their present income to cover all their needs. The third type of income is from an ‘acquired right’, which includes: income from current paid work; retirement pensions for those who have engaged
in paid employment; for widows, from their husband’s pensions or inheritance; pension and inheritance from their father; and income from business/properties. These sources of income are generally regular and stable. In this study, the present high income of many respondents is primarily because they are receiving multiple sources of income from ‘acquired rights’. Thus, among the three types of financial support, acquired right income is the most valuable source of income, and is considered the most secure.

Two participants who live alone and receive multiple sources of income said:

*I am receiving my father’s pension, social insurance, and regular financial support from my children. Alhamdullelah (thanks God), at this stage, everything is covered, but I don’t know what will happen in the future.* (Salma A, 66M)

*The main source of my monthly income comes from my sons, social insurance and charity association every 7 or 8 months. It is not enough, as you can see, my apartment is already damaged and I need to fix many things. During times of financial difficulties, I tried to sew clothes for my neighbours as I was a seamstress in the past, but I am not working hard now due to my health condition.* (Lola A, 65P)

It is also notable that inheritance of properties is a significant source of accumulating wealth for many older women. From Table 5.10, 26% of respondents received income as part of the inheritance from their late husband, and 12% from their father. Two of the respondents said:

*My monthly income comes from my husband’s pension because he worked in Advisory Council for a long time. The huge amount comes from my properties and inheritance.* (Farha US, 75H)
My financial situation was not affected when I became widowed, because my husband had no permanent income in the past. The main source of my income comes from the regular support of my children, husband’s inheritance and from the social insurance. But the property I inherited from my husband benefited me now. (Fattomah A0, 68M)

The well-being of older women is also influenced by their level of financial dependency. Children and immediate relatives, like siblings, have traditionally been expected to be the main source of support for older unmarried women in an Islamic society like Saudi Arabia. However, the financial support from children and immediate relatives, like siblings, is optional and vulnerable, and reflects the traditional Islamic value of familial piety. As shown in Table 5.10, 52% of respondents are receiving direct financial support from their children, and 14% from their siblings and other relatives. However, the amount of this ‘goodwill income’ is considered unstable and at risk if any circumstances affect the older woman’s relationship with her children, siblings or other relatives. On the other hand, the amount of social insurance provided to older women is limited (only 860 Riyals monthly). In contrast, present income from ‘acquired rights’ provides a much higher amount to respondents compared with ‘goodwill income’. To sum up, it can be clearly seen that older women’s financial resources may affect their financial security, and satisfaction in later life.

5.6 The Impact of Marital Status on the Financial Satisfaction

Socioeconomic status is an important determinant of QoL (Bielderman et al., 2014), well-being (Braveman and Gottlieb, 2014) and life satisfaction (Chen et al., 2016) of older people. However, in this study, the degree to which their lives have been affected by these three elements varies according to an older Saudi unmarried woman’s marital status (Divorced, Widowed or Never married). Table 5.11 shows the number of participants according to their marital status and socioeconomic class. 40% (20) of the participants were divorced; four from high class, nine from the middle class, and seven from the poor class. 56% (28) were
widowed; six from the high class, 15 from the middle class, and seven from the poor class. Lastly, 4% percent (2) were never married; one from the high class and the other from the poor class.

Table 5.11 Marital Status and Socioeconomic class of the Participants

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of participants</th>
<th>Economic Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>Divorce</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>Never married</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>11</td>
</tr>
</tbody>
</table>

Divorced older women were more unlikely to have financial difficulties. However, there can be exceptions, particularly among those who were naturally born in the higher class status. One participant said:

“I lost everything when my husband divorced me and I’d become depressed, but my brother supported me strongly”. (Fadiya A, 65H)

Divorced participants who were in the middle and poor-class are the group who are the most affected based on their marital status. Two participants said:

“Allahumma, my children support me financially, but despite this, even them suffers because of insufficient income”. (Salha UC, 65M)

“In the past, I was a lady with a good position in the society and had a great relationship with the people. Also, I used to invite people in my
home weekly and, due to the facilities provided by my husband, I was also helping unfortunate people. But now, I’m the one who is waiting for the donations came from the charitable institutions”. (Sumayah A, 70P)

For widowed participants who were in the middle and poor class, two participants said:

“I’ve kept my late husband’s inheritance to buy a small apartment, so at least I could get rid from the house rentals, although I’m suffering financially”. (Aiza A1, 75P)

“I have a regular income from my husband’s pension, and additional financial support from my son. I am quite satisfied financially, but I am still hoping to have some additional source of income for my medication”. (Maja S, 75M)

The financial status of older Saudi unmarried women is influenced by the reason they lost their married status, i.e., whether they are widowed or divorced. As expected, widowed women used to receiving an ‘Acquired Rights’ income, particularly the pension or inheritance they receive from their late husbands, something the divorced women do not have. Thus, older Saudi widowed women were more likely to be satisfied financially, whereas the divorced women were more likely to find themselves having financial difficulties, particularly the middle and poor class women.

5.7 Satisfaction with Present Income

Table 5.12 presents the level of satisfaction of older women concerning their present income in relation to their self-assigned socio-economic status. Almost all (13 of the 15) respondents from the poor class are dissatisfied, which contrasts with 20 out of 24 middle class being satisfied with their present income level and all 11 respondents from the high class.
Table 5.12: Satisfaction with Present Income
by Economic Status of the Participants

<table>
<thead>
<tr>
<th>Level of Satisfaction</th>
<th>Poor Class</th>
<th>Middle Class</th>
<th>High Class</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfied</td>
<td>13</td>
<td>2</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Partly Satisfied</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Satisfied</td>
<td>2</td>
<td>20</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>24</strong></td>
<td><strong>11</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Two participants from the poor class, said:

*I am receiving 2,000 riyals from my husband’s pension. The amount is not enough to support my needs, but my children and my brothers are helping me in everything.* (Katrina S, 74P)

*I am depending on the social insurance only and the amount is 860 riyals a month only. I am receiving irregular financial support from my children and they are pressured to help, but could not do anything. It is not enough at all. It is so sad that I don’t have enough money to cover my important expenses. During difficult times, I used to borrow from my children and other people.* (Neama S, 75P)

While three participants who are in the middle class, said:

*My monthly income comes from my property inheritance, financial support from my brother and nephews, and social insurance. It is around 4900 riyals monthly. Alhamdullelah, it is more than enough for my needs.* (Zana B, 75M)
I am receiving 10,000 riyals monthly from my retirement pension. Alhamdulilelah, it is enough because I am living in a modest life. During the difficult situation, I could use my savings. (Sarah A0, 65M)

My monthly income comes from my husband’s pension and my children always asked me if I need more, but I refused as I am contented and satisfied with what I have. The amount usually sums up to 8,000 riyals monthly. It was more when I had the bakery business. It is more than enough to support and cover all my expenses, as I only pay the salary of my personal maid and driver. (Hanadi S, 75M)

And, a participant in the high class, said:

My retirement pension is around 10,000 riyals monthly, and my children are giving a total of around 20 thousand Riyals. In addition, I have a regular steady income from my own properties to the value of 30 thousand Riyals monthly. The amount is more than enough for my needs and I also undertake the sponsorship and support five families and grant each 2,000 Riyals monthly, and I have other charity activities. (Nora A2, 70H)

The findings show that among the women in the sample there is strong variation in their present income. As expected, the present level of income and financial resources of older women has a strong effect on their financial satisfaction. Social insurance acts as an alternative source of income for almost half (42%) of older women, mainly poor or middle class women. In general, however, for respondents having a low income this is likely to have a negative impact on their well-being, while middle class and high class women are more likely to be the most privileged.
5.8 Conclusion

This chapter has provided an overview of the educational and socioeconomic characteristics of the participants. The majority of participants (56%, 28) were widowed while other participants were divorced (40%, 20) and never-married (4%, 2). Widowed older women were better off financially than were divorced women, and were more likely to live in their own house, and to receive an inheritance from their husband or from a husband’s pension. The illiteracy and low educational level, as well as the high proportion of participants who had never worked, was because of the influence of socio-cultural norms. Both the participants from the high class, and those whose guardians lived abroad were more likely to get the chance to obtain an education.

The income data showed that participants who are self-defined as middle or high class were the most satisfied with their present level of income. As expected, children and relatives were the primary sources of economic support for older unmarried women, as the value of family relationships in Saudi Arabian society is highly regarded. However, this type of support has no fixed amount and is considered vulnerable. Since present income played an important role in determining financial satisfaction among the study samples, income received as an ‘acquired right’ is considered as the most secure source of income among the three types of financial support, and could provide greater financial security to the older women.
Chapter 6
Social Support to Older Unmarried Women in Later Life

This chapter analyses the role and impact of social support in the lives of older unmarried Saudi women. In this research study, social support refers to the support received from their family in times of sickness, for engaging in social activities, financial matters and through visiting relatives and friends. Sources of social support are classified as coming from adult children living with older unmarried Saudi women, children living elsewhere, other relatives, friends and neighbours and from the government. The chapter also examines how the nature of social support received by older unmarried Saudi women is related to their socioeconomic status and present living arrangements. The chapter also contrasts social support differences regarding the children whom the older woman is living with, and the children who are residing in another household, or another city. In addition, relationships of older women with other relatives, friends, and neighbours are discussed.

6.1 Role of Social Support in Saudi Arabia

Strong social support can contribute to the psychological and physical well-being of older people. However, the role of social support for ageing people, especially for older women, is different between Western and Middle Eastern countries. Particularly, within the context of Islam, the topic of gender relationships is very sensitive, and women are often confined to the private sphere (Arab, 2011). Thus, the status of women in the Middle East context, especially in Saudi Arabia, is very different to that of women in Western societies. In the Western context, many older women are able to perform normal daily tasks such as driving, and household chores, and women in general can move at liberty (Warner, Adams and Anderson, 2016). In contrast, the rights of women in Muslim countries like Saudi Arabia are limited; for example, a woman can work and travel abroad only with the written permission of her male guardian, and there is strict implementation of
gender segregation whereby women are not allowed to mix socially with men outside their family (McCall et al., 2016). Due to influences of religion and socio-cultural norms, receiving social support can be critical for older women.

In this research study, the nature and levels of social support were analysed by answers to questions regarding: 1) who supports their financial needs, 2) how often do they go out of the house and who goes with them, 3) how often they visited or were visited by children, friends or relatives, 4) the availability of transportation, and 5) the availability of help if they became sick. This study compares social support received by older unmarried Saudi women living alone and received by those living with family members.

6.2 Types of Social Support
In this study, social support is categorised as including financial support, instrumental support, emotional support, and social interaction. The social support that older women receive will be analysed in terms of both the availability of social support and the satisfaction with the support received. This section will briefly outline the four main types of social support before discussing the sources of social support in more detail.

6.2.1 Financial Support
Financial support is any monetary assistance that adds to the present income of older people. Table 5.10 in Chapter 5 showed the sources received by participants indicating financial support received by respondents from children, siblings/relatives and charities. Although financial support only from children or other family members may not be sufficient to meet all the needs of older people, it is important to some, especially for those who are in poverty and have no regular sources of present income, for example, to cover essential expenses like groceries, house rental for those who are renting, and medical expenses when they get sick. In this research study, 52%, (see table 5.10) of participants said that their children provided them with financial support. In Saudi Arabian society, children
are expected to support their parents' income due to filial responsibility. However, some children, siblings and relatives who have economic problems may not be able to provide as much financial support as the older women expect or need.

6.2.2 Instrumental Support
Instrumental support is usually provided by co-resident children, siblings, relatives and housemaids or drivers for routine tasks such as cooking food, cleaning, laundering, purchasing groceries, doing other household chores and providing transportation. In the Western context, older people who are physically fit usually do these tasks for themselves, and instrumental support for these kinds of activities is only required by older people who are frail or have physical disabilities (Ko, Wang and Xu, 2013). However, in Saudi Arabia, it is very common for many Saudi families to employ a maid or household worker to take care of domestic tasks in their home, regardless of their physical health, and economic status.

Table 6.1 shows that among the respondents, the majority (70%) received instrumental support from their children, and 62% received support from housemaids/drivers. Minority sources of instrumental support included from siblings, other relatives, neighbours and friends.
Table 6.1: Sources of Instrumental Support that the Participants Received

<table>
<thead>
<tr>
<th>Sources</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>35</td>
<td>70%</td>
</tr>
<tr>
<td>Siblings</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Friends</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Neighbours</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Maids or Drivers</td>
<td>31</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td></td>
</tr>
</tbody>
</table>

In general, older women co-resident with their children and/or a housemaid/driver are likely to receive more instrumental support, particularly help in performing household chores, purchasing groceries, and providing transportation. Due to sociocultural norms and the values of Islam, sons are expected to take the main responsibility for providing financial support to their mother in her old age, while daughters and daughters-in-law are expected to provide instrumental support to an ageing mother with her routine activities. In the absence of older women’s children and/or other family members, the instrumental support provided by a housemaid and a driver can be a great comfort to them.

### 6.2.3 Emotional Support

Emotional support can influence the mental health of older women and contribute to their psychological well-being. It is important for older women to know that they are taken care of. The usual source of this support is family and friends. Non-resident children provide emotional support to older women by visiting them or making telephone calls. However, this kind of support depends on the quality of the past and present family relationships of the older woman.
In Table 6.2, family members, especially children (90%), were identified as the most important source of emotional support, followed by siblings (46%), friends (44%), and other relatives (26%).

Table 6.2: Self-reported Sources of Emotional Support that the Participants Received

<table>
<thead>
<tr>
<th>Sources</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>45</td>
<td>90%</td>
</tr>
<tr>
<td>Siblings</td>
<td>23</td>
<td>46%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>13</td>
<td>26%</td>
</tr>
<tr>
<td>Friends</td>
<td>22</td>
<td>44%</td>
</tr>
<tr>
<td>Neighbours</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Maids</td>
<td>4</td>
<td>8%</td>
</tr>
</tbody>
</table>

It is expected that the main sources of emotional support are from family members because in an Islamic society, like Saudi Arabia, the responsibilities of family members should be in accordance with Saudi socio-cultural norms and with Islam. The basic teaching of Islam is to take care of the family, especially the older members.

6.2.4 Support through Social Interaction

Unlike instrumental and emotional support, support through social interaction usually refers to communication and social relationships within the family and with networks of friends, neighbours and other relatives. These interactions are important for the participants’ well-being and quality of life. Social interaction is a type of support that can remind the older person that she is not alone, and she is respected and is an important part of the structure of the family and society.
Table 6.3 presents the sources of social interaction support received by the participants. In this research study, levels of social interaction support were determined by answers to questions about 1) when was the last time you went out, who with, and who did you visit, 2) who do you see regularly, 3) does anyone visit you in your house on a regular visit, and 4) how often do they come to visit you. The main provider of social interaction support to the respondents is their children (82%). Most respondents also received social interaction support from friends (52%) and some from their neighbours (24%), although they received little instrumental support from these two sources.

Table 6.3: Sources of Social Interaction Support that the Participants Received

<table>
<thead>
<tr>
<th>Sources</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>41</td>
<td>82%</td>
</tr>
<tr>
<td>Siblings</td>
<td>17</td>
<td>34%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>19</td>
<td>38%</td>
</tr>
<tr>
<td>Friends</td>
<td>26</td>
<td>52%</td>
</tr>
<tr>
<td>Neighbours</td>
<td>12</td>
<td>24%</td>
</tr>
</tbody>
</table>

Aside from children, siblings and other relatives, the research study shows that friends and neighbours are often sources of support, providing companionship and encouraging the older woman to participate in social activities, as well as providing emotional support. Furthermore, friends and neighbours may also provide immediate support, which is particularly important for older women whose family members are not available or do not live close by.

6.3 Sources of Social Support

Providing these four types of social support to older women is paramount as it directly affects their physical, mental, and general well-being. In this research study, there were four primary sources of social support, namely, family members, housemaids and drivers, friends, and neighbours. Each of these will be...
discussed in turn. These diverse sources of support can help older unmarried Saudi women in the four different ways outlined above by providing: financial support, instrumental support, emotional support, and social interaction support.

6.3.1 Role of Children and Other Family Members in Providing Support

Children and other family members often provided financial, instrumental, emotional, and social interaction support to older people. As discussed above, children are the main source of financial support (52%), instrumental support (70%), emotional support (90%), and social interaction support (80%). This is mainly because Saudi Arabian people are strongly influenced by Islam which emphasises the importance of family values. Furthermore, Islam argues that the values of family life are considered the foundation of society. Financial support from children and other relatives was discussed in Chapter 5: this section focuses on instrumental, emotional and social interactional support. Table 6.4 shows the reported provision of frequent visits to older women by their children, relatives and friends, with 22 out of 25 living alone frequently visited by their children.

Table 6.4: Reported Provision of Frequent visits by each source according to the Older Woman’s Living Arrangement

<table>
<thead>
<tr>
<th>Sources</th>
<th>Living Alone</th>
<th>Living with Other Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>22 (88%)</td>
<td>19 (70%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>8 (32%)</td>
<td>10 (40%)</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>7 (28%)</td>
<td>6 (24%)</td>
</tr>
<tr>
<td>Friends</td>
<td>13 (52%)</td>
<td>5 (20%)</td>
</tr>
<tr>
<td>Neighbours</td>
<td>7 (28%)</td>
<td>5 (20%)</td>
</tr>
</tbody>
</table>

Although some of an older woman’s adult children may have migrated to other cities due to work and their own family responsibilities, these women were still reliant on other children who were co-resident or lived nearby and provided not
only emotional support, but also social interaction and instrumental support. Older women who were living with their children, and those living alone, received emotional support from their children as illustrated here:

_I am living together with my unmarried children in our own house. Living with them is a good thing. My other daughters and my brother are used to visiting me twice a week._ (Ellen UC, 61M)

_I am living alone in my own home, but one of my sons is living nearby. Alhamdullelah (thanks God,) if one of my daughters does not come, the other daughter comes. My son who is living nearby is used to coming every day._ (Fattomah A0, 68M)

Many of the older women received emotional support through telephone calls, especially from their children. Being able to communicate with their children regularly made the older women feel happy. Salma said:

_I am living alone in an apartment owned by a Non-Governmental Organization. My children come every two months and my neighbour, who is an old woman like me, usually visits me weekly or every two weeks at least. I am used to telephoning my children every day as all of them are living outside Jeddah._ (Salma A0, 66M)

Although the majority of participants receive emotional support from their children and other relatives, some participants like Sabra, a very poor woman, expressed unhappiness; she said,

_I am living alone in an apartment which is in a bad condition. I do not have daily activities and I'm used to spending most of my days alone at home. Today is different and a joyous one, because you (the interviewer) are here. I have a daughter, but she is very busy at work and her visit_
schedules are very far apart. I saw her yesterday, but it had been nearly three months since we last met. My relationships with my three siblings who are well off is not good, as such, they seldom visit or help me. I do not have a telephone or any way to communicate with anyone. (Sabra A0, 60P)

Therefore, emotional support from family members to older women depends on the quality of relationships with their children and other relatives. It also depends on their socioeconomic circumstances. Most older women from the poor class do not have the means and are unable to visit their friends, relatives or children, which may result in loneliness and depression.

Living arrangements are important in relation to the availability of instrumental support like caregiving for older women, especially when they become sick or frail. Two participants who are living with their families said:

*I am living in my own house with my children. Also, my sister is living in the same building. I went to the hospital last month because of a problem with my legs. My children, especially my youngest son who is single, are always willing to go with me to the hospital. I don't have any medical insurance, but my sons always pay for my hospital care.* (Hedayah UC, 60M)

*I am living in an apartment with my daughters. I have medical insurance as one of my sons paid for it. I was in hospital last month for a check-up, and my medical insurance covered all the medical expenses. My children take me to the hospital when it is needed.* (Salha UC, 65M)

For older women who are living alone, instrumental support like purchasing groceries and transportation is provided by non-co-resident children and/or other
relatives. However, despite having a housemaid and a driver, Fayza, who is unique among participants because she buys her own groceries personally, said:

*I am living alone with my housemaid and driver and am used to going to the shops or the supermarket with my driver daily to purchase my needs by myself because I do not like to depend on my housemaid. I habituated myself already to eating alone and watching television alone for almost 25 years, and I feel comfortable and independent.* (Fayza, A2, 75M)

However, some of the participants did not receive much emotional and financial support from their children. Lola said:

*I am living alone in an apartment. I wished to live with one of my children but my oldest son is presently living in Dammam City, my second son is living in a very small apartment with his family, and my daughter’s husband’s salary is also minimal, thus unable to support my daily needs. I feel miserable in eating and watching television alone, as I used to eat and watch with my family in the past. If the program is comedy, I laugh. But if it is sad, I used to cry immediately. For me, this is a kind of releasing the emotion of sadness.* (Lola A0, 65P)

In summary, family members, especially children, were the major sources of social support. The findings illustrate the fact that almost all older women who lived alone received frequent visits from their children. This demonstrates the effect of positive relationships and contacts between older women and their children. Other family members and relatives maintained contact with the participants through visits to the home or telephone calls. Some of the co-resident children showed their concern for their mother by taking care of her, helping her financially, and assisting her to perform household chores. Also, present living arrangements and the socioeconomic status of children and other family members
have an influence on the provision of emotional and financial support to older women.

Older women from the poor class depended on their children financially and often the homes of their children were not big enough to accommodate their mother living with them in a cramped environment. This may mean that poor older women must live alone but cannot afford a housemaid. These circumstances in turn may lead to loneliness and feelings of depression (as discussed in Chapter 8). Among the middle class, often the older woman has a housemaid to help with daily chores. However, her children may have jobs which require long working hours or commutes and, therefore, they are unable to be with their mother on a daily basis to give her emotional support.

6.3.2 Role of Housemaids and Drivers in Providing Support
In Saudi Arabia, it is normal for a Saudi family to employ a housemaid, and some households also employ a driver. Housemaids and drivers are usually non-Saudi and are usually hired from Asian countries such as the Philippines, Sri Lanka, and India, and employed by the family on fixed length work contracts. A housemaid typically performs domestic chores such as cooking, washing, cleaning the house and grocery shopping. However, in the Saudi context, housemaids often also take on the additional role as a care giver of older people. Indeed, reliance on housemaids is normal, especially as older women’s children or family members are often busy at work or have migrated to other cities. Thus, when instrumental and emotional support are not available, some older women seek support from their housemaid.

In this research study, almost two-thirds (31) of participants or their co-resident families employed a housemaid. Table 6.5 shows that only 3 out of 15 poor class, whereas 17 out of 24 middle class, and all 11 high class respondents have their own housemaid. Among participants who live alone, poor women (4 out of 16) do
not have a housemaid. Therefore, having a housemaid is very strongly socio-economic class related.

**Table 6.5: Number of Participants with Housemaid by Economic Status**

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>With Housemaid</th>
<th>Total Number</th>
<th>Percentage with Housemaid</th>
<th>Living Alone</th>
<th>No Housemaid</th>
<th>Total</th>
<th>% with Housemaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>3</td>
<td>15</td>
<td>20%</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>33%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>17</td>
<td>24</td>
<td>71%</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>70%</td>
</tr>
<tr>
<td>High Class</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>9</td>
<td>-</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>50</td>
<td>64%</td>
<td>18</td>
<td>7</td>
<td>25</td>
<td>72%</td>
</tr>
</tbody>
</table>

Emotional support provided by housemaids may be essential for older women, especially for those participants who live alone and have a housemaid. In the research study, 4 of the 25 participants who live alone usually eat meals with their housemaid as a way of dealing with loneliness. Two participants said:

*I had a chance to live with my son and daughter-in-law, but I opted to live alone five years ago, despite my good relationship with them. I share my meals with my housemaid, as I don’t like to eat alone, as I feel distressed. Sometimes, I invite my neighbour to come and eat meals with me. My transportation is easy to arrange as I have my own driver.* (Alma A2, 73M)

*I do not have children, and now I am living alone with my housemaid. I feel that the world is empty from people if I eat alone. Therefore, I always ask my housemaid to eat meals with me.* (Hessa A1, 63H)
As mentioned in Section 6.2.2, children (70%) are the main source of instrumental support, followed by maids and drivers (62%). Most older women said they were tired and exhausted now from cooking, washing and cleaning. In the past, they had been responsible for all of the housework, and if a woman’s household standards had been poor in the past, her family and husband would never have been lenient with her. Therefore, with a housemaid in the house, older women are able to pass on these responsibilities to the housemaid, in addition to shopping and buying groceries. One participant who receives this kind of support said:

*I am totally dependent on my personal housemaid to perform my basic essential needs within the house and even outside. It is due to my health status. Without her, my situation would have been really desperate and hopeless.* (Maria S, 70M)

Table 6.6 shows that half (26) of the respondents have private drivers in their household who make it easier for older women to go out of the house when they wish to. Some drivers are employed fully by an older woman, while others are employed in the household for family use. Thus, some older women may not have access to a driver all the time and have to coordinate their schedule with other family members. Table 6.6 shows that 15 out of 24 middle class and all 11 high class respondents have their own driver, but no poor class women do. While some participants are living with their children and/or relatives who employ a driver, all 6 poor and 3 middle class participants who are living alone do not have a driver. Therefore, having a driver is very strongly class related.
Table 6.6: Number of Participants with Driver by Economic Status

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>With Driver</th>
<th>Total Number</th>
<th>Percentage</th>
<th>Living Alone</th>
<th>% with drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>0</td>
<td>15</td>
<td>0%</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>15</td>
<td>24</td>
<td>63%</td>
<td>6</td>
<td>67%</td>
</tr>
<tr>
<td>High Class</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>50</strong></td>
<td><strong>52%</strong></td>
<td><strong>15</strong></td>
<td><strong>60%</strong></td>
</tr>
</tbody>
</table>

The availability of transportation plays an important role in the life of older unmarried Saudi women because it enables them to maintain social participation and daily activities, and provides greater independence and autonomy. Thus, for most participants who have a driver, they are their primary source of transportation support:

*I have my own driver and Alhamdullelah; he has lived with us for 20 years now. But when he travels on his vacation I feel lost.* (Tala UD, 68M)

*I have my own driver and I like to go out, without my driver my life would breakdown, and I would become disabled.* (Nisreen A2, 60H)

Thus, the availability of instrumental and emotional support from housemaids and drivers depends on the socioeconomic status of the participants. As well as the financial cost, hiring a housemaid and a private driver is not easy or cheap, for it requires sponsorship and official procedures which take a long time. In addition, a driver needs lodging in the same premises and a regular salary, an obvious reason why no women from the poor class employ a driver.

It is noteworthy also that many adult children have become totally dependent on the presence of the housemaid who lives with their mother. Some children lead busy lives and have little time to spend with their mother, and even when they
have time to visit they do not have the time to help with chores or do the shopping for her needs. Thus, adult children often do not worry about their mother due to the presence of the housemaid who takes care of and even entertains her.

6.3.3 Role of Friends and Neighbours in Providing Support

Support from friends or neighbours is particularly important for older women who have no co-resident children or have no children living nearby their house. However, receiving support from friends and neighbours depends on their characteristics and capacity. Although financial support is rarely offered by neighbours, instrumental, emotional, and social interaction support is often provided. Three participants who live alone said:

My friends visit me in my house on a regular basis. When I am sick, I always go to the hospital with my driver and housemaid, or sometimes with my childhood friend, if I am very sick. (Hessa A1, 63H)

Alhamdullelah (thank God), I have my good neighbour who used to stay 3-4 hours with me during her regular visit. Whenever I cooked my foods, I included her. Sometimes, we ate our meals in my house, and sometimes within her house. (Layla, A2, 65M)

Every Tuesday, my neighbour usually invites her family and friends to her house. I always attend this gathering every week because this is the only day I can see more than five people together. (Lola A0, 65P)

In general, the type of support provided by friends and neighbours depends on the quality of the older woman’s relationships with them. Moreover, this source of social support received by older women may be one of the few and most important resources for older women who have limited or no social support from their family, and for those who live in poverty.
6.4 Role of Government in Providing Support

In Saudi Arabia, the government mainly helps older women through social insurance payments and provision of free medicine from primary health care centres. The eligible participants are: orphans, the disabled, senior citizens who do not have any form of retirement pension, women with no provider and families with no provider. These eligible women receive an amount of 860 Saudi Riyals monthly (approximately £200 sterling in 2013) as social insurance, recently revised to 1000 riyals (Ssa.gov, 2017).

6.4.1 Financial Support

Chapter 5 (see Section 5.4.1) discussed older women’s present sources of financial support, either from acquired rights, goodwill income, or welfare benefits. Financial status was identified as one of the important factors related to the life satisfaction of older women through influencing their ability to undertake social activities, be geographically mobile via access to transportation, and access to health care.

Table 6.7 shows that of the 15 participants in the poor class, 11 received social insurance. However, some older women who are in the middle economic status also benefit from this kind of financial support. Out of 24 middle class participants, 7 are enjoying the additional benefits of receiving social insurance to help cover their daily expenses. On the other hand, it is clear that financial support is not enough to cover any costs for social visits or activities.
Table 6.7: Number of Participants Receiving Social Insurance by Economic Status

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Receives Social Insurance</th>
<th>Total Number</th>
<th>Percentage Receiving Social Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>11</td>
<td>15</td>
<td>73%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>7</td>
<td>24</td>
<td>29%</td>
</tr>
<tr>
<td>High Class</td>
<td>0</td>
<td>11</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>50</td>
<td>36%</td>
</tr>
</tbody>
</table>

Older unmarried Saudi women who do not have enough financial and material support from their children, siblings, and other relatives usually received financial support from the government. However, some of these participants complained about the amount provided:

I am living in my old house with my divorced daughter and her two sons. The primary source of my monthly income comes from the social insurance and from my other daughters. It is not enough to support our financial needs or daily expenses. I am financially exhausted already because of the grocery expenses, plus my daughter is asking for money for her son. (Susan UD, 61P)

I have a monthly income of 860 Saudi Riyals from the social insurance and some small amount from my children. My children are pressured to help me financially but could not do anything. It is not enough at all and I am so sad that I don’t have enough money to cover my essential expenses. During difficult times, I used to borrow from my children and other people. (Neama S, 75P)

On the other hand, although the social insurance is small in amount, it provides an important additional financial resource for some older women, such as Hanan:
My monthly income comes from my social insurance amounting to 860 Saudi Riyals and regular financial support of 1,000 riyals and 500 riyals from my two daughters. An irregular amount comes from charitable people. Although the amount is not enough, my financial situation is much better now than when I was with my ex-husband because he was very greedy. (Hanan UD, 68P)

Thus, the government mainly helps poor women in terms of financial and material support. However, the financial support of the government to older women through social insurance is insufficient for some participants who primarily depend on it to cover all their financial needs. In summary, this kind of government support is limited, and the satisfaction of older women primarily depends on the quality and amount of financial resources also received from their children or other sources.

6.4.2 Obtaining Free Medicines from Primary Health Care Centres

In Saudi Arabia, all citizens are entitled to receive free of charge medicine in all government health care facilities, such as primary health care centres. However, in this study, use of primary health care centres depended on the awareness of the older women, availability of requested medicine for their health conditions, and their present economic status. Table 6.8 shows that two-thirds of participants from the poor class and 25% from the middle class were obtaining free medicine, which is equivalent to only one-third of study participants.
Table 6.8: Receipt of Free Medicines from Primary Health Care Centres by Economic Status

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Number Obtaining Free Medicines</th>
<th>Total Number</th>
<th>Percentage Obtaining Free Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>10</td>
<td>15</td>
<td>66%</td>
</tr>
<tr>
<td>Middle Class</td>
<td>6</td>
<td>24</td>
<td>25%</td>
</tr>
<tr>
<td>High Class</td>
<td>0</td>
<td>11</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>50</strong></td>
<td><strong>32%</strong></td>
</tr>
</tbody>
</table>

Lack of information about health centres is one of the main reasons for some older women not utilising health care services from the government.

*I am not aware of the free medication from the health centre. In fact, I never heard of it before. However, I don’t want to go to the hospital because it is too expensive.* (Majda A0, 60P)

*I never heard about the health centre and I have no idea of the free medication. Usually, my son takes care of all my medicine.* (Saleha S, 73P)

However, some participants who used the health centres complained that the medicine provided was insufficient. Two participants said:

*Yes, I am aware of the health centre. I went there, but they gave me a different medication. That’s why I refused to take it. I had been there twice but then I refused to go again, because I feel afraid from the medication.* (Talha S, 70P)

*I am aware of the free medication but believe me; I tried all the health centres near my district, but they are not giving all the required medications. Yes, it is easy to obtain, but the supply is limited. Usually,*
they are just giving essential medicine for a headache or stomach ache, but limited medication for chronic diseases. (Hanan UD, 68P)

In summary, the government support to older women through free medicines is limited, and is not utilised by some poor participants because they did not know about the existence of health centres which supplied free medicine or the required medications were not available. A more detailed analysis of health centres and availability of medicine will be provided in the next chapter. However, the results presented in this chapter show that the majority of health centre users are from the poor class, although five poor participants did not use health centres because they had no knowledge of their existence. Therefore, the findings show that the present socioeconomic status of older women influenced the use of free medicines, as the majority of the middle class and high-class older women did not need to go to health centres because they had their own medical insurance and were able to pay for medical expenses personally.

6.5 Social Engagement and Social Activities

In the Saudi Arabian context, the movement of women is restricted by gender segregation norms that limit their involvement in engaging in activities in the public sphere. The extent to which older women are able to participate in different types of social activities depends partly on their family support. For example, women are not allowed to drive by law, and usually have to depend on their male children or other male relatives to take them and collect them from friends' homes or shopping malls. Social activities of older Saudi women included: getting together with family and friends, shopping, and attendance at women-only groups or organisations.

The existence of strong social support, especially instrumental, emotional and social interaction support, was important as a motivational element to encourage them to participate. However, receiving this support depended on the relationship of each older woman with her family members and friends, as well as their
present socio-economic status. For poor class women, financially, it would be difficult for her to visit friends or relatives, the cost would be too much for a taxi or private driver. If the older woman has to depend on a male child to take her, then she would have to accommodate that person's schedule and the possibility that they were putting a financial strain on that relative. It is not part of the socio-culture norm for a woman to take a taxi, or leave her home alone or without giving prior knowledge to her children or guardian.

Another factor concerns cultural expectations related to visiting friends or family members in hospital or if they have had a baby. In the Saudi context, it is unheard of for a person to visit without taking a gift, which in itself can cause financial difficulties for women who do not have social insurance, or have little income. Most Saudi social activities are concerned with visiting friends or relatives on special occasions, a wedding or engagement party or the naming of a new child; and of course, during the month of Ramadan it is a religious duty to visit neighbours, friends and relatives. The older Saudi woman has never undertaken social activities independently, and even though Saudi socio-norms have changed a little, and the new generation of Saudi females are visiting friends, relatives and using taxis and private drivers without a male accompanying them, older Saudi women are generally not comfortable with this situation.

Engaging in social activities on a regular basis can have a significant positive impact on the well-being of older women. However, in this study, the main activities of older Saudi women were limited to activities within their home. The research findings show that the most commonly reported activities of the participants were praying, reading the Holy Quran, watching television, and attending family events such as weddings and gatherings. This is typical of most older Saudi women (see Appendix Table 3). Two participants who live alone said:

*I don’t have any common activity at all. Most of the time, I just watch television, and pray. I often feel lonely and sad.* (Aiza A1, 75P)
I spend my day reading and interpreting the Holy Quran, and watching television. I watch television alone but I have no problem with that. (Alma A2, 73M)

For older women who are entirely dependent on the family member for transportation, this may result in limited social activities. There is no public transportation system that is easily accessible for females in Saudi Arabia, so it is challenging for women to attend parties or gatherings or even visit sick relatives or friends independently; at all times, they have to arrange with their male relatives or male children transportation to and from venues. Salma, a poor woman, said that she received little social support from her family members:

I am doing nothing. I’m just staying at home and sleeping most of the time. Why do I need to wake up early to do nothing or think who is going to visit me! It is boring. My transportation is not easy to arrange, because I do not have a driver. My children have their own family and are now living far from me. (Salma A0, 66M)

I am living with my paternal Aunt, since my parents died. I go out only occasionally. My aunt and I went to the Corniche area for a picnic yesterday. It was special for me, because I have not been out of our home for almost two months. I don’t have any available friends. The friends I know are working and taking care of their children, too. Transportation is also difficult to arrange and it is under my aunt’s control even when I am sick. (Muzna R, 62P)

Muzna is totally dependent on her Aunt because of being single and has never been married. She says her transportation is difficult to arrange because the control is often restricted by her aunt. It is typical of older never-married Saudi women to feel a burden financially and socially on their relatives or siblings when
they do not have their own income and have to rely on their family for all their
needs, including times when they need to visit friends or neighbours.

In contrast, two participants who received instrumental and emotional support
from their children and friends, and who engage in social activities outside the
house, said:

*I'm not used to going out every day, but sometimes every 4 or 5 days. Just
yesterday, I went to Al-Madina with my children and my sister to attend a
relative’s wedding. I feel lonely if I do not visit relatives, friends or go out
for more than four days.* (Hedayah UC, 60M)

*Sometimes, I meet my relatives and some friends and neighbours. I have a
very good relationship with my daughter in-law and we agree on most
things and issues. I am thankful, that I don’t have any problem with my
family and relatives.* (Hanadi S, 75M)

Having a driver is a particular advantage for performing social activities outside
the home. A middle and a high class participant said:

*I don’t have a problem with my transportation because I have my own
driver who is available anytime I need him. I'm used to going out every
other day and meet my group of friends, mostly on Wednesday or
Thursdays weekly.* (Asma A2, 63M)

*I have my own driver, Alhamdullelah (thank God), my transportation is
very easy to arrange. I'm used to meeting my friends outside, or
sometimes, I invite them to come to my home to eat meals and watch
television together.* (Fadiya A2, 65H)
The research findings indicate that the social support of older Saudi women came from their families; this social support facilitates the participation of older women in social activities such as visiting the doctor, shopping, family gathering or even travelling as they age. However, not all older women feel satisfied with the levels of support received from children, siblings, relatives, and friends/neighbours to enable them to participate in social activities. Despite the importance of having an active social life, the frequency of undertaking social activities outside the home remains low because many older women have a low income and lack of social support. Thus, social support given by their children, siblings, relatives and friends is essential to improve the physical well-being of older unmarried Saudi women by increasing their social activities outside their home.

The older Saudi woman has very few choices of social activities, and is often influenced by the emotional and instrumental support that comes from their families primarily, and their domestic support (housemaids) for those who have it. These various forms of support play a major role in facilitating their participation in social life, such as attending happy or sad events like weddings and to offer condolences. In the absence of such support, older women lose a lot of their participation in social life, especially as there are no special places for older women, like social or sports centres, that they can attend. The government has started to build public parks and pedestrian areas in many cities, but these are mostly frequented by families and young Saudi women, not usually by older Saudi women. It is often the case that the older Saudi woman has become so accustomed to her way of life, and the sociocultural norms, that she fears any change and is unwilling to try doing social activities independently. For most older woman, they have not been habituated to socialise outside their homes, especially on their own and without their immediate social circle (such as her children).
6.6 Dependence, Independence and Autonomy

In the Saudi Arabian context, freedom of movement for women in the public sphere is limited as women are not allowed to drive cars, or travel abroad or travel anywhere without a legal guardian’s permission, throughout their life. Older Saudi women were raised on the notion that women do not go out of the house unaccompanied. In her parents’ house, she was used to only going outside with them; after getting married, she could never go anywhere without her husband's approval and consent. She has become like a caged bird that cannot fly even when the cage door is wide open.

According to Saudi socio-cultural norms, in the past, and even nowadays to some extent, men provide women with everything, even buying her clothes. When a husband dies, most women do not have the courage to go out of the house alone; she only goes out with her own, or her daughter's, private driver, or waits for her son or daughter-in-law to go out with her. Also, she presumes that others (including other family members) would consider it inappropriate for her to go out on her own.

Housemaid recruitment from overseas countries has been easily available for over 20 years, and older women, even some from the poor classes, have hired housemaids (see Section 6.3.2). This has had a large impact on women who have relied on housemaids and have not done housework, cooking or food shopping for many years. However, the result is that older women have become more dependent, and often feel entirely helpless, when the housemaid leaves (e.g. to go on vacation).

6.6.1 Dependence on Others for Transportation

In terms of transportation, gender restrictions have to be considered in Saudi Arabia as women’s lack of mobility remains a significant issue in the Kingdom. Thus, for older women who lack transportation assistance from children, other relatives, or the availability of drivers, rather than being independent and
autonomous, their lives can be transformed into isolated dependency. Table 6.9 shows the self-perceived level of transportation availability for participants: 70% say they are able to go out easily because of access to transportation. This is the case for the majority of the middle class (88%), and all high-class women. Whereas, the majority of poor class older women (80%) have difficulty with access to transportation.

**Table 6.9: Self-Perceived Level of Transportation Availability for Participants by Economic Status**

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Easy</th>
<th>Difficult</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
</tr>
<tr>
<td>Poor Class</td>
<td>3</td>
<td>20%</td>
<td>12</td>
</tr>
<tr>
<td>Middle Class</td>
<td>21</td>
<td>88%</td>
<td>3</td>
</tr>
<tr>
<td>High Class</td>
<td>11</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>70%</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Older women, especially those who do not have a driver, have difficulties with independent living as they are usually entirely dependent on their family to satisfy their mobility requirements. One participant said:

*I do not have children as I am infertile. Now, I am living with my brother and his two wives in an apartment. I wish to have my own house, but I feel comfortable living with them because they are treating me right. My brother provides my transportation if I need to go outside, but it is difficult to arrange sometimes, because of his own daily schedule.* (Wadha B, 72P)

With lack of transportation assistance from family members, lack of accessible public transportation, and lack of financial capability to hire their own driver, 30% (Table 6.9) of participants, who are mostly from the poor class, have to depend on hiring a local taxi as their only alternative mode of transportation. Of
the 15 poor class participants, 12 of them experienced difficulties in arranging their transportation. Two participants said:

*I often use a taxi as my mode of transportation if I want to go out. However, it is difficult to arrange because men are bothering me, and it’s always hard to talk with the taxi drivers. Even when I was sick, I did not ask my son to bring me to the hospital, because I do not want my children to bear my expenses.* (Majda, A0, 60P)

*I always use a taxi when I want to visit my friends or relatives. However, it is difficult to arrange and also expensive. If I want to go to the hospital, my daughter would arrange a taxi and would send it to my house.* (Lola, A0, 65P)

At present, there is no public transportation for women in Saudi Arabia, such as buses or underground metros, unlike in Egypt and Western countries. These means of public transport in the West help older women to travel about safely. However, public transportation, in the city of Jeddah is available only for men and workers. Public transportation on buses is available, but due to Saudi socio-cultural norms, women are discouraged or not allowed to use buses without being accompanied by family members and/or a male legal guardian. There are private drivers and transportation companies that provide transportation upon request by a telephone call. However, only one of the 50 respondents had used such services because the majority did not know that such services exist, or they thought that these services were too costly and not practical. Only Fattomah used these services, and said:

*I often go out of the house every day to visit my children and friends, and attend my relative’s events. My children used to provide my transportation but sometimes, I arrange it by myself. I do not have a regular driver, but I have an on-call taxi driver.* (Fattomah A0, 68M)
Lack of transportation is likely to change in the future as in large cities in the Kingdom, such as Riyadh, Jeddah, Makkah, Madinah and the Eastern Province, large projects have been launched to develop public transportation and metro trains. However, they are confined only to large cities, and will not be finished for at least three years. As Saudi Arabian socio-cultural norms forbid women from driving, the metro trains may give women greater mobility as they will feature women-only and ‘family’ carriages.

6.6.2 Independence and Autonomy
Maintaining independence and autonomy in later life are often seen as key elements of successful ageing for older people. In Western societies, being independent is associated with being able to do things, to be self-supporting, and self-reliant. According to Fry (1989: 87), ‘how older people respond to these physical health changes reflects their sense of autonomy and self-determination developed over the life course’. In Saudi Arabian society, the independence and autonomy of older women may be compromised by sociocultural norms, poor health status, low socioeconomic status, loss of support from family and friends, and living arrangements.

