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**Care of Elderly Women in Saudi Arabia: a
Comparison of Institutional and Family Settings**

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by

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*In the name of Allah
The Most Gracious, The Most Merciful*

*I dedicate this work especially to my parents
And more importantly to my beloved husband for all his sacrifices, without his
support this work would never have been completed.*



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Abstract

In recent decades, the structure of social and economic life in Saudi Arabia has undergone enormous change, and among those most affected are the elderly. While Islam enjoins respect for and care of the elderly, economic and social factors are changing the traditional system of family-based care. This thesis investigates care of elderly women in institutional and family settings in Medina. It examines the experience of old age and the discourse surrounding it, focusing on the factors influencing care arrangements, elderly women's perceptions of their role in the family and society, the practical, economic, social and psychological implications of care for the elderly women and their relatives, the profile of carers, the dynamics of the care relationship, problems faced and support received.

Data for 20 elderly women in a care home were collected through participant observation during a three-month placement, together with semi-structured interviews with 5 residents and 31 members of staff. Data for seven elderly women in family settings were collected through semi-structured interviews with the women, their main carer(s) and domestic staff.

It was found that care decisions were influenced mainly by economic status and family structure. Women in family settings underwent a gradual transition, continuing to a great extent to enact former roles, while care home residents suffered an abrupt change and reconstruction of identity as "patients" and "victims". While both groups had subsistence and medical needs met, social and psychological needs were poorly met in the care home. Findings for both groups shed light on the roles of female carers, including a heavy reliance on migrant employees, whose motivations, working conditions and relationships with employers are explored. Implications from the findings are drawn for both ageing and migration theory, and for the support needed by elderly women and their carers in both family and care home settings.

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Chapter One

Introduction and Background

1.1 Introduction

In recent decades, the structures of social and economic life in Saudi Arabia have undergone enormous changes. Saudi Arabian society and culture have altered, especially in terms of immigration, family structure and the role of women. The people most affected by the changes taking place around them include elderly people, who feel lonely, saddened and confused (Al-Divayan, 2003).

In the past, elderly people were less affected by such problems. They had an important role and had plenty with which to occupy themselves: for example, elderly women would cook or care for children and elderly men were consulted for advice and information. Nowadays, however, as younger members of the family show less respect and concern for elderly people, it is clear that the situation has changed (Hess and Ferree, 1987). This fact has prompted me to study in depth the problems of elderly women in Saudi Arabia, in particular in the city of Al-Madinah Al-Munawarah (Medina) with the objective of improving their quality of life. A further impetus was provided by a visit to the care home that eventually became the focus of the present study, during which I was saddened by the plight of the elderly female residents. They were housed along with the mentally ill, and appeared to be unhappy. As far as the facilities were concerned, they had the best that technology could offer. However, my conversations with the residents revealed that they missed their families and wished to be cared for in their own homes. They felt neglected and imprisoned within the confines of the care home. Some residents felt helpless and cursed their families for keeping them there. Their only contact made with the outside world was the "Happiness" group, a voluntary social service organisation formed by students at a local teacher training college, which visited and provided outings for orphans and the elderly. When one of the residents complained of having no visitors or outings except when this group came, the care home supervisor appeared nervous and kept interrupting with excuses as to why

the residents had not been out. My concern that elderly people's emotional and social needs were perhaps not being met made me want to study further the situation of the elderly in daily life. I focused specifically on women for several reasons. First, gender segregation is strictly observed in Saudi Arabia, so men and women in institutional care are separated. Second, the same norm of segregation would make access to male participants difficult for a female researcher. Third, in a traditional patriarchal society, cultural values may have specific impacts on women, that I was keen to explore.

Elderly people represent a sizeable category of the population in all societies. Nonetheless, many societies' perceptions of elderly people are ambiguous. In many societies elderly people are disenfranchised, and lack the power to press the society to respect their rights as members of it (Al-Tahhan 1999). By and large, societies channel their resources into looking after the younger generations because they are perceived as the category of citizens that can build the society.

As far as the material development of society is concerned, the role of elderly people according to Al-Tahhan (1999) has been judged to be generally negligible. As a consequence, in most cases, society gives little consideration to this group within it. This prevalent attitude towards the elderly puts severe and negative psychological pressure on them, and they can be left to feel that they are inferior members of society. This can be compounded all the more if an elderly person has lost his or her spouse. In addition, elderly and retired people may find they have little with which to occupy their time. Society needs to consider that humans, by nature, need to interact with others and need the respect of their society. Otherwise, adverse consequences will ensue (Al-Tahhan, 1999).

Traditionally, the different stages through which human beings pass in the course of their lives are said to be the same for us all. They begin with the weak and dependent state of childhood, and come to a close with the same characteristics in old age (Al-Sadhan, 1998). In practice, not all old people are weak, but this socially constructed view is still prevalent. The Quran (21:54) tells us: "*Allah is the one who created you from weakness, then made after weakness strength, then made after strength weakness*". According to Islamic values, as our parents once cared for us, so too may we one day

care for them; and as our children need our care, so may we one day have the same need for care from our children. Because each person will face this stage of life, younger generations should take responsibility to help old people (Al-Abt, 1999).

As Prophet Mohammad (pbuh) says, ‘You are not one of our group if you don’t have mercy upon children and have respect for elderly people’. Islam commands its followers to respect old people, because if we were to ask ourselves whose these people are, the answer is that their parents or grandparents were actually related to us and ours. The Qur’an imposes an obligation of filial obedience and attention to the comfort of one’s parents (15:23-24):

“And your Lord has decreed that you not worship except Him, and to parents, good treatment. Whether one or both of them reach old age [while] with you, say not to them [so much as] ‘uff’ (an expression of disapproval or irritation), and do not repel them but speak to them a noble word. And lower to them the wing humility out of mercy and say “My Lord, have mercy upon them as they brought me up [when I was] small” (Qur’an 15:23-24).

Islamic practice emphasises that as well as paying their dues to their parents and elders, Muslims should care for all human beings from their birth until old age.

Furthermore, in Arab society and in particular in the Gulf society, elderly people are traditionally generally highly regarded because they are resources of knowledge and experience, and, what is more, many aspects of Islamic culture and tradition replicate and reinforce this. The elderly continue to have much to offer younger generations (Al-Qassar 1999:36-7, 39), and it is important that society does not belittle the importance of the elderly people and that it does not consider them as burdensome and redundant. In accordance with the practice of Islam, and repeatedly iterated in the Qur’an, the needs and roles of elderly people should not be abandoned. However, the significant economic changes that have occurred in society at large have had strong impacts on family structures and ties. As a result, Saudi writers (e.g. Faleh, 1983, Al-Thaaqib, 1986, Al-Tuwaijri, 2001), have increasingly criticized what they see as deleterious effects on family life, a loss of respect for the elderly and a growing trend for elderly

care to be delegated to the state. However, so far the claims have not been supported by empirical evidence. At this time of social change there is a real need to understand the current situation of elderly care, and the implications for families and the state.