Although the older women in this research study have all lived alone, they cannot be assumed to display independence in everyday living. In a highly conservative society like Saudi Arabia, displaying independence in everyday living is strongly mediated by variables such as gender, sociocultural norms, and economic class. Gender plays a particularly significant role in the dependence and lack of autonomy of Saudi women because their roles are marginalised in most aspects of society due to strong cultural norms. This traditional role has influenced women to limit their activities primarily to inside the home and to restrict their activities in the public sphere. However, being an individual of means can help older women to be as independent as possible. With enough financial resources, some older women who live alone are able to employ housemaids and a driver that support their physical mobility and access to transportation, to cover their medical
care and support their everyday needs. Whereas poor women generally live alone because of constraints rather than choice. As most are not financially independent and rely on social insurance or funds from their adult children, they are unable to make any independent choices concerning their social activities, or even visit the primary health care centres or hospitals, because they do not have the finances to do these activities. Consequently, they will always be dependent on someone, and can never feel free of the control and restraints of siblings and or children.

In the Saudi context, availability of transportation plays an important role in the life of older women because it enables them to perform daily activities, participate in social life, and preserve independence. In general, older women who do not have transportation assistance from their family, and/or do not have their own driver, have more difficulties with independent living. The lack of mobility of older women is principally due to Saudi cultural norms that prohibit women from driving. However, for wealthy older women who can afford to hire a driver, engaging in social activities may not be problematic because they are able to pay for transportation. They are therefore advantaged compared to older women who are in the poor class. Two participants said:

*Living alone gives me some freedom. In the past, I was not allowed to do anything without the permission of my husband. Now, I have my own driver and this enables me to go out easily to meet my friends.* (Nayla, A2, 70H)

*I never had a chance to live with my children because all of them have their own family already. I am living now in my own house with my two housemaids and a driver. My transportation is easy to arrange because my own driver is staying in the provided room attached to my house.* (Sanabel, A2, 63H)
Some more wealthy older women in the research study have money and live a happy, independent, and autonomous life with their children with whom they have a good relationship. My research shows that money plays a major role in an older woman’s life and in her relationship with her children; it reduces the pressure of isolation. Older women who were from the middle or high class groups were happier and seemed less stressed than participants who had to rely on their children or relatives for finances; also, these poorer women were obliged to conform to the rules and wishes of their children or relatives. Whereas, having a substantial income made some older women’s children depend on her financially, and some lived at the property owned by the older woman. Therefore, the older women had more freedom of choice. Farha, a high income older woman said:

*I live in my house with my son who is a doctor*. His wife is very kind. *He does not refuse anything that I ask for, because I own the house that we all live in and we share the expenses. And thank God, I have seven maids and a lot of money, and my children visit me regularly.* (Farha, US, 75H)

In Western societies, it is common to find older women who live alone, but this is not usual in the Saudi context as the sociocultural norm is for older women to live with their children, siblings or members of a family unit headed by their adult children or other relatives. This unit is assumed to ensure family members are readily available to provide assistance. Older women may therefore engage in only limited physical activities such as cooking and cleaning their room, and at times they may go and do grocery shopping with the aid of a housemaid or are accompanied by a family member. Therefore, from the Saudi Arabian perspective and in accordance with sociocultural and Islamic ideals, Saudi older women could be considered as partially independent. Also, when children or other family members living in close proximity to older women are supportive and respectful of their privacy, and allow them to engage in social activities of their choice, for

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4Farha’s son, who is a doctor, is living in the same building. Thus, she considers her son living together with her.
example, visiting friends, neighbours, going to social gatherings and maybe attending seminars and meeting in mosques, then these older women may have an active social life in the public sphere, which may result in a high quality of life. However, older, poor women who are living alone are more vulnerable to loneliness, and some of them are deeply affected by the issues of poverty, which create major hurdles for them to obtain the support that they need, and it is impossible for them to have an active social life.

6.7 Relationship of Social Support to Socio-Economic Status

When an older woman's socioeconomic status is adverse, receiving support from their family is one of the most important elements in overcoming her lack of income. However, the availability of social support also depends on the socioeconomic status of her family, relatives, friends and neighbours. For instance, Nadia, who is from the poor class, has difficulties in arranging her transportation because her son is poor. She said:

*My son who is living with me provides my transportation, however, it is difficult to arrange, especially if I want to go out suddenly. He has a small vehicle and he is using it for delivering vegetables. I am always thinking of our daily expenses.* (Nadia S, 73P)

In contrast, the issue of mobility and transportation is not a problem for Faerouze, a high class older woman, because she has her own driver. Faerouze said,

*Transportation for my personal needs and errands is easy to arrange because I have my own driver, but if he does not exist, I will feel lost.* (Faerouze, UD, 65H)

In this research study, the perception of having adequate social support is greater among older women with a high income, while those dissatisfied with social
support from family members were mainly women with poor socio-economic status. One participant from the poor class said,

*I am living alone and spend most of my time cleaning my house. I rarely go out, because of the difficulties in arranging a taxi. When my children come to visit, they usually only stay for a short time. They used to gather in my house every Wednesday, but they didn’t bring anything. They don’t even give me money for expenses.* (Sumayah, A0, 70P)

In contrast, some participants had their main sources of income from an inheritance, husband’s pension, and/or own pension and did not experience financial difficulties, because of their greater financial well-being. Participants from the middle and high classes said:

*I am living alone with my three housemaids, a driver and house guard. I spend most of my time travelling, but whenever I am in Jeddah I am used to gathering with my children, sisters and friends. When I travel, I spend a lot of money enjoying myself, I consider travelling to be one of the most enjoyable things in my life. Alhamdulilah, I never feel lonely, because my life is full of events and my children, sisters and friends are always around me.* (Dina A5, 65H)

*I am living with my brother, his wife and their children. My income as a University lecturer and properties inherited from my late husband are almost enough for all my needs, because I don't have any financial responsibilities, such as house rent or a housemaid's salary, My brother and his wife usually offer to let their driver take me out for any activities I need to do, even my daily commute from the house to university, but I refuse to do all my errands with their driver, I do my own errands and go to parties or weddings and shopping with my own personal driver. When*
Thus, socioeconomic status plays an important role in the everyday life of older women. Socioeconomic status is also associated with the availability of instrumental, financial, emotional and social interaction support. In this research study, an older woman with her own higher income is more likely to have adequate social support and to participate more actively in the public sphere. However, social engagement and involvement in activities are more difficult for older women who experience economic disadvantage and viewed their financial status less positively than those who had enough financial resources.

6.8 Conclusion

While it is usual in Saudi society to consider that most social support comes from family members, there are some situations in which family members cannot be totally supportive of older women due to their own financial responsibilities and lack of finances, their present geographical location or living arrangements. The younger generation, differ from the older generation, in that many have been forced to leave their hometown in search of employment. Therefore, this becomes a problem when culturally they are expected to give social, emotional and instrumental support to their aged parents. The findings show that living arrangements, particularly the active presence of children, siblings, relatives and housemaids or a driver in the household, are predictors of stronger social support.

The quality and the nature of relationships with other family members are important to older women as they age. In this research study, older women who are living alone found that in the absence of family member's support, having mutual relationships with neighbours and friends formed an important part of their social support network. Thus, friends are particularly important for older women who live alone. On the other hand, older women who live with other family members seem advantaged in terms of financial, instrumental and
emotional support as their family can assist in arranging transportation and telephone calls to friends of the older woman, and may have a close network for social support. However, older women who live with others may have restrictions on their independence and social activities if family members, especially the male legal guardian, can control older women’s physical activity and mobility. Often, the male guardian or adult child will feel the necessity of handling the financial affairs of the woman, and will also feel responsible for providing for the woman’s needs. In rich and middle class families, there were few restrictions with regards to travel or visiting friends or interacting socially with other family members, because the male adult child or guardian had the finances to provide either a driver solely for the purpose of taking and bringing the older woman to her destinations or arranging with a private driver to take her to and from various venues. On the other hand, women from the poor class did not have the chance or choice to visit friends or family members without the support of a male member. Often, the older woman would not ask her child or guardian to take her to visit socially, because she felt that she was a burden and caused more financial stress for the family.

Women who are able to live on their own because they are financially stable and educated felt more secure and confident in themselves. These older women could be considered partially independent, but cannot be considered totally independent, because they still have to adhere to sociocultural norms and traditions, and do not wish to lose the respect of their children or relatives by not conforming to these norms. In the Saudi context, family is most important, and having respect from family is significant. A large network of friends is also an added benefit to older women who are not totally dependent on their children; they often feel lonely because they do not live with their children, and thus rely on the support of their friends to help them feel loved and respected. Often older women build relationships with other women who are of the same class and have similar circumstances and interests. Many of the older women have made friends after losing a husband, or after their adult children have moved away, or are not able to
visit daily. The older women become partially dependent on each other socially and emotionally and sometimes for instrumental support. The older woman who lives with her children or siblings often does not have the freedom to entertain friends in her home, or visit friends, because she must take into consideration the needs of their children or siblings. Women from the poor class are restricted more because they do not have sufficient income or their own money to entertain friends or go out with friends, and this can lead to loneliness and a feeling of anguish with their circumstances and fear for their future welfare.

Economic status had a major influence on the level of satisfaction with the availability of transportation among participants. The majority of the middle class (88%) and all of the high class women (100%) reported being satisfied with their transportation access, compared with only 20% of poor class women, who expressed difficulties of accessing transportation due to expensive charges and arrangement difficulties.

The extent to which an older woman in Saudi Arabia achieves personal independence and autonomy is highly related to social norms related to gender and her economic status. Indeed, the importance of gender norms as a determinant of levels of autonomy in Saudi Arabia is significant for women because, although women are treated with respect, they have less freedom to be independent. Considering the concept of independence in a broader perspective, and within the norms of the Saudi culture, wealthy Saudi older women can be described as partially independent financially and socially. Although, they have limited freedom, compared to women of the poor class they have more freedom to travel and visit friends and family. Even though all Saudi women still have to obtain permission from a male guardian, women from the middle and high class can be more independent than poorer women. In turn, this feeling of independence affects their physical health, social activities, and mental well-being.
Chapter 7

Health Status and Health Care Access of Older Unmarried Women

This chapter presents a brief background on the health care system in Saudi Arabia, followed by detailed discussion of the health status and access to health care of older unmarried Saudi women living alone and living with their family members. It examines both the concept of healthy ageing and how to support older women in Saudi Arabia to be healthy in later life. The chapter also discusses the causes why older women in Saudi Arabia have a very poor health status despite the level of development in the country. Factors that influence the physical health and social well-being of older women are analysed, as well as how present health status affects their quality of life. Finally, it discusses inequalities in access to health care by examining the Saudi Arabian socio-cultural norms and the participants’ educational status.

7.1 Health Care System in Saudi Arabia

The health care system is critical in any country in terms of catering for the medical needs of its citizen. In Saudi Arabia, the Ministry of Health is the main provider of health care services. According to Moustafa, (2014) health care services in Saudi Arabia have been given a high priority by the government, wherein the country allocates the highest percentage of its budget to the health care system. In 2013, the Gross Domestic Product (GDP) per capita of Saudi Arabia was US$ 24,914 (about £16,192) and the devoted budget to health care was 6.6%. The World Health Organization (2000, cited in (Moustafa, 2014) state that the Saudi health care system was ranked 26th among 190 of the world’s health systems in terms of overall health system performance. The health care system of each country was measured by the WHO through the ‘overall level of health; the distribution of health in the population; the overall level of responsiveness; the distribution of responsiveness; and the distribution of financial contribution’ (WHO 2000: 27). In fact, WHO (p. 154) argues that Saudi
Arabia comes before many other international health care systems, such as Canada (ranked 30th), Australia (32nd), New Zealand (41st), and other systems in the region such as the United Arab Emirates (27th), Qatar (44th) and Kuwait (45th).

The health care system in Saudi Arabia has seen remarkable development through the strong effort of the Saudi government. There has been continuous progress in developing overall health care resources, health facilities, and health related man power during the last decade through the Ministry of Health (Alaslani et al., 2016). However, despite all of this development, Saudi Arabia still faces many challenges with regard to the health care system. Although the availability of physicians was not directly discussed in this research study, the researcher observed during her visits to various primary health care centres that the Saudi health care system was still challenged by the shortage of Saudi health care professionals, as the system mainly depended on foreign medical and nursing staff from different countries. According to Alaslani et al. (2016), the estimated number of physicians in Saudi Arabia is 53,000 of whom only 11,000 (21%) are Saudi nationals. Considering the total population of almost 25 million, including Saudis and non-Saudis, this means that there is one doctor for every 500 people, a very high rate by international standards. Thus, the availability of physicians may not be enough alone to ensure a good level of health care for all citizens.

A good health system is not only important for older women’s mental and physical well-being, but is likely to play a significant role in enhancing their quality of life. Although this research study is focused only on the experiences of older unmarried Saudi women, the findings will have implications for the health care system of Saudi Arabia that will benefit older people in the Kingdom in general.
7.2 Definition of Healthy Ageing

It is critical to study the health needs of older women because of changing patterns of illnesses with age. According to Borowy (2014), older adults in the United States viewed healthy ageing as having the physical, mental, and financial means to do something worthwhile. For the World Health Organization (WHO 2002: 2012), ‘active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age’. There is limited research exploring how older women in Saudi Arabia define healthy ageing; therefore, the responses of participants in this study will illustrate the extent to which older women perceive themselves as ageing healthily. In this research study, healthy ageing is considered by most participants as being in good physical and mental health, having the ability to obtain medication and having accessibility to good public health services.

For some older women, their health problems are related to multiple chronic illnesses which have an impact on their physical well-being. However, despite the level of development in Saudi Arabia, especially in the health care sector, older unmarried Saudi women have very poor health status as discussed in the next section. Several factors such as sociocultural norms, limited physical activity, and limited social engagement in the public sphere affect the health status of older women in Saudi Arabia.

7.3 Health Status of Older Unmarried Women

Given the growth of the older population in Saudi Arabia (see Section 2.2 in Chapter 2), and increasing health care costs in the Kingdom, it is important to understand what influences older women’s health. As women age, they face distinctly different challenges in maintaining their health as they live longer, develop different chronic conditions, and experience a higher prevalence of functional limitations than older men. A variety of health conditions may impact on the lives of older women due to multiple diseases they are suffering from. It may become difficult to manage this change in physical health, and older women
may need to rely more on practical and medical assistance. However, maintaining
good health has the potential to enable older women to remain independent, stay
socially engaged, and enjoy a satisfactory quality of life. Thus, awareness of the
various health conditions affecting older women may allow their health care
needs to be addressed more effectively.

7.3.1 Number and Type of Chronic Illnesses
My research found that all, except one older woman, reported three or more
chronic illnesses (see Appendix 5d). Table 7.1 shows the number of reported
chronic illnesses for participants with different socio-demographic characteristics.
The difference in the number of chronic illnesses was considerable across the
group, according to the age factor and education levels. Almost all older women
aged 65–75 reported six or more chronic illnesses, whereas the majority of
participants aged 60-64 reported 3-5 chronic illnesses; also, older women who
never went to school reported more illnesses than those who received formal
education. Only a small minority of University graduates reported six or more
illnesses, unlike women with other educational levels. In terms of economic level,
the proportion of older women reporting six or more chronic illnesses was
relatively lower in the high-class group, and highest among poor class women.
Table: 7.1 Number of Self-Reported Chronic Illnesses of Participants by Socio-Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of Illnesses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 – 2</td>
<td>3 – 5</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 – 64</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>65 – 69</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>70 – 75</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td><strong>Educational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never went to school</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Studied through informal education or drop out from primary school</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Primary school graduate or dropout from secondary school</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Secondary school graduate or dropout from college</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>University graduate</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>Economic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Class</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Middle Class</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>High Class</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td><strong>ALL</strong></td>
<td>1</td>
<td>23</td>
</tr>
</tbody>
</table>
Table 7.2 shows the type of chronic illnesses self-reported by all participants and by age group. The most frequently reported conditions were high blood pressure (72%), visual impairment (72%), fatigue (68%), diabetes (58%), and osteoporosis (52%). Other less common illnesses reported by participants were hearing impairment (38%), isolation (26%), anxiety (24%), and high cholesterol (16%). Similarly, according to Alghamdi, Mattar and Yamani (2016), the Ministry of Health of Saudi Arabia pointed out that ‘obesity, diabetes, hypertension, and high cholesterol level were among the risk factors that Saudi society faces’.

Regarding age and reporting different types of self-reported chronic illnesses, the proportion of older unmarried women with the highest percentage of illnesses are aged 70–75.

Table: 7.2 Type of Chronic Illnesses reported by Participants by Age Group

<table>
<thead>
<tr>
<th>Illness</th>
<th>60–64</th>
<th>65–69</th>
<th>70–75</th>
<th>Frequency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>14%</td>
<td>20%</td>
<td>38%</td>
<td>36</td>
<td>72%</td>
</tr>
<tr>
<td>Visual Impairment</td>
<td>18%</td>
<td>18%</td>
<td>36%</td>
<td>36</td>
<td>72%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>10%</td>
<td>20%</td>
<td>38%</td>
<td>34</td>
<td>68%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6%</td>
<td>16%</td>
<td>36%</td>
<td>29</td>
<td>58%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>12%</td>
<td>12%</td>
<td>28%</td>
<td>26</td>
<td>52%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>8%</td>
<td>14%</td>
<td>24%</td>
<td>23</td>
<td>46%</td>
</tr>
<tr>
<td>Depression</td>
<td>8%</td>
<td>12%</td>
<td>22%</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td>Heart Problem</td>
<td>10%</td>
<td>8%</td>
<td>22%</td>
<td>20</td>
<td>40%</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>4%</td>
<td>10%</td>
<td>24%</td>
<td>19</td>
<td>38%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4%</td>
<td>6%</td>
<td>14%</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>4%</td>
<td>4%</td>
<td>8%</td>
<td>8</td>
<td>16%</td>
</tr>
</tbody>
</table>

Despite the level of development in Saudi Arabia, especially in the health care sector, older unmarried Saudi women have poor health status. Several factors
such as sociocultural norms, limited physical activity, and limited social engagement in the public sphere affect the health status of older women in Saudi Arabia. In addition, intermarriage between relatives contributes to the present poor health status. Although this was not directly discussed with participants, it was usual in the Saudi Arabian context, especially in the past, to marry within the same family, especially cousin marriage, because of cultural norms. Thus, there is a greater risk of genetic conditions or health problems.

In Saudi Arabia, aspects of the lifestyle of older women which may have health consequences clearly relate to the socio-cultural roles of Saudi women. In the past, women were assumed to stay at home, and doing household chores for their family was her main activity. Since Saudi women had restrictions in relation to their movement outside their homes, praying, reading the Quran, watching television and eating snacks were their main activities during their leisure time. This kind of lifestyle remains the same today, except that housemaids generally do the household chores. Also, some women gather in other relatives' homes, where they enjoy drinking coffee, tea, and eating sweets, or they get together and undertake a leisurely walk at the shopping malls. According to Al-Eisa and Al-Sobayel (2012:1) because of the ‘cultural factors faced by Saudi females could prohibit or limit exercise activities, thereby increasing the prevalence of physical inactivity among such population’. In addition, the employment of housemaids contributes to their low level of activity in everyday life. Three participants from different socioeconomic levels said:

*I do not have any daily routines. Most of the days, I spend my time praying, watching television, and drinking tea with my 37-year-old female neighbour.* (Lola A, 65P)

*Most of the time, I spend my day reading and interpreting the Holy Quran, watching television, and visiting some of my relatives and acquaintances if there is an occasion.* (Alma A2, 73M)
I spend my days watching television with my friends or with my housemaid. Sometimes, I invite my old female neighbour who lives in the same building to come and have a talk while watching television. (Farrah A2, 74H)

In addition, the lack of fitness facilities for women, lack of physical activity, and the lack of motivation to exercise often leads to a very sedentary life for older women, and high levels of obesity. Two participants said:

There is nothing to do and no place to go. That’s why most of the time, I spend my days sleeping, watching television, drinking coffee, and if I feel active on the weekend, I clean the house. (Saleha S, 73P)

I have nothing to do every day, because women’s movement is limited and so difficult in the Kingdom. That’s why I try to entertain myself by making telephone calls with my close friends, and watching television with my sister who is living in the same building. (Hedayah UC, 60M)

Almost all the older women in this research study reported three or more chronic illnesses. However, the number of self-reported chronic illnesses differed somewhat across different age groups, education levels, and socio-economic levels. My findings showed that older women with a higher level of education, and a higher economic level tended to have a better health status than the other groups. Sociocultural norms have a strong effect on Saudi women’s health status. Cultural norms and values in Saudi Arabia are more permissive for boys to undertake physical activity, and restrict females to the domestic domain (Al-Asmari et al., 2015). In addition, many Saudi schools in the past did not have any physical fitness activity for women as they were not encouraged to exercise, thus the high prevalence of inactivity of women in the country may be linked to their ‘sedentary lifestyle and limited quality physical education programmes in the schools’ (Al-Asmari et al., 2015:600). Yet, despite the assurances by the Saudi
authorities to introduce physical education classes at girls’ schools, ‘the gap between sports facilities at boys’ and girls’ schools is still immense’ (Al Arabiya News, 2014). Because women are prohibited from driving and require a male legal guardian for travelling, this limits their exercise activities, and increases the prevalence of physical inactivity.

7.3.2 Effects of Chronic Illness

The way older unmarried women live, eat, and their lack of physical activity contributes to an increased prevalence of chronic conditions. Chronic illnesses may have an adverse effect on the quality of life of older unmarried women. A high prevalence of high blood pressure, diabetes, and heart disease was observed in this research study (see Appendix Table 5d). These illnesses, and other chronic illnesses such as arthritis, osteoporosis, visual impairment and fatigue, were reported by many older women, and are likely to restrict physical mobility.

Chronic illnesses often lead to complications, with participants reporting that they have some kind of disability because of their illness. Some respondents noted a decline in function and therefore reductions in their activities. The following two participants were typical:

*I have high blood pressure, depression, fatigue, and anxiety. I have to take medicine for my high blood pressure, but I have fear in taking a lot of medicine, so I am just taking Panadol instead. I am very sick and unable to perform any activity. (Talha S, 70P)*

*I have arthritis, osteoporosis, and lack of vitamin D. I do not have medicine for all my conditions as I only have pain killers. My health is good in general, but I cannot move easily because of my legs. (Hedayah UC, 60M)*
All participants reported taking medication for their chronic illnesses. However, those living on a low income had experienced difficulties in obtaining medicine for their conditions. Two poor participants said:

*I have high blood pressure, a heart problem, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, and hearing impairment. I only have eye glasses and medicine for my heart problem. My daughters are planning to pay for my medical insurance, even the cheapest insurance package. Everything is expensive now, as the doctors in the private sector hospitals are charging too much. I need medical assistance, but I think it is too late now, because my sickness is progressing already. I had a heart attack and I think it would be a miracle to avoid the second one.* (Hanan UD, 68P)

*I have high blood pressure, diabetes, depression, fatigue, hearing and visual impairment, and osteoporosis, arthritis, anxiety, and a heart problem. I have medicine for my blood pressure and diabetes only. I got it through charitable people as my income was not enough to cover my medical expenses. I wish I could get my medications for free and hope the government could provide better, and free medical care and services.* (Sumayah A, 70P)

In summary, all except one participant suffered from three or more chronic illnesses, which in turn contributed to their poor physical health. When older women began to experience health problems, their physical mobility and social engagement started to decrease, and many became more dependent on the housemaid to do the basic tasks in the home. Although some participants continued to be active, having chronic illnesses imposed limitations on the lifestyle of others. A lack of financial resources could be seen to contribute to the development of some of these illnesses. In addition, health status can be influenced by the older person's present living arrangements. If the older person is
living with an adult child/and or sibling, she could be able to go out of the house accompanied by them; whereas, an older woman living on her own would not be able to leave the house without a male guardian or sibling. Therefore, it may be even more difficult for an older woman living alone to partake in any physical activity, which in turn may lead to deterioration in her health status. Thus, the present poor health status of older women in this research study indicates the importance of raising awareness regarding older women’s health problems and the ageing process.

7.4 Access to Medical Insurance for Older Unmarried Women

According to Alghamdi et al., (2016), access to health care depends on social security and health insurance systems, the latter is usually linked to previous employment in the formal sector of the economy. This is very relevant to the Saudi Arabian context as most of the participants in this research did not engage in paid work due to sociocultural norms. Table 7.3 shows that the majority of respondents had no medical insurance.

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>With Medical Insurance</th>
<th>Without Medical Insurance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>1</td>
<td>7%</td>
<td>15</td>
</tr>
<tr>
<td>Middle Class</td>
<td>8</td>
<td>33%</td>
<td>24</td>
</tr>
<tr>
<td>High Class</td>
<td>7</td>
<td>64%</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>32%</td>
<td>50</td>
</tr>
</tbody>
</table>

Of the 50 participants, only one-third of participants had medical insurance coverage. This varies by economic status: (64%) of high-class older women have such coverage, one-third from the middle class (33%), but only 7% of the poor class have medical insurance. The following two participants from the poor class, who do not have medical insurance, said:
I don’t have medical insurance and I cannot afford to have one. I have high blood pressure, diabetes, depression, isolation, fatigue, and visual impairment. I am only taking medicine for my diabetes, but it is not regular. Then, I take pain killers like ‘Panadol’ for my high blood pressure. (Lola A, 65P)

I don’t have medical insurance but my children and my siblings are taking care of my medicine and hospital expenses. I have high blood pressure, a heart problem, diabetes, fatigue, arthritis and osteoporosis, and hearing impairment. I wish to have a medical insurance with good coverage that would be helpful to my situation. (Katrina S, 74P)

Table 7.4: Who Provides Medical Insurance by Economic Status

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Provided by</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Son</td>
<td>Brother</td>
</tr>
<tr>
<td>Poor Class</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Middle Class</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>High Class</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7.4 shows the main provider of medical insurance for the 16 participants with medical insurance; 9 (56%) paid personally themselves, all of whom were from the middle or high-class levels. Three participants with contrasting sources of medical insurance said:

*My brother pays my medical insurance yearly. However, I need more medical and social assistance from the government. Yes, I have medical insurance but if God forbid, and something happened to my brother, I would have none.* (Wadha B, 72P)
I am paying personally for my medical insurance and it costs me around 20,000 riyals (about £3,600) yearly. I am satisfied with the present services of my insurance, unlike when I was under the insurance of my ex-husband. (Fadiya A, 65H)

Although I retired as a manager three years ago from the Ministry of Social Affairs, they still provide me with a medical insurance. All expenses are covered by my medical insurance and I only pay personally if the services are not under the plan. (Sanabel A2, 63H)

In Saudi Arabia, there is no specific policy for older people, such as free comprehensive welfare services for the elderly or health insurance coverage. Ward and Younis (2013: 28) state that one part of Saudi Arabia’s Ministry of Health (MOH) goals is to ‘provide universal free medical care for Saudi citizens’. Presently, about 60% of health services in the country are provided by the Ministry of Health and 18% by other government hospitals, such as university and military hospitals which are open to the public. The remaining 22% of health care is provided by private hospitals, which are regulated by the MOH.

Usually, companies in Saudi Arabia provide medical insurance for their employees and their immediate family. However, better medical insurance is mostly provided by government companies such as: Saudi Arabian Airlines, Saudi Aramco, Petro Rabigh, large government hospitals such as the National Guard Hospital, hospitals for the military, and the university hospitals. In contrast, there is no specific programme of medical insurance for older women, the majority of whom cannot afford to buy private medical insurance because of having a limited income. In addition, due to their chronic health conditions, it is more difficult for older people to obtain medical insurance because medical insurance companies' preconditions often lead to higher premiums or denial of coverage.
In summary, socioeconomic status plays a major role in the availability and access to medical insurance among older women. The findings show that the most privileged older women have access to medical insurance, those mainly from the middle or high class. Having their own financial resources was the major source of payment for the medical insurance of these participants, followed by their sons who are currently employed or had been employed, and only one was from her brother.

7.4.1 Cost of Medical Insurance in the Kingdom of Saudi Arabia
The cost of medical insurance in the Kingdom has become a most important issue because of the increasing health care costs for elderly people. The cost of a medical insurance policy for an older person ranges from SAR 4,000 to 25,000 (about £700 to £4,400) per year, while most of the participants in the research study live on only SAR 2,000 (about £350) monthly. Thus, the cost of medical insurance for older women is high, and they must have enough financial resources to maintain health insurance membership. Three participants said:

In the past, I had several surgeries (operations). Four of them were on my knees. Whenever I need to go to the doctor, my son accompanies me. Sometimes, I go there by myself. I personally arrange my medical appointments, and I go everywhere with my driver, except to Government Authorities. When serious health issues arose, which required surgeries, I used to go to the specialist hospital in Riyadh, where my son works as a doctor. Alhamdullelah (praise to God), my son pays my medical insurance and it costs him around 15,000 riyals (about £2,800) annually. (Hanadi S, 75M)

I never considered going to the health care centres, as I am well off financially and my late husband was a doctor. I have medical insurance and I am satisfied with the services they provide. I always renew my medical insurance on a yearly basis, and whenever I find a better
insurance company, I change it instantly after the coverage period. At the moment, I pay 35,000 riyals (about £5,400) for one-year coverage. (Nora A2, 70H)

*I am working as a security guard in King Abdulaziz Airport and my medical insurance is provided by my employer. I am using it regularly. However, not all of the medicine for my illnesses are covered, thus I am paying some from my own pocket. Presently, I don’t need any medical assistance, but I am thinking that after my dismissal from work because of being old, I would be in need of medical and social assistance.* (Dania A1, 63M)

In general, medical insurance services are only available for the categories of the population who are in paid work or who are well-off and can afford medical insurance. In this research study, the high cost of medical insurance limits access and availability to only some older women who have a middle or high level of income. Thus, participants in the poor class have no other option but to depend on the primary health care centres or public hospitals in the Kingdom, or pay privately from their own or their children's resources.

7.5 Access and Use of Primary Health Care Centre

The need to have access to a primary health care centre is extremely important for older people, especially for those with chronic illnesses. According to Alaslani et al., (2016), primary health care services are provided through a network of health care centres, which included 2,259 centres kingdom wide in 2013. In 2009, there were 80 health care centres in Jeddah which increased to 108 in 2013, a larger growth of 35% than in other regions in Saudi Arabia (p. 36-38).

Primary health care centres have been established for more than 20 years in the Kingdom, but most participants were not satisfied with their services, as reflected in the small number of participants obtaining free medicine from them. In
addition, present financial resources and socioeconomic status, present health status, geographical distance, and/or lack of information about health centres were the most common reasons why health centres were underutilised by older women. Table 7.6 shows the number of participants who were aware of the availability of primary health care centres.

Table 7.5 Awareness by Participants of Primary Health Care Centres

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Aware</th>
<th>Not Aware</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Middle Class</td>
<td>20</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>High Class</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>15</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Table 7.5 shows that more than two-thirds of participants were aware of primary health care centres, especially among the middle class (83%) and poor class (67%). However, although 83% of participants from the middle class were aware of primary health care centres, Table 6.7 (Chapter 6) showed that only 6 (25%) middle class participants were obtaining free medicine. Among the research participants who considered that their needs for primary health care were not met, the most commonly reported reasons for not using primary health care centres were; (1) lack of knowledge about primary health care centres; (2) lack of knowledge about the availability of free medicine from primary health care centres; (3) negative experiences related to the quality of service and unavailability of free medicine from primary health care centres; and (4) geographical location and difficulty in accessibility of primary health care centres, in other words they did not know the location or had problems travelling to primary health care centres. Each of these reported barriers will be discussed in turn.
7.5.1 Lack of Knowledge about Primary Health Care Centres

Knowledge of and access to primary health care centres can directly affect all aspects of older unmarried women’s health. For older women who have poor health status, chronic illnesses, lack of financial resources, lack of medical insurance, and limited access to a range of health services, preventive treatment can be critical in preventing illness and improving quality of life. Two participants who were not aware of the existence of primary health care centres said:

*I did not know of the existence of a primary health care centre. I only depended on my children for my medication and medical expenses.* (Katrina S, 74P)

*I have no idea about the primary health care centre. I usually go to a public hospital if I need to.* (Sarah A, 65M)

In this research study, one of the reasons identified for not using primary health care centres was older women’s lack of awareness about the availability of free medicines. Two participants said,

*I am not aware of the free medication from the primary health care centre, as I have never heard of it before.* (Majda A, 60P)

*I did not know that there is free medication from the primary health care centre. I only heard it from you now when you asked me.* (Naheed A2, 73H)

7.5.2 Lack of Medicines and the Limited Supply

Because of the limited supply of medicine for their health conditions, some participants preferred to go to private hospitals or purchase their own medicine, which was paid for from their own pockets, instead of through the obtaining of
free medicine from the primary health care centre. In some cases, children or immediate relatives provided the necessary medicine for participants’ health conditions because of dissatisfaction with the medicine provided. One of the participants said:

Yes, I am aware of the free medication and believe me, I tried all the health centres near my district but they were not giving me all the important medications. It’s easy to obtain medication but the supply is limited. Usually they are just giving basic medicine for a headache or stomach ache, but limited supply for chronic diseases. Most of the time, I personally pay for my hospital care and medicine with the help of my children. (Hanan UD, 68P)

7.5.3 Negative Experiences Related to the Quality of Service
For some older women who knew about the primary health care centres, their use was influenced by the acceptability of services and the adequacy of the medicine supply. The personal experience of some participants who had previously obtained free medicine had made them hesitant to come back because of the poor quality of service provided to them. Two participants said:

Yes, I am aware of free medication from primary health centres, but they are not giving suitable medications according to the illness. I have been there many times but received no benefits at all. I really am not satisfied with the services. They gave me a wrong medicine too. Also, they don’t have qualified doctors and they did not find the right diagnosis. Thus, I always borrow money from my daughters and other people to pay for my hospital care. However, going to a private hospital is very expensive nowadays. (Susan UD, 61P)

I am aware of free medication but it is hopeless. The primary health care centre could not provide all my important medications for my health
conditions. I really need medical assistance or free good health care to support my health. (Muzna R, 62P)

7.5.4 Geographical Location and Difficulty in Accessibility

The issue of geographical distance is also important in a large country like Saudi Arabia with limited means of transportation for older women who do not have their own driver, and for those who live in remote areas with poor transportation access. For the purpose of the research study, the researcher personally tried to locate several primary health care centres, but she found that the location of the centres was hard to find as there was no signage or directions that existed. The researcher also tried to ask Saudis in the streets, but most were not aware of the centres’ existence.

Issues of access to primary health care centres in terms of distance were raised by two participants. It is notable that these two participants did not use primary health care centres primarily because of dissatisfaction with the services provided, but also mentioned problems of access.

I am aware of free medicine from the primary health care centre and I have been there twice two years ago. I did not go again because it was far from my home and there is no primary health care centre nearby. (Dania A1, 63M)

Yes, I am aware of free medicine from the primary health care centre, but I don’t trust their services. I also tried them once but the appointment system was not organised and the location is far from my home. (Ellen UC, 61M)

7.5.5 Summary

In summary, while improvements in the health care system of Saudi Arabia have been undertaken, especially in the development of primary health care centres, a
number of challenges still remain. Despite, the fact that all the services provided by the primary health centre are free of charge for all Saudi Arabian citizens, the underutilization of health centres was observed in this research study. Access of older unmarried women to primary health care centres was mainly affected by: lack of knowledge about the existence of primary health care centres, lack of knowledge about the availability of free medication, concerns about the quality of medications provided, and lack of medicine provided, as well as difficulties of geographical access. Recognising all these factors, a great need exists to develop an accessible and better quality primary health centre system. If quality services are available and there is an adequate supply of medicine, this may enable older women to obtain free health care services regularly from health care centres.

7.6 Access to Public Hospitals
In Saudi Arabia, the Ministry of Health has established a number of public hospitals which are free for all Saudi citizens. However, in this research study, the participants experienced difficulties in obtaining medical treatment and getting an appointment for a consultation; also, an operation took longer to wait for in a public hospital than in a private hospital in Saudi Arabia. Two participants said:

*I was hesitant to go to a public hospital because of the difficulty in obtaining an appointment, this is the reason why I preferred to go to a private hospital. (Alhamdulilah) thank God. I am able to pay my medical needs through my health insurance. (Fadwa UC, 68M)*

*I went to a government hospital painstakingly and paid 50 riyals for transportation. The fare from my house to the hospital is expensive. However, the hospital staff gave me an appointment and asked me to go back the following day to open a file. I cried and complained, but there was not available appointment or bed. I left without the proper treatment. I thought of going back, but what would be the benefit? (Sabra A, 60P)*
One of the concerns expressed by some older women is related to the quality of services and lack of free medication provided by public hospitals. Despite the tremendous budget allocated by the government to the health care system, medicine for various chronic illnesses was not available in some major public hospitals in Jeddah. The result of experiencing difficulties in accessing free treatment and medicine had made some older women hesitant about going back to the public hospitals. Two participants said,

*I don't want to go to the private hospital, because they are too expensive. However, when I go to the public hospitals, they just give me basic medicine, such as, Panadol and nothing specific for my health issues or illnesses.* (Majda A, 60P)

*I used to go to King Fahad Hospital but they could not provide me with most of the medicines I need and am taking. I have all the medicines I need now, because I personally buy them and part of the money is paid by my children monthly.* (Salma A, 66M)

In summary, older unmarried women reported a low rate of public hospital utilisation as they were dissatisfied with the quality of the health services they received. The participants emphasised their need for medical insurance for themselves as they believed that by having their own medical insurance, they would gain easy and immediate access to medical assistance if they needed it. They also stated that the ability to be treated in a private hospital would be best for them.

7.7 Inequalities in Access to Health Care

While the overall health care system in Saudi Arabia has improved over the last couple of decades, there still exist noticeable inequalities in access to health care for older citizens. In Saudi Arabia, socioeconomic status and educational status are strongly linked to inequalities in access to health care for older women. In
general, older Saudi women tend to have a lack of financial resources, less education and/or limited work participation that may limit their ability to pay for their own medical insurance and medical treatment in private hospitals.

In the Saudi Arabian context, women's access to health care, and freedom to make independent decisions regarding their health are bound by their legal guardians' permission before they may be treated. Women are under the legal control of their closest male relative and often lack choices in making personal decisions (Alaslani et al., 2016). There can be reasons for this: a) many older women are illiterate and unable to read and sign any document pertaining to their health and/or treatment, b) lack of financial resources to enable them to make decisions, c) sociocultural norms, it is not accepted by society that a woman could enter a hospital for treatment or undergo an operation without a male relative having prior knowledge. In addition, as women are not allowed to drive cars, women's access to transportation if they require a visit to the hospital is often dependent on having their own driver, male children and other male relatives.

### 7.7.1 Socioeconomic status and Inequalities in Access to Health Care

In the Saudi Arabian context, women are disproportionately affected by poverty because of their gender as they have limited options for employment, access to transportation, and ability to act independently. The socio-economic status of the respondents has important effects on their health, especially if they were unable to buy the required medicine for their illness. Two participants from the poor class said:

*I have high blood pressure, diabetes, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, hearing impairment, and visual impairment. I need medical health care. I have to take medicine for the blood pressure and diabetes, but my medicine was too quick to finish, and I could not buy the medication regularly.* (Neama S, 75P)
I have high blood pressure, heart problem, diabetes, depression, fatigue, hearing impairment, and high cholesterol. Yes, my children are trying to provide all the medication I need, but not on a regular basis because they are poor also. (Nadia S, 73P)

The research findings show that socioeconomic status was associated with better physical health (see Table 7.1). The level of participants’ income has a direct relationship with their access to health care because women of lower socioeconomic status have limited access to medical insurance and medical treatment in private hospitals. Greater financial resources are one of the key factors for health as it may enable older women to have better access to health care.

7.7.2 Level of Education and Inequalities in Access to Health Care

In this research study, half of the older women participants were aged 70–75, most of whom had little formal education (see Table 5.3 in Chapter 5), and women over 70 had comparatively poor health status (see Table 7.1). With reference to participant’s educational attainment, the research study showed that a majority of the older women never went to school, or dropped out from primary/secondary schools, owing to strong cultural norms that prevented older women from having adequate access to education.

The minority of educated older women were aware of their rights and had sufficient information about the available health care services. For instance, Fayza, an educated woman said:

I had my heart operation at King Fahd Hospital and I felt good after the procedure. I have knowledge of the medical services and I asked the hospitals to provide me with all health information. I followed up my medications with them every month and I regularly received it all. Thus, I am satisfied with their services. (Fayza A2, 75M)
In contrast, uneducated women found it problematic to obtain information on health services as they did not know their rights to free treatment as a Saudi citizen. Aiza is one of the uneducated women, and she found it difficult to get free medications and to make appointments in the hospital.

*I had my knee operation at King Fahd Hospital. However, after difficulties in setting an appointment, I waited for a long time, because the hospital was crowded. After the operation, I found it difficult to obtain medicine in the hospital. Comparing my experience with my neighbour in the same building, she has medical insurance in the National Guard Hospital, and it was easy for her making appointments and obtaining private medical care.* (Aiza A1, 75P)

As shown in Table 7.1, educational status is linked to older women’s health, as literate older women who are mostly aged 60-64 had fewer chronic illnesses than illiterate older women who were mostly aged 70-75. Hence, health is linked with literacy, and literacy is linked with age. Older women who have a higher level of education also have better physical health. Educated older women are more likely to be able to understand and use health information, as well as negotiate with health care staff to get appointments and medicine when needed. Also, their greater access to paid work and income affects their living standards. Aside from this, a higher level of education provides greater knowledge and awareness of the benefits of the health care system, and of disease prevention, which may, therefore, lead to fewer illnesses. Thus, educated older women are also more likely to live a healthy lifestyle and make positive choices.

7.8 Conclusion
The research indicates that almost all of the older unmarried women suffer from multiple chronic illnesses. A possible explanation for this may be due to limited physical activity, poor health education, and aspects of lifestyle that are influenced by the socio-cultural norms of Saudi Arabia. In addition, specific
factors, such as a lower level of income and lack of education, influence the health status of older women. This research study found that the physical health of older women with a lower level of income was the most disadvantaged, indicating that socioeconomic status of older unmarried women is associated with their physical health.

Satisfaction of older women with health services differed according to their economic level, with financial status playing an important role in the participants’ satisfaction with health services. Older women with a high economic level were more likely to have medical insurance, be able to afford the best medical treatment, and access better health services.

The results also showed that older women who have better education have better health status, demonstrating the importance of women’s education. In general, education makes it easier for older women to use and benefit from health care information. In addition, lack of education impedes older women's chances of having paid work and gaining income for a living. Also, the level of income to support their personal needs, such as food, housing rent, and personal medications is limited. The provision of health education is important for older women, especially for those who are illiterate or have low education, to provide them with more knowledge about accessing health care and disease prevention.

Access to private health care is dependent on income; in most cases, older women with a high-income level were more likely to have their own medical insurance because they could afford it. The underprivileged participants were unable to access private healthcare due to the high cost of insurance plans, thus increasing health care costs are making the gap between rich and poor older women more apparent. In this research study, the older women who have medical insurance and good economic status enjoyed better physical health. Therefore, the development of a free and high-quality medical insurance programme for older people is essential, especially for those older women who are financially dependent.
In this research study, poor access to, and poor quality of, received public health care remain addressable problems for older unmarried women. Despite the development of thousands of primary health care centres in the Kingdom by the Ministry of Health, utilisation of such health centres remains low. To encourage older women to utilise primary health care centres, better information dissemination, and resources to promote health care centres is essential. This may increase the likelihood that older women would utilise primary health care centres for their health needs. However, a key concern was not just unawareness of services, but the poor quality of treatment received and lack of available medications for chronic illnesses.

Other barriers to seeking health services from primary health care centres included the difficulty of access because of their geographical location. Even though Saudi citizens are entitled to free treatment and medication, they are still faced with financial problems in relation to accessing health care services. Due to limited transportation for older women, some of them found health centres difficult to get to as they were too far away. This inconvenience hindered some older women from using public health care services. Thus, providing transportation for older women and making it a free service or at least a reasonable fare system may help encourage these women to utilise primary health care centres, and consequently improve their health.

The financial ability of older women to afford health care played a vital role influencing access to health care services. Some participants in this research chose to attend public hospitals when they needed medical help because of relatively low health care costs. However, most older women complained that in public hospitals they had experienced difficulties in obtaining medication for chronic illnesses, and were unable to make appointments for follow-ups with doctors, due to the long delays. This was often compared with the better care provided by private hospitals. Thus, improving the quality of health services, facilities and
systems in hospitals are essential to increase health care service use and satisfaction of older women.

Overall, the development of the health care system in Saudi Arabia is ongoing. It is essential to improve the services to cater to the specific needs of older people, particularly older women. In this research study, the majority of older women suffered from poor physical health due to multiple chronic illnesses, which directly affected their physical and functional ability. Therefore, it is vital for the health service to engage in active health promotion so that ageing people, especially older women, remain in good health for longer, and reduce their need to go to primary health care centres or hospitals for treatment. Another factor to be taken into consideration is the importance of awareness of how to improve the health of the older people. To this end, special training should be given to health care staff in order to help them instruct the older women about diet and lifestyle changes which can improve their overall health.
Older people have different experiences as they age. Each person is likely to have a unique perspective about the quality of life based on their own situation. Quality of life has been analysed in many ways, and the methods and assessments have involved various definitions. This chapter analyses the definition and concept of quality of life for older unmarried women in Saudi Arabia. It explores the significant factors related to the quality of life of older unmarried women living alone and living with their family members. It also examines the relationship between self-reported QoL and older women’s educational level, economic position, living arrangements, health status, and life circumstances. Since research and knowledge about the quality of life of older unmarried women in Saudi society is limited, this research study will be vital in providing information and addressing ways to improve older women’s QoL.

8.1 Measuring Quality of Life

The study of quality of life of people in Saudi Arabia is limited. Measurement of older unmarried women’s quality of life is a challenge as it has different meanings for every individual. A large number of tests and a variety of QoL measurements have been developed by different researchers. However, according to Farquhar (1995: 1440) these different tests and measurements ‘vary widely in concept, construction and content, and therefore cannot always be compared directly with each other, therefore the validity of quality of life measures is difficult to establish’. As suggested by Farquhar (1995: 1441) the ‘two ways to measure quality of life are through structured and non-structured interviews’. In this research, a non-structured interview technique was used to measure the quality of life of older unmarried women. Farquhar (1995: 1441) argues that ‘non-structured interview techniques have an important role to play in achieving a better understanding of quality of life’.
By using the unstructured qualitative interview approach, the participants were allowed to define quality of life based on their own perceptions, and identify the factors which contribute to their life based on their own circumstances. Although most studies about quality of life have been viewed from a health perspective, this research study was based on qualitative interviews with participants which focused on a range of factors, including their education level, socioeconomic status, living arrangements, health status, and life circumstances. In this research, older women’s subjective self-assessment of personal experiences and individual well-being is used to measure their QoL.

8.2 Definition and Concepts of Quality of Life

QoL, or the lack of it, depends on what older people perceive as valuable. Everyone has their own perception of quality of life. According to the World Health Organization Quality of Life Group (1995: 1405), quality of life is the ‘individual’s perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns’. Further, it is a ‘broad ranging concept that affected individuals in a complex way in terms of their own physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationship to salient features of their environment’ (p. 1405).

Participants in my research were keen to discuss their lifestyle and some were satisfied and others were not. Their level of satisfaction was linked to their perspective on quality of life. Kim, Hong and Kim (2014:1) stated that life satisfaction is an important indicator of quality of life. Therefore, it is important to obtain the general understanding of an individual about what factors make him or her satisfied. In this study, older women discussed issues such as financial security, relationship with family members (adult children and siblings), the availability of a good health system, living arrangements, wherein all of these factors helped them to assess their QoL.
In this research study, QoL is defined based on the level of satisfaction or sense of well-being of older women’s experiences in later life. Several overall themes emerged from the older women and these themes include; financial status, health status, social and family relationships, living arrangements, and social activities.

8.3 Factors Affecting the Life Satisfaction of Older Saudi Unmarried Women

According to Bowling (2005: 18), the best predictors of life satisfaction of older people are ‘earlier life satisfaction, health status, functional ability, mental health, social networks and activity, and socioeconomic status’. In Saudi Arabian society, economic level, living arrangements, and educational status are among the socio-demographic variables that had significant relationships with QoL of the older unmarried women.

Life satisfaction is expectations and perception of outcomes of salient components of life such as social situations, relationships, self-worth, and finances across multiple and broad domains and long-time periods (Kane and Kane, 2000). Wallace (2008:12) states that life satisfaction indicates the older person’s happiness with his or her environment, existing conditions, activities, and lifestyle. Moreover, Bartram (2011:2) defines ‘life satisfaction’ as a cognitive component, the evaluations we make of how well our lives are going. Thus, life satisfaction is a personal insight of an individual about what factors in life make him/her happy or satisfied.

In this study, the participants had self-reported the factors affecting their life satisfaction. I classified these participants into four (4) categories of life satisfaction (very satisfied, satisfied, partially dissatisfied and very dissatisfied) based on their verbatim comments and an overall assessment from the whole interview of each individual.

Table 8.1 shows the classified level of life satisfaction of participants by their economic status and living arrangements. The key factor associated with life
satisfaction was economic status, all 15 poor women were dissatisfied. This contrasts with high class women who were all satisfied, with 9 out of 11 who were very satisfied. Of the 25 participants living with their children or other relatives, 12 older women were partially dissatisfied and 2 fully dissatisfied with their present life. There was somewhat greater life satisfaction among older women living alone, with only 8 out of 25 partially or very dissatisfied. However, it is important to disentangle how both economic status and living arrangements are related to life satisfaction.

Table 8.1: Level of Life Satisfaction of the Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Very Dissatisfied</th>
<th>Partially Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Class</td>
<td>6</td>
<td>9</td>
<td>-</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Middle Class</td>
<td>-</td>
<td>7</td>
<td>13</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>High-class</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Alone</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Living with children or with relatives</td>
<td>2</td>
<td>12</td>
<td>6</td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>

Tables 8.2 and 8.3 shows the level of life satisfaction of participants who are living alone and living with others by economic status. All poor class women have some degree of dissatisfaction with their life, but this is greater among those who live alone. Four out of the six poor women who live alone are completely dissatisfied with their life, compared with those living with others where seven are partially dissatisfied and only two fully dissatisfied. Therefore, for poor class women, living with others is a better living arrangement than living alone. In contrast, older women who are living alone from the high class groups, whether
living alone or living with others, tend to be more satisfied with their life. In addition, the two high class women who live with others are both very satisfied.

Table 8.2: Level of Life Satisfaction of the Participants who are Living Alone Based on Economic Status.

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Very Dissatisfied</th>
<th>Partially Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Middle Class</td>
<td>-</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>High class</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 8.3: Level of Life Satisfaction of the Participants who are Living with Children or with Relatives Based on Economic Status.

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Very Dissatisfied</th>
<th>Partially Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>2</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Middle Class</td>
<td>-</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>High class</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>12</td>
<td>6</td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>

Among the middle class, the majority are satisfied with their lives, but slightly more are partially dissatisfied (5 out of 14) from those who were living with others than those living alone (2 out of 10). A key finding of this research study is that older women in the lowest income group expressed moderate to total dissatisfaction levels, and none are satisfied with their QoL compared to the
majority of the older women, who are in a better financial situation, and only a few of whom expressed partial dissatisfaction.

8.3.1 Educational Status
In this research, most of the older unmarried women have a lower education (see Table 5.3 in Chapter 5) due to socio-cultural norms and the late introduction of education for girls in Saudi Arabia. In general, older Saudi women in the past were expected to study suitable courses that were related to women only, and in accordance with socio-cultural norms. These courses emphasised mainly the Arabic language, home economics, child caring, and religious instruction. As a result, this limited the paid work opportunities for older women in Saudi Arabia. Most of the older women were satisfied with their level of education; some expressed their anger at not being allowed to continue further education and being forced into marriage at an early age. The women who were able to continue their education seemed more satisfied with their lifestyle and quality of life (Table 8.4). The women who continued their education, can read and partake in different activities, and were able to learn to deal with modern technology, which had helped them to feel content and have a fuller life; whereas the women who were illiterate often experienced boredom and depression.

Education level is often considered as an important factor related to QoL. In this research, the older women who had completed their college degree had the choice to work or not, but they also were able to expand their skills and knowledge through reading and learning the new technology. The older women, who never had an education, became bored in the later stages of their lives because of lack of activities. Previously, their lives had consisted of daily tasks related to taking care of the family and their husband, but as this situation changed, they had fewer activities to undertake. If they had had a better education, they would have had greater opportunities to partake in hobbies, learn new skills and, therefore, be less likely to feel bored and depressed.
Table 8.4 shows the level of life satisfaction of the participants by educational status. Older unmarried women who were illiterate or only had a very basic education showed a lower life satisfaction than those who completed college education or a university degree.

Table 8.4: Level of Life Satisfaction of Participants

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Dissatisfied</th>
<th>Partially Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never went to school</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Studied through informal education or drop out from primary school</td>
<td>-</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Primary school graduate or dropout from secondary school</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Secondary school graduate or dropout from college</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>University graduate</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>16</strong></td>
<td><strong>15</strong></td>
<td><strong>13</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Participants who had a university degree were very proud of their achievement, and it made them feel important within their nuclear family and society. There were very few women in their age group that had had a university education.
They were the elite and felt blessed and this gave them a lot of self-confidence. Two participants said:

_I am a university graduate. The knowledge and education has shaped my personality. I had the opportunity to work in the government because at that time, only few women were educated. I consider myself distinctive from other Saudi women, especially in the society of Jeddah, and in particular at my age now._ (Nora A2, 70H)

_I am a university graduate with a PhD Degree. Alhamdulilelah (thank God), I am satisfied with my life and I feel better than the other older woman, because I am in good status._ (Sarah A0, 65M)

In contrast, participants in this research who were illiterate or had a very basic education expressed the sentiment that their life would be better than it is today if they had completed their education in the past. Two participants said:

_I am a dropout from primary school because my father refused for me to continue my education. If I had finished my education in the past, I think my life would be in better condition now._ (Salha UC, 65M)

_I am a dropout from primary school because my husband refused to continue my education. If I had finished my education, I would be a successful person now and it could be easy to overcome all my problems._ (Susan UD, 61P)

In addition, some participants reported that with education, their lives would be better in all aspects, and education could have contributed to improving their honour and dignity within their family. Two participants said:
I never went to school because of the beliefs that it was shameful for a woman to go out from the house. If I had finished my education, I would have honour in my family. (Neama S, 75P)

I am a dropout from primary school because of my early marriage. Maybe if I continued and finished my education, I would have a good life with the dignity I was looking for. (Majda, A0, 60P)

In Saudi Arabian society, unequal opportunities between women and men hamper women’s ability to lift themselves from poverty to improve their QoL. The research findings showed that education is one of the important instruments for enhancing women’s position in society, and their well-being in later life. In general, older women with higher education in this research were more satisfied with their QoL. Possible reasons for this relationship of higher level of education with QoL is that older women who are well educated are more likely to have a much better status as a woman, and to have engaged in paid work, and thus have a much better source of income to support their needs. The study also found that educated women tend to use health services more often. In addition, they were more likely to be able to take an interest in reading, cultural pursuits, current affairs, as well as using of computers and other new technology.

8.4 Living Arrangements and QoL: Choice and Constraint

Living arrangements are very important to older unmarried women because they can serve as a source of social support and can facilitate independence too. Often women’s living arrangements change, possibly because of the death of their husband or divorce or retirement from paid work. The participants had to adapt their former lifestyle from living with their spouse to living with an adult child or sibling. Some participants were financially stable and were able to live independently with a housemaid and/or a driver and others may have had no other option except to live alone.
Moreover, various living arrangements are important to the life satisfaction of older adults because living arrangements are powerful in defining social roles and providing social support functions and interaction (Kooshiar et al., 2012:3). In this study, more older unmarried Saudi women living alone were ‘very dissatisfied’ than those who were living with their relatives, but more of the older women who were living with their relatives were ‘partially dissatisfied’ than those who were living alone. This section shows the relationship between living arrangements and level of life satisfaction, in particular how the level of their life satisfaction may vary with the nature of their relationship with their family members.

8.4.1 Choosing to Live Alone

In this research, one of the most significant factors affecting older women is their current living arrangements as discussed in section 8.3.1, Table 8.5 shows that 5 out of the 9 high class women choose to live alone, which means the majority of the high class women are currently living alone. These older women, who had a higher economic status, preferred to live alone with their housemaid and a driver, and were able to travel in and out of the city, and felt a kind of freedom. For these women, with age had come a certain degree of freedom of movement, because socially it is more acceptable for older women to travel and visit friends and neighbours without a male guardian. It is sufficient that she have a housemaid and/or driver with her, and that she be above the age of 60. Traditionally, women are still required to have a male guardian, but it was clear for those older women who have a higher level of education, or have travelled and lived abroad, that their adult children were more accepting of their mother being independent and, therefore, allowed her some freedom of movement.
Table 8.5: Number of Participants who choose to Live Alone by Socio-Economic Class.

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Total Living Alone</th>
<th>With Housemaid</th>
<th>With Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>1</td>
<td>17%</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Middle Class</td>
<td>3</td>
<td>30%</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>High class</td>
<td>5</td>
<td>56%</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>36%</strong></td>
<td><strong>25</strong></td>
<td><strong>8</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

Only one of the six poor women who lived alone had chosen to do so (Table 8.5).

She said:

*I am living alone in an apartment. I had a chance to live with my son, but I refused as I preferred to live alone. And yes, I am living alone, but I don’t feel being alone because my children and their families used to come on a regular basis. Then, I used to visit my friends every week.* (Majda A0, 60P)

In contrast, middle and high class older women who are living alone but with their maids and/or driver expressed satisfaction, and particularly valued the independence in their life of living alone rather than with family members. Three participants said:

*I am living alone with my housemaid and driver. I had a chance to live with my children and my sisters but opted to live alone because I want to live freely and have an independent life.* (Fayza A2, 75M)

*I am living alone with my housemaid and my driver. I had a chance to live with my son and daughter in-law but I opted to live alone, so that no one*
can control my life. I want to live independently. I feel that living with others restricts my freedom. (Alma A2, 73M)

I do not have children, and now I am living alone with my housemaid. I had a chance to live together with my mother before she passed away 7 years ago but I refused as I want to be free. (Hessa A1, 63H)

8.4.2 Forced to Live Alone

While living alone might not be the arrangement of choice for some older unmarried women, those who felt they had been forced to live alone feel the most disadvantaged. Not only is it likely to be associated with less frequent contacts with their family, and feelings of loneliness, but there is also a greater chance that their urgent needs for social support will go unattended. Table 8.6 shows that 5 out of the 25 participants felt that they had been constrained to live alone, and these were more likely to be in the poor economic group.

Table 8.6: Number of Participants who were forced to Live Alone by Socio-Economic Class.

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Total Living Alone</th>
<th>With Housemaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Class</td>
<td>4</td>
<td>67%</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Middle Class</td>
<td>1</td>
<td>10%</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>High class</td>
<td>-</td>
<td>0%</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>20%</td>
<td>25</td>
<td>1</td>
</tr>
</tbody>
</table>

This part of the research investigates participants who were forced to live alone because of having a dispute with siblings, being estranged by their stepchildren, or having no children or other relatives to live with. For example, two participants said:
I never had a chance to live with my children, but I wish to live with any of them. I really feel alone especially when the dusk is coming. At this time, I remember that I used to have the company of my children and my ex-husband, but now I am alone and sometimes I feel depressed. (Lola A0, 65P)

I feel orphaned and bored without my family. I need a place where I can see and talk with the people and communicate every time I feel alone. (Salma A0, 66M)

Of the five participants who were forced to live alone, only one older woman was living with her personal housemaid. Despite being in a poor class and having little monthly income, Aiza was constrained to live alone because of having a dispute with her stepson. Although Aiza managed to have a housemaid, she still felt lonely and ‘orphaned’. She said:

I feel lonely and orphaned because of living alone. I wished to live with my children, but after my husband passed away, my stepson from my second husband treated me badly. He requested me to leave the house as he does not like me to be with them anymore. My other two daughters cannot take me because they are also living in poverty. Now, I am living alone in an apartment with my housemaid. (Aiza A1, 75P)

8.4.3 Satisfaction Living with Others

In a society dominated by the importance of having a nuclear family, it can be easy to assume that older unmarried women who are living with their adult children or with other relatives are having a good QoL. According to this research, 11 of the 25 participants who live with others are satisfied with their situation (see Table 8.3).
Some older women who are living with their children or relatives had a high QoL. Two participants said:

*I am satisfied with my living situation because my children are living with me. I feel happy living with them because I consider my children as the source of my happiness.* (Fadwa UC, 68M)

*I am living now with my son and his family. I’ve been living with them for almost 10 years now. Alhamdullelah (thank God), I am happy living with my family.* (Katrina S, 74P)

However, 12 participants living with their children or relatives (five from the middle class and the rest from the poor class) were partially dissatisfied and two were very dissatisfied. These following two participants stated:

*My Brother and his wives provide me all the love, care and support I needed. They had provided me the necessities I needed that ease the difficulties I’m facing, especially financially. Despite of all these, the support that I received was not enough to cover my daily living.* (Wadha, D, 72P)

*I had a good relationship with my daughters who are living with me and we are supporting each other, however I have depression due to the financial crisis I’m facing especially because my husband’s pension was not enough and also my daughters have no stable job and currently my eldest one is about to divorce.* (Ellen, W, 61M)

In summary, life satisfaction among the participants varied according to their living arrangements and their socioeconomic status. In this research, living arrangements was an important indicator of life satisfaction, particularly for the
older women living alone with a low economic status, and especially those without a maid, who were likely to be dissatisfied with the quality of their lives. However, for all women, irrespective of their living arrangements, a key issue was the nature of the relationship of the participants with their family members, particularly for those older women living with others. The better the relationships were with their family members, the better was their life satisfaction, even though they were experiencing some economic or financial difficulties. However, although many older women expressed high satisfaction with living with their children and/or relatives, the level of satisfaction among women living alone was primarily influenced by their socio-economic status. Thus, improving older women’s economic level and their relationship with their family may contribute to enhancing their QoL.

8.5 Social Support and Quality of Life of Older Unmarried Women

Social support for older women, regardless of their socioeconomic status, has a strong bearing on their QoL. Traditionally, Saudi Arabian people are strongly influenced by the values of Islam, which emphasise the importance of filial responsibility, which means the family, especially children, are the primary source of different kinds of social support, such as financial support, instrumental support, emotional support, and support through social interaction with other people. These types of social support are a vital factor in enhancing older women’s QoL, and can decrease loneliness, improve social participation, and improve psychological well-being. However, the satisfaction of older women with the support received from different sources mainly depends on the quality of that social support.

8.5.1 Instrumental Support

Instrumental support refers to help with undertaking typical tasks such as cooking food, cleaning, laundering, purchasing groceries, doing other household chores, and providing transportation. In the Saudi Arabian context, regardless of physical health and socio-economic level, it is very common for Saudi families to employ
a maid or household workers to take care of most of these tasks. Table 6.1 (see Section 6.2.2 in Chapter 6) showed that children (70%) were identified as a provider of instrumental support, followed by housemaids and/or a driver (62%).

In this research, some of the older women highlighted the importance of having someone for companionship to take meals with them and accompany them when they go shopping or visiting friends and family. Some participants expressed the importance of living with supportive children, in particular that their children helped with instrumental support, such as helping with daily household chores, taking them shopping or visiting hospitals. Others expressed that they depended on their housemaid for companionship; often the housemaid became a substitute for family members. The following two participants said:

*I like living with my children. They really love me and they appreciate all my sacrifices I made for them in the past. My children provide my transportation and it is available all the time.* (Fadwa UC, 68M)

*I feel very comfortable because my children are with me. My sons are used to providing my transportation. Alhamdulilelah (thank God), it is easy to arrange, and I consider myself a lucky woman.* (Hedayah UC, 60M)

In the absence of family members, availability of a housemaid and/or a driver plays a major role in providing instrumental support to older women, such as in the following two participants statements:

*I am single and never been married. I am living now with my housemaid and driver. I have a very weak body and my health is not in good condition. My housemaid is used to helping me with all the household chores. Because I have money to employ a driver, my transportation is easy to arrange.* (Farrah A2, 74H)
I am totally dependent on my personal housemaid to perform my basic and essential needs within the house, and even outside, due to my health status. I have a driver for my transportation. If I did not have a housemaid and driver, my situation would have been really desperate and hopeless.

(Maria S, 70M)

In summary, instrumental support is important in predicting life satisfaction of participants as this type of support helped older women in performing household chores and in carrying out daily activities. However, the older women who live alone but without a housemaid are particularly disadvantaged by a lack of instrumental support, especially if the woman was not in good health and finds it difficult to undertake activities like cooking, cleaning, purchasing groceries, and travelling etc. In general, older unmarried women who receive instrumental support have a greater life satisfaction as this type of social support can enhance both their mental well-being and physical health.

8.5.2 Emotional Support

Receiving emotional support is part of having a good QoL for older unmarried women. This type of assistance enables older women to feel that others care about them and would always be supportive if they had a problem. Table 6.2 (see Section 6.2.3 in Chapter 6) showed that family members, especially children (90%) were identified as the most likely to provide emotional support, followed by siblings (46%), friends (44%), and other relatives (26%).

The frequency of contacts with children, relatives, and friends has a great impact on the well-being of older women. In this part of the research, some older women who live alone said that they do not feel alone because of the regular visits from their children, which gave them emotional support through closeness and a sense of security. The following two participants said:
I am living alone in my apartment and I don’t have children. I had many chances to live with my brother and sisters but I refused. They used to come once a week, and sometimes I was the one going to their home. I am habituated to be alone and my sister is living in the same building. (Sarah A0, 65M)

I am living alone with my two maids and driver. I am used to seeing all my children regularly. They come every day if I am available in the house, while my other relatives and friends come twice a week. I don’t feel myself that I am alone because of my children’s visits. (Naheed A2, 73H)

Geographical location and distance between the older women’s home and the home of their children have a clear impact on how often they see them. Participants who see their children frequently are likely to feel satisfied and contented with their life. The following two participants stated:

I am living alone in my own house, but one of my sons is living nearby. My son, who is living nearby comes every day. He used to eat meals with me. I am satisfied with my life. Alhamdullelah, God will enrich my life. (Fattomah A0, 68M)

My sons who are living nearby come every day and stay for 30 minutes. My other son visits twice a week. Two of my daughters-in-law requested me to live with them for two days, but I refused. I always think of my youngest son who has Down’s Syndrome. Alhamdullelah (thank God), I am satisfied with my life, but I am asking God to keep me long, because of my son’s condition. (Farha, US, 75H)

Some participants, however, had no close living relatives. Particularly for these participants, it was often housemaids, friends, and/or neighbours who provided companionship and emotional support. The following two participants said:
I used to gather with my neighbours. Living alone enables me to do anything with pleasure and joy. I share my meals with my housemaid, as I don’t like to eat alone as I feel distressed. Sometimes, I invite my neighbour to come during meal times and we share whatever food is available. (Alma A2, 73M)

I am living alone with my housemaid. My children from Mecca and Madina used to come every other week. Thus, most of the time, I used to eat meals, and watch television with my housemaid. My housemaid’s presence makes me comfortable. (Dania A1, 63M)

In summary, family members, especially children, were important in providing emotional support, and their presence contributed significantly to the participants’ quality of life. In the absence of their family, friends and housemaids were the alternative providers of emotional support. In general, receiving emotional support influences the mental health of older unmarried women, with this type of support contributing to their better psychological well-being. To sum up, emotional support affects not only the mental health but also the QoL of older unmarried women.

8.6 Loneliness

According to Mushtaq (2014), loneliness is the absence of social relationships, dissatisfaction with the extent or quality of such relationships, or low levels of social engagement and social participation. For older unmarried women, feelings of loneliness and a lack of closeness in relationships with family and friends are elements of subjective social isolation that adversely affect their QoL.

Table 8.7 shows the level of loneliness of the participants, with the majority of participants reporting a low to moderate level of loneliness. Only 7 out of 50
participants reported a high level of loneliness, the majority of whom were in the poor class (see Table 8.8).

Table 8.7: Level of Loneliness of the Participants.

<table>
<thead>
<tr>
<th>Loneliness Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>22</td>
<td>44%</td>
</tr>
<tr>
<td>Moderate</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td>High</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 8.8 shows the loneliness level of the participants according to economic level and living arrangements. A strong association between economic class and level of loneliness is observed as 7 out of 11 high class women are experiencing a low level of loneliness, with none high on loneliness, while only 3 out of 15 poor class women are low and 6 out of 15 are high on loneliness. In contrast, there were no clear differences in loneliness level between the living arrangements.

Table 8.8: Level of Loneliness of Participants by Different Living Arrangements and Economic Status.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Low Level</th>
<th>Moderate Level</th>
<th>High Level</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Alone</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Living with Children or with relatives</td>
<td>12</td>
<td>11</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Economic Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Class</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Middle Class</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>High-class</td>
<td>7</td>
<td>4</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>21</td>
<td>7</td>
<td>50</td>
</tr>
</tbody>
</table>

For some older unmarried women, they acknowledged that being alone and some degree of loneliness was a normal part of getting older. The following two participants stated:
I never feel lonely. I have no problem being alone. Even if my housemaid is not around, I can sleep at home without any difficulties. I can strongly deal with loneliness. I have always told myself that Allah Almighty is with me. (Alma A2, 73M)

I think it is normal to have a loneliness feeling. I have been living with my son and his family since my husband died 25 years ago. When I feel lonely, I go to pray and read the Holy Quran. (Neama S, 75P)

For some higher class older women, fewer feelings of loneliness are experienced if they are socially active and have extensive social networks. Two high class participants said:

I don’t feel loneliness, because I feel free after my husband died. He used to control my life when he was alive. I am now doing everything that I was prevented to do in the past. For example, I am used to spending time now with my friends. I go out of the house every day. (Nayla A2, 70H)

I never feel loneliness. Alhamdulilelah (thank God), my life is full of events, outings, and meeting other people. I always have my children, sisters, and friends around me. (Dina A5, 65H)

In addition, regular contact or visits by family and friends to older women provided ways to mitigate any feelings of loneliness, which made older women feel comfortable and secure. Two participants said:

I first felt alone when my children got married. But it lessened because they are living nearby. To deal with loneliness, I just watch television or most of the time, I read the holy Quran. My children, my relatives and my
neighbours come every three days or sometimes it depends on their circumstances. (Rogaiyah A1, 75M)

I don’t have any daily routines. If any of my friends or daughters-in-law call me to go out, I never object or refuse. The loneliness is killing me, but I have learnt to deal with it. Alhamdullelah (thank God), I have my own driver and it’s easy for me to go out. (Fatima A2, 74M)

In the case of Fatima, she was categorised as experiencing ‘moderate’ loneliness, and it was noted that even though she had a driver and housemaid, which meant that she was financially more secure, she was often lonely. Other participants also stated that even though their children and grandchildren came to visit regularly, they still felt lonely. This is because each woman had her own way of dealing with loneliness, with prayer and reading the Quran giving comfort to many of the participants. Some of the participants had been taught to tolerate their loneliness as a test from God, and they did not complain as they just dealt with it.

In the absence of family members, the research found that friends, housemaids or neighbours helped older women to cope with any feelings of loneliness. Two participants said:

I feel loneliness most of the time despite living with my auntie and my cousin. Our housemaid used to come to my room and sit with me more than with my auntie and my cousin. But when she left, I started to become sad again. (Hanan UD, 68P)

I feel loneliness every night. I am single and how I wished to have my own child to be with me. I used to invite my neighbour nearby to watch television programmes together and then chat. Sometimes, my friends visit me and I eat meals with them. (Farrah A2, 74H)

Engaging in social activities and staying connected with others is important to minimise loneliness and maintain a good QoL. However, there was dissatisfaction
among the participants in terms of social activities. The main reasons for their dissatisfaction included a lack of events and activities that are suitable for older women, and a limited number of elderly-friendly public spaces, such as parks and exercise areas. Maja said:

\[I'm\ \textit{a sociable person and I feel the loneliness when I don't have any activity. I really like walking as exercise, but it's difficult to find a safe and good place to walk in the Kingdom.}\ (Maja S, 75M)\]

Because of sociocultural norms, often older women’s activities are confined to the home, limiting their activity to cooking, watching television, praying, reading the holy Quran, and telephoning their other family members. Two participants said:

\[I'm\ \textit{very gloomy and sad about living alone. I rarely go out, mostly to the hospital for my doctor’s appointment only. I spend my time in watching television, praying, reading the holy Quran, and cleaning my house. Otherwise, I spend a lot of time sleeping to escape the loneliness.}\ (Sumayah A0, 70P)\]

\[I'm\ \textit{just staying at home and sleeping most of the time. To deal with loneliness, I used to telephone my children who are all living outside Jeddah.}\ (Salma A0, 66M)\]

In summary, some older unmarried women have a high level of loneliness because of their poor economic status, physical health limitations, and social inactivity. Loneliness is connected to lack of social contact, and if older unmarried women have frequent contact with their family members, they are less likely to experience loneliness and usually have a higher level of life satisfaction. Some older women needed help in performing their daily activities due to health problems. This contributed to their decline of social activity, and limited their choice of activities because they had to adjust their activities according to the
schedule and availability of their family members. Thus, loneliness was more prevalent if older women were dissatisfied with their family and social relationships, or if support from their family was not available. Moreover, because family members, especially adult children, were the major sources of social support, frequent contact with older women through regular visits to the house or telephone calls resulted in reduced loneliness.

8.7 Self-rated Health Status and Quality of Life

In this research, the majority of the older unmarried Saudi women had very poor physical health (Chapter 7). The presence of chronic illnesses was identified as one of the factors that affected the QoL of older unmarried women. Older women who reported having multiple chronic illnesses were more likely to express a low QoL. Older Saudi women believed that having chronic illnesses slowed down their routines and physical mobility. The research shows the importance of physical health to older women’s QoL. Two poor women said:

*I have nothing to do every day. I am very sick and unable to perform any activity. It’s more than enough to have my daughter around. I really feel that I am a weak person because I can’t go and visit other people. Nothing worse than getting old and I can’t assist myself.* (Talha S, 70P)

*My health is in a very bad situation because I have pain all over my body. I feel like I am dying. I don’t have any activity every day.* (Nadia S, 73P)

In contrast, according to some participants, being healthy was important because it allowed them to be more active in their life. Two higher class participants said:

*I have all the medicines I need for my health condition. Alhamdullelah (thank God), it makes me feel good if I take the medication regularly. Because of having a good health, I’ve been to many places already.* (Nayla A2, 70H)
I am not suffering from any serious illnesses because I am taking regular medication for my health condition. Being healthy and in good shape, I can perform my daily activities. Usually, I visit my small shop of house accessories daily and I could not stay at home for one day. (Hessa A1, 63H)

Socioeconomic inequalities among older women have a great impact on their health status, with poor women having more chronic illness, as discussed in Chapter 7. Therefore, income influenced the physical well-being of older women directly and also had an indirect effect on their quality of life via their health status. Many participants revealed that good health mattered for their QoL, and discussed how poor physical health made it difficult for older women to undertake activities of daily living. Thus, the study found that good health represents one of the significant contributing factors to a higher level of life satisfaction among older unmarried women.

8.8 Influence of Sociocultural Norms on Quality of Life

In Saudi Arabian society, sociocultural norms influence all aspects of the life of older women. Saudi Arabian law requires a woman to have a male legal guardian, whereby his agreement must be obtained before a woman can seek work, obtain education, travel, or go out in public. Often women are invited to social gatherings which are sometimes late at night and it would be seen as inappropriate for a woman to be with only a driver or be without a guardian at night. Often women would not go to these gatherings because of the disapproval of the males in their family. For women in this research study, their male guardian was a son, brother, or more distant male relatives, and some women did not have a male guardian. In the case of not having a male legal guardian, women may be forced into taking extreme actions in order to find a loophole or a solution to this problem.
In the Saudi Arabian context, women in general are not allowed to undertake domestic or foreign travel alone. For some women, such as Farrah, this is problematic:

*I tried to go for vacation abroad but I was not allowed to travel because I don’t have a male legal guardian. I went to my cousin and I told him in front of his wife to marry me in paper only, just to have a legal guardian, but he refused.* (Farrah A2, 74H)

In addition, strict gender segregation especially in public transportation, is one of the main reasons for women’s lack of physical mobility. Table 6.8 (see Section 6.5.1 in Chapter 6) showed the self-perceived ease of transportation for participants, resulting in the majority of the poor class (80%) having difficulty accessing transportation, which adversely impacts on their QoL. In contrast, the majority from the middle class (88%) and all high class women were able to go out whenever they wished because of easy access to transportation. Hanan from the poor class said:

*I want to visit my friends sometimes, but I opted to stay at home because of difficulties to arrange my transportation. I have to pay a lot for the taxi. Only if there is affordable transportation, can go whenever and wherever I want.* (Hanan UD, 68P)

In Saudi Arabia, there is strict gender segregation of gyms, and health and sports facilities. Health and sports clubs are prevalent for men, but there are few for women. In fact, according to a local newspaper (Al-Rawi, 2017), Saudi Arabia licensed women’s sports clubs opened for the first time in only 2013. Thus, women’s involvement in physical activities that promote health is negligible. Two participants said:
There is no life for older women in the Kingdom because there is no health clubs or facilities that exist for us. (Fadwa UC, 68M)

I have nothing to do every day because women’s movement in the Kingdom is limited and so difficult. That’s the reason why I tried to entertain myself by making telephone calls with my close friends only. (Hedayah UC, 60M)

Hessa is a divorced and financially comfortable participant who wants to remarry again, but is considering the reaction of her family and society. She said:

I am financially comfortable but socially alone in the society. I really need a companion. I loved my husband when I was 16 years old, but his family was not in favour of me. Then, I went to America for my study and when I came back, I became his second wife. I agreed, but he left me after two years. Now, I also need to have a relationship with a good man, because I am sure that he could understand me well. But then, the society will persecute me. (Hessa A1, 63H)

In Saudi Arabia, it is part of cultural norms and acceptable in the society for a Saudi man to marry more than one woman. According to Sharia Law, a Muslim man may have four wives, provided that the man can support and treat them all equally. Yet in the case of Hessa, although she is financially comfortable and well-educated, her marriage was both influenced by sociocultural norms, and the judgement of her husband’s family which resulted in divorce. Older unmarried women are discouraged from remarrying. For example, Naheed, a widow who belonged to the high class group, wanted to remarry again two years after her husband died, but she experienced disagreement with her children. She said:
Two years after my husband died, my children refused my plan to re-marry again. They thought that it will be shameful at my age. (Naheed A2, 73H)

In addition, Muzna, a never married participant who is living with her paternal aunt, experienced restrictions from her relative. She said:

*My Aunt and her family controlled my life as they prevented me to marry. They just want to keep me serving them. I’m illiterate and I don’t have any facilities to meet my friends or invite them in my aunt’s home. I’m also a poor person and my parents did not leave anything for me. I was forced to leave the apartment where my parents lived because I could not pay the monthly rent.* (Muzna R, 62P)

In summary, the influence of sociocultural norms on the QoL of older unmarried women is very substantial in Saudi Arabian society. In Saudi Arabia, the decisions about whether women can travel are often in the hands of their male legal guardian, which can substantially affect their QoL. The reputation of women is important, and Saudi society does not accept women travelling or leaving their homes without a male guardian. There is a specific law in the country that prohibits women from performing sports and physical activities in public, and the sociocultural norms further limit women’s participation in performing these kinds of activities. There are few health clubs for women. It is clearly known that to get permission to build a health club for men is easier than getting permission to build a sports centre for women. Therefore, the availability of social health clubs for women is negligible in the Kingdom.

Thus, some older women undertake no, or very limited, physical activities to enhance their QoL. Also, wearing an *abayya* (a robe-like outer-garment) is part of the religious teachings and is strictly enforced in Saudi Arabia; however, it causes restriction to women’s movements. For women, it is problematic to walk outside
as a form of exercise because the rules of society and religion forbid a woman from being alone in a public place. Walking is a cheap form of exercise, but the issue in Saudi society is not the cost it is the fact that women are controlled by gender norms in the society. Thus, social norms may impact strongly on the levels of life satisfaction of older women in terms of their social engagement and activities.

8.9 Religion and Quality of Life

Saudi Arabia is a very traditional and religious country with Islam as the state religion. Islam teaches people to accept the will of God and face difficulties, illness and any problems with patience and a strong faith. This study shows that religion is positively related to self-assessed QoL among older unmarried women in Saudi Arabia. For some older women, it provides valuable coping skills, and the mental strength to face their life difficulties. It is notable that most older women say “Alhamdullelah” (thank God), despite the difficulties they face and dissatisfaction with aspects of their quality of life.

In this research study, the participants never stated any anger about their status in life because they have been taught by religious scholars that every person in this world is given his or her place by God, and if circumstances change and improve or get worse, they must be patient, pray, read the Quran and they will be rewarded in the hereafter (paradise). Thus, religion plays an important role in affecting older women’s psychological and emotional well-being, and it even acts as a source of mental strength. Two poor participants said:

"God has protected me in the years gone and I pray he will protect me in the years to come. I don't consider myself as very old, but I am satisfied with my life as everything comes from God and I have to accept that."

(Majda A0, 60P)
Alhamdullelah (thank God), I am living with my son and his family since my husband died. I’m happy living with them and it is better than facing loneliness alone. I’m satisfied with my life and I’m praying to God to protect my children. (Talha S, 70P)

In summary, religion plays an important role in affecting older women’s psychological and emotional well-being. Islam acts as a source of mental strength for older women who are facing difficult situations in life. This is especially the case for older unmarried women who are experiencing chronic or acute illness and financial or other difficulties in later life.

8.10 Conclusion
This chapter has examined the QoL of older unmarried women living alone and living with their family members. The study found that older women who had a lower level of education, poorer financial status, poor health status, had lower levels of social support, and experienced loneliness were less satisfied with their QoL.

Socioeconomic differences are important in determining the types of social support older unmarried women receive and their levels of life satisfaction. Support in financial matters was needed more by older women from the lower economic group compared to middle and high socioeconomic women. Older women from the middle and high socioeconomic groups reported less need for additional instrumental support to perform social activities and to visit friends. A large proportion of older women in this study showed moderate to high satisfaction with the emotional support they received from their family members. Overall the life satisfaction of older women whose income levels were poor was substantially lower than for older women who belong to the middle and high class group. Although, for some older women, economic status was not the main determinant of a QoL.
It appears that family relationships and available support from family members are valued components of a good QoL. Often, the family members provided companionship and support, as well as daily help to older women. In this study, strong family relationships led to a better QoL for older unmarried women. Having a good quality of family relationships enhances older women’s overall mental health and social support; and provides a nurturing environment for them.

Greater satisfaction with QoL was observed among older unmarried women with a higher level of education, while those who had primary or no education had the lowest QoL. Indeed, having more education equipped older women with a greater opportunity to engage in paid work and provided them with adequate knowledge and awareness of the benefits of the health care system, social activity participation, and disease prevention, which may, therefore, lead to fewer illnesses compared to poor and uneducated elderly women who are less aware of opportunities provided by the government and social organizations.

Feelings of loneliness were associated with a lower QoL among older unmarried women. In this research study, if older women had a higher level of social support, they reported a lower level of loneliness and a higher QoL. Family members were the main source of social support, and played an important role in alleviating loneliness among older women. Thus, in order to avoid or reduce the feelings of loneliness of older women, an intervention to promote social engagement and having someone to talk to and to call on for everyday help are important to improve the quality of older women’s lives.

In summary, for older unmarried Saudi women, having a good QoL was found to be associated with good health, secure finances, education, and availability of family support. The findings underline the notion for older women that the combination of all these related factors is important for quality of life in later life. This finding is supported by Felce and Perry (1995: 56) who argue that ‘overall satisfaction with life may reflect satisfaction in a number of life domains such as
material comforts, health, work, recreation, living situation, relations with family, social relations, leisure, finances, religion, standard of living, friendships, education, and own self". 
Chapter 9
Discussion of Findings

9.1 Introduction
As Saudi Arabia’s elderly population continues to grow in size, understanding the quality of the lives of older unmarried women is important in order to promote healthy ageing. In particular, it is important to compare the lives of those women who are living either alone or with family members in order to shed light on their position in the city of Jeddah in Saudi Arabia. This would be the first step to opening up the way for more research on this age group of women, and developing a pressure group based on the data collected by the researcher in order to improve the lives of older Saudi women. This research also highlights the difficulties older unmarried women faced in the past, and are still facing in the 21st century.

This research aimed to explore the health status, living arrangements, educational level, economic level, and circumstances of older unmarried women by investigating the impact of these social factors on their quality of life, and developing an explanatory model of their quality of life (QoL) that is relevant to Saudi Arabian society. In order to fulfil this study’s objectives, qualitative interviews were conducted with a purposive sample of 50 older unmarried women, aged 60-75 years old, who were either living alone or with their relatives in the community.

Previous research literature indicates that QoL reflects both macro-societal and socio-demographic influences, as well as the personal characteristics and concerns of individuals. As QoL is also subjective, it depends on the interpretations and perceptions of individuals (Ziller, 1974). Bearing this in mind, the researcher interviewed older unmarried women in the privacy of their homes. Gaining admission and permission to talk to these women alone was at times an obstacle,
especially because Saudi society as a whole is very private and does not generally allow non-family members or friends to enter the home, even if that person is a woman or a Saudi national. The researcher had to gain the families’ trust before she was able to conduct the interviews, and before the older woman felt able to talk unreservedly about her circumstances. The researcher was usually alone with the older women when conducting the interviews, but occasionally another female relative was present. The questions were unstructured in order to encourage the older women to give honest and direct responses and opinions. In this respect, the researcher was able to appreciate the perspectives of various older women from different socioeconomic and educational levels on the same issue or topic in order to compare views and concerns.

Existing research on QoL in old age generally focuses on people’s perceptions of QoL (Farquhar 1995; Fry, 2000; Bowling et al. 2002), but minimal subjective research has been conducted on QoL in the Middle East and especially in Saudi Arabia, so this is a neglected area. In this study the researcher explored the experiences of older women in the context of Saudi society, including how men’s dominant position influences the QoL of unmarried older women.

In the four analysis chapters, various aspects of the lives of older unmarried women were explored to provide a better understanding of these older women and their position in Jeddah, an urban centre in Saudi Arabian society. In the Saudi context, women generally have a limited role with very little autonomy or control over their daily lives. During the interviews, the older women constantly referred to their QoL as being ‘bearable’ and often used the phrase Alhamdullelah (thank God); most came across as tolerant and believed that it was normal for women to have minimal control over their daily lives. This may be related to their religious beliefs and the sociocultural norms within the Saudi context, as discussed in Chapter 2. Older widows or women who have never married generally live in better circumstances than older divorced women.
9.2 The Four Pillars of Active Ageing

The concept of active ageing is relatively new in Saudi Arabian society. Conceptually, the World Health Organization (WHO, 2002:12) defines active ageing as “the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.” The WHO (International Longevity Centre-Brazil, 2015) in a recent study added ‘lifelong learning’ as a fourth essential component of active ageing. In the western context, these four pillars of active ageing are considered significant components of the concept of “ageing well” for older people. In my study, these four pillars of active ageing are regarded as essential for achieving and maintaining well-being in later life in relation to older women’s physical and mental health. Each will be examined in turn in relation to the findings from my study.

Active ageing is important to develop and improve the QoL of elderly people, and especially older women, in Saudi Arabia. According to this study the four pillars (health, financial security, social participation, and lifelong learning) that support older women in Saudi Arabia in achieving ‘active ageing’ are challenged by socio-cultural norms and the patriarchal context. Therefore, in this study, I have analysed the experiences of older unmarried Saudi women based on the four pillars of active ageing to determine the factors affecting their everyday lives. To date, knowledge – or even interest – has been lacking in Saudi Arabian society regarding the importance of active ageing. Thus, the following figure of the four pillars is important, as it provides a framework with which to create future plans based on my study and other scientific studies for improving the well-being of Saudi older people.
Figure 9.1 presents a conceptual model of the important elements of the four pillars of ‘active ageing’ based on the findings from my study. It shows the elements that influence older Saudi women to access the full support of the four pillars of active ageing. However, due to the restrictions they are facing, these four pillars have not been obtained by most older women in Saudi Arabia.
9.2.1 The Health of Older Unmarried Women

Health, is an important factor which affects the QoL of all older women. The research found that older women of all economic levels confirm that when they feel well and are not suffering any pain, they have a positive approach to their daily activities and tolerate any negative factors that bother them, such as their living arrangements, restrictions on their movements, or lack of income. However, the prevalence of chronic illness among the participants was very high in this study. It was measured by asking the participants whether they had any chronic illnesses which they have listed. All of the participants, apart from one, had three or more chronic diseases, and many had depression and feelings of loneliness. Almost all of the older women had chronic diseases such as obesity, diabetes, hypertension, rheumatism, and arthritis. As women in Saudi Arabia become older they do fewer activities, with even simple household chores done for them by a housemaid or a family member, daughter, daughter-in-law or sibling. They do not have the freedom to leave their homes and do physical exercise such as walking, or go to the gym. The difficulties older women encounter related to obtaining health care became very apparent during the interviews; they often complained that they were unable to easily go to a hospital or clinic, and had to wait for a male member of the family to take them to check-ups or appointments.