1.2 Aim and Objectives

The aim of this research is to explore issues centring on elderly (female) people in the city of Al-Madinah Al-Munawarah, with regard to their psychological, physiological, financial and social needs, and specifically how the female elderly and their families are coping with the issues raised by recent social changes. I will explore both the care provided within the family and the care provided by the State in a care home. I will discuss the following:

- Is the elderly person cared for by the nuclear or extended family or in a care home, and what are the factors influencing the decisions made on care arrangements?
- How do elderly women perceive their role in the family and society and has it changed in relation to the care arrangements?
- What are the practical, economic, social, and psychological implications of various care arrangements for the elderly woman and their relatives?
- Who provides care, in terms of age, gender, ethnicity, role and relationship?
- What are the attitudes of the carers towards the elderly? What are the dynamics of the care relationship?
- What problems do the carers face and do they receive support? If so, from whom?
- Is there a difference between care in an informal setting at home and in a formal setting in a residential home?

1.3 The Significance of the Study

There are two significant aspects in this study; in the first place its findings will contribute to knowledge, and, secondly, it has great scope for practical utility. There is no doubt that the care of the elderly is an important subject in the area of family sociology. However, no study in a Saudi context has taken as its specific subject the female elderly and so there exists a considerable gap in knowledge which the present study aims to redress. In this way, it will contribute to knowledge of an area into which Saudi Arabian society has done little research but into which, given the changes that have taken place in the society, such study is imperative.

An important contribution of this work is its contextualization of elderly care by paying particular attention to the formal and informal providers of care; their motivations, circumstances, attitudes towards their elderly relatives or clients, and the difficulties they face. In Saudi Arabia, a large part is played in the care of the elderly, in both domestic and institutional settings, by migrant workers (see Chapter Three). This study therefore contributes to the migrant literature, as well as the elderly care literature, with rich, contextualized data on the experience of these employees, in Saudi Arabia – one of the main receiving countries of migrant labour (Kurian, 2004) yet a setting where their experience has received little attention.

In terms of its practical value, this research will shed light on how the care needs of the elderly can be met, taking account of how to meet their economic, psychological and social needs. Its findings may provide input to future policy-making on social support and care for the elderly, whether in the family or in residential care. The research will offer families and policy makers insight into how the elderly feel, how care provisions can be improved and what support may be needed to enhance the quality of care. It may contribute in restoring the important role of the elderly so that families and society can benefit from their experience and wisdom.

1.4 Research Methodology

This research, conducted between July 2007 and January 2008, as a continuation of the research conducted when studying for a Master's degree in 2005, takes an interdisciplinary approach, combining the approaches of anthropology and sociology with library research.

The target population was elderly women (aged over sixty years old), their families and carers, in the city of Al-Madinah Al-Munawarah, located in the western part of Saudi Arabia. I chose this city because, as an important religious centre it has a reputation for upholding traditional Islamic values, and so was expected to provide a useful insight into family relationships. Moreover, it is where I grew up and work, which facilitated gaining access. This was an important consideration, given the potential difficulty of gaining access, due to the private nature of family life in Saudi Arabia.

The research objectives required data to be collected both in a care home and in the family setting. In order to investigate the situation of women cared for in a home for the elderly, I employed participant observation. I obtained a three-month placement within the only care home in Medina, facilitated by my university there. This initial intensive placement was followed up by a number of shorter subsequent visits. While working in the care home I kept a reflective journal, recording sights, sounds and smells, in an attempt to understand how the elderly women live, think and feel, in line with Okley's (1994b) emphasis on drawing on 'knowledge beyond language' that uses all the senses of the researcher and the participants. These observed data were complemented by semi-structured interviews with the care home supervisor and nurses/carers, and with a small number of residents.

Such an approach is consistent with my phenomenological/interpretive stance; in phenomenological research, the interview as a research tool is often considered superior to other data-gathering devices. As Cohen (1985:292) highlights, the interview (qualitative research) focuses on the insider's viewpoint. A further consideration in choosing the interview technique for this research is because people usually are more willing to talk than to write (Gillham 2000).

With regard to women cared for in family settings. I studied seven elderly women, five of whom were drawn from the original sample which participated in my Master's study. In these cases, I interviewed, in addition to the women themselves, the relative who was each woman's main carer, and, where relevant, housemaids or other staff employed to assist in care provision. Thus, I was able to pursue questions raised by the earlier research and follow up possible change over time since my last meeting with these families.

A detailed rationale for, and description of, the research methodology can be found in Chapter Four.

1.5 Difficulties of Research

The main problems in this research concern the readiness and willingness of the respondents to share information and experiences in semi and unstructured interviews. Although interviewing is considered the most vital technique in the social sciences in general, and particularly in sociology (Hyman 1965; Holstein and Gubrium 1998), it may not prove effective if the interviewees are not able to express freely their thoughts, feelings or opinions; if for reasons of privacy or other obstruction they control their information. Okely (1994a), for example, comments on how the presence of others can have a constraining effect. Writing of elderly people in rural France, she notes that: "*the gaze, however benign, of their carers changed their conversation*" (p3).

There are, moreover constraining influences in the interview setting itself, as noted by Oakley (1981) in her classic article, "Interviewing Women". Oakley (1981) perceives a contradiction in the traditional interview paradigm, in which researchers are urged to "establish rapport" but also to maintain an objective distance:

"For the contradiction at the heart of the text book paradigm is that interviewing necessitates the manipulation of interviewees as objects of study/sources of data, but this can only be achieved via a certain amount of humane treatment" (p33).

She argues that “rapport” in this paradigm takes on a different meaning from its dictionary definition (“a sympathetic relationship”-O.G.D) to imply the respondent’s passive acceptance of and adaptation to the researcher’s definition of the interview situation. She criticises the dominant-subordinate relationship typically created and sustained between researcher and respondent, and the failure of the traditional paradigm to take account of and give due importance to emotion.

In this research, my feminist interpretive stance required me to bring my own subjectivity to the research and interact with the participants to explore the meanings of their experiences, as well as be reflectively aware of the impact of class, age and status differences. This issue will be discussed further in the Methodology chapter, where I explain the methodological and ethical considerations involved when women interview other women, drawing on the experience of feminist social research such as Oakley (1981) and Finch (1984).

This raises another difficulty that I had to face, with regard to ethical codes of practice which impact on different ethical principles and moral dimensions. Researchers have to be able to distinguish between ethics in general and research ethics in particular as somehow distinct from the rest of morality. Morals and attitudes cannot be expressed in or reduced to the form of rules comprising a code of ethics. However, ethics is not just a matter of duties and responsibilities; a list of ‘things to do’ and ‘things not to do’. Rather, it is concerned with humanity and preserving human dignity. At the same time, the researcher should have the final word concerning what is appropriately ethical and what is not, according to her own judgement and the research context.

This raised issues for the research such as how to press participants for information, especially on sensitive and distressing topics; judging whether participants, especially elderly women, adequately understood my role and the implications of their participation, deciding how much of their stories to reveal, and so on. I had to maintain a balance between fulfilling the aims of the research and meeting my responsibility to report accurately what I observed and understood on the one hand, and protecting the interests of participants on the other (see Chapter Four for more details).

1.6 Structure and Layout of Research

This thesis is divided into seven further chapters. Chapter Two sets the context of the study with a general overview of the family phenomenon of population ageing. The definition of ageing is also discussed, with special reference to the Islamic perspective on ageing. Particular attention is paid to the way ideologies and attitudes contribute in the social construction of age, with implications for the way old people are treated. The chapter also considers the forms and functions of the family, as the context in which much elderly care is provided.

Chapter Three looks more closely at the way forces of social change, including globalization and neo-liberal economics are impacting on the care of the elderly, both internationally and Saudi Arabia in particular. Attention is drawn to gender and class issues in the economics and politics of social care, the phenomenon of migration and migrant workers' role in care provision.

Chapter Four explains the method and sample for the study. Participant observation was carried out among the 45 residents of the care home in Medina, their carers and relatives, noting and describing incidents and procedures, in order to understand the day-to-day life, interaction and relationships between the elderly and their carers. Moreover, research interviews were used to collect data from elderly women living with their families, and their carers. The procedures used in the research are explained, reflected upon and evaluated.

Chapters Five, Six and Seven present an analysis of the research findings. Because of the volume and complexity of the data related to institutional care, data from the care home are divided between two chapters. Chapter Five focuses predominantly on the elderly residents of the home, and addresses research questions 1-3, concerning the rationale for the care decision, the way elderly women perceive their situation, and the various implications of the way care is provided and experienced in the care home. Chapter Six provides complementary insights on the care providers: their profile, their attitudes toward the elderly in their care and factors constraining or supporting them in the service they provide – thereby addressing research questions 4-6. In Chapter Seven,

the same issues are addressed with regard to the elderly women being cared for in a family setting.

Chapter Eight concludes the thesis, with a summary of the main themes emerging in the preceding chapters, from which a synthesis is made enabling research question 7 to be answered, I present my reflections on the research experience and the theoretical and practical contributions of the study, before offering suggestions for further research to build on the contributions of this study.

Chapter Two

Ageing, the Elderly and the Family

2.1 Introduction

The purpose of this chapter is to provide a background for the subsequent discussion of care of the elderly in Saudi Arabia, by exploring definitions and perceptions of old age, and different types of family structure which impact on the status of the elderly and arrangements for their care.

In this chapter, and the following one on globalisation, social change and care of the elderly, I draw on the common discourse of Islamic teachings, located in the Quran (the Holy Book of Islam) and the Hadiths (sayings of the Prophet, pbuh), taking shape through the form and quality of interpersonal encounters between carer and cared for. The research draws from a wide body of source material, including published accounts, my own and other people's field work and press reports. I have also included autobiographical material and personal reflections. In all of these, various ideas about dependency are exposed. Alongside Arab and Islamic 'ethnographic' texts I have placed material related to 'Western' societies, drawing on an anthropological perspective. These provide points of comparison that help to highlight the different ways in which ageing and impairment can be culturally perceived. This use of the comparative method makes my approach part of an 'interpretive humanity' (Holy, 1987 in Hockey and James, 1993: 6) concerned with cultural specificity and diversity.

The discussion is presented in four main sections. First, a global statistical overview of population ageing is presented then the concept of old age is examined. Attitudes and ideologies related to ageing and the elderly, in the Islamic perspective, are discussed. I then examine concepts of the family, as the context in which much elderly care takes place.

2.2 Global View

Demographic ageing is a global phenomenon. According to research (Kraan et al. 1991, Kosberg 1992), the world population is ageing at a steady and quite impressive rate. This trend can be seen in the following data (Table 2.1) for the UK, published by the Office for National Statistics – ONS (2001),

Table 2.1: Life Expectancy 1841 – 1998

Year	Men	Woman
1841	41	48
1901	45.7	49.6
1931	58.1	62.1
1961	67.8	73.7
1981	70.9	76.8
1991	73.2	78.8
1998	74.9	79.8

Source: Social Trends, ONS (2001) in Easterbrook (2003)

In a more recent report (ONS 2010) it was suggested that assuming the continuation of present mortality rates, life expectancy at birth for individuals born in 2007-2009 would be 71–7 years for men and 81-9 years for women, compared to 71 and 77 years respectively in 1980-82. However, given that mortality rates are expected to improve, the same report projects that life expectancy at birth in 2009 could actually be as high as 88.7 years for men and 92.3 years for women. The same trend is reported across Europe. According to a recent economic report (European Commission, 2009), life expectancy at birth in the European Union is expected to rise from 76 years for men and 84.5 years for women in 2008 to 82 years for men and 89 years for women in 2060.

Generally the life span has lengthened considerably in the last century, such that average life expectancy in the world for the year 2000 was 82 years (O’Leary 1996). The total number of people aged 60 and above in the world increased from 200 million in 1950 to 629 million in 2002 and is projected to reach nearly 2 billion by the year 2050 (, 2002). It has been estimated that in the EU, the population aged 65 years and over will almost double between 2008 and 2060 (European Commission 2009). The old

age dependency ratio (the ratio of people aged 65 and over to working population) for 2050 is expected to be 27% in Asia, 31% in Latin America, 36% in Northern America and 48% in the EU (UN 2008, cited in European Commission 2009). The number of people aged 80 and above is the fastest growing population group in the world and continues to grow even more spectacularly, having gone from 13 million in 1950 to over 50 million today, and projected to increase to 137 million in 2025 (Kosberg 1992:1-2). As a percentage of the over-60 population, the over 80s are predicted to increase from the current 12% to 19% by 2050 (Sayan, 2002). Women, who tend to live longer than men, make up a larger proportion of the 'old age' group (UN, 2010). Two-thirds of people over 80 are women, and according to research, by 2025, the number of women aged over 60 will increase by 150% (HelpAge International 2000; Ewing 1999: 33-45).