The life expectancy of older women at the age of 65 and above is lower than older men in Saudi Arabia, which is in direct contrast to gender differences in human life expectancy worldwide. This study has revealed a serious fact as yet unremarked by researchers or the Saudi health service; namely, that there are fewer older Saudi women (43%) over the age of 65 than older Saudi men (57%) (see Table 1.1). According to my study, older women in Saudi Arabia have an unhealthy lifestyle; they are less active, most of them have never had paid work, and they rarely do their own domestic chores which are done by relatives or maids. This may have been one of the significant factors that is linked to the lower life expectancy of older women in Saudi Arabia.
Drivers and maids are considered to be crucial for most urban Saudi families. They are often employed specifically to serve older women, and their absence has a negative effect on Saudi families as family members have their daily routine disrupted because they have to spend more time taking care of the older women in the family. Partly due to the lack of activity on the part of older Saudi women, they are prone to many chronic diseases. Because of their age these accumulated chronic diseases make them weak and suffer pain. It is different for older men in Saudi Arabia, who take part in lots of activities such as sports; they can walk outside their homes, some of them are still in paid work, and they can go independently to the hospital for consultations or hospital admittance if they are sick or experiencing pain.

In this study, older unmarried women aged 60-75 in the lowest income group had the most chronic diseases. However, older women who had a better education and were from middle or higher social classes tended to have better health. These women had easier access to health services and the financial resources to employ a driver, and were therefore able to go to the hospital and see a doctor as required and usually used private healthcare. In contrast, many older women from lower social classes were on long waiting lists at government hospitals and could not afford the high costs of visiting a private hospital. Some older woman had private healthcare insurance that was either funded by a male child, paid for by them personally, or from a previous job. These women generally had better health, but still complained that they were frequently unable to easily get hospital appointments. Women from poor socioeconomic backgrounds generally have more health problems, and there is a lack of transport to take them to hospital due to the fact that they are completely reliant on a male legal guardian to accompany them to a clinic or hospital. Some older women take a taxi to hospital, which is an extra expense that they can hardly afford. Additionally, some older Saudi women do not have health insurance that can help them in times of their sickness; because of this, they endure their sickness rather than go to the hospital due to costs.
In this study, many older unmarried women confessed to feelings of boredom and loneliness which could be attributed to their lack of physical exercise, minimal social activities, and poor health, which in turn affected their mental well-being. Many older women said they missed their traditional lifestyle, the Badia or “Life of the Desert,” and that this change from a traditional, rural lifestyle to an urban one had adversely affected their health.

9.2.2 The Financial Security of Older Unmarried Women

This study’s findings confirmed the importance of financial security in order for older women to be active in their old age, and for most participants, their economic status was one of the key predictors of their QoL. The economic status of their family influences the living arrangements, health, and QoL of older unmarried women. Most older unmarried women from middle or higher economic classes were satisfied with their lifestyles, complemented for some by their choice to live alone, which provided them with privacy and freedom. Older women who were financially comfortable could afford to have a housemaid and driver, and to travel abroad, especially the few who had some kind of autonomy over their daily lives. However, older women from lower economic classes were unable to choose their living arrangements or to have the freedom to leave their homes; this in turn affected their physical and psychological well-being. Many older women from middle or high social classes remarked that they felt like different people when they travelled abroad and were able to walk around freely and enjoy their new environment and the feeling of ‘freedom’. In addition, travel enabled them to discover that they had been deprived of their independence in the past; even if they had adapted to it, they realised that this adjustment was due to a lack of alternatives.

Most older women from the middle or higher economic classes who live alone could be considered partially independent; they cannot be considered totally independent because even though they may be economically comfortable, they still have to conform to Saudi socio-cultural norms and traditions. Many of these
older women stated that they did not want to lose the respect of their children or relatives by not adhering to the rules and norms of Saudi Arabian society. The most disadvantaged group of older women were poor women who lived alone, who were both financially disadvantaged and socially isolated.

During the in-depth interviews, a range of opinions and statements contributed to the researcher’s understanding of the effects of being financially secure or insecure, as well as the general health of ageing women. Older women from lower economic classes were prone to more chronic diseases and were more likely to be dissatisfied with their present living circumstances. These older, poorer women often expressed resentment about the fact that they did not have enough money to improve their health or living arrangements, although they would then openly show remorse and regret due to having discussed these negative feelings. From an Islamic perspective, a person should be grateful for their economic status; they should not focus on this life, but on the rewards, that they will receive for being patient and thankful for their current lifestyle.

Most wealthy older women said that they felt well respected by their children, and that they had control over their lives, such as the ability to travel and attend social occasions freely. In addition, the wealthy older women were the ones who often provided financial support to their children, and they earned greater respect and status because of their ability to support their children’s financial security. Moreover, this study discovered that older poor women who have no inheritance or pension often depend on small amounts from social insurance (1000 Saudi riyals per month, plus their electricity bills are paid for them). All the older women receiving social insurance payments criticised the amount, as it was considered to be too low and inadequate, resulting in them being unable to afford medical insurance (see chapter 7), transport, or other daily necessities. This was especially true for the study participants who lived in rented accommodation, where they or their relatives were responsible for the rent.
This study found that over half of the participants receive at least part of their financial support from their children, which is considered as “goodwill” income and was an insecure source of income. Social insurance provides money only for those who are financially incapacitated or whose monthly salary is not enough to cover their daily needs, and this falls into the category of a “welfare benefit.” Some women were financially advantaged receiving pensions or an inheritance from their deceased fathers or husbands, and such provisions are characterised as an “acquired right.” Therefore, the financial security of older Saudi women varies economically according to the source of their income, and is closely linked to their socioeconomic class. The inadequacy of financial support for many older women will be discussed in section 9.3.5.

9.2.3 The Social Participation of Older Unmarried Women

Social participation is one of the factors that enables older Saudi women to enhance their well-being, and provides the only way that these older women can entertain themselves through interacting with other people and gaining social awareness of the changes that have been happening in the society. However, in Saudi Arabia, due to the implementation of strict cultural norms and the existence of patriarchy in society, women in Saudi Arabia are not permitted to socialise in public places, for example, interacting or mixing with unrelated men. This is despite statements in the Qur’an that older women should not be socially restricted. The Qur’an states; “Such elderly women as are past the prospect of marriage, there is no blame on them if they lay aside their (outer) garments, provided they make not wanton display of their beauty; but it is best for them to be modest; and Allah is One Who sees and knows all things” (Qur’an, 24:60). This verse from the Qur’an is a special consideration for older women who have reached their menopause and do not intend to remarry; thus, according to Islamic teaching they are allowed to uncover their faces and interact with other people whenever necessary. However, in reality most of these older women, and in particular those who were illiterate, experience the same restrictions as younger
Saudi women, although they should be treated differently from younger people according to this Islamic teaching.

In this study, most of the participants never or rarely engaged in social activities outside of their homes. In general, older women were confined to their homes, thus limiting them to cooking, watching television, praying, reading the Holy Quran, telephoning family members, and attending family gatherings if they had transport. They were very limited in terms of their participation in activities in the public sphere, as women are forbidden from interacting with unrelated men in any regard. Furthermore, women are not allowed to drive, and they required written permission to travel abroad or go anywhere without a legal guardian.

In the Saudi Arabian context, religion and sociocultural norms have influenced women to limit their activities to mostly inside their homes and to only interact with members of the public if absolutely necessary. Older women from middle and higher social classes were typically better equipped to deal with these restrictions because they had drivers, and therefore more freedom to travel to different public places. However, most older women from poor social classes faced many difficulties when trying to meet their travel requirements, because they could not afford a private driver or public transport such as taxis. Most older Saudi women were challenged because of the restrictions they face in society when leaving their homes or participating in events such as religious meetings, weddings, or family gatherings. Commonly, older women were not allowed to travel alone with an unknown driver to social events or family gatherings, and had to rely on their male siblings or male children to accompany them.

In Saudi Arabia, it is considered acceptable for women to work in gender segregated workplaces or places solely for women, but many women are not allowed to work because their husband, father, or male guardian does not feel that this is culturally acceptable, or he feels ashamed to admit that they need women to work to aid their financial situation. In many Western societies, women are
expected to work and help with the finances of their family, or to become financially independent. In this study, a small number of educated participants were able to adapt and protect their rights because of their knowledge of the laws and duties in Islam, which in turn made them more aware of what they should and should not be doing. In addition, some of these older educated women enjoyed attending mixed-gender meetings in the context of their careers (although they were still restricted from attending mixed-gender social occasions such as weddings) despite being aware that they were criticised by conservative members of society. In contrast, most of the illiterate older women in this study were confined to their homes, which limited their social activities and geographical mobility. Moreover, some of these illiterate older women, especially those living alone and experiencing financial problems, also experienced isolation, depression, and sadness, which in turn adversely affected their health. Other illiterate older women living with their children or relatives had time to interact with them before or after their relative’s paid work or studies. In general, older Saudi women still take part in some social activities, although these typically occasionally occur, such as attending weddings and family gatherings, or visiting their children.

This study showed a strong relationship between being involved in activities focused solely inside their homes, and between the socio-economic class and educational level of the participants. The findings revealed that the level of social participation outside the home was lower in the lowest economic group. Older women belonging to the poorest social class experienced difficulties in accessing transport, while older women from middle and high social classes were able to go out when they wished because they had a driver or easier access to transport. A relationship between social participation and educational level was found in that older women with a higher level of education were more likely to have an active social life. Older women with better education or a college degree, were also more able to develop their skills and knowledge through reading and learning about new technology. Educated older women took part in diverse social
activities, and in addition their education helped them to enhance their status as a woman within their own family and in society.

9.2.4 Life Long Learning of Older Unmarried Women

The fourth and final pillar of active ageing is lifelong learning. Lifelong learning is defined as all learning activities undertaken throughout life with the aim of improving knowledge, skills, and competences within a personal, civic, and social and/or employment-related perspective (Yazici and Ayas, 2015:1). It is the process of an individual continuously acquiring knowledge throughout his/her lifetime. In this study, over half of the participants were either illiterate or dropped out of primary school. Most of the participants who did not finish their education were primarily confined to their homes, some of them were occupied with doing domestic work but most spent their time watching television or reading the Qur’an.

In this study, some of the participants from the middle and high social classes had finished their formal education, and most of these women who completed their formal education had been employed in paid work. Through education and being in paid work, they had a greater experience of knowing how to interact socially. However, most of the illiterate participants spent their time at home and had no opportunity to expand their knowledge or experience.

Due to modernisation, most older women are experiencing culture shock because of the rapid changes occurring in the Kingdom of Saudi Arabia. In addition, their lack of education influences older women’s adaptation and their ability to cope with these changes, particularly with the arrival of new technologies in the country. In contrast, the participants who had a formal education were able to use the most pervasive forms of technology such as computers, cell phones, and the internet.
Being involved in active lifelong learning is important for the acquisition and updating of skills, sociocultural participation, individual well-being, intergenerational solidarity, and social inclusion (Dantzer et al., 2012:5). However, in this study, due to cultural norms, restrictions from their male-legal guardians, and lack of formal education, most older Saudi women were limited in their ability to be engaged in any kind of lifelong learning and they were more dependent.

9.2.5 Summary
This study shows the importance of the four pillars of active ageing in the lives of older women in Saudi Arabia. However, achieving these four pillars was hindered because of sociocultural norms and patriarchy. Most older women in Saudi Arabia experienced difficulties in improving their health status, in sustaining their own financial needs, in being socially active, and in improving their knowledge and awareness, which in turn all had an adverse influence on their QoL.

9.3 Key Factors Influencing the Lives of Older Unmarried Saudi Women
The purpose of this study was to determine the key social factors influencing the quality of the everyday lives of older unmarried women. The impact of Saudi Arabia’s sociocultural environment on older unmarried women’s QoL has become very clear from this research. To date, knowledge about how older women in Saudi Arabia perceive their lives and experience ageing has been virtually non-existent. Thus, the results of this study will help develop programmes that will enable older women to live in an environment that enhances their capabilities, promotes their independence, and provides them with adequate support and care as they age.

This section will discuss the five social key factors that influence older unmarried Saudi women’s QoL, namely their marital status, socioeconomic status, living arrangements, educational level and social supports.
9.3.1 Marital Status

Divorced women were the most disadvantaged group of older Saudi women in all aspects. The findings show that older widowed women are financially more secure than older divorced women. Many widowed women live in their own houses and receive a monthly income from their deceased husband’s pension. Some widows have an inheritance from their deceased spouse and are satisfied with their lifestyle. These women are mentally and physically stronger than those who have a lower level of income and have to rely on their male children to provide food, medication, accommodation, and other needs, thus putting financial stress on these children.

Of the 28 widows, 19 owned their own houses and only 9 lived in rental housing. In contrast, three-quarters of the 20 divorced women lived in rented housing and only a quarter owned their own homes. Most of the widows felt that they were financially secure compared to a minority of the divorced older women. Securing their financial rights following a divorce was challenging for divorced women in this study. Although family law in Saudi Arabia contains legal rights and protections for women during a divorce, these are not generally enforced by the courts. The monthly allowance of only 1000 SAR from social insurance plus irregular amounts received from their sons/daughters, relatives, friends, and other non-governmental organisations was a contributing factor to the feelings of dissatisfaction of older women from the poorer social classes, especially those who were divorced.

The older unmarried women who were most discontented with their lifestyles were those who were divorced. Most of these women lived in rented apartments and had very low incomes. In contrast, the few divorced older women from the middle or high social class particularly who received an inheritance from their fathers were much more financially secured and they had more control and greater autonomy. In the Saudi Arabian context, a woman who is divorced or widowed has fewer restrictions and is able to make some independent decisions concerning
her lifestyle. These women typically have more freedom than when they were married.

An underlying stress factor that was noted during the qualitative interviews with older divorced women was the past behaviour of their husbands towards them, and the socio-cultural norms that expected these women to tolerate any abuse, either physical or mental, as well as the fact that it was a stigma for a woman to have to return to her father’s home after getting divorced. Many of the older women who were divorced had married at a very young age and they stated that they were expected to satisfy the needs and be submissive to their husbands as the alternative of getting a divorce was seen as a loss of family “honour.” For those women who were divorced, their family “honour” was restored if she remarried, but a second divorce would not be tolerated by the family. Many of the divorced older women’s second marriages lasted longer than their first, as they felt this was due to their maturity and the experiences gained from their first marriage, in addition to feeling under pressure to save their second marriage “at all costs.” Therefore, the older divorced women's identity was built on marriage, and they suffered, and still suffer, both emotionally and psychologically, due to their divorce as they were only taught and conditioned to be a wife and mother, and had little or no other aspirations.

9.3.2 Socioeconomic Status
Socioeconomic status was found to be very important in influencing the level of satisfaction that older unmarried women had with their life. Older women from middle and higher social classes had a superior QoL. They were more able to meet their daily needs than the participants who experienced financial stress in their daily lives. Most older women from middle and higher social classes were able to employ a housemaid and/or a driver, which helped them live independently, which in turn enhanced their QoL.
The factor that affected the mental and physical well-being of older unmarried women the most was their economic status. Older women from the poorest social class were more likely to be in bad health and suffer from multiple chronic diseases, as well as more likely to complain of boredom and loneliness. These older women had a very limited lifestyle, undertaking almost no activities outside of their home. Unmarried women with a low income had no choice about the possibility of living alone and some were forced to live with their children or a male sibling.

Some older women with a low economic status considered social insurance to be the most important source of their income, despite it being such a small amount that it failed to relieve the financial stress they had to deal with. Many older unmarried women were challenged by a limited income resulting from inequalities they had faced in society throughout their lives. Most of the older women from the poorest social class did not have a fixed income other than the sum of money they received from social insurance, and therefore they relied on help from their male children, siblings, or donations from charities. In contrast, older women from higher and middle social classes had ample incomes and many were able to travel abroad and entertain friends. Many of them lived on their own, a choice that they were happy with. Few older women from this group demonstrated high levels of loneliness or boredom.

The research findings clearly show that older unmarried women who were the most secure financially, either from an inheritance or income from a deceased spouse or father, were the same women who reported satisfaction with the quality of their lives. Most of these older women from the middle or higher social classes had private medical insurance or enough income to allow them to attend private hospitals or clinics. They had better access to healthcare services and most were mentally and physically strong, unlike women with a low economic status. Women from the high or middle social classes had some control over their lives,
whereas women from poorer social classes had no such control, and were controlled by male relatives.

In this study, children and male siblings were the primary sources of economic support for many older unmarried women. Older women from lower economic classes often felt that the money they received from this source was not adequate, but they would not consider saying this to their children for fear of upsetting them or making them feel guilty. Social insurance was also a source of economic support, and even though this was not a large amount, it helped many of the older women. A few older women stated that their economic status would be significantly improved if they could rely on the economic support from their child/children and/or siblings on a regular basis, since often this support was not regular or consistent. The stress of having to balance their budgets was also a factor in feelings of dissatisfaction with their QoL.

9.3.3 Living Arrangements

This study was designed to identify what factors in older unmarried women’s lives affected their active ageing and QoL, in particular to explore the effects of the living arrangements of older women in Saudi society. The findings showed that most women who lived in their own homes or on their own usually had a housemaid and driver, particularly those who came from the higher and middle class. In contrast, divorced women tended to live in rented apartments usually with a male child or sibling and some had no other option but to live alone.

Many older women from a high social class chose to live alone in order to have some form of independence, and those with a driver felt they had substantial control over their movements outside their homes. Some older women from the middle social class chose to live with a male child and his wife, and were satisfied with their living arrangements; they claimed to be well taken care of and they shared the driver and sometimes the housemaid with their son’s family. Respect and feelings of being cared for by their children were a bonus for many of these
older women. They were thankful for their position in the extended family and did not contemplate complaining because in general they felt fortunate.

The proliferation of nuclear family-style accommodation in Jeddah makes it more difficult for some older women to live with their families, and even in some cases forces them to live alone. Many older women from middle or high social classes receive their income from a business; either a family-owned business or one belonging to their late husband. Some of these older women own the house they are living in, and are willing to share it with their family in return for emotional and practical support. In Saudi Arabia, women living on their own is not generally acceptable from a societal perspective, and this is particularly true for older women.

In this study, it is clear that living arrangements and socioeconomic status were significant factors affecting the QoL of older unmarried Saudi women, particularly for those who were living alone. Older women, either in the high or middle economic class, who chose to live alone have a higher level of life satisfaction and QoL. Older women who were forced to live alone and in the poor class had the worst possible QoL. Moreover, older unmarried Saudi women who live with their family either in the high, middle or poor class were either satisfied or partially dissatisfied with their QoL. However, the degree of their satisfaction may vary depending on their socioeconomic class, and also on the nature of their relationship with the family member with whom they are living.

9.3.4 Education

Due to sociocultural norms and the late introduction of female education in Saudi Arabia, almost two-thirds (32) of the research participants had either no formal education or only a minimal education (see Section 5.2 in Chapter 5). Before the introduction of the formal education system in 1959, women were only taught to read the Quran, and taught basic writing and reading skills in Arabic. Usually
these women came from the middle class or were merchants’ daughters or wives. This was an accepted tradition, and many of their mothers and grandmothers had also been taught this way. As a result, many of interviewees had limited paid work opportunities. However, some older women who had been forced to drop out of school and forced into an arranged marriage expressed anger that they had not been allowed to continue their education, and stated that they felt certain that if they had continued their education they would feel more satisfied with their lives.

The women who had achieved a higher education were satisfied with their level of education. In this study, it was observed that older women with a higher level of education had a better QoL compared to those who had only primary or no education, except for a small number of uneducated women who were in the highest socio-economic group. As discussed in Chapter 5 (see Table 5.5 in Chapter 5), 11 of the 50 participants had obtained college university degrees. These older women with a higher level of education may have better social interaction skills, and are more likely to have a higher economic status as a result of primarily being in paid work. These factors enabled them to access social activities and extend their social networks within society. However, older women who were illiterate or who had only a basic education seem less satisfied with their lives and expressed feelings of boredom. In contrast, many older women who had completed their education at degree level had the choice of taking up paid work or running a small business. Other well-educated women from high or middle social classes did not work, but were able to read for enjoyment, use technology to widen their knowledge, and overall seemed satisfied and content.

The majority of the unmarried older women who were illiterate became bored as they aged. These older women were previously occupied with performing daily tasks for their husband and children. When their lifestyle changed due to the death of their spouse, divorce or their children leaving for employment or to get married, the impact of not having any family-related tasks to do on a daily basis
was keenly felt and they often became dissatisfied with their lives. However, some older women who received informal education provided by the mosque, or undertook primary or secondary level education, were satisfied with their lives and content to read the Quran or listen to the radio and watch television. This tolerance of their circumstances is a product of their culture and upbringing, which affects their perception of the quality of their lives and their overall satisfaction.

In summary, the majority of older unmarried Saudi women have poor QoL particularly those who were not able to undertake education due to traditional beliefs. Additionally, most of them were discouraged by their guardians or family members, who believed that when women reach their adolescence, they must get married and focus on taking care of their husband and children.

**9.3.5 Social Support**

Different sources of social support were crucial for the QoL of older Saudi women, including from family members, friends and neighbours. Social support was a vital component in enhancing older women’s QoL, and could decrease feelings of loneliness, improve social participation, and improve psychological well-being. Some older widows and divorced women atoned for the loss of their spouse through the companionship of their children, married sons, and their other relatives. This was less likely for divorced women, who often lived alone or with a male sibling or unmarried male child, and had poorer relationships with their family members.

Social interaction played a vital role in the well-being of older unmarried women. Social interaction included communication and meeting family members; children, grandchildren, other relatives, neighbours, and friends. In the Saudi context, women felt happy when they could often interact with their family and friends. Older unmarried women who did not have children relied on interacting with their siblings, friends, and neighbours. In Islam, there are many elaborate
texts encouraging interaction between people and their neighbours, family, and relatives. Maintaining ties with relatives is obligatory for Muslims and severing these ties is undesirable in Islam, so families are aware of not neglecting this duty.

Many noble teachings (hadiths) from the Prophet Mohamed emphasise the importance of visiting one another, maintaining cordial relationships with neighbours and friends, visiting the sick, and fulfilling the needs of one’s elders. Even older women who are illiterate or have a very basic education were taught these principles and try to ensure they abide by them. Older unmarried women felt less depressed and lonely when they interacted and socialised with others both inside and outside their homes. Often women complained and felt some dissatisfaction with their living arrangements or economic status because their male guardians prevented them from visiting family, friends, and neighbours; for example, women living with family members felt uncomfortable because they did not have a place of their own to entertain others.

The lifestyles of women and men are very different in the Saudi context compared to those in the Western world. For example, male and female siblings can share activities, sports, or similar interests in Western societies, whereas in the Saudi context, males and females do not have similar interests. Furthermore, because social events are segregated, they cannot go to public places together other than shopping malls or restaurants. Even attending a wedding together is not allowed as the men’s hall and women’s hall are separated.

For older women who do not have any children or close family members living nearby, the availability of a housemaid or a driver plays a major role in providing instrumental and emotional support. Their driver cannot live in the same building, and is provided with nearby separate accommodation suitable for a male employee; whereas, their housemaid would be expected to sleep in the older women’s home. Drivers and housemaids are almost all migrant workers, often from the Philippines, Indonesia or Sri Lanka. The housemaid often accompanies
the older woman to hospital and the supermarket, and when she visits family or friends. The housemaid assists with instrumental support and often becomes a companion and confidant of the older women. However, poor class women did not have a housemaid or driver.

Emotional support for older women came primarily through visits from children and grandchildren, and from frequent contact on the telephone and face-to-face with relatives. This support was regarded as a filial duty, and most children did not hesitate to fulfil this duty to older women in their family. The sociocultural norms in Saudi Arabia dictate that family members should take care of older women and provide all kinds of support; emotional, instrumental, financial, and social. The treatment of older people is still an important value within the structure of the Saudi family, irrespective of their economic and educational level. Family support and taking care of older people in society are considered to be fundamentally important priorities and duties. This is despite the challenges and burdens children face when they are required to look after sick family members, particularly when it is for a long period of time.

9.4 The Changing Role of the Family in Saudi Arabian Society
The changing role of the Saudi family has profoundly influenced the lives of older unmarried women in Saudi Arabia. In the past, children lived in or near their parents’ home and often worked in the family business, or within a close distance from the parental home. Many male siblings married girls from the same tribe; often the mother chose their future daughters-in-law from their relatives’ female children. Nowadays, this is no longer the norm, and older children are moving away from the cities where they were born in order to find jobs and improve their economic status, often leaving a void in the lives of their ageing parents.

Furthermore, the expansion of Jeddah city has adversely affected the mental and physical health of older women. It has led to increasing isolation due to the structure of the housing units which do not comply with their needs, for example,
some of these older women live in buildings with multiple floors and are forced to use the stairs. According to Vision’s Centre for Social Studies (2010:28), urbanism in KSA has led to older people avoiding public places as access is difficult. In turn they are distanced from their peers and the opportunities to meet with friends and family become limited.

In my research, for many older women, their children lived in another city or another part of Jeddah. For the older women in the middle or high social classes they were able to visit their children frequently, and with little difficulty, due to their financial ability to employ a driver or pay for transport, but older women with lower income levels faced many challenges when trying to visit their children. There is no public transport in the city of Jeddah, and even if a reliable system was available, older women would not use it because they would be afraid of their family members’ reaction to them going out in public just to visit their children. The cost of a taxi is very high for many women with a lower economic status, and it is often difficult to find a reliable taxi. This highlights one of the factors that causes many lower income and some middle income women to express dissatisfaction with their lives.

Some older women chose to live alone, particularly those who were middle and high class women, as they viewed it as important for their independence and QoL, whereas others chose to live with family members, as they viewed this as the “right thing to do”. There were also some adult children who lived with their ageing mother, but because of their busy lifestyles, the children were unable to provide emotional or instrumental support for the elderly parent. They showed their concern and support by providing a housemaid to help with the household chores and grocery shopping, and to assist their mother when she had to travel around the city to visit the doctor or go to family gatherings.

The change of family structure in Saudi Arabia affects older women severely; this includes insufficient time and support provided by their family. These older Saudi
women had expected to be living in an extended family setting together with their family and relatives. However, due to modernisation and the era of the oil boom, which has resulted in greater opportunities for Saudi people to migrate to the cities in order to earn money, the adult children have often migrated to work in the city, leaving their older parents behind.

9.5 The Influence of Sociocultural Norms on Quality of Life
Sociocultural norms have played a very important role in the lives of older women in Saudi Arabia, especially for women who were born over 60 years ago. The women born then were subjected to many very traditional sociocultural norms and Islamic values. A prominent example of cultural norms that influenced the lives of these older women was the belief that girls did not need any form of formal education, and that it was preferable for them to stay in their homes and learn domestic skills that would enable them to manage a household and be good mothers and housewives.

In this study, the most negative impact of these sociocultural norms is that many older women did not have an adequate income. Most did not undertake any paid work, partly because of their low level of education. These older women had limited job opportunities and were not allowed to do any paid work that required them to interact with males in the public sphere. The gender-segregated labour market is crucial and still exists in Saudi Arabia. In the Western context women with a low level of education are able to work in many different occupations such as hospital workers, waitresses, cashiers in supermarkets, hairdressers, and seamstresses, which may help them save for their old age and pay into a pension scheme. However, Saudi women do not have that choice, or the ability to make their own decisions concerning their future, as all their decisions are made for them by their male guardians as part of the patriarchal system that is still prevalent in Saudi society.
Most older women face many difficulties with transport because of gender restrictions in Saudi Arabia, and their lack of mobility remains a significant issue in the Kingdom. This study found that the majority of older women from middle and poor social classes are subject to disapproval from their children if they travelled without a male legal guardian, even if it was for something important such as visiting a doctor or a sick married daughter. The sociocultural norms dictate that women must not travel alone, and if they are obliged to travel to another city or abroad, they have to submit written agreement from their male legal guardian to obtain government permission to travel.

In contrast, some older unmarried women in the Saudi context are fortunate because their male children or male guardians are open-minded and educated enough to allow them to travel without a guardian or male family member. However, women who have guardians that are more conservative or less educated face many obstacles when they want to travel, even to another city, to visit a relative, or take part in a family event. Transport, or lack of transport, is an overwhelming issue in the lives of older women in Saudi Arabia. Older women of all socioeconomic and educational levels require transport, but unless they have their own drivers, the sociocultural norms prevent or restrict their access to transportation, thus forcing them to spend most of their waking hours in the privacy of their homes. In Western society, women are able to travel freely and do not require permission from any family member in order to travel locally or abroad, which is a luxury in the eyes of Saudi women.

9.6 Conclusion
This study has examined to what extent the four pillars of active ageing supported the lives of older unmarried women in Saudi Arabia. These four pillars of active ageing are namely; health, financial security, social participation and life-long learning. Although these pillars could enhance older women’s daily lives, due to conflicts with socio-cultural norms and the Saudi family system, they could not be achieved by most older unmarried women in KSA.
This study found that most of the poor class participants who were living alone expressed their life satisfaction negatively. These older unmarried poor women had a lower level of education, with little or no income of their own, and received irregular financial support from their adult children and relatives. Although the financial support given to these older women may have been relatively small or irregular, it was found in this study that the level of emotional support from and relationships with their families had a crucial positive influence on their level of satisfaction and their QoL.

Historically, women in the Saudi context have always perceived that their role in the home is to provide love and care for their husbands, children and/or siblings. In return, they believe that the males in their family, particularly their sons, will provide for them financially, especially in times of financial difficulties. However, due to societal changes that have happened, this traditional belief has not been fully observed by their adult children, mainly because of their family responsibilities and secondly, living in an urban city results in higher expenses compared to living in rural areas. Furthermore, older women are dependent on the males in their families if they have to undergo any medical procedures, and if they wish to travel to another city or abroad. In the event that their male legal guardian is living in a different city, older women are expected to wait for him in order to obtain his approval, which in turn further affects their health and access to medical appointments, surgeries or doctors. Often, older women who do not have any form of pension or money from an inheritance are totally dependent on their male family members.

My findings show that family support is one of the main factors that enhances the QoL of older women. Family members, especially children, are the main source of social support. Although some older women from a higher social class led more independent lives and could live on their own with the aid of one or more housemaids and sometimes a driver, the importance of emotional support from
their children and other relatives was still substantial. Their children entertained them even when they were busy with their work, and some older women who were living with their family stated that they were content and felt privileged and did not feel they were a burden. Older women typically had the view that they had sacrificed a lot in order to protect their children and families, and as a result they should be compensated as a religious duty and a moral right.

Family fragmentation due to some older unmarried women’s adult and married children migrating to other cities, has had a substantial impact on older women’s living arrangements and quality of life. This fragmentation has influenced family structure in Saudi Arabia, and is eroding family relationships. Nevertheless, in this study, traditional family values still strongly influence older women; as for the majority of women, their adult children were the main providers of social and financial support, and housing in many cases.

The researcher had not anticipated some important findings such as the negative impact of the lack of education, and how socio-cultural norms and the patriarchal system had such a strong influence on the QoL of older women. Despite the complete separation between the genders in the past and how it negatively affected older Saudi women, some of the participants were indignant at the possibility of gender-mixing, and they did not encourage it nowadays. In addition, a key problem faced by both widowed and divorced participants was the loss of their husband, which often caused strong feelings of loneliness.
Chapter 10
Conclusions and Recommendations

10.1 Introduction
This study examines the quality of life (QoL), social support, and family relationships of older unmarried Saudi women living in Jeddah city. In particular, the study explores the gender-related issues, sociocultural norms, and family structures influencing their well-being and QoL. In addition, this study investigates the factors that either support or do not support older unmarried women in Saudi Arabia in maintaining their QoL. By addressing these research issues, my study contributes empirical knowledge about this specific age group (60 - 75) of older unmarried Saudi women living in Jeddah city in particular and Saudi Arabia in general and also provides a better understanding of their experiences and how these affect their QoL, both past and present.

As discussed in Chapter 4, the methodological approach was a qualitative, in-depth, unstructured interview in order to acquire rich and substantial data on the reality of the QoL of older unmarried Saudi women. In particular, I focused on my participants’ living arrangements, marital status, health, socioeconomic status, education level, and main sources of financial support. Moreover, my research was designed to compare the situation of those who were living alone and those who were living with their families, either with children or other relatives.

In this final chapter, I discuss the key findings of my research using some of the conceptual frameworks discussed in Chapter 3, such as intersectionality theory, modernisation theory, patriarchy, gender segregated lives, gendered cultural norms, and structured dependency. This chapter provides recommendations for further research as well as recommendations to be undertaken by authorised officials to improve the situation of older unmarried women in Saudi Arabia.
The four analysis chapters (Chapters 5–8) examined the different factors affecting the well-being and QoL of older unmarried Saudi women. Chapter 5 focused on the educational and socioeconomic resources of older women. Chapter 6 explored the different types of social support that older unmarried Saudi women have received. Chapter 7 examined the reality of their health and access to the health system. The final analysis chapter explored how socioeconomic status, living arrangements, and other social factors contribute to the overall life satisfaction and the QoL of older unmarried Saudi women.

Based on these analysis chapters, this study firstly concludes that gender segregation in Saudi society has the most powerful influence on the overall QoL of older unmarried Saudi women. This key conclusion is discussed first and is linked to the five further conclusions: (1) Older unmarried Saudi women have a high level of dependency socially and instrumentally, and many are also dependent financially on the goodwill of their children or other relatives. (2) The health of older unmarried Saudi women is poor and many suffer from multiple chronic diseases. (3) Older divorced Saudi women are very likely to experience financial disadvantage and social isolation. (4) Lower class and many middle class older unmarried Saudi women who live alone are dissatisfied and suffer from depression, isolation, and loneliness. (5) Urbanisation and changes in family structure represent sociocultural changes that have shocked and adversely affected the QoL of older unmarried Saudi women. Each conclusion is discussed in turn.

Intersectionality theory is highly relevant as a means of explaining the intersection of multiple factors affecting discrimination against Saudi older unmarried women as found in my study. My study identifies three main factors as the primary elements contributing adversely to the social position of Saudi older unmarried women: (1) education, (2) socio-economic class and (3) marital status. Additionally, Saudi Arabia’s culture and traditions have subordinated women to their make-kin, as well as restricted their decisions and geographical mobility. The intersection of these societal factors has helped create a situation in which
most Saudi women have limited control over their finances, lack independence in decision-making, and are denied their rights to education.

### 10.2 Influence of Gender Segregation in Saudi Society on QoL of Older Unmarried Women

Saudi society has been strongly influenced by traditional and religious Salafi conservatism. Adhering to this culture has affected the position of Saudi women in society. The practice of gender segregation has severely restricted Saudi women’s involvement in education and work opportunities (HRW, 2016). In this study, only 22% of the participants had finished at least a college degree due to the strong implementation of gender segregation. These older women were in the middle or high socioeconomic groups and either studied abroad or inside the kingdom. In addition, the parents of these older women were influenced by other cultures, which led them to allow their daughters to partake in higher education. The remaining 78% of the study participants either did not undertake formal education or dropped out from primary, secondary, or tertiary education because of the strong beliefs of their parents that women should prioritise getting married and being good wives and mothers for their children.

The practice of gender segregation strongly influenced the participation of older Saudi women in paid work. Most of the participants who had completed higher education had also participated in the labour force, and this work provided them with financial benefits after their retirement which assisted them in their daily necessities during their later life, particularly when they became widowed or divorced. In contrast, Saudi women who did not participate in paid work had limited financial resources later in life, especially for those women who were in the lower and middle socioeconomic groups.

The study participants did not complain about gender segregation in their past lives; they adapted to life away from men except for their guardians. Some of the participants complained about the current relaxing of gender segregation and
expressed anger during their interviews about their daughters and granddaughters in relation to work. Some stated that it was inappropriate for their daughters or granddaughters to have interactions with the opposite sex in the workplace. In their minds, even innocent mixing with men was haram (taboo) and not acceptable, customarily or religiously. All the participants showed active obedience to their guardians’ instructions and took their guardians’ directions for granted. Thus, gender segregation was considered the strongest concept and an important substructure in Saudi society—in the past and still in the present—which restricts the social lives, physical activities, and geographic mobility of older women. The patriarchal system represents a superstructure that underlies the application of extreme gender segregation in Saudi Arabia.

Nevertheless, it is important to distinguish the differences between the implementation of gender segregation in the past and the present. Whereas the study participants experienced the extreme application of gender segregation at a young age, understanding Salafism as discussed in Chapter 2 is vital in recognising Saudi social identity as well as understanding the segregation of the genders in Saudi Arabia, because the current gender segregation practice in Saudi Arabia has been ‘cultured’ within the medium of Salafi religious and political ideological discourse (Alhazmi & Nyland, 2015:90).

Gender segregation is the strongest norm that exists in Saudi society and has obstructed the lives of Saudi women. As stated by Stamper et al. (2000:1), a norm is more like a field of force that makes the members of the community tend to behave or think in a certain way, and shared norms define a culture or subculture. Cultural norms are major factors affecting gender equality in any society, and as discussed, Saudi society has very conservative rules and regulations which affect every aspect of Saudi life (Alsaleh, 2009:125). The application of gender segregation in Saudi society is based on the ideology of gender-specific roles for men and women, boys and girls, in Saudi Arabia.
In the past, strict gender roles were applied in Saudi society; women were expected to be at home and were responsible for domestic work. According to Walby (1990:91), “socialisation is considered to take place primarily during childhood, during which boys and girls learn the appropriate behaviour for their sex”. In this study, the participants were taught very gender-specific activities due to their cultural and traditional norms. Elkin and Handel (1988) argued that the family is usually the first unit with which children have continuous contact and the first context in which socialisation patterns develop. According to Frone (2015:11), parents transmit cultural patterns to their children, and shadows of these patterns influence the children as unconscious norms, beliefs, and imaginations. The cultural and traditional practice in giving specific gender roles to children affected older unmarried Saudi women in their early days; these women were unprepared for independence, and they did not have the experience of socialising with other people except their family members. As a result, older women in their early life were secluded socially, which weakened their capabilities both physically and mentally. They also had the attitude of being submissive to men because these women have habitually applied the teachings and rules given by their guardians, and such influences have decreased the level of their autonomy.

Bhandari, Kutty, and Ravindran (2016) found that in Nepal, the education status of women is a key predictor of women’s autonomy. Additionally, Fuseini, and Kalule-Sabiti (2015:1832) stated that in Ghana, culture and religion are intertwined, and cultural practices have been demonstrated to influence women’s autonomy. In Saudi Arabia, there is an intense level of compliance with cultural norms, evident particularly in beliefs about women’s place being restricted solely to the domestic sphere. This common belief affected the early lives of these older unmarried Saudi women, which in turn affected the autonomy of these women in later life. Moreover, Saudi society has a strong belief that marriage is the only way to protect women’s chastity and honour. Most of the participants who were uneducated or did not continue their education said that their family was focused
on their marrying a good man and bearing children. Therefore, Saudi society, particularly in the past, emphasised following their sociocultural norms and traditions, which have led women in this society to become dependent on their male kin.

In this study, as mentioned earlier, only 22% of the women obtained any college or higher education due to the strong implementation of gendered cultural norms in Saudi Arabia. The arguments about girls’ education in Saudi Arabia were similar to those launched in the West before the widespread establishment of girls’ schooling; schools were considered unnecessary for girls’ future as wives and mothers and would damage their morals (Zuhur, 2011:233). This perspective was one of the factors that influenced the minds of the male Saudi guardians in discouraging their daughters from embracing education in the 1950s and 1960s. However, the more educated participants self-reported that they received great encouragement from their guardians in achieving their respected educational degrees. One of the reasons for this supportive attitude is that their guardians have taken business trips abroad and spent more time outside the Kingdom of Saudi Arabia. Commins (2015:52) stated, “the first step to educate Saudi girls came during the 1930s, when affluent families began to spend extended time in Egypt and Lebanon, where they would enrol their daughters in school.” Thus, contact with other cultures opened the minds of some male Saudi guardians about the importance of education for their daughters, which contributed to enhancing the autonomy of some older Saudi women.

For many older Saudi women, the results of gender segregation—the practice of being isolated, uneducated, and unemployed—included total dependence, particularly financial dependence, on their family, especially their male guardians (which will be discussed fully in Section 10.3). My findings in Saudi Arabia are unlike in Morocco, where CNDH (2015) found that older women participated in the labour force, although they faced discrimination in the form of pay inequalities. Additionally, Joseph and Nagmabadi (2003:1) pointed out that older
women in Egypt have become more economically active by participating in paid work in later life. Although these Middle Eastern countries had a history of gender segregation, the early influence of western culture created great societal change which provided some empowerment of women in their countries, unlike in Saudi Arabia.

10.3 Dependency of Older Unmarried Saudi Women
This study found that older unmarried Saudi women had a high level of dependency, influenced by the cultural norms and traditions that exist in Saudi Arabia. As Townsend (1981:9) argued that the society creates the framework of institutions and rules within which the general problems of the elderly emerge and, indeed, are manufactured. Additionally, Baltes (1995:14) defined dependency as a characteristic of individual behaviour (e.g., accepting help, being passive, asking for help). Baltes elaborated on this definition of dependency, stating that dependency is the outcome of a learning process. The cultural and traditional roles, as discussed in the previous section, were strictly followed by Saudi society and taught by the male guardians to their children. The nature of the role of women in Saudi society is to depend on their male kin, primarily for financial support and decision-making, and these women have habituated their whole lives to this role, which caused them to decrease the level of their autonomy. As stated by Khan and Ram (2009:1), while women's autonomy is conditioned largely by gender stratification and patriarchal authority in the society in which they live, education can increase women's autonomy. Most of the study participants were uneducated, which contributed to the loss of their autonomy and their heavy dependency, particularly on their male kin. The control of older women by their guardians has become a habitual tradition and cultural norm which has decreased Saudi women’s level of autonomy.

The nature of Saudi culture, particularly in the past, made these women dependents. The patriarchal system in Saudi Arabia is the key factor contributing to the dependency of older Saudi women. The male’s authority affects all aspects
of the family (Sonawat, 2001), particularly in the lives of women under male guardianship. Every decision should be made according to his will. Demir (2015:56) stated that according to the patriarchal mentality, women should be good at home duties and pleasing their husbands. He also added that according to the patriarchal mentality, education for women was necessary only for doing domestic duties well. This kind of mentality from the male legal guardians was reported by most of my participants.

In Saudi Arabia, as stated by HRW (2016:64), society prefers to negotiate with men, and therefore it is difficult for women to buy or rent property without a male relative; as a result, a woman cannot establish her own business without her guardian’s permission. Therefore, as Neal (1999:334) argued, “women’s lack of opportunities for personal and career development is a serious stumbling block to the achievement of equal opportunities for men and women, a gross waste of talents, skills, and abilities and helps to maintain men’s perception of women’s traditional role”.

In this study, older unmarried Saudi women were socially dependent, particularly on their family members. Due to the restrictions imposed by their fathers in participating in education, these women were prevented from having social interaction with different people, and their social lives were limited to interaction inside the family. These women have accepted this kind of living situation in the past, especially those who did not attend school. However, when these women became widowed or divorced and most of their children also needed to leave them because of education or paid work, these women were left without options.

Older unmarried Saudi women in this study were also instrumentally dependent on family members due to traditional Islamic beliefs about respecting the elderly, chronic illnesses that affected their mobility (which will be discussed in Section 10.4), and the employment of maids and drivers by Saudi families. From their early lives, a Saudi woman is obligated to be responsible for household chores
However, once they become a grandmother, their position in the family is taken into consideration. The young Saudi women or the maids take over the household chores because of their respect and normative obligations to take care of the elderly in their family.

A few of the participants in this study who were living alone, particularly those in the upper class, were satisfied in their lives due to the independence that they were experiencing. The influence of education, paid work, and financial stability helped these women to have greater autonomy. These women have all the means to survive independently; however, there are some factors which make them only partly independent. The structure of the system in Saudi Arabia did not allow them to be fully independent. Because women cannot drive in Saudi Arabia, they must rely on their drivers to provide this service for them, and they still had to rely on the permission of their male guardians to travel abroad.

The dependency of older unmarried Saudi women in this study is directly related to the patriarchal system, traditions, and religious beliefs in Saudi Arabia. This group of 60- to 75-year-old Saudi women experienced the greatest restrictions in their early lives, as discussed in Section 10.2, which developed their dependency from when they were young to their current age. Nonetheless, the only social factor that supports these older women is the Saudi belief that older people have a high position in society, as discussed in Chapter 2. Al Khateeb (1987) stated that as Saudi women get older, their status and participation in decision-making in the family increases. The cultural ideology is that older Saudi women are a symbol of honour and dignity or reputation of the family; they are respected and valued by each member of the family and society.