In many countries, the growing elderly population and a declining youth cohort are creating two key problems: the mounting need for personal carers and an increasing amount of resources to support them (Kraan et al. 1991:227ff). The figures quoted above are illustrations of a quiet revolution, but one which has far-reaching and unpredictable consequences and which is now affecting the social and economic structures of societies both globally and nationally. Societies are faced with the task of adapting their social and economic policies to the ageing of their populations, especially as regards social security and care.

Ageing has gone beyond the realm of welfare concern and needs to be viewed as a developmental challenge. It is essential that ageing-related issues be mainstreamed into national development agendas and relevant policies, including "gender sensitive initiatives" (Dwyer and Coward, 1992:17) to address the feminisation of the elderly resulting from the gender difference in longevity, noted previously.

Saudi Arabia is no exception to these global trends. Modern health care has contributed to a population explosion of an estimated 3.5 percent a year, from about 2 to 4 million in the 1960s to more than 20 million by 2000 (United Nations, 2002). Table 2.2 shows the actual and predicted growth in the 65+ population in Saudi Arabia.

Table 2.2: Total population, Total 65+ (in thousands) and Percent 65+, 1975, 2000, 2025, 2050

Year	Total Population	Total 65 +	Percent
1975	7251	218	3.0
2000	20346	602	3.0
2025	40473	2294	5.7
2050	59683	5191	8.7

Source: UN, World Population Ageing, 2007

The third development plan (1980-1985) of Saudi Arabia for the first time asserted the government's interest in ensuring social care for elderly by reinforcing the family role in this field, and exhorting its young members to take care of its aged. The government has concentrated its own efforts in providing better health care for the elderly. Thus, there is a split in responsibility for care of the elderly, with the government taking the role of provider of medical care, while social care remains largely the responsibility of the family and community (I shall return to this point later). Therefore, in my research of Saudi Arabian literature I have found more material in the field of medical healthcare of the elderly than the social care of the elderly. According to the 9th Development Plan (2005 - 2009), social care for elderly people who are unable to attend to their own needs and whose families are unable to take care of them is provided by 10 elderly homes. The total number of beneficiaries at these homes was 664 in 1423H (2003) (United Nations, 2003). Based on the UN estimate of a 65+ population of 625,000 in 2000, this represents only 0.1% of the relevant population, indicating that most elderly are cared for within their own or a relative's home. The reasons for this and the social forces that contribute in sustaining or challenging this pattern will be explored in this and the following chapter.

First, however, it would be appropriate to consider how old age is defined and conceptualized.

2.3 The Concept of Old Age

There is no consensus on a universal definition of old age. A statutory definition of old age, such as Kaufman's (1986), indicated as being 65 years and over, is perhaps less useful a definition than it is a practical one. Old age can be described in terms of chronological age, functional age, or in terms of important life events such as widowhood, retirement and dependency (Arber and Ginn 1990).

Other standards include social age, in terms of the social roles which the individual performs in his/her social environment and his/her relations with others; and psychological age, which is concerned with the individual's needs and motives, his/her psychological functioning, and changes in his/her behaviour.

Ageing is a natural development of human beings who, like any other organism on Earth, have a limited life span. In practical terms, old age, or 'later life', applies when people start deteriorating physiologically, psychologically and mentally. However, because of cross-cultural differences, including measures of socio-economic and technological development as well as socialisation, the critical age will vary from one society to the other. The truth is that much of what we understand by "old age" is socially constructed (Finch, 1989; Hockey and James, 1993:33). As an example of structure and agency, society produces a framework of institutions and rules that structure the situation of the elderly. According to Fouad Ahmed (2001:3), the international committee responsible for population matters has classified the Elderly into three categories: 'Young old' for those whose age varies between 60 and 74, 'Old' for those whose age varies between 75 and 84 and 'Rather old' whose age is 84 and more. In Islamic ideology there are specific terms which combine chronological and social standards, to classify these same age groups. The terms used for old people are as follows (Abdulhamid, 1982): **Kahel (Young old person):** a person who is between the age of 60 and 75 and still contributes to social life; **Sheikh (old):** a person who is between the age of 75 and 85 and whose contribution in society has decreased. The term Sheikh is used for a person who is noted for their wisdom and learning. **Haarm (Rather old):** a person who is 85 or more and usually stays home because of his or her frailty, **Al-Moamer (Centurion):** a person who reaches 100 or more. Perhaps these Islamic terms could be adopted by the international community to take away the

ambiguity and contradiction in terms like 'Young old', 'Old old' or 'Rather old', then academics and professionals involved in the study of the aged would be able to refer to the same specific terminology throughout the world.

Islamic teachings accord old people status and position, maintain their rights and respect, and urge families to look after their elderly members. How these principles are reconciled with the demands of modern life, and the extent to which the ideal is met in practice, will be explored in later chapters.

2.3.1 The Changes in Old Age

From the Islamic perspective, it is a strongly held belief that elderly people are in constant need of help and care because of their inevitable physical and psychological deterioration. Ezzat (1983: 69) identifies the stage of old age as “*a stage in which the deterioration of the physical and mental functions is very clear, can be measured, and has its impacts*”. Therefore, the term old aged person refers to everyone who is unable to take care of him/herself due to old age, not due to handicap or disability.

In the Holy Qur’an, it is stated:

“It is Allah who created you in a state of (helpless) weakness, then gave you strength after weakness, then after strength gave you weakness and a hoary head: He creates whatever He wills, and it is He Who has all knowledge and power” (Surat Ar-Rum 30, Ayat 54)

This is a common perspective on old age, which views it in terms of physical, social, psychological and economic change.