### 10.4 Poor Health and Chronic Diseases of Older Unmarried Saudi Women

This study showed that many chronic diseases associated with ageing are common and widespread amongst older unmarried Saudi women. The previous studies in Saudi Arabia, such as Jarallah and Al-Shammari (1999) and Ibrahim,
Ghabrah, and Qadi (2005), reported that the higher the age of a Saudi woman, the poorer her health, but previous research did not examine other factors associated with older women’s health. My study found that education plays a vital role with regard to the health status of older unmarried Saudi women. The more literate they were, the fewer chronic illnesses they had. According to Haley and Andel (2010:386), people with more education simply have more knowledge about the benefits of being physically active. However, socioeconomic status of older Saudi unmarried women was not a significant factor affecting their health, despite being in the high or middle class and having a strong economic status which granted access to better health services such as personal medical insurance.

In this study, one of the main factors affecting the health of older Saudi unmarried women was their unhealthy lifestyle, particularly physical inactivity. Health status depends on the everyday lives of the women—what they eat, how they lead their lifestyle, and their level of physical activity—to neutralise the effects of ageing for as long as possible (Purath, 2006). In Saudi Arabia, Jarallah and Al-Shammari (1999) reported that the two greatest factors associated with the poor health of older Saudi women was the inability to perform standing prayers and the total number of diseases diagnosed. Haley and Andel (2010:375) stated that the positive role of physical activity in promoting functional health, delaying or preventing the onset of disease and disability, and reducing mortality has been well established. Thus, physical activity for older women could improve their health condition and minimise the effects of their chronic diseases.

As discussed in Chapter 2, women’s activities in Saudi Arabia have been limited because of cultural norms. Participants in this study spent most of their lives indoors, and the only specific healthy tasks these older women did was preparing food. When visiting relatives, transportation was via car, even if nearby. Additionally, the presence of maids in Saudi families has created inactivity and affected older women’s health. Previous research focusing on the lifestyle of women in Saudi Arabia reported similar findings to my own. Alshaikh et al.
reported that physical inactivity of Saudi women was high and that the influence of cultural norms on the lives of older unmarried Saudi women has substantially contributed to their physical inactivity, which adversely affects their health status. This contrasts with older women in western countries. For example, the study by Pantelic et al. (2012) found that older women across Europe have a sufficient amount of physical activity, particularly relating to housework, leisure, and walking. Physical activity of an older woman may enhance their physical health and avert the possible chronic illnesses associated with ageing. As Gregg et al. (2003:2384) found in their UK study, physical activity works as much by slowing decline, enhancing recovery, and extending life in those who already have chronic conditions as by preventing the onset of new diseases.

Mobaraki and Soderfeldt (2010:117) state that a Saudi woman cannot be admitted to hospital without her male guardian and is not allowed to give her own consent for an invasive medical procedure. Thus, it is difficult for an older Saudi woman to be admitted to a hospital until her guardian approves and gives his consent for her to visit a doctor. However, according to HRW (2016, 75-76), recent health regulations in Saudi Arabia do not prohibit women from receiving health care without a guardian’s consent. A 2014 medical code of ethics prepared by a state institution declares that a woman’s consent should be sufficient to receive health care. It also added that guardian permission is normally required for certain medical procedures such as surgery at hospitals, but in cases of emergency, other male relatives may approve a surgical operation, or the hospital may proceed without male permission. However, because of habituated dependency of older Saudi women on their male guardians, they cannot make decisions on their own, particularly about their health, without the advice or consent of their male legal guardian. A similar situation appears in Nepal, where women commonly have less power and autonomy than men in making decisions about their own health care (Acharya et al., 2010). Due to their habitual dependency on their male kin and their low level of autonomy, as discussed in the previous section, most of the study participants do not make any decisions for themselves or even visit a
hospital alone. Autonomy is considered essential for decision-making in a range of healthcare situations, from health care seeking and utilisation to choosing amongst treatment options (Osamor & Grady, 2016:191). Furthermore, some of the participants reported that they had a difficult time consulting a doctor due to the lack of physicians in Saudi Arabia (Almalki, Fitzgerald, & Clark, 2011). As a result, some of these participants did not go back for their follow-up check-up, which negatively affected their health.

Overall, the health status of older unmarried Saudi women is strongly influenced by sociocultural norms. For one example, women of this generation were unable to walk alone in the streets as a form of exercise. The situation has changed now in Saudi Arabia, and women now have special places to walk, such as shopping malls and theme parks that can women access and that are structured for maximum surveillance of visitors and consumers (Le Renard, 2014). However, the ingrained cultural and traditional norms in these senior women—that women should only be inside their homes—limit these women’s access to the outside sphere that could help them to be more physically healthy. Additionally, with the introduction of housemaids, older unmarried Saudi women decreased their household duties and became more inactive, which adversely affected their physical health. Promoting healthy lifestyles and awareness for older unmarried Saudi women will be a key element in enhancing their QoL. However, comprehensive cultural and environmental changes are likely required (Albugami et al., 2015:201) to allow older women to undertake various physical activities that could enhance their health.

10.5 Financial and Social Problems of Older Divorced Saudi Women
My study highlights the plight of older divorced Saudi women, most of whom were living in poor conditions. According to Bourassa, Sbarra, and Whisman (2015:497), divorce is a stressful event and is associated with negative outcomes in the US. In Saudi Arabia, being a divorced woman and being called divorced
causes shame from society. The pressure from families because of this shame affected the QoL of the divorced Saudi women.

Furthermore, my study found that those in the worst situations in financial and social situations amongst participants were the divorced older women. In the US, Haider, Jacknowitz, and Schoeni (2003) reported that the most important financial support available to elderly divorced women were social security benefits and pensions. Among older divorced women in the US, social security income represented more than 50% of their income in 2012 (Women’s Bureau, U.S. Department of Labor, 2015:4). However, in Saudi Arabia, because of several reasons such as early marriages, late start of education and the restrictions of their male legal guardians in accessing education and paid work, women’s status as divorced often leads them to poverty. Some exceptions in my sample included a few divorced older women who had high economic status and received an inheritance from their father that helped sustain their daily living.

For some of my participants, the shame of being divorced had such a negative impact that often the participant agreed to remarry to avoid the stigma. Although divorce carries fewer stigmas within today’s Saudi society, my older Saudi participants were under a great deal of stress because of negative attitudes towards divorced women. In Turkey, the number of divorces has increased, making divorce more acceptable in the society, but as Kavas and Unduz-Hosgor (2010:120) stated, this does not mean that negative attitudes have disappeared and divorced people escape blame and judgement. Additionally, the researcher added that women still feel that they are held accountable and blamed for their divorce, and divorced women in particular feel this pressure.

Divorced women in Saudi society are not allowed to be the guardians of their children. They cannot make decisions concerning their children’s welfare or futures. Furthermore, divorced older Saudi women do not inherit anything from their ex-husbands. Many of my participants did not own their homes or have any
assets, which made them vulnerable to poverty and stress, and they felt deprived. In contrast, older widowed Saudi women have the important privilege of taking care of and making decisions for their children’s futures and welfare. Additionally, many of the widowed participants lived in their own homes and were financially stable because of the inheritance from their late husband, unlike the divorced participants.

10.6 Effects of Socioeconomic Status and Living Arrangements on Mental Health and Well-Being

This study reveals that socioeconomic status affects the psychological well-being and QoL of older unmarried Saudi women, particularly those who are living alone. Similarly, in the US, Ross and Mirowsky (2006) confirmed that disadvantaged socioeconomic status and depression are highly associated, and surveys in European countries (WHO, 2014) found that depression is associated with material disadvantages. In this study, older unmarried Saudi women in the lower class who were living alone were more likely to suffer from depression and had poor QoL. As discussed in Section 10.2, these older women had not undertaken paid work, and their financial burdens caused them to be more depressed. These older women primarily depended on social security and goodwill income from their children; participants complained about having insufficient amounts of money necessary to sustain their lifestyles. Additionally, chronic illnesses affect their everyday activities, increasing dependency on their maids or relatives to do things for them. As stated by Kim et al. (2013:4), physical disabilities often prevent people from engaging in leisure activities and seeing friends and family members, and such ailments can lead to loneliness and social isolation. Therefore, the participants’ physical inactivity was connected to their psychological well-being; the more they were physically and socially active, the better their psychological well-being. Thus, older unmarried Saudi women who are poor and living alone may be one of the most disadvantaged groups in Saudi Arabia. Their living arrangements, poor socioeconomic status, and chronic illnesses affect their psychological well-being and QoL negatively.
The major causes of depression for these women include divorce (O’Connell Corcoran, 1997) and loss of interpersonal relationships with family members (Beattie, 2005). Loneliness can be viewed as a subjective measure of one’s state of mind and the negative feelings about one’s level of social contact, often involving an unwanted discrepancy between existing and desired relationships (Lim & Kua, 2011). Townsend (1968) argued that the concept of living alone and loneliness are not the same things. Being alone does not necessarily cause feelings of loneliness, but it may provide vulnerability to loneliness. In my study, many middle class older Saudi women who were living alone suffered from loneliness due to the memories of their past, particularly related to their previous husbands, experiences in their previous jobs, and social interaction with their children. Additionally, the absence of or infrequent social interaction with their children often causes them to be lonely. Although most of the participants who had maids were living with them, and they had some leisure time for walking, going to shopping malls, and meeting with some of their friends, their relationship with their family members was weaker than they would wish, and this limited contact with family members resulted in their loneliness.

Several studies have shown that loneliness and depression are associated with poor QoL (Mellor et al., 2008; Caccioppo, 2006; Chou & Chi, 2004), and increase the problems associated with both physical and mental health in elderly people (Cornwell & Waite, 2009; Hicks, 2000). In this research study, living alone for a poor older unmarried Saudi woman was not a successful living arrangement due to their habituated dependency upon male kin plus the financial burden that participants were experiencing. Strong attachment to their family members may ease the situation and provide a much better experience in their daily lives.

10.7 Adverse Effects of Urbanisation on the QoL of Older Unmarried Saudi Women

Srivastava (2009) stated that urbanisation resulted in the movement of young people from rural areas to urban areas. Rapid urbanisation has also created many
economic opportunities that have profoundly affected Saudi society. Many people were encouraged to migrate from rural and Bedouin areas to urban areas to find employment (Assead, 2007). Often, fathers were forced to move their families to an urban area near their workplaces. The structural system of the city as a whole reduces local community relationships, thereby often turning each individual’s life towards greater solitude (El-Haddad, 2003:2a). Therefore, these structural changes in the environment and family relationships often provided a severe burden for the older women. In rural areas where they lived in the past, it is easy for them to visit their relatives and interact socially. The urban areas provided a different environment than their past habituated style of living. In summary, urbanisation affected the traditional family by replacing patrilocally extended families with nuclear families (Moghadam, 2010:27). As a result, older women have experienced difficulties in seeking support from family members which had been very stable when they lived in an extended type of family.

The societal modernisation process imposes new demands and challenges on older adults (Bai, Lai, & Chow, 2016:1), particularly in their geographical mobility. My research found that older unmarried Saudi women were not comfortable with the societal changes that had happened in their lives and most still longed for an environment akin to the one they had when living in rural areas during their earlier lives. In this study, older women had been affected by these changes; in particular, their social interaction with their children was lessened because their children attended education or paid work.

Modernisation theory is significant to the findings of this study, which describes how societal changes affected the lives of older Saudi women in the past, as well as how these changes affect older Saudi women’s lives today. Changes that occurred during the era of the oil boom, as well as internal rural-urban migration and changes in family structure, have caused radical alterations in their environment. These changes created a ‘culture shock’ for older women, which has not only made them more dependent on the people surrounding them but also
restricted them due to Saudi Arabia’s cultural norms. Thus, as suggested by Cowgill and Holmes (1972), a primary reason why older people lose their power and influence in society relates to the parallel forces of industrialisation and modernisation.

10.8 Strengths and Limitations of the Study
No previous study examined the QoL of older Saudi women aged 60–75. Prior studies, such as Albugami et al. (2015), about older Saudi people focused on the general health and chronic diseases amongst this entire demographic. This study specifically focuses on older unmarried Saudi women living in Jeddah city. It is possible that older unmarried Saudi women living in other cities in Saudi Arabia would respond to the questions differently than these study participants. Therefore, the current findings are not generalizable to other cities in Saudi Arabia. Additionally, the study focused on older women who were unmarried. Thus, the findings do not represent married older women in Saudi Arabia and also did not represent anyone over the age of 75. Hence, future research is needed on older married Saudi women to investigate the factors affecting their QoL and to understand the differences of their ageing experiences compared with widowed and divorced older women. The goal of my study was to explore the factors affecting the QoL of older unmarried Saudi women, about which there has been no previous study.

I felt it was important to interview these older women in their everyday environment in order for me to better understand the current environment that they were living in and to enable my participants to feel more at ease. For example, during the interview, in case of emergency, they were immediately able to take medicine that they needed. However, this effort meant that I had to spend more time with participants because of the hospitality that was given and the frequent interruptions from relatives present in their houses who often gave irrelevant answers to my research questions. Interviewing older women in a separate location could have taken less time, and their hospitality and family
interruptions could have been avoided. They could have provided more precise answers for my research questions rather than detailed stories which were sometimes irrelevant and increased the length of the interviews.

The qualitative interview helps me to obtain in-depth data which portray the older Saudi women’s QoL. The use of an audio recorder was essential in my interviews, because as the older women became more comfortable, they tended to deviate from the topic and spoke about other issues; with the assistance of the recorder, I was able to listen to the various dialogues and subsequently delete irrelevant material. However, the recorder was a problem at times due to the reluctance of some of the participants to have their voices recorded. This reluctance by the participants affected my stress levels. Ethically, I had asked the participants before I started the interview if it was acceptable for the conversations to be audio recorded. However, a few participants apologised and refused to answer my research questions before the start of the interview because of the audio recorder.

There is one very significant point that I would like to emphasise: a strength of this study is that I interviewed older Saudi unmarried women from all economic levels: high, middle, and low class. During the pilot interviews, I initially wanted to divide the participants equally into these three economic levels, but it was not always easy to differentiate between the various economic classes based on the housing structure, design, and furniture of the participants; therefore, it was difficult to categorise the participants equally into the three economic levels. However, the poor class was obvious from their low economic level. In particular, the gatekeepers and I found it difficult to distinguish between the high and middle classes. Therefore, I recommend that future researchers should telephone their participants before the interview and ask some specific information, such as their name, age, and socioeconomic class, as an initial reference of the participants. However, in Saudi society asking such specific personal questions about income levels may be too sensitive and not seen as acceptable. To determine the participants’ socioeconomic class, I based my assessment on the participants’
self-reported answers from the interview questions related to their monthly income.

10.9 Future Research
I analysed a wide range of aspects of older unmarried Saudi women’s lives in order to obtain a detailed picture of their QoL. I feel this was successful, but it was stressful and tiring to analyse each aspect. Therefore, I recommend that future researchers focus on only some specific factors and use my study findings as a data resource. First, future researchers should concentrate on the health factors, because these older Saudi women have multiple chronic health conditions and health is critical for QoL. Second, research needs to compare the life of older unmarried Saudi women with older married Saudi women. Third, it is important to conduct research that will provide information about the health care facilities available for older women and to assess their perspectives about these health facilities.

Finally, researchers should focus on the implementation of lifelong learning activities. It is important, as suggested by Al-Megren et al., (2011), to “promote research and development in the areas of adult education and lifelong learning by strengthening existing research and development centres of lifelong learning”. At present, publications about lifelong learning in Saudi Arabia are mostly based on the opinions and suggestions from western countries, the studies should be based on the needs and real situations of older Saudi women as these experiences are not similar to the situation of older women in the West. Future researchers should also take advantage of the research centres, universities, and medical facilities of the Ministry of Health to contribute to advancements in health and medical sciences that will help older women.

10.10 Recommendations
Based on the findings of my research, I recommend that the Saudi government should focus on special residential areas to incorporate units suitable for older
Saudi women. These units should be complete with facilities for entertainment and also designed for disabled women or women in poor health. There should be a comprehensive health insurance system for older Saudi women which includes health insurance, may include nursing, personal, and domestic services as needed, and is equivalent to the system recommended by the European Commission in 2010 to improve the sustainability and efficiency of social and health care systems (Commas-Herrera et al., 2010).

The Saudi government should provide free day centres and long-term care facilities staffed by specialists, such as graduates of sociology and psychology, therapists, nutritionists, and doctors, to guide older people, examine people individually to identify their needs, and take any necessary actions that could improve their health. In European countries, this has been a policy priority; as stated by WHO (2008:6) “primary care (such as home-based nursing services, hospital, and hospice-at-home care) is seen as central to ensuring the quality of life, and this has been coupled with a shift of resources from acute and long-stay beds to community care within the health and social service systems.” Providing greater attention to issues related to the health of older people in the media and highlighting them through programmes and advertising are high priorities. A study by Ibrahim, Ghabrah, and Qadi (2005) recommended promotion of healthy lifestyles and behavioural changes through the introduction of a community-based health education programme for the elderly in Saudi Arabia.

Additionally, the community as a whole needs greater awareness about the requirements of older people, in particular the physical and psychological health of elderly people. Following the recommendations of the Brasilia Declaration, Myers (2012:4) advocates for “health awareness and early screening programs that address the needs of ageing beyond diabetes and hypertension and include prevention and enhanced care for degenerative disease of older persons.” Families should be provided with awareness and training on how they should support and care for older Saudi women in order to help them engage in activities that
contribute towards their overall QoL. A family member or a volunteer should provide older women with assistance in using technological innovations and in acquiring knowledge about nutrition to ensure that they have a healthy and proper diet. As recommended by Perez-Cuevas et al. (2014:1464), there should be “education for the appropriate use of leisure time and communication technologies.” This would enhance older Saudi women’s experiences and allow them to enjoy their ageing lives.

Moreover, the government should make public announcements about the programmes they have for educating older people. The Ministry of Education has formulated a programme to provide education for older Saudi people to reduce the illiteracy rate (Al Shaer, 2007). However, none of my participants mentioned or were even aware of this programme, and some said they wanted to continue their education.

Finally, a key recommendation is that social security income should be increased to meet the important needs of older unmarried Saudi women. For example, some participants struggled to cover the costs of medicine and rent for accommodation. In the US, according to Sass (2015), social security has been successful in reducing old-age poverty due to an increase in the number of benefits covered by social security income.

10.11 In Conclusion
This study has identified the key factors and elements influencing the well-being and QoL of older unmarried Saudi women. Previously, there was a lack of understanding regarding the reality of their everyday lives. Surprisingly, their QoL, in general, was unexpectedly poor because these women were living in such a rich country that is, Saudi Arabia. This study has revealed their actual situation and how their societal position, family relations, physical and mental health problems, and past experiences have affected their overall life satisfaction.
This study identified the need for an in-depth qualitative research study of older unmarried Saudi women to explore their experiences deeply and provide a clear understanding of the factors that limit the position and roles of Saudi women in the home and society from the past to the present. Most of the older unmarried Saudi women in this study had never experienced the freedom to pursue their desires and preferences because of the ingrained cultural and traditional norms in the society that affect their lives and particularly their participation in education and paid work. From the time that they were young to their current age, these women were like ‘a bird in a cage with an open door’; they were unable to go outside their cages because of their inexperience and inability to make choices and live independently.

This study has shown that through the circumstances these older unmarried Saudi women have experienced, and based on the key findings of this study, the women’s relationships with their families were the most important aspect that influenced their overall life satisfaction and QoL. This fact is true whether the women were living alone or with their relatives; were of poor, middle or high class socioeconomic status; or were divorced, widowed, or never married. This study is considered the first scientific and practical knowledge about the QoL of older unmarried Saudi women and will contribute to the creation of policies for the benefit of older women in Saudi society as Saudi Arabia is considered to be a nation of prosperity and giving however, this important information has been previously unknown to policymakers because of the nature of the conservatism of Saudi Arabian society.
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List of Appendices

Appendix 1a - Interview Guide (English Version)

Introduction:

The purpose of this research study is to determine and understand the inner experiences of elderly Saudi women aged from 60 to 75 years old. The interviews will allow them to express their opinions, feelings and disclose their experience in their own words freely. All interviews will be tape-recorded and are expected to vary in length from one hour to one hour and thirty minutes. The interviews will be informal and open-ended, and carried out in a conversational style. The participant can answer freely because there will be no “right” or “wrong” from their answers.

A. Personal Information

- Age
- Marital Status
- Number of Children
- Living arrangements (number of person living in the same house and relationship to her)

B. Social Structure and Commitment

- Loneliness
- Social relationship
- Proximity to family, relatives and friends
- Feeling of living together /away with family

C. Health / Social Services

- Access to and use of health care services
- Health condition
- Frequency of seeking medical care
- Quality of services
D. Financial and Education Information

- Employment Status
- Income (source and amount)
- Economic Status
- Financial situation
- Education

E. General Conditions

- Complexity and solution to overcome the elderly women welfare
- Vision and plans after 5 years

Interview Questions

(For elderly unmarried women living alone, living with their children, son/daughter in-laws or distant relatives)

Part A. Personal Information

A.01. How old are you?

(If the interviewee is “less than 60 and greater than 75 years old”, thank her and terminate the interview)

A.02. What is your current marital status?

1. Never Married
2. Divorced
3. Desolated (pending divorce case in the court or awaiting 4 years to divorce legally)
4. Widowed
(If the interviewee is “married and living with husband”, thank her and terminate the interview)

If the answer is “Single”, proceed to question # A.07)

A.03. If the answer is “Divorced or Desolated” and living with others, how long ago did you stop living with your husband and started living with others?

__________________________________________________________________

A.04. If the answer is “Divorced or Desolated” and living alone, how long ago did you stop living with your husband and started living alone?

__________________________________________________________________

A.05. If the answer is “Widowed”, how long ago did your husband died?

__________________________________________________________________

A.06. Do you have children? If Yes, how many? Their ages / male or female?

__________________________________________________________________

__________________________________________________________________

A.07. Are you living in your own house? If the answer is YES, who lives with you? If NO, proceed to question # A.08.

1. Alone  5. Relatives
2. Children  6. Housemaid
3. Brother / Sister  7. Others __________
4. In-laws

A.08. Are you living in an apartment? Who is paying of the rental fee?

1. Children  5. In-laws
2. Grandchildren  6. Friends
3. Brother / Sister  7. Others __________
4. Other Relatives

__________________________________________________________________

A.09. Who lives with you in the apartment?

1. Alone  5. Relatives
2. Children  
3. Brother / Sister  
4. In-laws  
6. Housemaid  
7. Others ______________

A.10 How long have you been living in this house/apartment (or living with these people)?
________________________________________________________________
________________________________________________________________

A.11 Have you had a chance to live on your own and then moved in with your children? If so, why?
________________________________________________________________
________________________________________________________________

A.12 Have you had a chance to live with your children or other relatives and then moved to lived on your own? If so, why?
________________________________________________________________
________________________________________________________________

Part B. Social Structure and Commitment

B.01. Tell me about how you spend your days?
________________________________________________________________
________________________________________________________________

B.02. What sort of things do you do each day?
________________________________________________________________
________________________________________________________________

B.03. What is your common activity every day?
________________________________________________________________

B.04. What did you do yesterday?
________________________________________________________________

B.05. Who do you usually eat meals with?
B.06. If the answer is “Alone”, how do you feel about eating alone?

B.07. Who do you usually watch television with?

B.08. If the answer is “Alone”, how do you feel about watching alone?

B.09. If the interviewee is “living alone”, do you ever feel lonely in living alone? How often?

B.10. If the interviewee is “living with others”, do you ever feel lonely even though you are living with your children / son and daughter in-laws or immediate relatives? How often?

B.11. When do you feel lonely?

B.12. How you deal with loneliness?

B.13. How often do you go out of the house?

B.14. When was the last time you went out? Who with? Who did you visit?
B.15. Who do you see regularly?
________________________________________________________________

B.16. Does anyone visit you in your house on a regular basis?

1. Children
2. Grandchildren
3. Brother / Sister
4. Other Relatives
5. In-laws
6. Friends
7. Others __________

B.17. If YES, about how often do they come to visit you?
________________________________________________________________
________________________________________________________________

B.18. Who provides your transportation if you wish to visit your friends/relatives?

1. Children
2. Brother / Sister
3. Relatives
4. In-laws
5. Friends
6. Others __________

B.19. How easy is this to arrange?
________________________________________________________________

B.20. If the interviewee is “living with others”, do you like living with your children / son and daughter in-law or immediate relatives?
________________________________________________________________

B.21 If the interviewee is “living with others”, what are the best things about living with your children / son and daughter in-law or immediate relatives?
________________________________________________________________

B.22. If the interviewee is “living with others”, what do you think is the worst (or the less good) things about living with your children / son and daughter in-laws or immediate relatives?
________________________________________________________________
B.23. *If the interviewee is “living with others”, how much time do you spend with your children / son and daughter in-law or immediate relatives?*

__________________________________________

B.24. *If the interviewee is “living alone”, how do you feel about living alone?*

__________________________________________

B.25. *Is there any other place where you would prefer to be living in? Why?*

__________________________________________

Part C. Health and Social Services

C.01. *Do you have any medical insurance?*

* (If the answer is “None”, proceed to question # C.04)

__________________________________________

C.02. *About how often do you use your medical insurance?*

__________________________________________

C.03. *Are you satisfied with the services provided by the medical insurance services? If NOT, Why?*

__________________________________________

C.04. *Are you aware of free medication provided by the health centre? If YES, have you been to the health centre to obtain free medication?*

__________________________________________

C.05. *Is it easy to obtain medication from the health care centre? Do they provide all of the medication for your requirements?*
C.06. Do you suffer from any chronic or long term illnesses?

*(Indicate which of the following conditions she is suffering from or ask about each if not mentioned).*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<td>Blood Pressure</td>
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<td>Heart problems and Heart Attack</td>
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<td>Stroke</td>
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<td>Diabetes</td>
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<td>Anxiety</td>
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<td>Arthritis and Osteoporosis</td>
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<td>Dementia</td>
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<td>Hearing impairment</td>
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<tr>
<td>Visual impairment</td>
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<tr>
<td>Any others?</td>
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</tbody>
</table>

C.07. Do you have regular medicines for your medical conditions? If “Yes”, are you satisfied with the medical supplies provided?

________________________________________________________________________

________________________________________________________________________

C.08. When you are / were sick, who takes you to the hospital?

1. Children                        4. In-laws
2. Brother / Sister                5. Friends
3. Other Relatives                 6. Others ______________
C.09. When was the last time you went to the hospital for check-up?
________________________________________________________________

C.10. Who paid for your hospital care?

1. Children  
2. Brother / Sister  
3. Other Relatives  
4. In-laws  
5. Friends  
6. No charge / Public hospital  
7. Others ____________

C.11. How is your health status?
________________________________________________________________
________________________________________________________________

C.12. In general, are there any kinds of medical and social assistance that you would need more?
________________________________________________________________
________________________________________________________________

Part D. Financial and Education Information

D.01. Did you have any paid employment before?
________________________________________________________________
________________________________________________________________

D.02. If Yes, what kind of job(s) did you do? When?
________________________________________________________________

D.03. Do you have social security?
________________________________________________________________
________________________________________________________________

D.04. Do you have any monthly income now? If Yes, how much?
(If the answer is “None”, proceed to question # D.07)
D.05. What are the main sources of your monthly income?

1. Children  
2. Brother / Sister  
3. Relatives  
4. In-laws  
5. Inheritance  
6. Donations  
7. Social Security/Pension  
8. Others ________________

D.06. Is your monthly income enough to support your financial needs or daily expenses? If the answer is “NO”, how are you managing in this difficult situation?

D.07. How do you rate yourself in terms of economic status?

1. Low  
2. Middle  
3. High

D.08. From which persons or organizations do you get any financial support or assistance?

1. Children  
2. Brother / Sister  
3. Relatives  
4. In-laws  
5. Friends  
6. Charitable institution  
7. Others ________________

D.09. *If the interviewee is “living alone”, how do you evaluate your financial situation?*

D.10. *If the interviewee is “living with others”, how was your financial situation affected when you became widowed / got divorced / desolated?*
D.11. What is your educational status?
   1. Never went to school
   2. Dropout from primary school; did not continue
   3. Primary school graduate
   4. Dropout from secondary school; did not continue
   5. Secondary school graduate
   6. Drop out from college or university; did not continue
   7. College or university graduate

*If “did not continue / graduate” from school or university*”

D.12. What are the reasons for not going to school / not continuing your education?

_____________________________________________________________________

D.13. If you had finished your education in the past, do you think your life would be better today? In what ways?

_____________________________________________________________________

_____________________________________________________________________

Part E. General Condition

E.01. Which of the following are problems that you are facing now?

*(The interviewer must probe the participants’ answers in detail.)*

1. Financial problems

_____________________________________________________________________

2. Housing / Accommodation

_____________________________________________________________________

3. Pressure from the family / society

_____________________________________________________________________

4. You were held in contempt for getting divorced / desolated

_____________________________________________________________________

5. Being exposed to verbal or physical abuse

_____________________________________________________________________

6. Legal problems
7. Problem arising from the children

E.02. To overcome such problems, could you tell me what kind of governmental service would make your life easier? Which of the following would help you? In what ways? What difference would they make?

1. Place to stay
2. Financial support
3. Medical support
4. Psychological support
5. Legal support

E.03. How satisfied are you with your life now?

E.04. Where do you see yourself in 5 years time?
الغرض من هذه الدراسة هو التعرف على التجارب الشخصية للنساء السعوديات اللائي تتراوح أعمارهن ما بين 60-75 عاما. المقابلات ستستند لهذين الفرصة التعبير عن آرائهن، والكشف عن مشاعرهن وتجاربيهن في الماضي والحاضر، من خلال تسجيل كافة المقابلات في أشرطة تسجيل، ومن المتوقع أن تتفاوت مدة المقابلات ما بين ساعة واحدة إلى ساعة وثلاثين دقيقة. تميز المقابلات بصفتها مقابلات لا تقيد بإجابة محددة أو وقت محدد (مقابلات مفتوحة) ويجب إجراءها بأسلوب التحدث والحديث بين الطرفين. يمكن للمشاركين إجابة بحرية حيث يتم تحليل إجاباتهم من حيث "الصحة" و"الخطأ".

أ. المعلومات الشخصية

• العمر
• الحالة الاجتماعية
• عدد الأطفال
• ترتيبات المعيشة (عدد الأشخاص المقيمين في نفس المنزل وطبيعة علاقاتهم بالمشاركة)

ب. الهيكل الاجتماعي والالتزامات الاجتماعية

• العزلة والشعور بالوحدة
• العلاقة الاجتماعية
• القرب من الأهل والأقارب والأصدقاء
• الشعور حيال العيش مع العائلة أو بعيدا عنها

ج. الخدمات الصحية/اجتماعية

• سهولة الوصول إلى خدمات الرعاية الصحية واستخدامها
• الحالة الصحية
• تكرار الحاجة إلى الرعاية الطبية
• جودة الخدمات

د. معلومات عن الوضع المالي والتعليمي

• الحالة المهنية
• الدخل ومصدره وتحديد المبلغ
الطبقة الإجتماعية (طيبة غنية، متوسطة أو فقيرة)
• الوضع المالي عامة
• مستوى التعليم
•

• ظروف العامة
• التعقيدات والحلول المطروحة للتعامل مع مصاعب مشكلات رعاية المسنين
• الرؤية والخطط لما بعد 5 سنوات

أسئلة المقابلات

(مخصصة للنساء الغير متزوجات (لم يسبق لهن الزواج، أرملة أو مطلقة) اللاتي يسكنن بمفردهن أو مع أبنائهن وأزواج/زوجات أبنائهن أو الأقارب)

الجزء أ. المعلومات الشخصية

أ.1. كم عمرك؟

(إذا كانت ضمنية المقابلة "أقل من 60 عامًا أو أكبر من 75 عامًا" قومي بشكرها وإنها المقابلة)

أ.2. ما هي حالتك الاجتماعية الحالية؟

1. لم يسبق لها الزواج
2. مطلقة
3. منفصلة/معلقة (قضية طلاق قائمة في المحكمة أو في انتظار 4 أعوام للحصول على الطلاق الشرعي)
4. أرملة
إذا كانت الإجابة "عمرتة"، منذ متى توفي زوجك؟

أ.3. إذا كانت الإجابة "مطلقة ومنفصلة" وتعيش مع أخرين، منذ متى توقفت عن العيش مع زوجك وبدأت العيش مع الآخرين؟

أ.4. إذا كانت الإجابة "مطلقة ومنفصلة" وتعيش بمفردها، منذ متى توقفت عن العيش مع زوجك وبدأت العيش بمفرده؟

أ.5. إذا كانت الإجابة "أرملة"، منذ متى توفي زوجك؟

أ.6. هل لديك أطفال؟ في حالة الإجابة بـ "نعم"، كم عددهم؟ ما هي أعمارهم / إناث أم ذكور؟

أ.7. هل تعيشين في منزلك الخاص؟ إذا كانت الإجابة "نعم" من يعيش معي؟ وإذا كانت الإجابة "لا"، انتقل إلى السؤال رقم أ.8.

| الأقارب | الأحفاد | الأبناء | الأخوة / الأخوات | الأهل الزوج
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<td>أ.8. هل تعيشين في شقة؟ من يدفع قيمة الإيجار؟</td>
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<tr>
<td>1. الأبناء</td>
<td>2. الأحفاد</td>
<td>3. الأخوة / الأخوات</td>
<td>4. غيرهم من الأقارب</td>
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أ.9. من يعيش معك في الشقة؟
1. مفردك
2. الأبناء
3. الأخوة/ الأخوات
4. أهل الزوج
5. الأقارب
6. الخادمة الخاصة
7. آخرون

أ.10. منذ متى تعيشين في هذا المنزل/الشقة (أو منذ متى تعيشين مع هؤلاء الأشخاص؟)

أ.11. هل سأنتلك الفرصة للعيش بمفردك ثم الانتقال للعيش مع أبنائك؟ في حالة "نعم"، ما سبب ذلك؟

أ.12. هل سأنتلك الفرصة للعيش مع الأبناء أو غيرهم من الأقارب ثم الانتقال للعيش بمفردك؟ في حالة "نعم"، ما السبب وراء ذلك؟

الجزء ب. الهيكل الاجتماعي والالتزامات الاجتماعية

ب.1. أوصفي لي كيف تقضين أيامك؟

ب.2. ما هي الأمور أو الأشياء التي تقومين بها بصورة يومية؟
ب.3. ما هو نشاطك المشترك اليومي؟

ب.4. ماذا فعلت بالأمس؟

ب.5. في العادة، من يتناول معك الوجبات؟

ب.6. إذا كانت الإجابة "بمفردي"، كيف تشعرين حيال تناول الوجبات بمفرเดك وحيد؟

ب.7. في العادة، مع من تشاهدين التلفزيون؟

ب.8. إذا كانت الإجابة "بمفردي"، كيف تشعرين حيال مشاهدة التلفزيون بمفردي وحيد؟

ب.9. إذا كانت ضيفة المقابلة "تعيش بمفردها"، هل ينتابك الشعور بالوحدة جراء العيش بمفرده؟ ما مدى تكرار الإحساس بشعور الوحدة؟
ب. 10. إذا كانت ضيافة المقابلة "تعيش مع أخرين"، هل ينتابك الشعور بالوحدة رغم أنك تعيشين مع أبنائك/ابنك وزوجته أو الأهل؟ ما مدى تكرار الإحساس بشعور الوحدة؟

________________________________________________________________
________________________________________________________________
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ب. 11. متى ينتابك الشعور بالوحدة؟

________________________________________________________________
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ب. 12. كيف تعاملين مع الشعور بالوحدة؟

________________________________________________________________
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ب. 13. ما مدى تكرار خروجك من المنزل؟

________________________________________________________________
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________________________________________________________________
________________________________________________________________

ب. 14. متى كانت آخر مرة خرجت فيها من المنزل؟ برقة من؟ هل قمت بزيارة أحد؟ من؟

________________________________________________________________
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ب. 15. ما هي الأمور أو الأشياء التي تقومين بها بصورة منتظمة؟

________________________________________________________________
________________________________________________________________
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________________________________________________________________

ب. 16. هل هناك من يقوم بزيارتك في منزلك بصورة منتظمة؟

1. الأبناء
2. الأحفاد
3. الأخوة/الأخوات
4. غيرهم من الأقارب
5. أهل الزوج
6. الأصدقاء
7. آخرون
ب.17. إذا كانت الإجابة "نعم"، ما مدى تكرار زيارتهم لك؟


ب.18. من يوفر لك وسائل التنقل في حالة رغبتكم في زيارة الأصدقاء/الأهل؟

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<th>أهل الزوج</th>
<th>الأصدقاء</th>
<th>الأخوة / الأخوات</th>
<th>غيرهم من الأقارب</th>
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ب.19. ما مدى سهولة تنظيم وتذبير المواصلات؟


ب.20. إذا كانت ضيفة المقابلة "تعيش مع آخرين"، هل تحبين العيش مع أبنائك/ابنها وزوجته أو الأهل؟

ب.21. إذا كانت ضيفة المقابلة "تعيش مع آخرين"، ما هي في رأيك أفضل الأمور أو مميزات العيش مع أبنائك/ابنها وزوجته أو الأهل؟

ب.22. إذا كانت ضيفة المقابلة "تعيش مع آخرين"، في رأيك ما هي أسوأ الأمور (أو الأقل ميزة) في العيش مع أبنائك/ابنها وزوجته أو الأهل؟

ب.23. إذا كانت ضيفة المقابلة "تعيش مع آخرين"، ما هو الوقت الذي تقضينه مع أبنائك/ابنها وزوجته أو الأهل؟

ب.24. إذا كانت ضيفة المقابلة "تعيش بمفردها"، ما شعورك حيال العيش بمفرده؟
ب.25. هل هناك مكان آخر تفضلين العيش فيه؟ لماذا؟

الجزء ج. الخدمات الصحية الاجتماعية

ج.1. هل لديك أي تأمين طبي؟
(إذا كانت الإجابة "لا"، انتقل إلى السؤال رقم ج.4.)

ج.2. تقريبا كم مرة تستخدمين تأمينك الطبي؟

ج.3. هل تشعرين بالرضا حيال الخدمات المقدمة من قبل تأمينك الطبي؟ إذا كانت الإجابة "لا"، لماذا?

ج.4. هل لديك علم عن الأدوية المجانية المقدمة من قبل المراكز الصحية؟ إذا كانت الإجابة "نعم"، هل ذهبت إلى أحد المراكز الصحية للحصول على أدوية مجانية؟

ج.5. هل يسهل الحصول على أدوية من مراكز الرعاية الصحية؟ هل يقدمون كافة الأدوية التي تحتاجين إليها؟

ج.6. هل تعاني من أي أمراض مزمنة أو طويلة الأجل؟
(رجاء تحديد أي من الحالات الصحية التالية تعاني منها، أو استفسر عن كل واحدة منها في حالة عدم ذكر هنا)

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ج. 7. هل تتناولين أدوية بطريقة منتظمة لعلاج ظروفك الصحية؟ إذا كانت الإجابة "نعم"، هل أنت راضية عن خدمات توفير الأدوية المقدمة لك؟

________________________________________________________________
________________________________________________________________

ج. 8. في حالة إصابتك بالمرض، من يأخذك إلى المستشفى؟

1. الأبناء
2. الأصدقاء
3. غيرهم من الأقارب
4. الأخوات
5. أهل الزوج
6. الأطفالي

ج. 9. متى كانت آخر مرة ذهبت فيها إلى المستشفى من أجل عمل فحوصات طبية؟
ج.10. من الذي تكلف بدفع نفقات المستشفى والخدمات الصحية المقدمة لك؟
1. الأصدقاء
2. الأخوة / الأخوات
3. غيرهم من الأقارب
4. أهل الزوج
5. الأبناء
6. دون نفقات / مستشفى عام
7. آخرون____________

ج.11. ما هي حالتك الصحية؟

ج.12. بصفة عامة، هل هناك أي مساعدات طبية أو اجتماعية إضافية تحتاجين إليها؟

الجزء د. معلومات مالية وتعليمية

د.1. هل كنت لديك في السابق وظيفة براتب ثابت؟

د.2. إذا كانت الإجابة "نعم"، ما هي هذه الوظيفة/الوظائف؟ ومتي كنت تعملين فيها؟

د.3. هل تتلقين راتب الضمان الاجتماعي؟
4. في الوقت الحاضر، هل لديك دخل شهري ثابت؟ إذا كانت الإجابة "نعم"، ما قيمة هذا الدخل؟ (إذا كانت الإجابة "لا يوجد"، انتقل إلى السؤال رقم 7)

________________________________________________________________
________________________________________________________________

5. ما هي المصادر الرئيسية لدخلك الشهري؟

1. الأبناء
2. الأخوة/الأخوات
3. الأقارب
4. أهل الزوج
5. ميراث
6. تبرعات وصدقات
7. الضمان الاجتماعي/التقاعد
8. أخرى____________

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6. هل يكفي دخلك الشهري لتغطية احتياجاتك المالية ونفقاتك اليومية؟ إذا كانت الإجابة "لا"، كيف تتعاملين مع هذا الوضع الصعب؟

________________________________________________________________
________________________________________________________________

7. كيف تعنيك نفسك من حيث المكانة/الطبقة الاقتصادية في المجتمع؟

1. الطبقة الفقيرة
2. الطبقة المتوسطة
3. الطبقة العليا

________________________________________________________________

8. من هم الأفراد أو المنظمات التي تقدم لك الدعم أو المساعدة المالية؟

1. الأبناء
2. الأخوة/الأخوات
3. الأقارب
4. أهل الزوج
5. الأصدقاء
6. المؤسسات الخيرية
7. أخرى____________

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د.9. إذا كانت ضيفنة المقابلة "تعيش بمفردها"، كيف تقييمن وضعك المالي/الاقتصادي؟

د.10. إذا كانت ضيفنة المقابلة "تعيش مع الغير"، كيف تؤثر وضعك المالي/الاقتصادي عندما أصبحت أرملة/ مطلقة/منفصلة/مهجورة؟

د.11. ما هو مستوى التعليم؟

1. لم تذهب إلى المدرسة أبدا
2. انقطعت عن الدراسة الابتدائية، ولم تستمر
3. تخرجت من المرحلة الابتدائية
4. انقطعت عن المدرسة الثانوية ولم تستمر
5. تخرجت من المدرسة الثانوية
6. انقطعت عن الدراسة في الكلية أو الجامعة، ولم تستمر
7. تخرجت من الكلية أو الجامعة

إذا "لم تستمر/لم تخرج" من المدرسة أو الجامعة

د.12. ما هي الأسباب وراء عدم ذهائك إلى المدرسة / عدم استمرارك في التعليم؟

د.13. إذا كنت قد تعلمت تعليمك في الماضي، هل تعتقد أن حياتك كانت ستصبح أفضل اليوم؟ وكيف؟

الجزء H. الظروف العامة
أي من المشاكل والصعوبات التالية تواجهينها في الوقت الحاضر؟

(على القائمة الباشحة استدراج المشاركة للتحدث بالتفاصيل الدقيقة حول أجوبتها)

1. مشاكل مالية/اقتصادية
2. السكن والمعيشة/إقامة
3. ضغوط من قبل الأهل/المجتمع
4. التعرض للمعاملة باذدراء واحترار نتيجة الطلاق/الانفصال
5. التعرض للإساءة والاعتداء اللفظي أو الجسدي
6. مشاكل قانونية
7. مشاكل ذات علاقة بالأبناء

للتغلب على مثل تلك المشاكل، هل يمكنك إخباري عن الخدمات الحكومية التي قد تجعل حياتك أكثر سهولة ويسرًا؟ أي من الحول التالية يمكن أن تساعده؟ من أي ناحية وما الفرق الذي ستحتله؟

1. مكان للإقامة والسكن
2. الدعم المالي
3. الدعم الصحي
4. الدعم النفسي
5. الدعم القانوني

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3. وما مدى رضاك عن حياتك في الوقت الحاضر؟

4. كيف ترين او تتخيلي نفسك بعد 5 أعوام من الآن؟
Appendix 2a – Letters for Access (1): Letter from the Vice-President for the
Graduate Studies and Research – King Abdulaziz University (English Translation)

Kingdom of Saudi Arabia
Ministry of Higher Education
KING ABDULAZIZ UNIVERSITY
P.O. Box 80200, Jeddah 21589
Tel. (+966 2) 695 2015
Fax. (+966 2) 695 2441
http://gsar.kau.edu.sa

Office of the Vice President of Graduate Studies and Research

Director General of Social Security in Jeddah

Peace be upon you and Allah’s mercy and blessings

The Vice President for Graduate Studies and Research would like to greet you, and indicate that the Department of Sociology, Faculty of Arts and Humanities, is one of the scientific departments offering Graduate Programs (to both males and females), and some studies to obtain a master's and PhD degree require the obtainment of information and data to be used in the scientific study.