Physical change can be a biological dysfunction such as amnesia, limitation in the five senses, and sluggishness in movements, hypertension, sexual impotence (for males) and reduction in immunity. From this perspective, ageing is "a decline in strength and a changing physical appearance, but the degree and meaning of change are very variable" (Wilson 2000:3). It is perceived as a progressive loss of an individual's adaptability as time passes (Grimley-Evans 1993:5); Hunt (2005) notes that notions of ‘wear and tear’ leading to natural deterioration with age, and of decline in immunity in later years,

result in a perception of ageing as associated with inevitable decline, which is very much a medical construct. This is, however, only one perspective, and its validity is increasingly called into question. Scrutton (1999), for example, asserts that fitter and more active older people can bear testimony that the socially perceived pre-ordained decline of health in older age is not inevitable. Easterbrook (2003) quoting research in the UK by ONS (2001) casts doubt on whether old age necessarily equates to illness or disability. Although healthy life expectancy (the number of years spent “disease free”) is not improving as much as overall life expectancy (ONS, 2001) the portion of older people experiencing severe illness and difficulties is said to be reducing, while the number with mild problems has increased (Wanless, 2002). Indeed it has been suggested that with medical advances and lifestyle changes it is increasingly possible to accomplish “the evasion of old age (Hunt, 2005: 202)

In terms of social change the elderly may experience altered living circumstances, physical or financial reliance on others, and they may suffer from limited social interactions. These social situations suggest a series of psychological changes such as depression, distress, melancholy, memory weakness and disabilities of thinking: to the extent that these result in dependence, psychologically, old age may be viewed as a second childhood. When they become dependent, the elderly may be perceived to behave and act like infants, but more significantly, however, their treatment by carers is often of an infantilising nature, engendering feelings of social marginalisation, loneliness, humiliation and emotional vulnerability (Hockey and James 1993:10). This view, too, however, is open to challenge. Nolan et al. (2001) suggest that approaches to quality of life of the elderly exhibit a youthful bias, reflecting taken-for granted notions of autonomy and independence as the ideal against which the experience of the elderly is measured and found unsatisfactory. This dominant conceptualization of quality of life based on objective criteria of questionable relevance (O’Boyle, 1997; Reed and Clarke, 1999) has been accused of “[losing] the human being” (Kivnick and Murray, 1997, cited in Nolan et al., 2001: 8). The portrayal of elderly people as suffering from personality deterioration and social losses (Whitebourne and Hulicka, 1990), however, is not borne out by research (Scrutton, 1999). Nor is loneliness, as often conceptualized, a problem specific to old age, as Victor et al. (2005) demonstrated in their survey of this nature and extent of loneliness in old age in Britain, conducted on a nationally representative

sample of 999 men and women aged 65+, living in the community. Only a minority of their example, 7 per cent, reported that they were always /often lonely. Similarly, in two Australian studies in Queensland (Lauder et al., 2004) and Perth (Iredell et al., 2003), severe loneliness was reported by only 6.1.per cent and 7 per cent, respectively. Such findings suggest that it would be unwise to accept too readily the stereotype that “the normal experience of old age is of social neglect, isolation and a reliance on fragile social networks” (Victor et al., 2005: 35). Equally, mental decline is not necessarily concomitant with old age; young people can suffer from dementia, while most people, old or young, do not; the causal link between ageing and mental deterioration is by no means a straightforward one (Scrutton, 1999).

The economic changes affecting the elderly include a diminished income as the result of retirement, clinical visits and medicines, rising prices in general and inflation; diminution of money purchasing power (Ahmed, 2001:3-4). From the point of view of the economist or policy-maker, the elderly, since they do not expect to be active figures in the production process, are a financial burden. Regrettably, it is unfeasible to keep the elderly as active members of the social organisation by always maintaining older people in the labour force, when there is significant pressure from other social forces to keep them outside the productive system. However, older people’s unproductivity may be a result of social policy rather than their own infirmity, and enforced by compulsory retirement (Scrutton, 1999). Retirement ages vary from one country to another and are not always linked with individual needs. The reduction of mandatory retirement ages in some countries may be related to the growth of unemployment and the wish to provide a greater guarantee of work for younger generations (Hunt, 2005). Even where this is not the case, the phenomenon of early retirement has become more prevalent, for a variety of reasons, including family demands, the desire for leisure, health, and technological change (Hunt, 2005). In the UK, for instance, the percentage of people aged 60 (for women) and 65(for men) years and over, still in paid employment was recorded by Victor (1997) as only 13 per cent, whereas in 1961, two thirds of men continued in paid employment after the age of 65 (Social Trends, 1997, cited in Hunt, 2005: 191). Having said this, it should be noted that in the UK and other European societies, the official retirement age, at which state pensions become payable, is being increased in order to reduce government expenditure. Moreover, it is advocated by many that elderly people

should be active and productive (although this need not mean paid employment) and this seems to be essential to maintain their well-being. Kivnick and Murray (1997) suggest the importance of vital involvement for the elderly, and call for a focus on their assets, values, interests, commitments and strengths, rather than their deficits. Lawton et al. (1995) argue the need, not only for activity, but also for meaningful social engagement and the opportunity to display competence and mastery. Steverink et al. (1998) propose that well-being in old age depends on success in achieving five instrumental goals, two physical and three social, namely: comfort (satisfaction of needs and absence of fear and pain), stimulation (exposure to novelty, challenge and interesting events), behavioural confirmation (the sense of having performed adequately); affection (being loved by self and others); and status (being valued in comparison to others). These were recognised by the World Health Organisation (WHO) on World Health Day in April 1999, when the WHO Director – General, Gro Harlem Bundtland, expressed the organisation’s recognition that it is key for older people to go on playing a part in society (Shanine, 1999) In Islamic societies, the Qur’an lays down the rights of the elderly to live a dignified life and to be respected, to work if able, to enjoy family and health care (Qur’an XVII: 70).

The ageing process is a biological reality which has its own dynamic, largely beyond human control. It is, however; also subject to the constructions by which each society makes sense of old age (Gorman 1999, in Randel et al. 1999:7). Socially, old age can be a time of fulfilment or a time of denigration and marginalisation. The idea of active ageing stands in sharp contrast to the much debated theory of a process of mutual disengagement between the elderly and society (O’Leary, 1996). O’Leary (1996) argued that the elderly voluntarily retreat from many obligations in which they were previously engaged. According to O’Leary, there are four steps in the process of disengagement. Firstly, the elderly person’s social contact is affected by change, such as the death of a spouse or other close contemporary, or a changing physical, psychological and economic position or socio-economic role. Second, the elderly person accepts these changes in their social interactions, and thirdly, as a consequence, their social interaction becomes more passive. Finally, this behaviour becomes self-perpetuating (Berger 1994). It is presumed that old people want to disconnect themselves from the world, to retreat from life in preparation for death. Disengagement, it is argued, can

benefit society by removing from the workforce those whose deteriorating physical and mental abilities weaken their economic role, making way for younger people with greater capabilities and with the most up-to-date skills and training (Hunt, 2005). For the elderly, it can be a positive choice, representing freedom from pressure and stress (Scrutton, 1999) Johnson and Barer (1991) suggest a degree of detachment from certain aspects of life may be part of a necessary process of reconstitution of a self- concept that is consistent with the realities of later life. Moreover, a psychological need for active involvement may give way to one of inactive contemplation of the meaning of life in the face of impending death (Hunt, 2005).