In this context, the Vice President for Graduate Studies and Research would like to take this opportunity to inform you that the lecturer Seham bint Hassan Salamah, is currently collecting scientific material for her PhD study under the title "The impact of financial and social support on elderly women in the city of Jeddah for the age group (85-75 years)."
The subject of this scientific study requires the obtainment of statistical data on families registered at the Social Security, that have been collected through field survey carried out by the Social Security on the elderly women (divorced, widowed, married and unmarried), including:

☐ The living standard of all social classes (poor, very poor, middle class, above middle class)
☐ General health state (illness, with specific if any, the neighborhood, income and its source)

In this respect, the Vice President for Graduate Studies and Research, out of his eagerness to cooperate with the Civil Society institutions, and seeking to provide graduate students (both males and females) with the required information and data for their Theses/ Dissertations, we would like to request you to direct the responsible person to provide such information to the lecturer Seham bint Hassan Salamah, to be utilized in her PhD Thesis/ Dissertation, with the assurance that such information will only be used for the purpose of this scientific research.

Please accept our sincere greetings and appreciation.

Professor Dr. Adnan bin Hamza Mohammed Zahid
Vice President of Graduate Studies and Research
Appendix 2b – Letter for Access (1)

Letter from the Vice-President for the Graduates Studies and Research – King Abdulaziz University (In Arabic)
Appendix 3a — Letters for Access (2): Letter from the Ministry of Social Affairs

(English Translation)

SAUDI ARABIA                          In the name of Allah, Most Gracious, Most Merciful

No.: 1315

Ministry of Social Affairs                          Date: 8/2/1432+1 (12/1/2011)

Deputyship of Social Care &                        Attachment: (1)

Development

Office of the Social Supervision for Women in Makkah Province

Head of the Board of Direction, Iktifaa Society

Peace be upon you and Allah’s mercy and blessings

In reference to the letter from the general supervisor of the Joint Supervision Program at King Abdulaziz University’s Vice President for Graduate Studies and Research, No. (N/A) dated N/A (see attached copy) indicating that Mrs. Seham bint Hassan Salamah, lecturer in (Soci010U) at King Abdulaziz University in Jeddah, is preparing her PhD Thesis (The impact of financial and social support on elderly women in the city of Jeddah), in particular for the age group (55-75 years). As the research requires statistical data on the families surveyed by the Iktifaa Society, she would like to obtain statistical data regarding the elderly women as follows:

- The standard of living for all social classes
- Health State
- Income and its sources
- Neighborhood

And as Mrs. Seham mentioned that she has previously discussed her thesis with some of the officials at the Society, it was made clear to her that providing the required information would not be an issue. Thus, we would kindly request you to provide her with the information required within the rules and regulations of the Society, emphasizing on her commitment to deal with and treat the given information and data with confidentiality and to used for the sole purposes of the research only.

Director-General
Social Supervision for Women in Makkah Province

Noura bint Abdul Aziz Al-Sheikh
(Ghada Bint Mansour Abdul Ghaffar)
سلامها الله

سعيدة رئيسة مجلس إدارة جمعية استكشاف

السلام على هموم ورحمة الله وبركاته

إشارة إلى خطاب المرشد العام على برنامج الإشراف المشترك بيوكلالة جامعة الملك سعود

المزgün للدراسات العليا والبحث العلمي رقم (2970) تاريخ 8/2/2014

بيان الإفادة

بيان الاستاذة سهام سلمان معاوضة في قسم (علم الاجتماع) بجامعة الملك سعود وبنجاء وفق إصدار رسالة الدكتوراه عن مثل الدعم المالي والاجتماعي على مدار السن في مدينة جدة للǐلة العمرية من 55 - 60 تفهيدا ويجب تتبعة البحث ببيانات إحصائية عن الأسر التي تم مسحها فمسطرة جمعية استكشاف وترحب بإرسالهم على بيانات إحصائية عن معبر السن مكالتياً:

- مستوي المعيشة لجميع الطبقات الاجتماعية
- الوضع الصحي
- الدخل ومصدره
- اسم الحي

ويذكر الاستاذة سهام انها مديمة لمناقشة نقطة بحث مشابهة مع بعض المستشارات في الجمعية.

وواضحة بأنه لا مانع لديهم من تزويدنا بالمعلومات المطلوبة عليه نأمل التفاؤل بالإطلاع والاحترام.

وإن هذين حواليا توجيه من تورون بدورها بملفات المندوبات وفق النصوص والأنظمة المعمول بها بالجمعية مع التأكد من الأتتام بسرية المعلومات واستخدامها ضمن البحث.

غمزة عبد الله

النورة بنت عبد العزيز آل الشيخ

الإدارة العامة

للإشراف الاجتماعي النسائي بمنطقة مكة المكرمة

نورا بنت أحمد آل الشيخ

أطمن معلمة
Appendix 4a - Participant Information Sheet (English Version)

STUDY TITLE: The Quality of Life, Social Care and Family Relationships of Older Unmarried Saudi Women Living in Jeddah: A Qualitative Study

Hello,

I would like to invite you to take part in this research study. I am a University Lecturer from King Abdulaziz University completing my Doctoral Degree in Sociology. I am undertaking a research project in which you may be interested.

Before you decide whether or not to take part, I would like you to understand why the research is being undertaken and what it would involve for you. This information sheet will tell you the purpose of my study. Please ask me at any point if there is anything that is not clear.

**What is the purpose of the study?**
The main objective of my research is to identify the issues and challenges facing elderly Saudi women aged 60 to 75 years by analysing their social lives, living patterns, daily affairs and relationships with their relatives and friends. It focuses on social integration, health services, financial aspects, social policies and economic implications of ageing women who are no longer married. An additional focus is on how the life satisfaction of elderly women is associated with relations with their family members and others.

**Why me?**
You have been invited to take part in this research study because you are aged 60 to 75 years and are:
- Never-married/widowed/divorced and you are living alone or living only with a housekeeper, driver or maid.

- Widowed and divorced and you are living with your children, son/daughter-in-law or immediate relatives.

Please note that you have the right to withdraw from the research study at any time without giving a reason.

**How long will it take?**
The interview would take no longer than 90 minutes but may vary depending on the conversation flow at the time of the interview.

**What type of questions will I be asked in the interview?**
The interview will be an open conversation where you can ask for a break if you feel the need to do so. Your agreement to be part of my study would mean that I would visit you at a place you felt comfortable in, probably your home. I would talk with you about the things that help or do not help you enjoy your life, what makes things easier for you, and what makes things harder. However, if you think some of the questions are too personal and feel uncomfortable giving answers, you do not have to do so. In addition, some of the questions relate to things that have happened in the past and I understand that it can sometimes be difficult for you to remember these things precisely. In this case, please do your best to give me an accurate answer.

**Who will benefit from my research?**
You may or may not receive any direct benefit from taking part in the research study. However, information obtained during the research will help the families of
elderly women, the general public and the government to be more aware of the concerns of older women in the Kingdom of Saudi Arabia.

**Confidentiality:**
In order to preserve and protect your identity, I will not use your name in my research study, instead I would give you a different name throughout the process and this measure would ensure that you will not be identified in any publication of the results of the study. Nothing you say will be communicated to your children or immediate relatives. At the same time, this interview will be audio recorded, but the interview tapes will be coded and kept safely to maintain the confidentiality.

If you would like to ask any questions or want to be a part of my research study, please contact me.

Seham Salamah
Department of Sociology
King Abdulaziz University
Jeddah, Saudi Arabia
Contact Number: (054) 006 – 1891
Email Address: shs.kau2012@gmail.com
عنوان الدراسة: جودة الحياة والدعم الاجتماعي والأسري للنساء المسنات غير متزوجات في مدينة جدة/ دراسة كفيفة

مرحبا.. (السلام عليكم ورحمة الله وبركاته)،

أود هنا دعوتكم للمشاركة في بحث علمي. أنا أستاذة جامعية من جامعة الملك عبدالعزيز أتمت دورة الدكتوراه في علم الاجتماع وأقوم بإجراء هذا البحث الذي قد يستغرق إهتمامكم. وقبل أن تتخذوا فرتر في المشاركة، أو عدم المشاركة، أود منكم فهم هدف هذه الدراسة ودورنا فيها وورقة المعلومات هذه سوف توضح لكى الغرض من هذه الدراسة بالتحديد والرجاء إذا كان لديكم أي استفسار لاتترددي في طرح أي سؤال.

ما هو الهدف من الدراسة؟

إن الهدف الرئيسي وراء بحثي هو تحديد القضايا والتحديات التي تواجه المرأة السعودية من كبار السن من الفئة العمرية بين 60 و75 عاما، وذلك من خلال تحليل حياتهم الاجتماعية، ونماذج حياتهم، وشروطهم اليومية، وعلاقاتهم مع أقاربةهم وأصدقائهم. إن الدراسة تركز على الاندماج الاجتماعي، والخدمات الصحية، والجوانب المالية، والسياسات الاجتماعية، والأثار الاقتصادية للنساء من كبار السن غير المتزوجات. كما تركز الدراسة أيضاً على ارتباط رضا النساء المسنات عن حياتهم بعلاقاتهم مع أفراد أسرهم وغيرهم من أفراد المجتمع.

لماذا تم اختياري؟

لقد تم دعوتكم للمشاركة في هذه الدراسة البحثية لكونكم من الفئة العمرية بين 60 حتى 75 عاما، علامة:

- لم يسبق لكي الزواج أو أمثلة تعيشين بمفرده أو مع مديرة منزل أو سائق أو خادمة
- أرملة أو مطلقة تعيش مع أحد أبنائي (ابن / ابنت)، أو زوجة ابنك أو زوج ابنتك أو أحد الأقرباء المباشرين

يرجى ملاحظة أن لديك الحق في الانسحاب من الدراسة البحثية في أي وقت دون إبداء أي سبب لذلك.

كم من الوقت تستغرق المقابلة؟

لا تزيد المقابلة على 90 دقيقة، إلا أن المقابلة الشخصية قد تختلف اعتماداً على تدفق الحديث أثناء المقابلة.
ما نوعية أسئلة المقابلة؟

إن المقابلة عبارة عن محادثة مفتوحة، وبإمكانك طلب وقت للراحة أثناء المقابلة إن شعرت بالحاجة إلى ذلك. إن مناقشتك على المشاركة في دراستي يعني أنني سأقوم بزيارتك في أي مكان تحددينه، وسأركز على الأمور التي تجعل حياتك أكثر سهولة ويسرا أو التي تجعلها أكثر صعوبة. ومع ذلك، إذا شعرتي في أي لحظة أن بعض الأسئلة قد تتشكل أمورا شخصية وخاصة جدا ولا تستطيعين أن تتحدثين بها، ليس من الضروري الإجابة عليها. أما فيما يخص المسائل المتعلقة بأمور قد حدثت في الماضي، فأنا أفهم أنك في بعض الأحيان قد يصعب عليك تذكر نصيحتها، في مثل هذه الحالة أرجو منك بنقل قصص أو حالات إعطاء أجوبة وتفاصيل دقيقة قدر الإمكان.

من المستفيدين من بحثي؟

قد تحصل على فائدة مباشرة من المشاركة في هذه الدراسة البحثية. إلا أن المعلومات التي أحصل عليها من جراء المقابلات سوف تستفيد من كبار السن وعامة الناس والمسؤولين في الدولة من فهم عادات الحياة كبار السن حتى يزيد لديهم الوعي والإدراك بقلق وهموم وشؤون كبار السن من النساء في المملكة العربية السعودية.

السرية:

من أجل صون وحماية هويتك، لن أستخدم اسمك في الدراسة البحثية هذه، بل سأعطيك اسم مستعارا مختلفا في هذا البحث. وهذا من شأنه أن يقلل عدد الأسئلة التي ستدل على أي من المعلومات التي ستدل على أي منك أو أقرانك المشارين. في ذات الوقت، سوف يتم تسجيل هذه المقابلة، إلا أن أشرطة المقابلات ستكون مشفرة وتحفظ في مكان آمن حفاظا على سرية محتواها.

رجاء واكرر عدم التردد في الاتصال في حالة رغبتك في الاستفسار عن أي أمر أو طرح أي سؤال، وفي حالة رغبتك في المشاركة في دراستي البحثية هذه.

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Appendix 5 - Annotated Transcript of Coding

To analyse my data, I used thematic analysis, as discussed in Section 4.11 of Chapter 4. In the first phase of my analysis, during and after the interviews, I encountered noticeable actions, such as participants’ body language and facial expressions, especially when I asked sensitive questions related to their past experiences. These actions were added to the transcribed data. Additionally, the interview questions that the participants answered focused on factors that affect their overall quality of life, such as living arrangements, family relationships, control and autonomy, daily activities, social support, social engagement, loneliness, financial dependency, independence, health, education, employment and overall life satisfaction. Furthermore, I listened to the audio-recorded interviews to transcribe each participant’s data. This transcribed data was summarised in the personal profile of each participant (Appendix 6a).

After transcribing all the data from the audio-recorded interview and the notes I took during the interviews, I highlighted the relevant codes for each participant’s personal information, including general characteristics such as age, marital status/history, educational level, sources of financial support, living arrangements, medical insurance indicators, social engagement, primary activities, chronic illnesses and life satisfaction. These formed the basis for the measurement of an individual’s quality of life.

Using Microsoft Excel, I transferred the highlighted data from the participants to tables (Appendix 6b, 6c and 6d) so that I could more easily compare and analyse the common codes from the participants and gather all the emerging themes from these common codes. Furthermore, I combined the codes that related to each other (e.g. about health – health status, number and types of chronic illnesses, medical insurance, pattern of health care utilisation) so that I could see the full picture of how a combination of factors affected their quality of life. I followed the same
process with the remaining factors (social activities, financial resources, relationships with family and friends, living arrangements, education and employment), and came up with several over-arching themes, such as the living arrangements of participants; the education and socioeconomic status of older women; the health, social activities, social support and family relationships of older women; and the overall quality of life of participants.

In the next phase of my analysis, I identified themes that formed a consistent pattern. I read and re-read the interview data about participants’ personal information and constantly compared the data and themes so that I could confirm whether the emerging themes provided a consistent pattern with respect to the research study. Moreover, I checked each summary of the provided information gathered from the three tables (Appendix 6b, 6c, 6d); for example, among the 50 participants, how many older Saudi women receive financial support from their children (sons/daughters).

After finishing my review of each emergent theme, I defined four over-arching themes that I analysed in the four-analysis chapter (Chapters 5-8). These four themes were: the general characteristics and socioeconomic resources of older women; the social support receives by older unmarried women in later life; older unmarried women’s health status and access to health care; and the overall quality of life of older unmarried women.

After I defined these four over-arching themes, continuous comparison between the collated data and codes and the emergent themes gave me a clear understanding of the factors influencing the quality of life of older, unmarried Saudi women. Moreover, in checking the validity of these four final themes, I wrote a summary of each final theme to determine whether the arguments and evidence related to these themes were relevant to the data set. This process gave me an empirical and theoretical understanding of the factors affecting older Saudi women’s quality of life.
Here is an example of transcript record of an actual interview annotated with some of my codes. The blue highlighted text was the important information came from my participants, and the red text words were the codes used in my study.

Interviewee: Nora
Interviewer: Seham Salamah

SS: How old are you?

Nora: I am 70 years old.

SS: What is your current marital status?

Nora: I am **widowed**.

SS: How long ago did your husband died?

Nora: It’s **almost 20 years ago**.

SS: Do you have children?

Nora: Yes, I have 3 sons and 1 daughter

SS: Are you living in your own house?

Nora: Yes, I am **living here alone**.

SS: How long have you been living in this house?

Nora: I moved into this house five years after my husband’s death. My husband had planned and designed the house so that we could move and live here after the
SS: Tell me about how you spend your days?

Nora: I am a person who loves to enjoy every moment of the day. I go to sleep early and wake up early. In the morning, I have my breakfast and I exercise. As I don’t like to walk in hot weather, I have an equipped exercise room in my house. I also go out to visit people and I am a member of various associations. Social activities.

SS: What is your common activity every day?

Nora: Despite that I like a bit loneliness and quietness. I don’t like to stay at home; so, I either go to cultural gatherings, and sometimes, I organise gatherings in my own house. I hosted a literary gathering in my house every Tuesday. Social activities - outside home; and inside own home.

SS: Who do you usually eat meals with?

Nora: I either eat alone or have a friend over and we share a meal. Every Thursday, all my children, and their spouses and children come over. Family visiting - weekly/ family relationship.

SS: When do you feel lonely?

Nora: Whenever there is any event, and the outing or visit comes to its end, the feeling of order to avoid retreating into the past. In general, I am able to avoid loneliness via various methods, when my friends are busy, and no one visits me. I love to read in all specialties and fields, noting that my major is Arabic language. Loneliness – strategies to avoid loneliness.

SS: How do you feel about living alone?
Nora: I am **happy and contented living alone in my own choice**, and I can always change the situation and not be alone. I am a retired woman who has always been controlled by my work before and now, **I have the chance to find myself and feel free.** **VALUES LIVING ALONE – GIVES FREEDOM.**

SS: Is there any other place where you would prefer to be living in? Why?

Nora: I could not say that there is any specific place because **I travel a lot**, and I possess a small house in Switzerland which is a small compensation for my family. **TRAVELS ABROAD** Also, **I often love to go to Madinah**, I don’t own a house there, so I stay in a hotel for 10 to 15 days. **AFFLUENCE. TRAVELS – RELIGIOUS.**

SS: How is your health status?

Nora: My **health status is a moderate one** **HEALTH STATUS** as my problem consists in **overweight and obesity** **CHRONIC ILLNESSES** as I don’t move enough, and **all my transportation is by car. OVER WEIGHT. LACK OF ‘EVERYDAY EXERCISE’.**
Appendix 6a - Summary Profile of 50 Older Unmarried Saudi Women

Appendix 6a1 - Participants who lives with others

Ellen

Ellen is 61 years old and widowed 17 years ago. According to her, she had a chance to be married again to the man she loved but changed her mind because she wanted to avoid any strange man in her daughters’ house. Ellen has five daughters and they presently live with her at her own house. Ellen’s oldest daughter (33 years old) is waiting for her divorce papers and the others are still unmarried. Ellen lived in a rental house for 15 years but she moved to her present house two years ago. She did not finish her college education because of her parents’ desires to get her married. Ellen tried to continue her education later but was not pursued because of having children. Although an undergraduate at college level, Ellen did not engage in paid employment.

Ellen usually feels lonely and sad in the evening. She writes poems to release and hide her unhappy memories or to express strong emotions such as anger and sadness. Sometimes, she prefers to stay in her room and read the Qur’an. Her brother and friends used to visit her twice a week. She mostly spends her days in watching television and uses her computer as her favourite entertainment. Ellen is aware of free medication from the health centre and tried them once but she was not satisfied with their services. Instead, she pays for her own medical insurance. She also tried to claim social security but the agency refused to give her that as she already has a pension from her husband. She feels that they prevented her from having it. Ellen suffers from depression, isolation, fatigue and anxiety. She considers herself at a middle class status. Her income comes from her husband’s pension and from a large amount of inherited properties from her husband. However, she says that it is not enough to support her needs and she needs to cut her expenses down and deal with the financial crisis. Ellen is satisfied with her life but she does not want to think about her life after five years.
Eman

Eman is 62 years old and widowed for 33 years. She has one daughter. Eman is presently living in her own house with her 38 year old divorced daughter. She was living with her housekeeper and driver for seven years and her daughter moved to her house three months ago. Eman had a chance to live with her aunt, grandfather, and brother but opted to live alone to become independent. Long ago, her siblings forced her to marry again to a three times divorced man but she strongly opposed this. Her siblings considered her a disobedient woman. Eman finished her college education and held a Master’s Degree. She was employed in paid work and retired two years ago as a lecturer in the College of Business Administration (CBA), one of the prominent business schools in the kingdom.

Eman says that feeling alone is very normal for her as she has been alone for 33 years. According to her, her life was more focused on work and studying. She spends most of her days reading religious books, biographies of different leaders, and about the lives of Prophet Muhammad, and cleaning her home. Eman says that they are interrelated family and wanted to stay together. Thus, her relatives and friends visit her house regularly. Her brother and nephew come every other day; her sister who lives in Al-Taif visits monthly, and her friends visit weekly. Eman has fatigue and a problem with her leg. Although aware of free medication from the health centre, Eman never tried to obtain medicine from them. She has no medical insurance but used to go to the military hospital; however, she is still not satisfied with their provided services. Mostly, she personally paid for her hospital care. Eman considers her health status to be good for her age. She says her finances are not enough to support her needs. Thus, she worked again in the CBA as contractual staff and held a position of assistant to head mistress in the school. She has other sources of income from her pension, social insurance, and additional income from the monthly lease of her upstairs floor. Eman considers herself in a middle class status. Eman feels satisfied with her life. She mentions that she does not want any medical insurance; instead a high-quality hospital would be much better.
**Fadwa**

Fadwa is 68 years old and widowed seven years ago. She has three daughters and three sons. Fadwa presently lives at her own house with her children. She has no chance to live alone because her children do not want to leave her. Fadwa did not finish her primary education because of early marriage and her father’s belief that girls should stay at home. She never engaged in paid employment in the past.

Fadwa spends her days taking care of her grandchildren and doing household chores with her housekeeper. She says that she never feels lonely because of her family. Fadwa’s siblings visit her every two weeks and her neighbour used to come every other day. Fadwa has medical insurance from her late husband who was working in the private sector. She often uses the medical insurance every month but sometimes needs to pay certain amounts. Although she is aware of the free medication from the health centre, Fadwa never tried to take medicine from there because of lack services. She has high blood pressure, heart problems, diabetes, fatigue, anxiety, arthritis and osteoporosis, a hearing impairment, and high cholesterol. Her hospital care is covered by her medical insurance and she usually pays for medication only. Fadwa’s main source of income is from her husband’s pension, children’s financial support, social security and social insurance. Although the amount is enough, Fadwa says that she faces financial constraints every month as her unmarried son and daughter are still studying and need to cover groceries and other expenses. She considers herself in a middle class status. Despite shortcomings, Fadwa is satisfied and still thankful for her life.

**Faerouze**

Faerouze is 65 years old and divorced for 15 years. She has three daughters. Faerouze started to live alone 10 years ago in her own house but sold it two years ago to buy a new villa. She then brought her mother, her 35 year old daughter and her housekeeper to live with her. Faerouze had a chance to live alone but does not
want to live her 35 year old, unmarried daughter. However, she considers herself to be living alone as no one can control her behaviour.

Faerouze was employed in a paid work and retired as a teacher from the Ministry of Education. After her retirement, she established her own private school and holds a position as directress. Her two daughters work with her. Mostly, she spends her time managing the school. Faerouze usually feels lonely every time she had an argument with her daughter. She deals with it by staying a long time in her room and keeps herself alone. Faerouze’s daughter treats her like an old lady but she hates it as she feels very weak and depressed. Faerouze’s other daughters used to visit with their spouses and her grandchildren every Thursday while her friends visit once a week. Faerouze has high blood pressure, diabetes, and a visual impairment. Presently, she has no medical insurance but she used to pay for her own medical insurance. A year ago, she managed to get free medical treatment at the Military Hospital for a breast operation. Faerouze considers herself in a high class status. Her main sources of income are from her retirement pension and school revenue and she has more than enough to cover her needs. According to her, she is satisfied with her life now.

Fafi

Fafi is 62 years old and became widowed four years ago. She married at 27 and divorced after three years because of mistreatment. Like Dina, she remarried again at 38. She has one son and is currently studying abroad. Unlike other participants, Fafi lives with her oldest brother, sister-in-law and their one daughter since her husband died. She finished college education and has a Master’s Degree.

Fafi was previously employed as a lecturer and retired at 60. After her husband had died, she spent her time attending family occasions and obligations. She later approached the university to work again and she is presently working as a contractual employee. She likes to stay at home because she is a domestic person. She comes out to visit her relatives for very important occasions and mostly
spends her times with her brother and sister-in-law watching television, shopping and she used to sit and talk with their housekeeper every day. Fafi argued that she does not have specific things to do every day but her common activities are simply going to university and the house accordingly. Fafi had a chance to live alone but refused as she is afraid of loneliness. She feels lonely every night and when she is alone in her room. Although her brother requested for her to use their family driver, she still refused as she does not want him to feel that she is a burden; instead, she often goes out with her part-time driver to visit her sister every Thursday. The primary source of her income is her salary and the monthly financial support from her husband’s family. Even though she is aware of the free medication from the government, like Dina, Fafi still pays for her own medical insurance. She has an eye problem, and sometimes feels fatigue due to age. Generally, she feels fine and content with her life.

**Farha**

Farha is 75 years old and one of the oldest participants. She became widowed 15 years ago. Farha has five sons, one daughter, and one adopted daughter of another nationality. Her oldest son died at 55. Her two sons and daughter are doctors, but her daughter lives in Riyadh. Presently, she lives in her own house with her 39 year old son with Down syndrome, adopted daughter, seven housekeepers and two drivers. Farha had a chance to live alone but she refused because of her son’s condition. She gave her nearby apartment to her adopted daughter on condition that she would take care of her son. Farha never went to school due to the late introduction of education in Saudi Arabia but she attended informal education at the Mosque.

Although Farha stays more at home, she says she never feels lonely. She used to spend her time watching television, reading the Holy Quran, talking with her son, and calling her daughter in Riyadh at least three times a day. One of Farha’s sons acquired a house nearby to visit her regularly. Thus, her son used to pass by every day for at least 30 minutes. Her other son visits her twice a week. Although her
sons and daughter-in-laws requested her to live with them for two days, Farha declined and says she has a duty to take care of her other son. She suffers from high blood pressure, arthritis and osteoporosis, visual impairment and had two operations on her knee. Farha has no medical insurance and is unaware of free medication. However, her sons managed to obtain her regular medication and her operation was performed in King Adbulaziz University Hospital and sometimes, she pays for it personally. Farha was never employed in paid work and considers herself in a high class status. Mainly, her sources of income are from her husband’s pension and revenues from inherited properties from him; the amount is more than enough to support her financial needs and daily expenses. Overall, she is satisfied with her life but hopes to live long to take care of her son.

Hanadi

Hanadi is 75 years old and one of the oldest participants. She married at 16 and became a widow at the age of 55 years. Hanadi has one daughter and two sons. She lives in her own house with her son, daughter-in-law and their daughter. She did not attend formal education but attended lectures secretly at the Mosque with her female friends and relatives. Hanadi’s father was doubtful and afraid to send her to school; as an alternative he used to bring books for her and her siblings.

When Hanadi’s husband died, she suffered from loneliness for five years but her son lived with her to help with the loss of their father. Hanadi preferred to go out alone and to deal with loneliness; she spends her time shopping, watching religious programs alone, visiting her siblings once a week and arranges gatherings occasionally but limits her relationship to family relatives only. Hanadi argues that sometimes, she entertains herself by using a laptop. She visits her other son in Riyadh regularly and stays with him for a month. In addition, mobility is not an issue with her as she has own driver and housekeeper. Unlike other participants, she had a small food business as a hobby that lasted for five years but closed when her housekeeper that served as her helper in the business decided to leave the kingdom. Hanadi has diabetes, hearing problems, high blood
pressure, high cholesterol, visual impairment, fatigue, and had a medical operation with her knee and back. She is not aware of free medication but has medical insurance paid by her son, income from her husband’s pension and enough financial support from her children. In general, Hanadi concluded that her life is comfortable because of adequate supports from her family.

**Hanan**

Hanan is 68 years old and divorced 18 years ago. She has two daughters who are both married. Hanan had no chance to live alone as after the divorce, she lived with her aunt, and later with her brother. However, she had a problem with her brother’s wife, and started to live again with her aunt, and her daughter. She pays the apartment rental fees. Hanan never went to school and never engaged in paid employment in the past.

Hanan used to go to an institution for memorising the Holy Quran every day. She spends her day reading it and when she returns home she cleans their house. She usually feels lonely every night despite living with her aunt and cousin. Once when she cried her housekeeper stayed with her in the room. Sometimes, she goes to her neighbour to have a talk. Hanan’s two daughters live in Riyadh, and they used to visit her every month or two months at least. She has high blood pressure, heart problems, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, and a hearing impairment. Hanan has no medical insurance and she used to pay her medical expenses with the help of her children. She has used the free medication from the health centre and even tried other centres from other districts but the medication is limited. Hanan’s main sources of income are from the regular support of her children, social security, and charitable institutions. However, the amount is not enough to support her financial needs, thus she considers herself in the poor class. In general, Hanan is unsatisfied with her quality of life as she says that they live in an unpleasant situation. The reason for this is that she does not know what will happen to her in the future.
**Hedayah**

Hedayah is 60 years old and has been widowed twice before her divorce 12 years ago. Her first and second husbands are siblings and both died in an accident. Hedayah has four sons and three daughters. One of her sons died from a heart attack at 22. She stopped living with her husband 12 years ago but never had a chance to live alone. Presently, she lives in her own house with her children and divorced sister. Hedayah did not finish her primary education due to an early marriage. She never engaged in paid employment in the past.

Hedayah states that she does not have any special program or activities every day. She feels lonely if she stays at home for days. To deal with it, Hedayah sometimes visits her close relatives at their place. Her children visit her regularly. She has arthritis and osteoporosis, and a lack of Vitamin D. Although aware of free medication from the health centre, Hedayah never tried to obtain medicine from them due to poor services. She has no medical insurance, thus her sons usually pay for her hospital care. Hedayah has regular income from her husband’s pension, and receives a reasonable amount of inheritance every six months; she sometimes receives money from charitable institutions. She had social insurance for four months but it was discontinued because of the pension from her second husband. Hedayah considers herself in a middle class status but during difficult financial situations, she feels in the poor class. Although her finances are not enough, Hedayah is satisfied with her life and she is more concerned about her health and looks.

**Katrina**

Katrina is 74 years old and one of the oldest participants. She became widowed four years ago. Katrina has one son and one daughter. Presently, she lives together with her 50 year old married son in an apartment. Since she and her husband fell ill 10 years ago, they moved to her son’s apartment. Katrina did not finish her primary education and was never engaged in paid employment.
Katrina spends her time eating, sleeping, praying, sitting with her grandchildren, reading, and watching television. She usually feels lonely during the day when her son and grandchildren are busy with their work and school. Her siblings and other relatives visit her two to three times a month. Katrina has no medical insurance and is unaware of free medication from the health centre. She has high blood pressure, heart problems, diabetes, fatigue, arthritis and osteoporosis, and a hearing impairment. Katrina usually goes to the public hospital for free medication and care but sometimes, her siblings and children pay for her hospital care. Her main source of income is from her husband’s pension. Although her monthly income is not enough, she says her children and her brothers help her with everything. Katrina considers herself at a poor class status. Despite shortcomings, Katrina is still thankful for her life.

**Layla**

Layla is 75 years old and got divorced after 30 years of marriage when her husband remarried another woman. She has seven daughters and two sons. After the divorce, she lived in an apartment with her children with the financial help of her brothers. When they get married and she became alone, she decided to move and live with her eldest son. Layla did not finish her primary education as her father did not believe in education for girls. She never engaged in paid employment in the past.

Layla spends her days watching television, reading the Holy Quran, reading newspapers, phoning her other children and relatives, and mostly chatting with her daughter-in-law. Layla states that she never feels lonely. Layla’s other children visit her every two weeks. Although aware of the health centre, she never tried to go there to use their services. Layla has high blood pressure, heart problems, diabetes, fatigue, arthritis and osteoporosis, visual impairment, and blood liquidity problems. She has no medical insurance and usually goes to public hospitals for treatment and medication. Occasionally, she pays for her medicine if needed. She has no social security and her main source of income is the financial
support from her children. Although the support is irregular and not a fixed amount, Layla argues that it is enough to cover her personal needs, thus she considers herself in a middle class status. In general, Layla is satisfied with her life and just worried about her future health status.

Maja

Maja is 75 years old and one of the oldest participants. She became widowed 15 years ago and continues living in the same home with her youngest son and his wife. Maja has four children but lost her two daughters long ago. Since Maja became widowed, she never lived alone. She did not finish her primary education because of a family belief that allowing a woman to leave the home was disgraceful and shameful to the family. Maja never engaged in paid employment in the past.

Maja is a sociable person and always feels lonely when she has no activities. She deals with loneliness by socialising with her friends and by spending time with her sons. Maja usually spends her days watching television, phoning her family, and sometimes visiting her old friends. Maja is aware of free medication from the health centre but states that the centre does not provide the important medication for her medical conditions. She has high blood pressure, diabetes, fatigue, visual impairment, and depression for 35 years due to the tragic loss of her six year old daughter. Maja pays for her medicine and hospital care. She has regular income from her husband’s pension, and son’s financial support. Maja states that her income is not enough but she is trying to budget it to cover her primary needs. She considers herself in a middle class status. Overall, Maja is satisfied with her life but hopes to have more financial and medical support to cover the rising price of medication.

Muzna

Muzna is 62 years old and single. Presently, she lives with her paternal aunt since her parents died 12 years ago. She moved to her aunt as she was incapable of
paying her apartment rent. Muzna did not finish her primary education because of her family encouragement to stay at home and take care of their family. She never engaged in paid employment in the past.

Muzna spends most of her days cooking, watching television, and taking care of her aunt. She feels alone because of a limited social network and lack of facilities to meet her friends. Her brother who lives in Makkah visits her once a month. Muzna’s monthly income comes from social security and her father’s pension. She has high blood pressure, heart problems, depression, isolation, arthritis and osteoporosis, and visual impairment. Muzna is aware of free medication from the health centre but she does not obtain medicine from them because they do not provide important medication for her condition. She has no medical insurance and her aunt pays her hospital care. Although Muzna considers herself in poor class status, she is satisfied with her life. However, she hopes that the government would provide enough support in terms of medication and financial aspects.

**Nadia**

Nadia is 73 years old and widowed 14 years ago. She has three sons. Presently, she lives in an apartment at her brother’s expense, with her son and her daughter-in-law. She never had a chance to live alone. Since her husband died, her son will stay with her until she remarries. Nadia never went to school because of their financial status at the time. Nadia works as a seamstress, following her mother’s profession.

Nadia spends her days cooking, reading the Holy Quran, and sewing clothes for people. She usually feels lonely at night and while thinking about her son’s economic status. To deal with it, she spends her time sewing for work. Her other sons and their families used to visit her every weekend. Others who come on a regular basis are her customers. Nadia has no medical insurance. She is aware of the free medication from the health centre and used to use the services; however she is not satisfied. Her children used to pay her hospital care if needed. Nadia
suffers from high blood pressure, heart problems, diabetes, depression, fatigue, a hearing impairment, and high cholesterol. She considers herself in the poor class status. Her main sources of income are from her children, husband’s pension, and income as a seamstress. The income is not enough to cover her needs as she is the one who pays for groceries, and sometimes the apartment rental fees. There are times that they went to bed without dinner. Due to their present condition, she is unsatisfied with her quality of life and she feels sad and stressed. Nadia adds that only God knows what will happen in five years’ time.

Najwa

Najwa is 70 years old and divorced 20 years ago. She has two daughters and one son. One of her unmarried daughter lives with her in the apartment since the divorce. She pays for six months’ rent and the other half is covered by her children. However, she used to move to another apartment every five years or once the apartment rent goes up. Najwa is illiterate due to the late introduction of education in Saudi Arabia. As part of Saudi culture, her father arranged her marriage when reaching pubescent age.

Najwa suffers from loneliness and isolation every day, even living with her daughter. She feels happy and excited if someone knocks at her door. According to her, her daughter is unsociable and an introvert. To deal with loneliness, she spends her time watching television, joins her friends in a religious group, and goes to a shopping mall once a week. Najwa’s other daughter used to visit her every Wednesday and her son will visit her once he comes to Jeddah. Najwa has social insurance and receives an inheritance from the property of her husband, plus irregular financial support from her children. She considers herself in a middle-class status. Najwa suffers from high blood pressure, diabetes, depression, isolation, fatigue, a hearing impairment, and a visual impairment. She only found out about the free medication from the health centre six months ago but she did not try to use them as her children provided her medication regularly. Overall, she
said that life was much better in the past. She added that she feels satisfied but worried about the coming years.

**Nawal**

Nawal is 74 years old and divorced 25 years ago. She has four daughters and three sons. After her divorce, Nawal’s brothers arranged a small apartment for her and her children. When they worked and got married, she moved to a bigger apartment. Presently, she lives with her eldest son and his wife. Like other participants, Nawal never went to school due to her father’s thoughts that education is not for girls and only her brothers were sent to school. She never engaged in paid employment in the past.

Nawal spends her days watching television, reading the Holy Quran, phoning her other children and relatives, and sometimes going out for social and family commitments. Every evening one of her sons and daughters visits for an hour, either alone or with their spouses and they usually gather every Friday with their families. Like other participants, Nawal is aware of free medication from the health centre but never tried to use their services. She has high blood pressure, heart problems, diabetes, fatigue, arthritis and osteoporosis, and hearing impairment. Nawal has no medical insurance and used to go to public hospitals and pay for her medicine. Her main source of income is the irregular amount of money from her children. Although the amount is not much, she says that it is enough to cover her needs. She considers herself in a middle class status. Generally, she feels satisfied and content with her life.

**Neama**

Neama is 75 years old and widowed 25 years ago. She has five daughters and five sons. Neama lost three sons due to a heart attack, a chest problem and a stomach disease. She presently lives with her son and daughter-in-law in an apartment. Her son pays the rent. She had no chance to live alone as she started living with her son since her husband died. Neama never went to school due to family beliefs that
it was shameful for a woman to go out of the house. She never engaged in paid employment in the past.

Neama has no activities and always feels bored as she could not do anything. Neama says that she needs to have a housekeeper to help her. She spends her day watching television, drinking coffee, and adds that sleeping most of the time helps her to escape the loneliness. She deals with loneliness by praying and reading the Holy Quran. Neama’s daughters visit her every weekend but due to family issues, her daughters asked her to visit their house instead. According to her, her daughter-in-law controls everything and she feels like that she is a slave. Neama has no medical insurance but is aware of free medication from the health centre. She used to go there when she was sick but preferred to go to a hospital when she had enough money. Neama has high blood pressure, diabetes, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, hearing impairment, and visual impairment. Neama is at a poor class status and her income depends on social insurance, irregular support from her children, and her neighbour. Thus, her income is not enough to support her daily needs. She says her financial situation was affected when her husband died. Presently she lives in poverty but looks forward to government assistance to have a decent living. Asked how satisfied she is with her life, she answers that she has to be thankful and does not want to think and imagine her life after five years.

**Saleha**

Saleha is 73 years old and widowed 35 years ago. She has three sons. Saleha presently lives with her son and daughter-in-law. Saleha never went to school as she and her sister were orphaned when they were young and were left with nothing. She never engaged in paid employment in the past.

Saleha spends her days watching television, drinking coffee and, if she feels active on weekends, she cleans the house. She says there is nothing to do and
there is no place to go which is why she spends most of her time in sleeping. Saleha feels lonely but she already accepted it. When it comes, she deals with it by watching television and praying. She says that she used to go and visit her neighbours as she has no other relatives. Saleha’s children and other compassionate people used to visit her day after day or every week. She has no medical insurance and is unaware of free medication from the health centre. Saleha sometimes pays her own medical expenses but mostly her son pays although his salary is not that much. She has high blood pressure, heart problems, diabetes, depression, fatigue, anxiety, and asthma. Saleha considers herself in a poor class status. Her main sources of income are from her children and social insurance. She feels the income is sufficient but adds that nobody would refuse if there is extra money. Overall, she was thankful for what she currently has.

**Salha**

Salha is 65 years old and divorced 23 years ago. She has eight daughters and two sons. Presently, she lives with her daughters in an apartment at her brother’s expense. She started to live alone after her divorce and, five years ago, her daughters moved to her apartment as per a court decision. Salha did not finish her primary education because her father refused that she continues. She never engaged in paid employment in the past.

Salha rarely feels lonely because her daughters are around. She usually spends her days watching television, praying, and reading the Holy Quran. She likes to go out every two days to shop with friends. Her brother and other friends used to come to visit her at home every week. Salha has high blood pressure, heart problems and suffered a heart attack, diabetes, depression, isolation, fatigue, arthritis and osteoporosis, and visual impairment. She has medical insurance at her son’s expense. Salha is aware of free medication in the health centre but she preferred to use medical services using her medical insurance. She has regular income from her children, brother, and social insurance. Salha says her income is not enough to support her needs. She wants to enrol her divorced daughter in
social insurance; the reason why she is at the social insurance office. Despite the needs of additional financial support, she considers herself in the middle class. Salha says she is satisfied with her life but she does not want to talk about her future.

**Susan**

Susan is 61 years old and widowed for 30 years. Her husband died in an accident. She has three daughters. Presently, she lives in her own house with her 38 year old divorced daughter. Susan had a chance to live alone when all her daughters got married. But now her divorced daughter who is sick is living with her. Susan did not finish her primary education due to the disapproval of her husband. She never engaged in paid employment.

Susan spends most of her days with her daughters talking, eating, and crying. Her other daughters used to visit every other day. She feels lonely and sad every time she asks her daughters for financial support to cover her needs. They used to gather regularly but when her divorced daughter’s son died in a recent accident, they now only meet during weekends. Susan has no medical insurance and is aware of free medication from the health centre. She has been in the health centre but has no appropriate medicine supply. Susan adds that they do not have a qualified doctor to read the diagnosis. She has fatigue, anxiety, and arthritis and osteoporosis. Susan used to borrow money from her daughters or other people to pay her medical expenses. She considers herself in a poor class status. Her main sources of income are her social insurance and charitable institutions. Susan says that is not enough to cover her needs. She adds that her daughter sometimes demands money for her expenses. Although her financial status is not stable, Susan says that she is satisfied with her life.

**Tala**

Tala is 68 years old and widowed 17 years ago. She has two daughters and two sons. Tala presently lives at her own house with her 43 year old divorced daughter
and 29 year old unmarried daughter. She had no chance to live alone since her husband died but also refused if there would be a chance. Tala wished to remarry because of loneliness but her children and brothers refused. Like Nora, Tala finished her college education and held a Master’s Degree from King Abdulaziz University. She accompanied her husband to the United States of America to obtain his PhD. When they returned to Saudi Arabia, Tala completed her studies and was employed at 35 in a paid work and retired as director of the Saudi Post.

After retirement, she used to spend her days surfing the internet, watching television, and having pleasant conversations and chatting with her daughters and sons. Her other children regularly come twice or three times per week and her other relatives visit once a month. Tala says that when she was employed she used to have meetings and was surrounded by people but now she feels lonely and depressed when sitting alone. To deal with it, she usually phones her friends and interacts with other people through events and travelling. She finds herself writing poetry in the last three years and now considers it as a hobby. Thus, Tala has published two books already and the contractor invited her to Beirut and Dubai to hold poetry readings despite the objection and outrage of her children due to the possible interaction with males.

Tala suffers from high blood pressure, heart problems, depression, anxiety, arthritis, insomnia, and visual impairment. Like Nora, Tala is also aware of free medication from the health centre but she says that medication for some chronic diseases is unavailable. She has no medical insurance but is able to get free medication and check-ups at Jeddah Specialist Hospital. Tala considers herself in a middle-class status. She has enough income from her retirement pension, some of her children’s financial support, and a fair income from her books. However, she complains that her daughters have lavish tastes and spend too much on unimportant things. In general, she is satisfied with her life but thinks a lot about her future.
**Talha**
Talha is 70 years old and widowed for 10 years. She has eight children and one of them died in an accident. Presently, Talha lives in an apartment with her 35 year old son. She has been living with him since her husband died. Like Wadha, Talha never went to school due to home location as they lived before in a tent located in the desert. She never engaged in paid employment in the past.

Talha spends her time watching television and praying. She is very sick and unable to perform any activities. She says sitting with her daughters every time they visit her is more than enough for her. Talha seldom feels lonely except when eating and watching television alone. To deal with it, she used to phone her daughters. She rarely goes out of the house and, according to her, her last outing was two months ago when she attended her daughter’s friend’s graduation party. Talha has no medical insurance. She is aware of free medication from the health centre and tried them twice but she was not satisfied with their services and does not want or is afraid of medication and hospitals. She has high blood pressure, depression, fatigue, anxiety, and fear of society. Talha considers herself in a poor class status. Her main sources of income are from social security and her children’s financial support. The income is not enough to cover her needs but she is thankful. She says she does not focus on anything and it is important for her to entertain herself until she stops thinking about her son who died in an accident. Overall, she is satisfied with her life and keeps on praying to protect her children.