Disengagement theory, however, has been subjected to strong critique for its failure to ask how far the observed disengagement is a natural social and psychological mechanism or accepted and integral part of ageing, and how far it is imposed by cultural expectations (Scrutton, 1999). Many elderly people may not wish to disengage themselves from social roles, thereby losing prestige and risking isolation; some cannot afford do so for financial reasons; disengagement results in a loss to society of at least some potentially productive human resources; and compulsory retirement necessitates the care of people who might be better able to care for themselves (Hunt,2005). Social disengagement may be to some extent a manifestation of structural ageism, whereby elderly people learn to “play the game” – not making demands, not complaining, suppressing their own feelings and needs in response to social expectations (Scrutton, 1999).

As the foregoing discussion indicates, it is important not to make the mistake of treating the elderly as a homogenous group with identical needs. “Not all older people are frail or without resources” (Victor, 1997: 26). Negative images of old age, according to Scrutton (1999: 13) come from the “oldest of older people” and the ‘young-old’ can and should have a more positive image. Moreover, there are differences between the elderly of the same age, in personality and objective circumstances. It is easier for some to adapt than it is for others, and studies have shown that the poorer, the less educated and the unmarried or widowed elderly fare far worse in their adjustment, and are therefore most likely to suffer from loneliness and socio-psychological misery (Gibson, 2000). For example, Abdul Wahed (1999) found that for Saudi women, there were direct

correlations between adjustment and age, income, place of living, marital status, and level of education. Arber and Ginn (1990) view well-being of the elderly as dependent on the inter-relationship between access to caring resources, health and access to material resources. Nilsson et al. (1998) meanwhile, argue that the conception of a good life in older age is related less to objective circumstances than to personal relationships, a feeling of being needed, a positive view of one's past, present and future, and a philosophy of life based on religious or other strong personal beliefs. Hunt (2005) acknowledges both the positive and negative experiences of elderly people, suggesting a need to view old age not as a homogenous state, but as a process – a gradual transition from the so called 'third age' when freedom from parenting and paid work allow a more active, independent life, to a 'fourth age' of eventual dependency. Thus, younger old age may be a time of self-realisation and empowerment (particularly as this age group emerges as a significant economic and political constituency) and of the pleasures of leisured retirement (Counts and Counts, 1996), while the decline and dependency traditionally associated with old age are experienced at older ages or by those whose social and economic circumstances have placed them in a disadvantaged position, even prior to old age.

The perspectives outlined above are applicable not only in the current empirical investigation, but also in reviewing the literature related to a different societal context such as the Arab-Islamic culture. However, the culturally specific aspects of caring for the elderly in Islamic culture, much of which is laid down in Holy Scripture or stems from the social structure of the extended family, require some explanation.

2.4 Islamic Attitudes and Ideologies in Relation to Old Age

As indicated in the previous section, irrespective of the biological changes associated with ageing, the concept of old age is to a great extent socially constructed. This section draws on Islamic scripture and sociological studies to outline the Arab world's perception of the elderly, the duty to care for them, and the role of the extended family in this. In order to highlight the distinctiveness of the Islamic perspective, brief reference is made to claims that, in the West, and Britain specifically, historical and cultural factors may have contributed to a discourse of 'infantilization' that, while well

intended, undermines the position of the elderly. It must be made clear, however, that this is only one perspective, nor is it intended to undertake a formal comparison. This discussion is included for the light it sheds on the background to care practices, but it should be noted that the views discussed only explain certain dimensions of what is an increasingly complex topic and, as will be seen later, there are many ways in which individual attitudes and practices may depart from those described here.

Islamic Law (Ar., Sharia'ah) points out some basic elements in relation to old age. First, human beings of any age are honoured. Second, the Islamic society, according to the Qur'an and Hadith (Prophet's speeches) must enjoy some kind of solidarity, consistency and continuity. Part of a Muslim's faith is that the young should respect and pay attention to and help the old; it has been reported that the Prophet (pbuh.) said: 'They are not Muslims who do not look after the children and respect the old' (Al-Sadhan 1998). From the Islamic perspective, care for the elderly is synonymous with compassion, respect and honour of the elderly. Ben Jaher confirmed the importance of respecting old people and dignifying them when he related from Prophet Muhammad (peace be upon him) that Muhammad said: "*Jebrel ordered me to respect and honour old people*" (Al-Divayan, 2003). In the Prophet's hadith, Abu Dawod Al-Tormozy related that Muhammad (peace be upon him) said: "*have mercy on those on earth you will get mercy from the one in heaven.*"

Islamic Law emphasises that sons and daughters should look after their parents when they reach the critical age (sixty and over). It is the child's principal duty to obey, to serve and to treat their parents well under all conditions:

"And your Lord has decreed that you worship none but Him. And that you be dutiful to your parents. If one of them or both of them attain old age in your life, say not to them a word of disrespect, nor shout at them but address them in terms of honour. And lower unto them the wing of submission and humility through mercy, and say: "My Lord! Bestow on them Your Mercy as they did bring me up when I was small." (Qur'an 17:23-24).

The duty of caring for the welfare of one's parents as they go into old age, by the provision of both financial and physical support, is considered an honour and blessing, and a chance for great spiritual growth: it is an act of worshipping God by honouring His commandments (Kamel 1992:113– 123). It is to this very obligation that the Prophet Muhammad (pbuh) linked success in the Hereafter, as it is narrated that Abu Hurayrah commented that the Prophet (pbuh) said: “The best deed one can do is the good deed to parents” (Al-Tuwaijri 2001; Kamel 1992). The appreciation and respect of parents is mentioned in the Qur'an eleven times; in every instance, Allah reminds children to recognize and to be grateful for the care and love they have received from their parents (Qur'an 29:8; 46:15; 2:83; 4:36; 6:151).

Islam does not, however, restrict responsibility for care of the elderly to their offspring, but extends it to other relatives and to the society as a whole. If an elderly person is childless, or if their children are unable, due to poverty, to take care of them, responsibility for the needy person is extended to the community at large (Altorki, 1986).

The teachings of Islam encourage its adherents to sustain close contact with family members and to care for each other, including the elderly and the extended family. Accordingly, the family must stay solid; even when they are separated and live in what is called the 'nuclear family', family and kinship relations must continue to be maintained (Al-Sadhan 2002). Socially, this takes the form of mutual visits and the redistribution of wealth through the exchange of gifts (Altorki, 1986, 100-106; 112-118). Family and kinship ties play an essential role in protecting the old in all societies as Eisdorfer (1981) stated: 'Folk wisdom has always maintained that the most important investment a person can make for a secure old age is raising a family' (Eisdorfer 1981: xv). In Islam, the desire to build the family can be found in the holy book of the Muslims, the Qur'an:

“And of His signs is this: He created mates for you from yourselves that you may find rest in them, and He ordained between you love and mercy. Most surely there are signs in this for a people who reflect” (Qur'an 30:21).