**Wadha**
Wadha is 72 years old and divorced for 20 years. She stopped living with her husband when he married another two women. Wadha is infertile and was thankful that she did not have children with her husband. Presently, she lives with her brother and his two wives. She has been living with them since her divorce. Wadha never went to school due to the late introduction of education and home location as they previously lived in a desert. She never engaged in paid employment in the past.
Wadha has a good relationship with her brother and his wives. She feels satisfied living with them and they consider her as the most important person in the home. She used to spend her days watching television and drinking coffee with them. Her brother’s children used to visit her regularly. Wadha has medical insurance at her brother’s expense. She is aware of free medication from the health centre but she preferred to use medical services through her insurance. She has high blood pressure, depression, and fatigue. The primary source of her income is from her social insurance only. She says her monthly income is not enough but her brother is trying to cover some of her financial needs. She considers herself in a poor class status. Although Wadha is living with his brother and his wives, she states that she is not happy but must be happy and accept the reality.

Zana
Zana is 75 years old and divorced for 24 years. She is infertile. After the divorce, she started to live with her widower brother. Zana never had a chance to live alone but she says that if she had, she would also refuse. Zana never went to school due to the late introduction of education and never engaged in paid employment in the past.

Zana has a good relationship with her brother, and her nephews and nieces. She feels satisfied living with them. She used to spend her days watching television and drinking coffee with them. Zana did not feel lonely but she wishes to have her own daughter to live with. She used to stay at home with her brother. Her other relatives used to visit her monthly. Zana has no medical insurance but her brother and his children usually pay for her hospital care. She is aware of free medication from the health centre but she is taking the basic medication only. Zana has high blood pressure, a heart problem, diabetes, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, and a hearing impairment. Her monthly income comes from her inheritance, financial support from her brother and nephews, and social insurance. She says her monthly income is enough to cover her financial needs.
Zana considers herself in a middle class status. She is very satisfied with her life and sees herself in the future as happy and content.
Appendix 6a2 - Participants who lives alone

Aiza
Aiza is the oldest participant at 75 years old. She married at the age of 10 and became a widow at the age of 65. Aiza has two children and presently lives alone with her housekeeper. Like Fatima and Manal, Aiza never went to school due to the late introduction of education in Saudi Arabia.

Aiza suffers from loneliness and deals with it through praying, crying and watching sad programmes on television. According to her, no one provided her with transportation and she has just used a taxi all her life; the main reason that restricts her from travelling outside her house. Aiza has social insurance and receives inheritance money from the property of her husband, plus irregular financial support from her children. Like Maria, Aiza has no medical insurance; hence she always covers her own medical expenses. She suffers from a skin disease, diabetes, hearing and visual impairment, memory loss, fatigue and she has a big wound on her leg which is not healing properly. In addition, Aiza has deep depression and has suffered emotional problems as a result of her two husbands. Overall, she said that she is not satisfied with the available financial support.

Alma
Alma is 73 years old and widowed 44 years ago. She married at the age of 16. Alma has two sons but one died in an electric accident five years after his husband passed away due to a car accident. Five years ago, she lived with her son and daughter-in-law but later requested her son to get an apartment as she decided to live alone. Although the treatment of her son and his family was okay, she likes to have her own house and expressed that she does not want others to control her. Presently, she lives with her housekeeper and driver. Like Hanadi, Alma never
went to school because of having a conservative father but she had informal education by attending different religious seminars and reading many books.

Alma is a sociable individual and has good relationships with family and friends. As a member of a religious organisation, Alma used to conduct religious lectures for people. She feels lonely rarely when she remembers her husband but otherwise states that she never feels lonely. Alma used to visit her three siblings every week, attended family occasions and regularly invited her neighbours regardless of age to spend time or eat with her. She spends her time reading the Holy Quran and prefers watching religious programmes alone. Alma is unaware of free medication from the government but she is not interested as she considered it a charity. She has income from her father’s pension and enough financial support from her son. Alma has diabetes, hearing problems, fatigue, osteoporosis, high cholesterol, high blood pressure, visual impairment and she had a major medical operation on her knee two years ago. She is active despite the problem with her knee and, like Hanadi, mobility is not an issue for her as she has her own driver and housekeeper. Overall, she says that her life will be easy if she has her own house to live in and if her health is fine. She is optimistic that she will still be alive after five years.

Asma

Asma is 63 years old and divorced 38 years ago. She married at the age of 21. She has one daughter but presently lives in her own house with her housekeeper and driver. After her divorce, Asma continued her education to obtain a Master’s Degree. She had a chance to remarry but refused due to experiencing mistreatment from her first husband.

Like Fafi, Asma was employed and retired from her previous work. Her daughter visits her occasionally. Asma feels lonely sometimes and, to deal with it, she spends her time watching television, doing exercise at home, attending family and friends’ occasions, and likes to travel with her friends. She used to gather with her
friends every two weeks but preferred to meet them outside her house. Occasionally, she feels regretful that she did not remarry. Her primary sources of income are her monthly pension and her father’s property revenue. In addition, she leases her one room in the house and gains income from the rental payment. Mobility is not an issue for her. Asma is aware of free medication but opts to pay her medical insurance personally. She has a heart problem, visual impairment, and high blood pressure. She underwent an operation related to her heart at least five years ago. Asma emphasised that her life is better after she retired because of not having any obligations. In general, she is satisfied with her life.

Dania

Dania is 63 years old and has been divorced for 20 years. She has two sons and two daughters. Presently, she lives alone with her housekeeper in an apartment. Dania had no chance to live with her children as all of them are married already, and work and live outside Jeddah. She did not finish her primary education. After her divorce, Dania started to work for security at King Abdulaziz Airport. Dania spends her whole day working. Her transportation between home and work is provided by her company. She feels lonely every night and, to deal with it, Dania usually calls her two friends, and invites them over and sometimes asks them to sleep with her. Her children and their families usually visit her every week; her other relatives visit monthly, and her friends visit her sometimes. Dania has medical insurance from her company and is satisfied with the services provided as all her medication is provided. She is aware of free medication from the health centre and tried to use the services twice; however, she is not satisfied with the services as there is a lack of medication. Dania has high blood pressure, isolation, arthritis and osteoporosis, visual impairment, and high cholesterol. Her hospital care is covered by her medical insurance but sometimes she personally pays for other charges. Dania’s main source of income is her salary and her children help her in paying the rental fee. Although her monthly income is not enough, Dania considers herself in middle-class status. She is satisfied with her
life but she adds that it would be far better if she and her children were financially stable. Dania wishes to see her children in the best and most comfortable position in the future.

**Dina**

Dina is 65 years old and married at the age of 20. She became a widow at the age of 50 and remarried after five years. After one year of marriage to her second husband, she asked for a divorce due to financial issues with him and later decided not to marry again. Dina has three sons and two daughters. She lives in her own house with her three housekeepers, driver and guard. Unlike other participants, Dina’s father asked her to continue studying abroad but she refused; thus, Dina finished primary education only.

Dina had an opportunity to live with her children but refused as she preferred to live alone. She started living alone when her daughters got married. Mobility is not an issue for Dina as she lives in a high economic status. She used to travel alone as she obtained a legal permit from her eldest son as male guardian. Dina used to invite her two sisters and friends to gather in her house every Tuesday and Thursday while her sons and daughter visit her every Friday. Her housekeeper who later became her close friend eats with her every day. Dina has inherited a number of real estate properties from her father which serves as her substantial source of income. Dina personally pays her medical insurance yearly. She underwent an internal operation five years ago. She has diabetes and an eye problem and, due to being overweight, she suffers from high cholesterol and a leg problem. In general, she is satisfied and optimistic about her life as she has everything to support her needs.

**Fadiya**

Fadiya is 65 years old and divorced 20 years ago. She married late because her father gave her the freedom to travel and decide on her own. She has one son and one daughter. Presently, she lives alone in her own house which was bought for
her by her brother after the divorce. Fadiya did not continue her college education because most of her family members were focused on women marrying good men and raising children. She engaged in paid employment in a bank after her divorce but decided to leave as the work was tiring.

Fadiya used to stay awake up from 5am to 6am every day and wake up in the afternoon. After breakfast, she spends her time in the gym and sports club every other day. Most of the time, she meets her friends at home. She has property in Al-Taif and used to spend her weekends there. Fadiya seldom feels lonely because of having many friends. Fadiya’s brother acted as her male, legal guardian. Her brother gave her permission and she enjoyed travelling. Her children and her siblings usually visit during weekends, and her friend visits whenever she is available at home. Fadiya has religious and poetic lectures at home every evening. In addition, her nurse comes every day to give her injections for multi-vitamins for her bones. She has high blood pressure, depression, fatigue, arthritis and osteoporosis, and visual impairment. Fadiya has medical insurance at her own expense and she is not aware of the free medication from the health centre. Her main sources of income are from inheritance, and from the regular financial support from her children and brother. She considers herself in a high class status. Overall, Fadiya says that she is satisfied with her life as long as she is in good health.

**Farah**

Farah is 74 years old and never married. Farah states that her father believed that a girl’s place should only be at home doing household chores. Although never married, Farah has a foster son. Farah unfortunately cannot travel because of her present marital status and does not have a male legal guardian. According to her, she tried to request her cousin to marry her in paper only but he refused. Presently, Farah lives alone in her own house with her two housekeepers. She did not finish her primary education and was never engaged in paid employment due to her father’s beliefs and influence of socio-cultural norms.
Farah has lived in her own house for almost 30 years with her parents and only brother until they died. She spends her days watching television and talking with her nearby friend and housekeepers. Farah feels lonely during bedtime and blames her father for her status. She says her life was wasted and she always hoped to have children. Her neighbour sees her daily, her foster son and his family used to visit her weekly and her other relatives visit her infrequently. Although Farah is discontented with her father, she was lucky to receive a good inheritance from him. Thus, she says her monthly income is more than enough for her daily needs. Farah suffers from high blood pressure, diabetes, depression, fatigue, visual impairment, and panic attacks. She is unaware of the free medication but she pays her own medical insurance. Farah is satisfied with the services provided by the private hospitals through her personal medical insurance. She considers herself at a high class status. Overall, Farah is pleased with her life but only raised the issues of needing to travel to seek medical advice abroad.

Fatima

Fatima is 74 years old and divorced 20 years ago. She got married at the age of 13. She has three sons but presently lives alone with her housekeeper and driver. Fatima said that she experienced her freedom again after her divorce. Fatima is illiterate due to the late introduction of education in Saudi Arabia. She stated that she was 10 years old when the government first opened schools for girls in Saudi Arabia, especially in Jeddah, and it was too late for her to enrol.

Fatima used to go out shopping to meet her friends within the same age groups to deal with loneliness. She has a medical insurance card but very rarely uses it as she takes advantage of the financial support she receives from her sons. She said she is satisfied with the financial support provided by her sons. Fatima has arthritis, osteoporosis and visual impairment diseases.
Fatoomah

Fatoomah is 68 years old and became widowed three years ago. She has three sons and two daughters. Fatoomah started living alone in her own old house since her husband died. Her other sons live in a nearby apartment. Like Rogaiyah, Fatoomah never went to school as they used to live in a semi-desert area. Also, she never engaged in paid employment but she was responsible for herding livestock instead.

Fatoomah spends her time eating, cooking, praying, reading, watching television, and house cleaning. She usually feels lonely every night but reading the Holy Qur’an helps her to deal with it. She was scared to live alone when her daughters got married but she became accustomed after three months of being alone. Her children visit her regularly. She says her daughters alternately come to see her and her son, living nearby, used to come every day. Fatoomah has high blood pressure, diabetes, fatigue, arthritis and osteoporosis, hearing impairment, and visual impairment. Fatoomah has no medical insurance but she used to pay for her hospital care with social insurance money. Fatoomah is aware of free medication from the health care but her diabetes medicine is not available; thus, she goes to a specialised hospital for diabetes and pays for the medication at her own cost. Fatoomah considers herself in a middle class status. Her main source of income is from her husband’s inheritance, children’s financial support, and social insurance. Although her monthly income is not enough, she feels satisfied with her life but she also highlights the need for complementary medication for elderly people.

Fayza

Fayza is 75 years old and widowed for 30 years. She has two children but presently lives in her own duplex house with her housekeeper and driver. Her sister lives in the neighbourhood. Fayza was fortunate to finish her education in a famous university in Egypt. Her father encouraged her to continue her Master’s Degree but she refused as there was an opportunity to work in the Ministry of
Education. She had obtained a position in the Ministry as first inspector/supervisor when the government opened schools for women in Jeddah.

After her husband had died, Fayza had a chance to live with her relatives but opted to live alone as she wanted to live freely. She spends her time in praying, walking, reading and watching televisions. Fayza is satisfied to her income from her retirement pension and inheritance. She appears to have saved reasonably over the years, as she mentioned that she sells stocks in marketable equities sometimes for major spending; such as buying her son a car. Thus, she considers herself at a middle class status. Fayza has visual impairment, fatigue, osteoporosis, and had a medical operation on her heart some years ago. She is aware of free medication in the health centre but she preferred to use medical services in a government hospital. Fayza feels comfortable living alone and considers herself financially independent. In general, she feels far better compared to other women her age.

**Hessa**

Hessa is 63 years old and desolated. She married at the age of 38 but did not have children because of a condition from her previous husband. Presently, she lives alone with her housekeeper in her own house. She had a chance to live together with her mother seven years ago but refused and preferred to live alone. Hessa finished her college education in the USA and spent four years living there at her father’s expense. She was employed in paid work and retired three years ago as a library administrative officer at a prominent University in Al-Madina.

After retirement, Hessa used to travel and buy some goods for her accessories shop business. She spends her time reading books, watching television, and managing her shop. She feels lonely while sitting with her friends and once she remembers her previous work. Hessa used to see her friends and shop customers regularly, and her siblings once a week or when their schedules allowed. Hessa has medical insurance at her own expense and it covers her hospital care and medication. She is not aware of free medication from the health centre. Hessa has
high blood pressure, heart problems, diabetes, depression, isolation, and visual impairment. She considers herself at a high class status. Her monthly income comes from her inheritance and pension. She says her monthly income is more than enough to support her needs because she lives alone, has her own house, and a business. Hessa is thankful and says that she is financially comfortable but socially alone in society.

**Layla**

Layla is 65 years old and widowed for 15 years. She has two sons but she lives in her own house inherited from her husband with her housekeeper and driver. She tried to remarry but her sons refused. Layla is a secondary school graduate and did not continue her education to college because she got a job immediately and no one encouraged her to do so. She had paid employment as a post office employee.

Layla is thankful to her neighbour who used to spend three to four hours with her daily. She spends her time watching television, praying and phoning but, according to her, her neighbour alleviates her loneliness every day. Her sons and their families visited her during festivals only. Layla has diabetes, high blood pressure, visual impairment and hearing impairment. She has no medical insurance but she is aware of the free medication in the health centre and used to obtain basic medication from them. The primary sources of her income are from her retirement pension and irregular financial support from her sons. She considers herself in a middle class status. Overall, she feels satisfied with her life but was disappointed in her sons when they refused to grant her the authority to travel alone.

**Lola**

Lola is 65 years old and divorced 16 years ago. She has two sons and one daughter. Presently, she lives alone in an apartment and her children help her to pay the monthly rent. After her divorce, she lived with her brother for six months
and then moved to her present apartment. Lola did not continue her primary education because her father insisted that a girl’s place should be with the family and in the husband’s home only. She never engaged in paid employment in the past.

Lola usually feels lonely all day, especially in the evening. She remembers that in the past, she had pleasant company with her children and previous husband. To deal with loneliness, she sometimes cries or walks outside her apartment for 30 minutes to an hour. Lola’s daughter and her grandchildren visit her regularly every Wednesday. Her divorced sister used to invite her to spend one day with her monthly. Most of the days, Lola spends her time in praying, watching television, and drinking tea with her 37-year-old neighbour. Every Tuesday, she attends the gathering at her neighbour’s house. Lola has high blood pressure, diabetes, depression, isolation, fatigue, and visual impairment. She has no medical insurance. Lola went once to a health centre for medication but they transferred her to a public hospital. She says it is not easy to obtain free medication monthly, thus Lola seeks intermediary doctor’s assistance to get medicine every two months. Although her children’s salaries are very low, Lola receives regular financial support from them. She has social security and manages to obtain financial assistance from a charitable institution every 7-8 months. However, her total income is still not enough to support her daily needs, especially when rent is due. To partially manage her requirements in the past, she accepted sewing work from her neighbours; however, her present health prevents her doing this. Thus, she considers herself in a poor class status. Lola says her life is underprivileged, and it is very difficult to grow old and live alone. She hopes to live with her son in the future.

**Majda**

Majda is 60 years old and divorced 30 years ago. She has one son and one daughter. Her son works in social insurance. Presently, she lives alone in an apartment and her children help her to pay the monthly rent. She had an
Majda does not feel lonely at all. Most days, she spends her time doing household chores, praying, watching television and, sometimes, visiting her very close relatives and friends. Majda’s children and grandchildren visit her regularly while some of her friends visit her alternately every week. Majda has high blood pressure, hearing and visual impairment. However, in general, she says her health is good. She is unaware of free medication from the health centre. Majda has no medical insurance but she and her children pay for her hospital care. Although her children’s salaries are average, Majda receives regular financial support from them. In addition, she has social insurance as the main source of monthly income. However, she says her total income is not enough to cover her financial needs as she has a debt to pay. Thus, she considers herself in a poor class status. Majda says she is satisfied with her life as everything comes from God and she has to accept it. However, Majda has a negative perception regarding her future as she sees death as the nearest thing for her.

**Manal**

Manal is 74 years old and divorced 20 years ago. She has nine children but lives in an apartment with her housekeeper only. Like Fatima, Manal is illiterate due to the late introduction of education in Saudi Arabia.

Manal suffers from loneliness and isolation every day. To deal with it, Manal spends her time praying and eating. Despite having nine children, Manal does not receive any financial support from them. Instead, she depends on the social insurance, her siblings and relatives and other large companies who provide charity. Manal has diabetes, fatigue, hearing and visual impairment, osteoporosis, high blood pressure and heart disease. She has no medical insurance; hence she
always covers her own medical expenses. Like Maria, Manal also emphasised the needs for free medication and financial assistance from the government.

**Naheed**
Naheed is 73 years old and widowed 15 years ago. She has two sons and two daughters. Presently, she lives alone in her own house with her two housekeepers. Naheed had an opportunity to marry again two years after her husband died but her children did not agree. She had a chance to live with her daughter at the same house; however, when her daughter married eight years after her husband died, her daughter moved and lived with her husband. Naheed never went to school because of a late introduction to education in Saudi Arabia and never engaged in paid employment in the past.

Naheed spends her days watching television, and phoning her children. She does not want to stay at home; instead she goes out with her housekeeper and roams the city of Jeddah. She usually feels lonely every night. To deal with it, she always cries and phones her daughter to have a talk and remember the past. Her son rented her other house that is located nearby and visits her regularly. Naheed’s other children visit her every day too, and her grandchildren and friends visit her twice a week. She has diabetes, fatigue, arthritis and osteoporosis, visual impairment, and high cholesterol. Naheed pays her own medical insurance and she is not aware of the free medication from the health centre. She considers herself in a high class status. Her main sources of monthly income are from inheritance and husband’s pension. The amount is more than enough for her needs and she used to help her children with their expenses. In general, she is satisfied and thankful for what she has right now.

**Nayla**
Nayla is 70 years old and has three sons and one daughter. She became widowed 16 years ago and continues living in the same four-storey building which was bought by her husband 20 years ago. She lives alone with her two housekeepers
and her children live on separate floors. With this living arrangement, she does not consider herself living alone. Although her father had enough wealth to support her education, Nayla did not finish her primary school as her father did not care about her studies. She never engaged in paid employment in the past but she was involved in a business operation as she entrusted her inheritance to her husband.

Nayla rarely feels the loneliness because her children are living with her in the same building. She used to wake up early to look after her grandchildren before and after the school. She eats her lunch with her children as they habitually come to her house. Her common activities involve doing exercise every evening and meeting her friends who have doctors’ appointments. Since Nayla’s family lives with her in the same building, they used to come to her room on a regular basis. She has high blood pressure, diabetes, visual impairment, and high cholesterol. Nayla has medical insurance at her son’s expense. She is satisfied with the services provided by the medical insurance but she used to pay other medical expenses. Although aware of free medication from the health centre, Nayla did not take their services. Nayla’s main source of income is from the inheritance from her father and her husband. She considers herself in a high class status as the amount she receives more than caters for her financial needs. She helps her children with their needs, and she let her divorced, women friends live for free in her small building. Overall, Nayla is very satisfied with her life but emphasised that women need to have a voice in society and there should be an organisation to protect others without homes.

**Nisreen**

Nisreen is 60 years old and widowed five years ago. She has two sons. Presently, she lives alone with her housekeepers and driver in her own duplex house. One of her sons lives in the United States of America while her other son lives in her neighbourhood. Nisreen completed her college education, obtained a Master’s
Degree in Canada, and was employed in a paid work. When her husband died, she retired early at 55 from an administrative position at a university in Jeddah due to a government policy to choose between her salary and her husband’s pension. However, the University asked her to stay as a contractual employee due to her working qualifications. Recently, she retired from her work in the university.

When Nisreen became a widow, she moved and lived with her brother for one year, and then moved to her own house. She then lived alone for one year and the lived with her son the following year. Later, she stayed in Canada for one year to obtain her Master’s Degree. Nisreen is not a fan of television, thus she spends most of her time on a computer. She feels lonely every night, during festivals or on any other occasion. Nisreen deals with it by looking at her picture albums. She adds that the feeling is not permanent. Her nearby son used to visit her regularly, while her siblings and in-laws with their children visit every Thursday. Nisreen has no medical insurance but had the privilege of free medication and a check-up in the Hospital affiliated with the university. She is aware of free medication but did not try to obtain it from the health centre. She has diabetes, visual impairment, and had an oophorectomy procedure recently. Nisreen’s main sources of income are her husband’s pension, children’s financial support, and the revenues from inherited properties from her husband. The income is enough to support her financial needs but she adds that it is not at the same level compared to when her husband was around. However, she still considers herself at a high class status. Nisreen feels satisfied with her life and sees herself as closer to God because of fewer work responsibilities now that she has retired, unlike in the past.

Nora

Nora is 70 years old and widowed 20 years ago. She had a great time with her husband as she says that he was a wonderful companion. Nora has three sons and one daughter and presently lives alone at her own house. All her children are professionals and are financially well off. They offered for her to live with them in a housing compound but she declined and opted to live alone with her
housekeeper and driver. She feels content living alone and has more opportunity to find herself and feel free. Nora finished her college education and was employed in a paid work at two government agencies. She retired 13 years ago from General Presidency for Girl’s Education in an administrative position.

Nora has a healthy relationship with her family. Her children, in-laws, and grandchildren visit her regularly on a weekly basis while her friends and siblings visit every second week. Nora loves to enjoy every moment of the day, thus she used to sleep and wake up early. She has an equipped exercise room in her house and preferred to do her exercise at home rather than outside due to hot weather. Nora is a sociable person and always wants to engage herself in cultural gatherings. She used to host literacy groups at her own house every Thursday and, recently, the gathering was attended by her children and their own families, and her friends with their spouses where all of them belong to the educated and literate class. Nora rarely feels lonely but if she does she deals with it through talking with her long-time friends over the telephone and by reading several books. She also used to travel once a month or during short holidays to Lebanon, Egypt and Dubai.

Although aware of free medication, Nora personally pays for her medical insurance and never considered going to a public hospital. She has heart problems, anxiety, arthritis, and visual impairment. Nora is at a high class status and has more than enough income from her retirement pension, husband’s inheritance, children’s financial support, and receives a steady income from her own properties. She is involved in charity activities and continuously supports five families by granting them monthly financial assistance. Overall, she is very satisfied with her life and sees her health better due to advancement in the medical fields.
Rogaiyah

Rogaiyah is 75 years old and one of the oldest participants. She became widowed only two months ago. Rogaiyah has four daughters and three sons. She has been living in the same house since she got married. Presently, she lives alone with her housekeeper but some of her children live in the neighbourhood. She never went to school because they used to live in a semi-desert area in the past. Rogaiyah never engaged in paid employment but she was responsible for herding livestock instead.

Rogaiyah says that she does not have any special program or activities every day. She feels lonely every night and, to deal with it, Rogaiyah spends her time praying, watching television, and reading the Holy Qur’an. She used to go out to see her children nearby every other day. Her children, other relatives, and her neighbour visit her in her house every three days or sometimes depend on their schedule. She has high blood pressure, heart problem and heart attack, diabetes, depression, isolation, fatigue, anxiety, arthritis and osteoporosis, hearing impairment, and visual impairment. Rogaiyah is aware of free medication from the health centre, and sometimes goes there to take basic medicine only as other medicine for her condition is unavailable. She has no medical insurance, but her children usually pay for her medicine and hospital care. Rogaiyah has regular income from her children and social insurance. Although receiving regular income, she says the amount is not enough sometimes to cover her needs. Rogaiyah considers herself at a middle class status. She is satisfied with her life but does not know what her situation will be after five years.

Sabra

Sabra is 60 years old and divorced three times. Her first married was at the age of 22, and she divorced him after four months. She got married again at the age of 35 to a 73 years old man and divorced after three months. Her last marriage was at the age of 41, and she then divorced him after one year. Sabra has one daughter
from her first husband. She finished secondary education but no one encouraged her to continue to college.

Sabra lives in poverty. She lives alone in a rental apartment with her two cats from the streets. Sabra’s daughter visits her occasionally and, according to her, the last visit was two months ago. She has three brothers and one sister but one brother, who lives in another city, used to call her weekly but is unable to visit her. Sabra suffers from isolation and loneliness all the time and to deal with it, she spends her time sleeping and crying. Sabra argued that she does not have any common activity besides throwing out the garbage and then going to a small store near her house. She was formerly employed but decided to resign due to the low salary and high transportation costs. Although her brother has a good position in the government, Sabra still feels sad as she argued that she is from a big family but is neglected. Presently, Sabra’s financial income comes from her father’s monthly pension and her cousins and uncle’s wife used to give her a small amount irregularly but that is still not enough to support her needs. According to her, the monthly rental of her apartment is already delayed by two months. She used to buy and loan foods from the small store and pays it every month end. Sabra has no medical insurance. She is aware of free medication and avails it but only basic medicine is available from the district infirmary and no check-ups are made. Sabra has high cholesterol, depression, hearing and visual impairment, osteoporosis, diabetes, high blood pressure and fatigue. Overall, she is highly depressed and feels that she will not be alive after five years but highlights that enough financial support will suffice to cover all her requirements to have a decent living.

Salma

Salma is 66 years old and has been divorced for 10 years. She has four sons and three daughters. Presently, she lives alone in an apartment owned by a non-governmental organisation. After her divorce she had an opportunity to live with her brother but had an argument with him due to inheritance issues. He then
expelled her from his house. Salma did not finish her primary education because of family beliefs regarding women leaving the home being disgraceful and shameful to the family. She never engaged in paid employment in the past.

Salma usually spends her days at home, doing nothing. She feels bored with her life and feels lonely all the time. All of her children are living out of Jeddah and they usually come to visit her every two months. Her elderly, female neighbour usually visits weekly. Salma has no medical insurance. Although aware of free medication from the health centre, Salma says that she receives basic medicine only. She pays for most of the medicine she needs and the hospital care is paid by her children. She suffers from high blood pressure, depression, fatigue, arthritis and osteoporosis, hearing impairment, and visual impairment. Her main sources of income are from her father’s pension, social insurance, and children’s financial support. The monthly income is enough to support her needs and she considers herself in middle class status. When asked about her satisfaction in life, Salma says she thanks God but feels alone despite having children.

**Sanabel**

Sanabel is 63 years old and widowed three years ago. She has two daughters and one son but lives alone with her two housekeepers in her own house. She never had a chance to live with others. Sanabel finished her college education and holds a Master’s Degree. She was employed in paid work and retired three years ago as a manager in a government agency.

Sanabel was employed in an important position in the government agency. She feels the emptiness after retirement. Sanabel spends her day praying, watching television, doing exercises and arranging visits to her neighbours. She feels lonely every morning as she misses her daily routine while at work. To deal with it, she reads some books and attempts to communicate with her previous staff. Sanabel’s daughters and friends visit her regularly every Thursday. Her son works in Riyadh and she used to travel to Riyadh monthly to see him. Sanabel has high blood
pressure, heart problems, fatigue, and visual impairment. She has medical insurance from the Ministry of Social Affairs and often uses it when needed. She is aware of the free medication from the health centre but most of the women she knows are unsatisfied with the provided services, which is why she is not interested in trying the services. Her monthly income comes from her inheritance, pension, and earnings from her business; thus, it is enough to cover all her needs. She considers herself in a high class status. Overall, she is satisfied with her life and believes she will be much better after more years.

**Sarah**

Sarah is 65 years old and widowed 20 years ago. She married at the age of 48 and only lived with her husband for three years. Sarah had a chance to live with her siblings after she became a widow and, three years ago, she opted to start living alone in an apartment. Sarah has no children due to her late marriage. She finished her college education and has a PhD Degree. Sarah was employed in a paid work and retired as a teacher in one of the big public schools in Jeddah. Like Nisreen, Sarah worked after her retirement as a contractual employee for four years. She is also engaged in voluntary services with 3-4 associations.

Sarah lived in Lebanon and returned to Saudi Arabia when she was 24 years old. According to her, she felt alone when she was living with her parents and also when she returned from Lebanon. However, Sarah has become familiar with being alone and says that she does not feel lonely now. Most days, she spends her time teaching and her common activities involve watching television and surfing the internet. Sarah usually sees her brothers and sisters once a week. One of her sisters lives in the same building with her. She used to pay her monthly apartment fees but her brothers want to help her now. Sarah has no medical insurance and is unaware of free medication from the health centre; instead, she pays her own medical expenses. She suffers from diabetes, fatigue, and visual impairment. Her main source of income is her retirement pension and, according to her, the amount is enough to cover her needs as she lives a very modest life. Sarah considers
herself in a middle class status. Overall, she is satisfied with her life and believes that she is better off than the other older women.

**Sumayah**

Sumayah is 70 years old and divorced 20 years ago. She has three daughters and three sons. Presently, she lives alone in an apartment at her brother’s cost. When her children worked and married, they all became busy and visit her rarely. She never went to school as her father did not believe in education for girls. Sumayah never engaged in paid employment in the past.

Since living alone, Sumayah usually feels lonely. To deal with it, she spends her time praying, watching television, and cleaning the house. Sumayah adds that sleeping most of the time helps her escape the loneliness. She brings up the feelings of sadness when she says that she spent the holy month of Ramadan alone. She argues that in the past, she used to eat meals with her six children but now she sits and eats alone all the time. Sumayah’s children rarely visit. If they do, they only stay a short period. She is aware of free medication in the health centre but never tried the services. She has no medical insurance and usually goes to public hospitals. Her medication commonly comes from charitable people. Sumayah has high blood pressure, heart problems, diabetes, depression, fatigue, anxiety, arthritis and osteoporosis, hearing impairment, and visual impairment. Her source of monthly income comes from her brothers, other relatives, and some donations from charitable institutions. She considers herself in a poor class status as the amount she receives is not enough to support her needs. Overall, she is not satisfied with her life and hopes to have enough financial and medical support, as well as a person to live with.
Appendix 6b
Family and Living Arrangements of Participants

<table>
<thead>
<tr>
<th>SN</th>
<th>Participant Name</th>
<th>Age</th>
<th>Marital Status &amp; History</th>
<th>Number of Children</th>
<th>Living Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fatima</td>
<td>74</td>
<td>Divorced / 20 years ago</td>
<td>3 sons</td>
<td>Living alone with her housekeeper and driver</td>
</tr>
<tr>
<td>2</td>
<td>Maria</td>
<td>70</td>
<td>Widowed / 15-16 years ago</td>
<td>10 children</td>
<td>Living with her son, daughter in-law and their children</td>
</tr>
<tr>
<td>3</td>
<td>Manal</td>
<td>74</td>
<td>Divorced / 20 years ago</td>
<td>9 children</td>
<td>Living alone in an apartment with her housekeeper</td>
</tr>
<tr>
<td>4</td>
<td>Aiza</td>
<td>75</td>
<td>Widowed / 10 years ago</td>
<td>2 children</td>
<td>Living alone with her housekeeper</td>
</tr>
<tr>
<td>5</td>
<td>Hanadi</td>
<td>75</td>
<td>Widowed / 20 years ago</td>
<td>2 sons and 1 daughter</td>
<td>Living in her own house with her son, daughter in-law and their daughter.</td>
</tr>
<tr>
<td>6</td>
<td>Alma</td>
<td>73</td>
<td>Widowed / 44 years ago</td>
<td>2 sons (1 died in an electric accident five years after her husband passed away due to a car accident.)</td>
<td>Living with her housekeeper and driver (living previously with her son and daughter in-law but opt to live alone)</td>
</tr>
<tr>
<td>7</td>
<td>Dina</td>
<td>65</td>
<td>Widowed / 15 years ago</td>
<td>3 sons and 2 daughters</td>
<td>Living alone in her own house with her 3 housekeepers, driver and guard</td>
</tr>
<tr>
<td>ID</td>
<td>Name</td>
<td>Age</td>
<td>Marital Status</td>
<td>Children</td>
<td>Living Situation</td>
</tr>
<tr>
<td>----</td>
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<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>Fafi</td>
<td>62</td>
<td>Divorced / at age of 30</td>
<td>1 son</td>
<td>Living with her oldest brother, sister in-law and their 1 daughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remarried at age of 38</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Widowed / 4 years ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Sabra</td>
<td>60</td>
<td>Married at age of 22</td>
<td>1 daughter</td>
<td>Living alone in an apartment with her 2 cats from the streets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and divorced after 4 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remarried at age of 35</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>to a 73 years old man and</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>divorced after 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remarried at age of 41</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and then divorced after 1 year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Asma</td>
<td>63</td>
<td>Divorced / 38 years ago</td>
<td>1 daughter</td>
<td>Living alone in her own house with her housekeeper and driver</td>
</tr>
<tr>
<td>11</td>
<td>Fayza</td>
<td>75</td>
<td>Widowed / 30 years ago</td>
<td>2 children</td>
<td>Living in her own duplex house with her housekeeper and driver. Her sister is</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>living in the neighbourhood. She had a chance to live with her relatives but</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>opted to live alone as she wanted to live freely.</td>
</tr>
<tr>
<td>12</td>
<td>Najwa</td>
<td>70</td>
<td>Divorced / 20 years ago</td>
<td>2 daughters and 1 son</td>
<td>One of her unmarried daughter is living with her in the apartment since her</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>divorce happened</td>
</tr>
<tr>
<td>13</td>
<td>Layla</td>
<td>65</td>
<td>Widowed / 15 years ago</td>
<td>2 sons</td>
<td>Living in her own house inherited from her husband with her housekeeper and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>driver</td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Marital Status / Years Ago</td>
<td>Living Situation</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
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<td>----------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Nora</td>
<td>70</td>
<td>Widowed / 20 years ago</td>
<td>Living alone in her own house with her housekeeper and driver</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Tala</td>
<td>68</td>
<td>Widowed / 17 years ago</td>
<td>Living at her own house with her 43 years old divorced daughter and 29 years old unmarried daughter. She had no chance to live alone since her husband died but would also refuse if there would be a chance.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Faerouze</td>
<td>65</td>
<td>Divorced / 15 years</td>
<td>She started to live alone 10 years ago in her own house but sold it 2 years ago to buy a new villa. She then brought her mother, her 35 years old daughter, and housekeeper to live with her together. She had a chance to live alone but does not want to live her 35 years old unmarried daughter. However, she considers herself living alone as no one can control her behaviours.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Farha</td>
<td>75</td>
<td>Widowed / 15 years ago</td>
<td>Living in her own house with her 39 years old son with Down’s syndrome, adopted daughter, 7 housekeepers, and 2 drivers. She had a chance to live alone but she refused because of her son’s condition.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Nisreen</td>
<td>60</td>
<td>Widowed / 5 years ago</td>
<td>Living alone with her housekeepers and driver in her own duplex house.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Ellen</td>
<td>61</td>
<td>Widowed / 17 years ago</td>
<td>Living with her 5 daughters at her own house.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Eman</td>
<td>62</td>
<td>Widowed / 33 years</td>
<td>Living at her own house with her 38 years old divorced daughter. She is living with her housekeeper and driver for 7 years and her daughter has moved to her house 3 months ago. Eman had a chance to live with her aunt, grandfather, and brother but opted to live alone to become independent.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Lola</td>
<td>65</td>
<td>Divorced / 16 years ago</td>
<td>Living alone in apartment and her children help her to pay the monthly rent.</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Marital Status</td>
<td>Years Ago</td>
<td>Children Details</td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>-----</td>
<td>----------------</td>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>22</td>
<td>Sarah</td>
<td>65</td>
<td>Widowed</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>23</td>
<td>Katrina</td>
<td>74</td>
<td>Widowed</td>
<td>4</td>
<td>1 son and 1 daughter</td>
</tr>
<tr>
<td>24</td>
<td>Farah</td>
<td>74</td>
<td>Single</td>
<td>-</td>
<td>1 foster son</td>
</tr>
<tr>
<td>25</td>
<td>Maja</td>
<td>75</td>
<td>Widowed</td>
<td>15</td>
<td>4 children but lost her 2 daughters long ago</td>
</tr>
<tr>
<td>26</td>
<td>Hedayah</td>
<td>60</td>
<td>Widowed twice before her divorced 12 years ago. Her first and second husbands are siblings and both died in an accident.</td>
<td>4 sons and 3 daughters. 1 of her son died of heart attack at age 22.</td>
<td>She stopped living with her husband 12 years ago but never had a chance to live alone. Presently, she is living in her own house together with her children and divorced sister.</td>
</tr>
<tr>
<td>27</td>
<td>Muzna</td>
<td>62</td>
<td>Single</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>28</td>
<td>Layla</td>
<td>75</td>
<td>Divorced</td>
<td>30</td>
<td>7 daughters and 2 sons</td>
</tr>
<tr>
<td>29</td>
<td>Sumayah</td>
<td>70</td>
<td>Divorced</td>
<td>20</td>
<td>3 daughters and 3 sons</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Status</td>
<td>Children</td>
<td>Note</td>
</tr>
<tr>
<td>---</td>
<td>--------</td>
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<td>-------------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>30</td>
<td>Nawal</td>
<td>74</td>
<td>Divorced / 25 years ago</td>
<td>4 daughters and 3 sons</td>
<td>After her divorce, Nawal’s brothers arranged a small apartment for her and her children. When they worked and got married, she moved to a bigger apartment. Presently, she is living with her eldest son and his wife.</td>
</tr>
<tr>
<td>31</td>
<td>Neama</td>
<td>75</td>
<td>Widowed / 25 years ago</td>
<td>5 daughters and 5 sons</td>
<td>She is presently living with her son and daughter-in-law in an apartment. She had no chance to live alone as she started to live with her son since her husband died.</td>
</tr>
<tr>
<td>32</td>
<td>Wadha</td>
<td>72</td>
<td>Divorced / 20 years ago</td>
<td>-</td>
<td>Living with her brother and his 2 wives. She has been living with them since the divorce took place.</td>
</tr>
<tr>
<td>33</td>
<td>Talha</td>
<td>70</td>
<td>Widowed / 10 years ago</td>
<td>She has 8 children and one of them died in an accident.</td>
<td>Living in an apartment with her 35 years old son. She has been living with him since her husband died.</td>
</tr>
<tr>
<td>34</td>
<td>Saleha</td>
<td>73</td>
<td>Widowed / 35 years ago</td>
<td>3 sons</td>
<td>Living with her son and daughter-in-law.</td>
</tr>
<tr>
<td>35</td>
<td>Susan</td>
<td>61</td>
<td>Widowed / 30 years ago</td>
<td>3 daughters</td>
<td>Living in her own house with her 38 years old divorced daughter. Susan had a chance to live alone when all her daughters got married. But now, her divorced daughter who is sick is living with her.</td>
</tr>
<tr>
<td>36</td>
<td>Salha</td>
<td>65</td>
<td>Divorced / 23 years ago</td>
<td>8 daughters and 2 sons</td>
<td>Presently, she is living with her daughters in an apartment at her brother’s expense. She started to live alone after her divorce and 5 years ago, her daughters moved to her apartment as per the court decision.</td>
</tr>
<tr>
<td>37</td>
<td>Rogaiyah</td>
<td>75</td>
<td>Widowed / 2 months ago</td>
<td>4 daughters and 3 sons</td>
<td>She has been living in her own same house since she got married. Presently, she is living alone with her housekeeper but some of her children are living in the neighbourhood.</td>
</tr>
<tr>
<td>38</td>
<td>Fattomah</td>
<td>68</td>
<td>Widowed / 3 years ago</td>
<td>3 sons and 2 daughters</td>
<td>Living alone in her own old house since her husband died. Her other sons are living in nearby apartment.</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Marital Status</td>
<td>Living Arrangement</td>
<td>Reason for Not Living Alone</td>
</tr>
<tr>
<td>---</td>
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<td>-----------------</td>
<td>--------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>39</td>
<td>Zana</td>
<td>75</td>
<td>Divorced / 24 years ago</td>
<td>-</td>
<td>After the divorced, she started to live with her widowed brother. Zana never had a chance to live alone but she says that if she had, she would also refuse.</td>
</tr>
<tr>
<td>40</td>
<td>Majda</td>
<td>60</td>
<td>Divorced / 30 years ago</td>
<td>1 son and 1 daughter</td>
<td>Living alone in apartment and her children help her to pay the monthly rent. She had a chance to live together with her son but she refused as she preferred to live alone.</td>
</tr>
<tr>
<td>41</td>
<td>Sanabel</td>
<td>63</td>
<td>Widowed / 3 years ago</td>
<td>2 daughters and 1 son</td>
<td>Living alone with her 2 housekeepers in her own house. She never had a chance to live with others.</td>
</tr>
<tr>
<td>42</td>
<td>Fadwa</td>
<td>68</td>
<td>Widowed / 7 years ago</td>
<td>3 daughters and 3 sons</td>
<td>Living at her own house with her children. She has no chance to live alone because her children do not want to leave her.</td>
</tr>
<tr>
<td>43</td>
<td>Hessa</td>
<td>63</td>
<td>Desolated</td>
<td>-</td>
<td>Living alone with her housekeeper in her own house. She had a chance to live together with her mother 7 years ago but she refused and preferred to live alone.</td>
</tr>
<tr>
<td>44</td>
<td>Naheed</td>
<td>73</td>
<td>Widowed / 15 years ago</td>
<td>2 sons and 2 daughters</td>
<td>Living alone in her own house with her 2 housekeepers. She had a chance to live with her daughter at the same house but when got married 8 years after her husband died; her daughter moved and lived with her husband.</td>
</tr>
<tr>
<td>45</td>
<td>Fadiya</td>
<td>65</td>
<td>Divorced / 20 years ago</td>
<td>1 son and 1 daughter</td>
<td>Living alone in her own house which was bought for her by her brother after the divorce.</td>
</tr>
<tr>
<td>46</td>
<td>Nayla</td>
<td>70</td>
<td>Widowed / 16 years ago</td>
<td>3 sons and 1 daughter</td>
<td>Living alone with her 2 housekeepers and her children are living in the separate floors. With this living arrangement, she does not consider herself living alone.</td>
</tr>
<tr>
<td>47</td>
<td>Hanan</td>
<td>68</td>
<td>Divorced / 18 years ago</td>
<td>2 daughters</td>
<td>She had no chance to live alone as after the divorced, she lived directly with her aunt, and later to her brother. However, she had a problem with her brother's wife, and started to live again with her aunt, and her daughter.</td>
</tr>
<tr>
<td>Age</td>
<td>Name</td>
<td>Age of Filing</td>
<td>Circumstances</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>-----</td>
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<td>---------------</td>
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<td></td>
</tr>
<tr>
<td>48</td>
<td>Nadia</td>
<td>73</td>
<td>Widowed / 14 years ago</td>
<td>3 sons</td>
<td>Living in an apartment at her brother’s expense, with her son and her daughter-in-law. She never had a chance to live alone. Since her husband died, her son stayed with her until she gets married.</td>
</tr>
<tr>
<td>49</td>
<td>Salma</td>
<td>66</td>
<td>Divorced / 10 years ago</td>
<td>4 sons and 3 daughters</td>
<td>Living alone in an apartment owned by Non Governmental Organization. She had a chance to live after her divorced with her brother but had an argument due to inheritance issue with him, a reason why he expelled her from his house.</td>
</tr>
<tr>
<td>50</td>
<td>Dania</td>
<td>63</td>
<td>Divorced / 20 years ago</td>
<td>2 sons and 2 daughters</td>
<td>Living alone with her housekeeper in an apartment. She had no chance to live with her children as all of them are married already, and working and living outside Jeddah.</td>
</tr>
</tbody>
</table>
## Appendix 6c

**Education and Socioeconomic Status of Participants**

<table>
<thead>
<tr>
<th>SN</th>
<th>Participant Name</th>
<th>Age</th>
<th>Education Level</th>
<th>Previous Paid Work</th>
<th>Income Level / Financial Support</th>
<th>Class Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aiza (A1, 75P)</td>
<td>75</td>
<td>Illiterate</td>
<td>No</td>
<td>Dissatisfied (has social insurance and receives inheritance money from the property of her late husband, plus irregular financial support from her children)</td>
<td>Poor Class</td>
</tr>
<tr>
<td>2</td>
<td>Alma (A2, 73M)</td>
<td>73</td>
<td>Literate (through informal education)</td>
<td>No</td>
<td>Satisfied (income from her father’s pension and enough financial support from her son)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>3</td>
<td>Asma (A2, 63M)</td>
<td>63</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Satisfied (Her primary source of income is her monthly pension and revenue from her father’s property revenue. Her additional source of income is from her rented room.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>4</td>
<td>Dania (A1, 63M)</td>
<td>63</td>
<td>Dropped out of primary school</td>
<td>Yes</td>
<td>Satisfied (Her main source of income is her salary, and her children help her in paying rent. Although her monthly income is not enough, she feels satisfied.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Completed Education</td>
<td>Satisfied Details</td>
<td>Economic Class</td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>5</td>
<td>Dina (A5, 65H)</td>
<td>65</td>
<td>Completed primary education</td>
<td>No</td>
<td>Very Satisfied (very high economic status and inherited a number of real estate properties from her father which have provided a substantial source of income)</td>
<td>High Class</td>
</tr>
<tr>
<td>6</td>
<td>Ellen (UC, 61M)</td>
<td>61</td>
<td>Secondary education, but dropped out of college</td>
<td>No</td>
<td>Somewhat Satisfied (Income is from her late husband’s pension, and she receives a significant amount from inherited properties from her husband. However, she says that it is not enough to support her needs and she has to cut down her expenses, especially in times of financial crisis and sickness.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>7</td>
<td>Eman (A2, 62M)</td>
<td>62</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Satisfied (Income from her pension, social insurance, and additional income from monthly lease of her upstairs floor)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>8</td>
<td>Fadiya (A, 65H)</td>
<td>65</td>
<td>Dropped out of college</td>
<td>Yes</td>
<td>Satisfied (Main sources of income are from inheritance and regular financial support from her children and brother.)</td>
<td>High Class</td>
</tr>
<tr>
<td>9</td>
<td>Fadwa (UC, 68M)</td>
<td>68</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>Satisfied (Main income is from her late husband’s pension, children’s financial support, social security, and social insurance. Although the amount is enough, she says that she is facing financial constraint every month because her unmarried son and daughter are still studying and she needs to cover the grocery bill and other expenses.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>No.</td>
<td>Name (Location, Age)</td>
<td>Age</td>
<td>Education</td>
<td>Completion</td>
<td>Satisfied Status</td>
<td>Comment</td>
</tr>
<tr>
<td>-----</td>
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</tr>
<tr>
<td>10</td>
<td>Faerouze (UD, 65H)</td>
<td>65</td>
<td>Completed college education</td>
<td>Yes</td>
<td>Very Satisfied (Her main sources of income are from her retirement pension and school revenue, and they are more than enough to cover her needs.)</td>
<td>High Class</td>
</tr>
<tr>
<td>11</td>
<td>Fafi (B, 62M)</td>
<td>62</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Satisfied (primary source is her salary and the monthly financial support from her late husband’s family)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>12</td>
<td>Farah (A2, 74H)</td>
<td>74</td>
<td>Semi-Illiterate (Dropped out of primary school)</td>
<td>No</td>
<td>Very Satisfied (Although she is discontented with her father, she was lucky to receive a good inheritance from him. She says her monthly income is more than enough for her daily needs.)</td>
<td>High Class</td>
</tr>
<tr>
<td>13</td>
<td>Farha (US, 75H)</td>
<td>75</td>
<td>Literate (through informal education)</td>
<td>No</td>
<td>Very Satisfied (Her sources of income are from her husband’s pension and revenues from inherited properties from him, and the amount is more than enough to support her financial needs and daily expenses.)</td>
<td>High Class</td>
</tr>
<tr>
<td>14</td>
<td>Fatima (A2, 74M)</td>
<td>74</td>
<td>Illiterate</td>
<td>No</td>
<td>Satisfied (provided by her sons)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>15</td>
<td>Fattomah (A, 68M)</td>
<td>68</td>
<td>Illiterate</td>
<td>No</td>
<td>Satisfied (Her main source of income is from her late husband’s inheritance, children’s financial support, and social insurance.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Satisfied</td>
<td>Class</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>16</td>
<td>Fayza (A2, 75M)</td>
<td>75</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Hanadi (S, 75M)</td>
<td>75</td>
<td>Literate (through informal education)</td>
<td>No</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hanan (UD, 68P)</td>
<td>68</td>
<td>Illiterate</td>
<td>No</td>
<td>Poor Class</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Hedayah (UC, 60M)</td>
<td>60</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>She considers herself in the middle class but during difficult financial situations, she thinks herself in the poor class.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Hessa (A1, 63H)</td>
<td>63</td>
<td>Literate</td>
<td>Yes</td>
<td>High Class</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Literacy</td>
<td>Employment Status</td>
<td>Job Description</td>
</tr>
<tr>
<td>-----</td>
<td>---------------</td>
<td>-----</td>
<td>-----------</td>
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<td>------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21</td>
<td>Katrina (S, 74P)</td>
<td>74</td>
<td>Semi-Illiterate (Dropped out of primary school)</td>
<td>No</td>
<td>Dissatisfied</td>
<td>(Her main source of income is from her husband’s pension. As her monthly income is not enough, she says her children and her brothers help her with everything.)</td>
</tr>
<tr>
<td>22</td>
<td>Layla (A2, 65M)</td>
<td>65</td>
<td>Completed primary education</td>
<td>Yes</td>
<td>Satisfied</td>
<td>(Her primary sources of income are from her retirement pension and irregular financial support from her sons.)</td>
</tr>
<tr>
<td>23</td>
<td>Layla (UC, 75M)</td>
<td>75</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>Satisfied</td>
<td>(She has no social security and her main source of income is the financial support from her children. Although the support is irregular and no fixed amount, Layla says it is enough to cover her personal needs)</td>
</tr>
<tr>
<td>24</td>
<td>Lola (A, 65P)</td>
<td>65</td>
<td>Semi-Illiterate (Dropped out of primary school)</td>
<td>No</td>
<td>Unsatisfied</td>
<td>(Her main source of income is from regular financial support from her children. She has social security and manages to obtain financial assistance from charitable institutions every seven to eight months. However, her total income is still not enough to support her daily needs, especially monthly rent for her apartment. To partially manage her needs in the past, she accepted sewing work from her neighbours, but her present health prevents her doing so.)</td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Satisfied (Reason)</td>
<td>Social Class</td>
<td></td>
</tr>
<tr>
<td>-----</td>
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<td></td>
</tr>
<tr>
<td>25</td>
<td>Maja (S, 75M)</td>
<td>75</td>
<td>Dropped out of primary school</td>
<td>No Satisfied (She receives regular income from her husband’s pension and son’s financial support. Maja states that her income is not enough, but she is trying to budget it to cover her primary needs)</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Majda (A, 60P)</td>
<td>60</td>
<td>Dropped out from primary school</td>
<td>No Dissatisfied (She receives regular financial support from her children. Social insurance is her main source of monthly income. However, she says her total income is not enough to cover her financial needs, as she has debts to pay.)</td>
<td>Poor Class</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Manal (A1, 74P)</td>
<td>74</td>
<td>Illiterate</td>
<td>No Dissatisfied (depends on social insurance, her siblings and relatives, and other large companies who provide charity)</td>
<td>Poor Class</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Maria (S, 70M)</td>
<td>70</td>
<td>Dropped out of secondary school</td>
<td>No Satisfied (provided by her one son and social insurance)</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Muzna (R, 62P)</td>
<td>62</td>
<td>Dropped out of primary school</td>
<td>No Dissatisfied (Her monthly income comes from social security and her father’s pension)</td>
<td>Poor Class</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Illiteracy</td>
<td>Satisfied</td>
<td>Class</td>
<td></td>
</tr>
<tr>
<td>-----</td>
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<td></td>
</tr>
<tr>
<td>30</td>
<td>Nadia (S, 73P)</td>
<td>73</td>
<td>Illiterate</td>
<td>Yes</td>
<td>Poor Class</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dissatisfied (Her main sources of income are from her children, late husband’s pension, and her own income as a seamstress. The income is not enough to cover her needs, as she is the one paying for groceries and sometimes rent on her apartment.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Naheed (A2, 73H)</td>
<td>73</td>
<td>Illiterate</td>
<td>No</td>
<td>High Class</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Satisfied (Her main sources of monthly income are from inheritance and her late husband’s pension. The amount is more than enough to meet her needs, and she used to help her children with their expenses.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Najwa (UD, 70M)</td>
<td>70</td>
<td>Illiterate</td>
<td>No</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Satisfied (She has social insurance and receives inheritance money from the property of her late husband, plus irregular financial support from her children.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Nawal (S, 74M)</td>
<td>74</td>
<td>Illiterate</td>
<td>No</td>
<td>Middle Class</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Satisfied (Her main source of income is irregular support from her children. Although the amount is not that much, she says that it is enough to cover her needs.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Nayla (A2, 70H)</td>
<td>70</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>High Class</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Satisfied (Her main source of income is the inheritance from her father and her late husband.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Married</td>
<td>Satisfaction</td>
<td>Notes</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>35</td>
<td>Neama (S, 75P)</td>
<td>75</td>
<td>Illiterate</td>
<td>No</td>
<td>Unsatisfied</td>
<td>(Her income depends on social insurance, irregular support from her children, and from her neighbour. Thus, her income is not enough to support her daily needs. She says her financial situation was affected when her husband died.)</td>
</tr>
<tr>
<td>36</td>
<td>Nisreen (A2, 60H)</td>
<td>60</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Very Satisfied</td>
<td>(Her income is from her late husband’s pension, children’s financial support, and the revenues from inherited properties from her husband. The income is enough to support her financial needs.)</td>
</tr>
<tr>
<td>37</td>
<td>Nora (A2, 70H)</td>
<td>70</td>
<td>Completed college education</td>
<td>Yes</td>
<td>Very Satisfied</td>
<td>(She has enough income from her retirement pension, husband’s inheritance, children’s financial support, and steady income from her own properties.)</td>
</tr>
<tr>
<td>38</td>
<td>Rogaiyah (A1, 75M)</td>
<td>75</td>
<td>Illiterate</td>
<td>No</td>
<td>Dissatisfied</td>
<td>(She has regular income from her children and social insurance. Although receiving a regular income, she says the amount is sometimes not enough to cover her needs.)</td>
</tr>
<tr>
<td>39</td>
<td>Sabra (A, 60P)</td>
<td>60</td>
<td>Completed secondary education</td>
<td>Yes</td>
<td>Unsatisfied</td>
<td>(She lives in poverty conditions. Her main income is from her father’s monthly pension, and her cousins and uncle’s wife used to give her small amounts irregularly, but it is still not enough to support her needs.)</td>
</tr>
<tr>
<td>No.</td>
<td>Name (Code, Age)</td>
<td>Gender</td>
<td>Education</td>
<td>Employment Status</td>
<td>Satisfied (Reason)</td>
<td>Class</td>
</tr>
<tr>
<td>-----</td>
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<td>-------</td>
</tr>
<tr>
<td>40</td>
<td>Saleha (S, 73P)</td>
<td>F</td>
<td>Illiterate</td>
<td>No</td>
<td>Satisfied (Her main sources of income are from her children and social insurance. She feels the income is sufficient but adds that nobody would refuse if there is extra money.)</td>
<td>Poor Class</td>
</tr>
<tr>
<td>41</td>
<td>Salha (UC, 65M)</td>
<td>F</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>Dissatisfied (She has regular income from her children, brother, and social insurance. She says her income is not enough to support her needs.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>42</td>
<td>Salma (A, 66M)</td>
<td>F</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>Satisfied (Her main sources of income are from her father's pension, social insurance, and children's financial support. The monthly income is enough to support her needs.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>43</td>
<td>Sanabel (A3, 63H)</td>
<td>F</td>
<td>Master’s degree</td>
<td>Yes</td>
<td>Satisfied (Her monthly income comes from her inheritance, pension, and earnings from her business which it is enough to cover all her needs.)</td>
<td>High Class</td>
</tr>
<tr>
<td>44</td>
<td>Sarah (A, 65M)</td>
<td>F</td>
<td>Ph.D.</td>
<td>Yes</td>
<td>Satisfied (Her main source of income is her retirement pension, and according to her, the amount is enough to cover her needs as she lives a very modest life.)</td>
<td>Middle Class</td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Education</td>
<td>Work Status</td>
<td>Satisfaction</td>
<td>Source of Monthly Income</td>
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<tr>
<td>45</td>
<td>Sumayah (A, 70P)</td>
<td>70</td>
<td>Illiterate</td>
<td>No</td>
<td>Dissatisfied</td>
<td>Her source of monthly income comes from her brothers, other relatives, and some donations from charitable institutions.</td>
</tr>
<tr>
<td>46</td>
<td>Susan (UD, 61P)</td>
<td>61</td>
<td>Dropped out of primary school</td>
<td>No</td>
<td>Dissatisfied</td>
<td>Her main sources of income are social insurance and charitable institutions. She says that it is not enough to cover her needs.</td>
</tr>
<tr>
<td>47</td>
<td>Tala (UD, 68M)</td>
<td>68</td>
<td>Completed college education</td>
<td>Yes</td>
<td>Satisfied</td>
<td>She has enough income from her retirement pension, some of her children’s financial support, and a relatively small income from her published books.</td>
</tr>
<tr>
<td>48</td>
<td>Talha (S, 70P)</td>
<td>70</td>
<td>Illiterate</td>
<td>No</td>
<td>Satisfied</td>
<td>Her main sources of income are from social security and her children’s financial support. The income is not enough to cover her needs, but she is thankful.</td>
</tr>
<tr>
<td>49</td>
<td>Wadha (B, 72P)</td>
<td>72</td>
<td>Illiterate</td>
<td>No</td>
<td>Unsatisfied</td>
<td>The primary source of her income is only from her social insurance. She says her monthly income is not enough, but her brother is trying to cover some of her financial needs.</td>
</tr>
<tr>
<td>50</td>
<td>Zana (B, 75M)</td>
<td>75</td>
<td>Illiterate</td>
<td>No</td>
<td>Satisfied (Her monthly income comes from her inheritance, financial support from her brother and nephews, and social insurance.)</td>
<td>Middle Class</td>
</tr>
</tbody>
</table>
### Appendix 6d
Health, Social Activities, Family Relationships and Quality of Life of Participants

<table>
<thead>
<tr>
<th>SN</th>
<th>Participant Name</th>
<th>Age</th>
<th>Medical Insurance / Services</th>
<th>Illnesses</th>
<th>Social Engagement</th>
<th>Main Activity</th>
<th>Contact with Family Members</th>
<th>Satisfaction with Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aiza (A1, 75P)</td>
<td>75</td>
<td>None</td>
<td>Skin disease, diabetes, hearing and visual impairment, memory loss, fatigue, as well as a big wound on her leg that is not healing properly</td>
<td>None</td>
<td>Praying, crying and watching sad programs on the television</td>
<td>Irregular visits from her children</td>
<td>Unsatisfied</td>
</tr>
<tr>
<td>2</td>
<td>Alma (A2, 73M)</td>
<td>73</td>
<td>None</td>
<td>Diabetes, hearing problems, fatigue, osteoporosis, high cholesterol, high blood pressure, visual impairment and had a major medical operation on her knee two years ago</td>
<td>Sociable individual and has good relationships with family and friends. She visits her neighbours regardless of ages to spend time or eat with them regularly.</td>
<td>Reading the Quran and prefers watching religious programs alone</td>
<td>She visits her three siblings every week and attends family occasions regularly.</td>
<td>Overall, she says that her life will be easy if she has her own house to live in and if her health is fine. She is optimistic that she will still be alive after five years.</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Paid (yes or personally)</td>
<td>Health Problems</td>
<td>Social Activities</td>
<td>Work Status</td>
<td>Comments</td>
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<td>3</td>
<td>Asma (A2, 63M)</td>
<td>63</td>
<td>Yes (paid personally)</td>
<td>Heart problems, visual impairment and high blood pressure. She underwent an operation related to her heart five years ago.</td>
<td>Gathers with her friends every two weeks but prefers to meet them outside her house.</td>
<td>Watching television, exercising at home, attending family and friends’ occasions and travelling with her friends.</td>
<td>She emphasised that her life is better since she retired because she does not have any work obligations. In general, she is satisfied with her life.</td>
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<td>4</td>
<td>Dania (A1, 63M)</td>
<td>63</td>
<td>Yes. She has medical insurance from her company and is satisfied with the services provided, as all her medication is provided. She is aware of free medication from the health centres and tried to avail the services twice;</td>
<td>High blood pressure, isolation, arthritis, osteoporosis, visual impairment and high cholesterol.</td>
<td>She usually calls her two friends, invites them for gathering, and sometimes asks them to sleep with her.</td>
<td>Working all day</td>
<td>Her children usually visit her every week with their families; her other relatives come monthly, and her friends visit her sometimes.</td>
<td>She is satisfied with her life but adds that it would be much better if she and her children were financially stable. She wishes to see her children in the best and comfortable positions in the future.</td>
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<td>5</td>
<td>Dina (A5, 65H)</td>
<td>65</td>
<td>Yes (paid personally)</td>
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<td></td>
<td>Underwent an internal operation five years ago. She has diabetes, eye problems, and due to her being overweight, she also suffers from high cholesterol and leg problems.</td>
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<td>Invites her two sisters and friends to gather in her house every Tuesday and Thursday, while her sons and daughter visit her every Friday.</td>
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<td>6</td>
<td>Ellen (UC, 61M)</td>
<td>61</td>
<td>Yes. She pays for medical insurance at her own expense. Although aware of free medication from the health centre,</td>
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<td></td>
<td>Depression, isolation, fatigue and anxiety</td>
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<td>She writes poems to release and hide her unhappy memories or to express strong emotions such as anger and sadness.</td>
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<td>Mostly watching television and using her computer as her favourite forms of entertainment. Sometimes, she prefers to stay inside her room and read the Quran.</td>
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<td>Her brother and friends used to visit her twice a week.</td>
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<td>She is satisfied with her life, but she does not want to think about her life after five years.</td>
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<td>In general, she is satisfied and optimistic about her life as she has everything to support her needs.</td>
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<td>7</td>
<td>Eman (A2, 62M)</td>
<td>62</td>
<td>None. She has no medical insurance. She used to go to the military hospital, but she is not satisfied with their provided services. Although aware of free medication from the health care centre, she has never tried to obtain medicine from them.</td>
<td>She has fatigue and problems with her leg.</td>
<td>In addition to cleaning her home, she reads religious books, biographies of different leaders and books about the life of Prophet Muhammad.</td>
<td>Her relatives and friends visit her house regularly. They are interrelated families and wanted to stay together. Her brother and nephew come day after day, her sister who is living in Al-Taif visits monthly and her friends come weekly.</td>
<td>She is satisfied with her life.</td>
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<td>Age</td>
<td>Fadiya (A, 65H)</td>
<td>Yes. She has medical insurance at her own expense.</td>
<td>Mostly, she personally pays for her hospital care.</td>
<td>She used to stay up to 5 or 6 in the morning and wake up in the afternoon. After breakfast, she spends her time in the gym and sports club every other day. Most of the time, she meets her friends at home. She has religious and poetic lectures at home every evening.</td>
<td>She has a property in Al-Taif and used to spend her weekend there. She seldom feels lonely because she has many friends. Her brother acted as her male legal guardian and allowed her to travel, which she enjoyed.</td>
<td>Her children and her siblings usually visit on the weekend, and her friend comes whenever she is available at home.</td>
<td>Overall, Fadiya says that she is satisfied with her life as long as she is in good health.</td>
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<td>9</td>
<td>Fadwa  (UC, 68M)</td>
<td>68</td>
<td>Yes. She has medical insurance from her late husband who worked in a private sector. She uses the medical insurance every month but needs to pay some amount of money sometimes.</td>
<td>High blood pressure, heart problems, diabetes, fatigue, anxiety, arthritis, osteoporosis, hearing impairment and high cholesterols</td>
<td>She used to take care of her grandchildren. Her siblings visit her every two weeks and her neighbours visit every other day.</td>
<td>Taking care of her grandchildren and doing household chores with her housekeeper</td>
<td>Her siblings visit her every two weeks, and her neighbours used to come daily.</td>
<td>Despite shortcomings, she is satisfied and still thankful for her life.</td>
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<tr>
<td>10</td>
<td>Faerouze (UD, 65H)</td>
<td>65</td>
<td>None. Presently, she has no medical insurance, but she used to pay for her medical insurance personally.</td>
<td>High blood pressure, diabetes and visual impairment</td>
<td>She was employed as a teacher and retired from the Ministry of Education. After her retirement, she established her own private school and currently holds a position as directress.</td>
<td>Managing the school</td>
<td>Her two daughters are working with her. Faerouze’s other daughters used to visit with their spouses and her grandchildren every Thursday, while her friends visit once a week.</td>
<td>She is satisfied with her life now.</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Paid for Medication</td>
<td>Medical Problems</td>
<td>Social Activities</td>
<td>Medical Services</td>
<td>Travel Needs</td>
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<td>11</td>
<td>Fafi (B,</td>
<td>62</td>
<td>Yes (paid personally)</td>
<td>Eye problems</td>
<td>Watching television and shopping</td>
<td>Lecturer (contractual employee) in the university. She visits her relatives only on very important occasions</td>
<td>Yes (paid personally)</td>
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<td></td>
<td>62M)</td>
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<td>and sometimes fatigue due to age</td>
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<td>She visits her relatives on important occasions and mostly spends her time with her brother and sister-in-law. She used to sit and talk with their housekeeper every day.</td>
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<td>12</td>
<td>Farah (A2,</td>
<td>74</td>
<td>Yes. She pays her own medical insurance. She is not aware of the free medication.</td>
<td>High blood pressure, diabetes, depression, fatigue, visual impairment and panic attacks</td>
<td>Watching television</td>
<td>Daily, she talks with her nearby friend and housekeepers. Unfortunately, Farah cannot travel because of her present marital status and due to not having a male legal guardian.</td>
<td>Her neighbour sees her daily; her foster son and his family used to visit her weekly, while her other relatives visit her infrequently.</td>
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<td>74H)</td>
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<td>Overall, she is satisfied with her life but only raises her need to travel to seek medical advice abroad.</td>
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<td>13</td>
<td>Farha (US, 75H)</td>
<td>75</td>
<td>None. She is not aware of free medication. Her sons managed to obtain her regular medication, and sometimes she pays for it personally. Her previous operation was performed at King Abdulaziz University Hospital.</td>
<td>High blood pressure, arthritis, osteoporosis, visual impairment and had operations on her knee twice.</td>
<td>She primarily remains at home and never feels lonely.</td>
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<td>Watching television, reading the Quran, talking with her son and calling her daughter in Riyadh at least three times a day</td>
<td>One of Farha’s sons acquired a house nearby to visit her regularly. Her son used to pass by every day for at least 30 minutes. Her other son visits her twice a week. Although her sons and daughters-in-law requested for her to live with them for two days, Farha declined and said she had a duty to take care of her other son.</td>
<td>Overall, she is satisfied with her life but hoping to live long enough to take care of her son.</td>
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<td>14</td>
<td>Fatima (A2, 74M)</td>
<td>74</td>
<td>Yes (paid by her son)</td>
<td>Arthritis, osteoporosis and visual impairment diseases</td>
<td>Meeting with her friends</td>
<td>Shopping with her friends</td>
<td>N/A</td>
<td>Satisfied</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Medical History</td>
<td>Activities</td>
<td>Living Conditions</td>
<td>Additional Notes</td>
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<td>15</td>
<td>Fatoomah (A, 68M)</td>
<td>68</td>
<td>None. She used to pay for her hospital care from social insurance money. Fatoomah is aware of free medication from the health centre, but medication for her diabetes is not available, so she goes to a specialised hospital to purchase diabetes medication at her own cost.</td>
<td>High blood pressure, diabetes, fatigue, arthritis, osteoporosis, hearing impairment and visual impairment</td>
<td>Her children visit her regularly.</td>
<td>Eating, cooking, praying, reading, watching television and cleaning the house. She was scared to live alone when her daughters got married, but she became accustomed after three months of being alone. Her children visit her regularly. She says, her daughters alternately come to see her and her son living nearby used to come every day.</td>
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<td>16</td>
<td>Fayza (A2, 75M)</td>
<td>75</td>
<td>None. She is aware of free medication in the health centre but she prefers to have Visual impairment, fatigue, osteoporosis and had an operation on her heart.</td>
<td>Praying, walking, reading and watching the television.</td>
<td>N/A</td>
<td>Her sister lives in the neighbourhood. She feels much better than other women in the same age range.</td>
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<tr>
<td>No</td>
<td>Name</td>
<td>Age</td>
<td>Medical Insurance</td>
<td>Medical Expenses</td>
<td>Medical Conditions</td>
<td>Social Activities</td>
<td>Quality of Life</td>
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<td>17</td>
<td>Hanadi (S, 75M)</td>
<td>75</td>
<td>Yes (paid by her son)</td>
<td>Yes (paid by her son)</td>
<td>Diabetes, hearing problems, high blood pressure, high cholesterol, visual impairment, fatigue, and had operations on her knee and backbone</td>
<td>Visits her siblings once a week and arranges gatherings occasionally, but limits her relationships to only those people in her family. She also visits her other son in Riyadh regularly and stays with him for a month.</td>
<td>She generally feels comfortable with her life because of adequate support from her family.</td>
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<td>18</td>
<td>Hanan (UD, 68P)</td>
<td>68</td>
<td>None. She has no medical insurance and she used to pay for her medical expenses</td>
<td>None. She has no medical insurance and she used to pay for her medical expenses</td>
<td>High blood pressure, heart problems, depression, isolation, fatigue, anxiety, arthritis, osteoporosis and</td>
<td>She used to visit an institution for memorising the Quran every day. She spends her day reading the</td>
<td>She is unsatisfied with her quality of life as she says that they are living in an unpleasant situation.</td>
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<td>19</td>
<td>Hedayah (UC, 60M)</td>
<td>60</td>
<td>with the help of her children. She avails the free medication from the health centre and even tried other centres from other districts, but the medication is limited.</td>
<td>hearing impairment</td>
<td>Quran and when she returns home, she cleans their house. Sometimes, she goes to her neighbour to have a talk.</td>
<td>None. Although aware of free medication from the health centre, she never tried to obtain medication from them due to poor services. Her sons usually pay for her Arthritis, osteoporosis and lack of Vitamin D</td>
<td>She sometimes visits her close relatives at their place. She states that she does not have any special program or activities every day. She feels lonely if she stays at home for days.</td>
<td>Her children visit her regularly. Although her finances are not enough, she is satisfied with her life, and she is more concerned about her health and looks.</td>
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<td>Name</td>
<td>Age</td>
<td>Medical Insurance</td>
<td>Medical Conditions</td>
<td>Activities</td>
<td>Social Life</td>
<td>Notes</td>
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<td>20</td>
<td>Hessa (A1, 63H)</td>
<td>63</td>
<td>Yes, at own expense</td>
<td>High blood pressure, heart problems, diabetes, depression, isolation and visual impairment</td>
<td>After her retirement, she used to travel and buy some goods for her accessories shop.</td>
<td>She used to see her friends and shop customers regularly and her siblings once a week or so, depending on their schedules.</td>
<td>She is thankful and says that she is financially comfortable but socially alone in society.</td>
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<td>21</td>
<td>Katrina (S, 74P)</td>
<td>74</td>
<td>No. She is not aware of free medication from the health centre. She usually goes to the public hospital for free medication and care, but sometimes her siblings</td>
<td>High blood pressure, heart problems, diabetes, fatigue, arthritis, osteoporosis and hearing impairment</td>
<td>N/A</td>
<td>Her siblings and other relatives visit her two to three times a month.</td>
<td>Despite shortcomings, she is still thankful for her life.</td>
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<td></td>
<td>Layla (A2, 65M)</td>
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<td>22</td>
<td>Layla (A2, 65M)</td>
<td>65</td>
<td>None. She is aware of the free medication in the health centre and used to obtain basic medication from them.</td>
<td>Diabetes, high blood pressure, visual impairment and hearing impairment</td>
<td>She spends three to four hours daily with her neighbour.</td>
<td>Watching television, praying and telephone calls, but according to her, her neighbour compensates for her loneliness every day.</td>
<td>Her sons and their families visit her only during festivals.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Layla (UC, 75M)</th>
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</thead>
<tbody>
<tr>
<td>23</td>
<td>Layla (UC, 75M)</td>
<td>75</td>
<td>None. She usually goes to public hospitals for treatment and medication. Although aware of health centres, she never tried to go there to avail the services.</td>
<td>High blood pressure, heart problems, diabetes, fatigue, arthritis, osteoporosis, visual impairment, and blood liquidity problems</td>
<td>Most of the time, chatting with her daughter-in-law</td>
</tr>
</tbody>
</table>

In general, she is satisfied with her life but just worries about her health status in the future.
<table>
<thead>
<tr>
<th>Age</th>
<th>Name</th>
<th>Gender</th>
<th>Occupation</th>
<th>Medical Conditions</th>
<th>Social Supports</th>
<th>Mental Health</th>
<th>Future Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>Lola (A, 65P)</td>
<td>F</td>
<td>Housewife</td>
<td>High blood pressure, diabetes, depression, isolation, fatigue and visual impairment</td>
<td>None. She went to the health centre once for medication, but they transferred her to the public hospital. She says it is not easy to obtain free medication monthly, thus Lola seeks intermediary doctor’s assistance to get medicines every two months.</td>
<td>To deal with loneliness, she sometimes cries or walks outside her apartment for 30 minutes to 1 hour. On most days, she spends her time praying, watching television and drinking tea with her 37-year-old neighbour.</td>
<td>She says her life is underprivileged, and it is very difficult to grow old and live alone. She hopes to live with her son in the future.</td>
</tr>
<tr>
<td>25</td>
<td>Maja (S, 75M)</td>
<td>75</td>
<td>None. She is aware of free medication from the health centre but states that the centre does not provide the essential medication for her medical condition. She pays for her medicines and hospital care at her own expense.</td>
<td>High blood pressure, diabetes, fatigue, visual impairment, and depression for 35 years due to the tragic loss of her six-year-old daughter.</td>
<td>She is a sociable person and always feel lonely when she has no activity. She deals with loneliness by socialising with her friends and spending time with her sons.</td>
<td>Watching television, talking on the phone with her family and sometimes visiting her old friends</td>
<td>Her family members call her on the telephone every day.</td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Age</td>
<td>Medical Conditions</td>
<td>Activities</td>
<td>Social Interactions</td>
<td>Satisfaction</td>
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<td>26</td>
<td>Majda (A, 60P)</td>
<td>60</td>
<td>None. Her children pay for her hospital care. High blood pressure and hearing and visual impairment</td>
<td>Doing household chores, praying, watching television and sometimes visiting her very close relatives and friends</td>
<td>Her children and grandchildren visit her regularly, while some of her friends visit her alternately every week.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Manal (A1, 74P)</td>
<td>74</td>
<td>None. Diabetes, fatigue, hearing and visual impairment, osteoporosis, high blood pressure and heart disease</td>
<td>She is suffering from loneliness and isolation every day.</td>
<td>Praying and eating</td>
<td>N/A Dissatisfied</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Maria (S, 70M)</td>
<td>70</td>
<td>None. Diabetes, high blood pressure, arthritis and osteoporosis, heart problems, fatigue, isolation, visual impairment, and starting hearing impairment</td>
<td>N/A Shopping with her friends or any close relatives</td>
<td>N/A</td>
<td>Somewhat satisfied</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Name</td>
<td>County</td>
<td>Reason for no insurance</td>
<td>Medical Conditions</td>
<td>Activities</td>
<td>Support from brother</td>
<td>Other comments</td>
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<tr>
<td>29</td>
<td>Muzna</td>
<td>R, 62P</td>
<td>None. Her aunt pays for her hospital care. She is aware of free medication from the health centre, but she does not obtain medicines from them because they do not provide the important medication for her condition.</td>
<td>High blood pressure, heart problems, depression, isolation, arthritis, osteoporosis and visual impairment</td>
<td>She feels alone because of her limited social network and lack of facilities to meet her friends.</td>
<td>Her brother, who is living in Makkah, visits her once a month.</td>
<td>She is satisfied with her life. However, she is hoping that the government will provide more support in terms of medication and financial aspects.</td>
</tr>
<tr>
<td>30</td>
<td>Nadia</td>
<td>S, 73P</td>
<td>None. She has no medical insurance. She is aware of the free medication from the health centre and used to avail the services, but</td>
<td>High blood pressure, heart problems, diabetes, depression, fatigue, hearing impairment and high cholesterol</td>
<td>Cooking, reading the Quran and sewing clothes for a living</td>
<td>Her other sons and their families used to visit her every weekend. Her customers also come on a regular basis.</td>
<td>Due to her present condition, she is unsatisfied with her quality of life and she feels sadness and stress. She adds that only God knows what will happen in five years.</td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Naheed (A2, 73H)</td>
<td>73</td>
<td>she is not satisfied. Her children used to pay for her hospital care if needed.</td>
<td>Diabetes, fatigue, arthritis, osteoporosis, visual impairment, and high cholesterol</td>
<td>N/A</td>
<td>Watching television and making telephone calls to her children</td>
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<tr>
<td>32</td>
<td>Najwa (UD, 70M)</td>
<td>70</td>
<td>None. She just heard about the free medication from the health centre six months ago, but she did not try to obtain</td>
<td>High blood pressure, diabetes, depression, isolation, fatigue, hearing impairment and visual impairment</td>
<td>N/A</td>
<td>Watching television, joining her friends in a religious group and going to the shopping mall once a week</td>
<td>Her other daughter used to visit her every Wednesday, and her son visits her when he comes to Jeddah.</td>
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<tr>
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<td>medication from there, as her children provide them regularly.</td>
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<td>33</td>
<td>Nawal (S, 74M)</td>
<td>None. She used to go to public hospitals and pay for her medicines. Like other participants, she is aware of free medication from the health centre but has never tried them.</td>
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<td></td>
<td>High blood pressure, heart problems, diabetes, fatigue, arthritis, osteoporosis and hearing impairment</td>
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<td></td>
<td></td>
<td>Sometimes going out for social and family commitments</td>
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<td>Watching television, reading the Quran, and talking on the phone with her other children and relatives</td>
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<td>Every evening, one of her children passes by for an hour, either alone or with their spouses, and they usually gather every Friday with their families.</td>
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<td></td>
<td>Generally, she feels satisfied and contented with her life.</td>
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<td>34</td>
<td>Nayla (A2, 70H)</td>
<td>Yes. She has medical insurance at her son’s expense. She is satisfied with the services provided by the medical</td>
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<td></td>
<td>High blood pressure, diabetes, visual impairment and high cholesterol</td>
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<td></td>
<td></td>
<td>N/A</td>
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<td></td>
<td>Exercising every evening and meeting her friends who have a doctor’s appointment</td>
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<td>She used to wake up early to look after her grandchildren before and after school. She eats her lunch with her children, as they are used to coming to her</td>
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<td>Overall, she is very satisfied with her life, but she emphasised that women need to have a voice in society and an organisation to protect the</td>
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<tr>
<td>Age</td>
<td>Name</td>
<td>Condition(s)</td>
<td>Activity</td>
<td>Current Living Situation</td>
<td>Notes</td>
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<tr>
<td>35</td>
<td>Neama (S, 75P)</td>
<td>High blood pressure, diabetes, depression, isolation, fatigue, anxiety, arthritis, osteoporosis, hearing impairment and visual impairment</td>
<td>N/A</td>
<td>homeless.</td>
<td>Neama has no activity and always feels bored, as she could not do anything. Neama’s daughters visit her every weekend, but due to family issues, her daughters asked her to visit their house instead. She has to be thankful and does not want to think and imagine her life after five years.</td>
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</tr>
<tr>
<td>36</td>
<td>Nisreen (A2, 60H)</td>
<td>Diabetes, visual impairment, and had an oophorectomy procedure recently</td>
<td>N/A</td>
<td>home.</td>
<td>She is not a fan of television and spends most of her time on the computer. She feels lonely every night, during festivals or any occasions. She deals with it by looking through her picture Her nearby son used to visit her regularly, while her siblings and in-laws with their children visit every Thursday. She is feeling fine with her life and feels more close to God because of fewer work responsibilities now that she has retired.</td>
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<tr>
<td>Age</td>
<td>Name</td>
<td>Health Issues</td>
<td>Social Activities</td>
<td>Overall, she is very satisfied with her life and sees her health improving due to advancement in the medical fields.</td>
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<tr>
<td>70</td>
<td>Nora (A2, 70H)</td>
<td>Heart problems, anxiety, arthritis, and visual impairment</td>
<td>Host literacy gathering at her house every Thursday, and just recently, her children, their own families and her friends with their spouses all attended the gathering. All of them belong to the literacy gathering.</td>
<td>Her children, in-laws, and grandchildren visit her regularly on a weekly basis, while her friends and siblings visit every second week.</td>
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<tr>
<td>Age</td>
<td>Name</td>
<td>Gender</td>
<td>Children</td>
<td>Medications</td>
<td>Special Programs / Activities</td>
<td>Medical Conditions</td>
<td>Future Situation</td>
</tr>
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<tr>
<td>38</td>
<td>Rogaiyah (A1, 75M)</td>
<td>F</td>
<td>75</td>
<td>None. Her children usually pay for her medicines and hospital care. She is aware of free medication from the health centre and sometimes goes there for basic medicines, though the other medicines for her condition are not High blood pressure, heart problems and heart attack, diabetes, depression, isolation, fatigue, anxiety, arthritis, osteoporosis, hearing impairment and visual impairment</td>
<td>N/A</td>
<td>Rogaiyah says that she does not have any special program or activities every day.</td>
<td>She used to go out to see her children nearby every other day. Her children, other relatives, and her neighbour visit her at her house every other day or so, depending on their schedule.</td>
</tr>
<tr>
<td>Age</td>
<td>Name</td>
<td>Available</td>
<td>High cholesterol, depression, hearing and visual impairment, osteoporosis, diabetes, high blood pressure and fatigue</td>
<td>N/A</td>
<td>She suffers from isolation and loneliness all the time, and to deal with it, she spends her time sleeping and crying.</td>
<td>She has three brothers and one sister, but only one brother living in another city used to phone her weekly.</td>
<td>Overall, she is really depressed and felt that she will not be alive after five years but highlights that enough financial support covering all her requirements to make a decent living.</td>
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<tr>
<td>39</td>
<td>Sabra (A, 60P)</td>
<td>60</td>
<td>None. High cholesterol, depression, hearing and visual impairment, osteoporosis, diabetes, high blood pressure and fatigue</td>
<td>N/A</td>
<td>She used to go and visit her neighbours, as she has no other relatives.</td>
<td>Watching television, drinking coffee, and if she feels active in the weekend, she cleans the house. She says there is nothing to do, and there is no place to go, so she spends most of her time sleeping.</td>
<td>Saleha’s children and other compassionate people used to visit her day after day or every week. She is thankful for what she has right now.</td>
</tr>
<tr>
<td>40</td>
<td>Saleha (S, 73P)</td>
<td>73</td>
<td>None. She is not aware of free medication from the health centre. Saleha sometimes pays for her own medical expenses, but most of the</td>
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<table>
<thead>
<tr>
<th>Time, her son pays, although his salary is not that much.</th>
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<tbody>
<tr>
<td>41</td>
</tr>
</tbody>
</table>

| None. Although aware of free medication from the health centre, she is only receiving basic medicines. Most of the High blood pressure, depression, fatigue, arthritis, osteoporosis, hearing impairment and visual impairment | N/A | She usually spends her days at home doing nothing. She feels bored with her life and lonely all the time. | All of her children are living out of Jeddah, and they usually come to visit her every two months. Her old lady neighbour usually visits weekly. | When asked about her satisfaction in life, she thanks God but she feels alone despite having children. |

<p>| 42 | Salma (A, 66M) | 66 | None. Although aware of free medication from the health centre, she is only receiving basic medicines. Most of the High blood pressure, depression, fatigue, arthritis, osteoporosis, hearing impairment and visual impairment | N/A | She usually spends her days at home doing nothing. She feels bored with her life and lonely all the time. | All of her children are living out of Jeddah, and they usually come to visit her every two months. Her old lady neighbour usually visits weekly. | When asked about her satisfaction in life, she thanks God but she feels alone despite having children. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Medication</th>
<th>Health Problems</th>
<th>Activities</th>
<th>Social Interactions</th>
<th>Overall Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Sanabel (A3, 63H)</td>
<td>Yes. She has medical insurance from the Ministry of Social Affairs and often uses it when needed.</td>
<td>High blood pressure, heart problems, fatigue and visual impairment</td>
<td>N/A</td>
<td>Praying, watching television, exercising, arranging visits to her neighbours, reading and communicating with her previous staff</td>
</tr>
<tr>
<td>63</td>
<td>Sarah (A, 65M)</td>
<td>None. She pays her own medical expenses. She is not aware of free medication from the health centre.</td>
<td>Diabetes, fatigue and visual impairment</td>
<td>She worked after her retirement as a contractual employee for four years. She is also engaged in voluntary services with three or four associations.</td>
<td>Teaching, watching television and surfing the internet</td>
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<tr>
<td>Age</td>
<td>Name</td>
<td>Gender</td>
<td>Age</td>
<td>Education</td>
<td>Health Status</td>
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<tr>
<td>45</td>
<td>Sumayah</td>
<td>Female</td>
<td>70</td>
<td>A, 70P</td>
<td>None</td>
</tr>
<tr>
<td>46</td>
<td>Susan (UD, 61P)</td>
<td>Female</td>
<td>61</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>47</td>
<td>Tala (UD, 68M)</td>
<td>68</td>
<td>None. She has no medical insurance but is able to get free medication and check-ups at Jeddah Specialist Hospital.</td>
<td>She usually telephones her friends and interacts with other people in events and while travelling. She began writing poetry in the last three years and considers it now as a hobby. Thus, Tala has published two books already and the contractor invited her to Beirut and Dubai to hold</td>
<td>After her retirement, she used to spend her days surfing the internet, watching television and having nice conversations with her daughters and sons.</td>
</tr>
</tbody>
</table>

Susan adds that they do not have a qualified doctor to read the diagnosis. since her divorced daughter’s son died in an accident recently, they have only met during weekends.
<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Age</th>
<th>Symptoms</th>
<th>Activities</th>
<th>Life Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Talha (S, 70P)</td>
<td>70</td>
<td>None. She is aware of free medication from the health centre and tried them twice, but she was not satisfied with their services and does not want or is afraid of medication and hospitals.</td>
<td>High blood pressure, depression, fatigue, anxiety and fear of society.</td>
<td>Watching television and praying. She is very sick and unable to perform any activity.</td>
</tr>
<tr>
<td>49</td>
<td>Wadha (B, 72P)</td>
<td>72</td>
<td>Yes. Her brother pays for her medical insurance.</td>
<td>High blood pressure, depression and fatigue.</td>
<td>N/A</td>
</tr>
<tr>
<td>50</td>
<td>Zana (B, 75M)</td>
<td>75</td>
<td>She is aware of free medication from the health centre, but she prefers to use her insurance.</td>
<td>None. Her brother and his children usually pay for her hospital care. She is aware of free medication from the health centre, but she is taking only basic medication.</td>
<td>High blood pressure, heart problems, diabetes, depression, isolation, fatigue, anxiety, arthritis, osteoporosis and hearing impairment</td>
</tr>
</tbody>
</table>