The peace and security offered by a stable family unit is greatly valued and seen as necessary for the spiritual growth of its members. Although with the shifting times the family, too, has changed, the socialization of the Saudi family in relation to the elderly remains constant (Najeeb 1980). Because the Islamic moral code saturates Saudi culture, children are actively taught these values, as well as passively absorbing the practices they observe around them. However, the ways in which these values are translated into practice may be changing, as will be discussed in Chapter Three.

The Islamic ideal described above stands in sharp contrast to the claims made by some writers in the West, notably Hockey and James (1993), who detail the different ways in which attitudes and beliefs structure personal everyday encounters and also sustain wider acts of discrimination at the level of social structure, asserting that public attitudes, prevailing ideologies and social structures sustain “practices of infantilization” (Hockey and James, 1993:6), that is, reduction of the elderly to an infant-like state.

Hockey and James (1993), in seeking to reveal the logic by which infantilizing practices in Western cultures are sustained, make extensive use of metaphors, specifically the metaphor of childhood applied to the elderly. Exploring the analogy between old age and childhood, Hockey and James (1993) look to the history of urbanization and industrialisation to show how both children and the elderly have been excluded from the world of work and consequently marginalised, as 'work' society came to provide the measure of personal worth and social status (Kohli, 1988).

Citing Walker (1982), they argue that dependency is primarily a social relationship resting upon the exercise of power; in this sense, dependency is created (Oliver, 1989). They claim that this practice is specific to Western cultures, and is an expression of the relationships of power within the society. Irrespective of the biological realities of old age or its distressing aspects it can be argued that the Western framing of such dependency as ‘childish’ is just one version, just one vision of old age, in which biological ageing and impairment have been made preconditions for socially constructed subordination, rather than a period of natural dependency (Phillipson, 1982; Morris, 1991).

Hockey and James (1993) explore the precise ways in which dependency is understood as 'childish' by looking at the physical body and examining the ways in which the bodies of the elderly people are socially constructed through metonym (a word that denotes one thing but refers to a related thing) as child-like: that is certain features are ascribed importance whilst others are dismissed. Thus, incontinence may mark an elderly person as a non-person, as child-like, despite his or her obvious physical maturity in other aspects of the body.

Hockey and James also consider the powerful role of a familialist ideology (the subordination of the personal interests and prerogatives of an individual to the values and demands of the family: Familism characterized the patriarchal family) in Western society, arguing that the model of care which the family provides may mask a quite rigid system of control which sustains dependency at the expense of independence.

This is not to ignore the reality that some human beings are physically and mentally impaired either throughout life or during certain periods of it, nor to deny that certain of life's biological stages, for example, infancy and deep old age, make human survival impossible without the periodic care and dedicated support of others. Moreover, I do not claim that the 'infantilization' of the elderly is confined to the West (although it is there that the critique of this discourse has emerged; I have found nothing similar in Saudi literature) or that all care of the elderly – whether in the family or elsewhere – reflects this. My aim is simply to give another example of the way in which a particular cultural discourse may contribute in the social construction of old age.

In fact, this is only one perspective; as indicated in section 2.2, the idea that old age is inevitably associated with frailty, incompetence and dependency is increasingly being challenged. Indeed, Hockey and James, (1993) themselves acknowledge that there are alternative ways of seeing and understanding, and some encouraging signs that the status of the elderly may be changing both politically and economically. Older people are beginning to assert their citizenship rights to independence; economic changes, too, provide segments of the elderly population with a powerful role in the consumer society, for example, Saga Holidays specialising in arranging holidays for the 'Grey panthers'.

Many elderly people are fit and active and, if no longer economically active themselves, contribute to their communities through charity work, volunteering in schools and youth schemes and taking care of grandchildren to enable mothers to go out to work. The position of the elderly in society is too complex an issue to be encompassed in a single theory and, moreover, is subject to the forces of social change. This will be apparent in the next section, which examines the family structure, and in Chapter Three, where I investigate how social change impacts on family roles and the care of the elderly.

2.5 The Family in Saudi Arabia

It is particularly salient, in this study, to consider the nature and role of the family because, first, it is the context in which much of the care of the elderly people takes place. Indeed, a study by the Eastern Mediterranean Regional Office of WHO (cited by Shanine, 1999) reported a widespread agreement that old people are better cared for within the friendly environment of their own families and communities. Second, as will be seen in later discussion, in Saudi Arabia, the family is commonly invoked as an ideological discourse by commentators claiming the detrimental impact of changes in residence arrangements and social roles. Third, the current debate on various aspects of family life is given impetus and focus by the central importance of the family in Islam, the source which Saudi Arabia invokes as the foundation of its constitution and the rationale for political decisions and social policy. For all of these reasons, an understanding of family living arrangements and functions is particularly salient when exploring practices and values in relation to care of the elderly in Saudi Arabia. Having said this, however, I recognise that the notion of “family” is complex and problematic. Thus, my aim here is not to describe or advocate any single view of the family, but to explore family forms and relations as an outcome of the interplay of a variety of individual and social factors.

There is some consensus that the family has existed in all human societies. However, sociologists are much less agreed about just how essential the family is to the existence of a society. Some see the replacement function as the central rationale of the family.

Reiss (1965) has suggested, however, that the core function of the family is to provide nurturant socialisation to its dependent young, and it is this function that characterises all families in all societies (Clayton 1975:21; Leslie 1973:17). Islamic scholars view the family as the core unit of society and interpret its functions in terms of social solidarity and the maintenance of Islamic values. The Islamic scholar Khurshid Ahmad (1974) says that the family is a part of the Islamic social order. He stresses that the family establishes an ideological society, with a high level of moral consciousness, strong dedication to the ideal of the *Khilāfah* - a word used in the Quran for Adam, as the vicegerent of the Almighty on Earth (Al-Thydvawy; 2002) and purposeful orientation of all human behaviour. This account can be seen as an example of the way monolithic invocations of “the family” reflect the use of this construct as a trope reflecting ideological positions in relation to how society is or “should be” organised (Doumani, 2003). However, given the “flexibility and fluidity of family forms as well as the diversity of household structures” (Doumani, 2003, p2) not only in different periods and settings, but even within the same setting (as I shall demonstrate in this section) makes taxonomies and generalizations about the family problematic.

Nevertheless, as Doumani (2003, p4) says, there has been a tendency in both popular and scholarly discourses to assume a “monolithic traditional family type”, with an extended structure, and to discuss its supposedly linear transformation to a modern nuclear family.

Many writings on the Middle East, by both Western and Arab writers, describe Muslim societies generally and Saudi society specifically as traditionally characterized by an extended family structure. The extended family refers to a family structure that extends beyond the nuclear family and includes other relatives in the household such as a grandparent or an uncle (Taylor 1997:78). Townsend (cited in Al-Kheil 1991) considered the extended family as a group of relatives with many direct families living all together in one or two houses and seeing each other on a daily basis. The “Muslim family” as described by Ahmed (1974:28) has a threefold organization. The first and the closest level consists of the husband, the wife, their children, their parents who live with them, and servants, if any. The next group consists of a number of close relatives, whether they live together or not, who have special claims upon each other, who move

freely inside the family, with whom marriage is forbidden and between whom there is no veil (Ar. *hijab*). They are regarded as (Ar.) *mahram*- these are people who also have a prior claim on the wealth and resources of a person, in life as well as in death (as beneficiaries). This constitutes the real core of the family, sharing each other's joys, sorrow, hopes and fears. This relationship emerges from consanguinity, affinity and foster-parenting. The community and society forms the next level. Although behavioural patterns have changed with incredible speed, these basic values are deeply held and are not likely to change rapidly over time. A harmonious social order is created by the existence of extended families and by treasuring children.

Typically, the Middle Eastern family is described as patrilocal, patrilineal and patriarchal, meaning that they generally lived in close proximity, computed lineage by the male line, and were guided by family elders. In keeping with the tradition, marriage in Saudi Arabia was endogamous, meaning that people married within their own clan or tribe – preferably a cousin on the father's side. However, first cousin marriage, and indeed endogamous marriage generally, are becoming less common, although they have not been entirely abandoned and co-exist with exogenous marriage (Al Seif, 1997, Al-Mutlag, 2003). Polygamy used to be a common phenomenon. Islamic law allows a man to have up to four wives, provided all are treated equally (although the difficulty of fulfilling this condition can be seen as an intention to discourage polygamy). The harsh conditions of traditional life among the desert nomads and rural communities may have made polygamy necessary in order to ensure sufficient family members to work the land and to defend the family and tribe from outsiders. Now, however, in more prosperous and stable conditions, these imperatives no longer exist, while the high cost of marriage and improved status of women also contribute to make polygamy less common than it once was (Al-Mutlag, 2003).

Whilst this depiction of the traditional family is a widespread view, and like any stereotype, not without its grains of truth, it is an oversimplification. Anthropological accounts of family and community life reveal both a wider variety and greater fluidity of family living arrangements than the stereotype suggests. Abu-Lughod (1986), for example, writing of a *bedu* community in western Egypt in the period 1978-1980, reports varied household composition, ranging from a nuclear unit of a couple and their

baby, to a household of 25 members occupying two houses. Moreover, the extended family could be fluid in composition. She describes the household of a senior member of the community, whose household consisted of himself, his senior wife and a number of their (15) children, sometimes his second wife and her children (with whom he had previously lived together with his mother and a brother and his family), sometimes his third wife and children, and at one point, a younger brother and his second wife; this brother also spent time in another house with his first wife. Thus, household composition was continuously shifting.

Abu-Lughod (1986) is not the only researcher to challenge the stereotypical picture of the traditional family. Fargues (2003), writing of mid-nineteenth century Cairo, challenges the assumption of dominance of the extended family, noting how short life-spans, high infant mortality and the mobility induced by involvement in military service and industrial projects made family composition highly volatile and limited the incidence of large, extended families. He also points out that household composition and residential location differed widely according to class, occupation, religious affiliation and the like. In contrast to the predominance of the simple conjugal household found in Cairo by Fargues (2003) and in Istanbul by Duben and Behar (1991, cited in Doumani, 2003), Okawara (2003) in Damascus found predominantly large and complex households, with high incidences of polygyny and of multi-generational households.

As those examples show, historically there have always been a variety of family forms in the region, and recognition of this fact reveals the limitations of discourses that assume a simple, linear change from one form to another. Nevertheless, as Doumani (2003) notes, when discussing family, it is necessary to consider “the interplay between micro and macro processes of change” (p1), and from this perspective it is fair to acknowledge that there have been discernible broad trends of change at family, community and national levels, albeit less uniform or linear than is sometimes portrayed. Notably, sedentarization of the nomad population, and increasing urbanisation, have both been widespread in the Middle East, including Saudi Arabia, with a variety of consequences for family living arrangements and relationships.

With regard to secularization, Eckelman (2002) reports a decline in pastoral nomadism throughout the region, from the beginning of the eighteenth century, for a variety of reasons, including expansion of cultivated land (making less available for grazing), disappearance of significant caravan traffic, and increasing ineffectiveness of nomads as a military force. For example, in Saudi Arabia, the nomadic population has shrunk from 40% in the 1950s, to 11% in 1970, and less than 3% today (Eckelman, 2002: 68).

To some extent, settlement of Middle Eastern nomadic populations was the result of specific political policies directed towards political control and, later, assimilation of nomads (Abu-Lughod, 1986). In Egypt, for example, Muhammed Ali (1804-1848) embarked on a settlement policy in order to increase agricultural production and tax revenues. Measures included land grants to tribal leaders, appointment of leaders to official positions (leading to their moving to towns to perform their duties and to enjoy their new wealth), and permission to register uncultivated land. As the economic rewards of pastoralism became more marginal, the shift to settled life became more pronounced (Eckelman, 2002). Abu-Lughod (1986) describes how measures of the kind indicated by Eckelman (2002), together with the provision of medical and social services to settled communities, gradually altered the local economy in Saudi Arabia. Formation of a modern nation-state and borders, opportunities for wage labour through enlistment in the National Guard and work for oil companies were also significant factors in sedentarization, as Lancaster (1997, in Eckelman, 2002) reports, although he suggests that *bedu* populations were in fact always open and flexible according to the economic opportunities available.

Sedentarization had contrasting implications for families. On the one hand, Bedouin involvement in the cash economy led to more marked social stratification, more individual ownership of land and property, and private control of resources, trends which might be thought to undermine the economic foundation of the extended family. On the other, in some cases, far from causing fragmentation of families, new levels of wealth actually enabled extended families to remain co-resident (Abu-Lughod, 1986).

Urbanization has been another macro-level trend in the region. For most of recorded history, the majority of the population of the Middle East has lived in agricultural

settlements (Eckelman, 2002). However, as households developed sources of income other than land, land became a capital investment, yielding earnings that were used to build new houses (Weir, 1985 in Eckelman, 2002). Such factors, together with the increasing opportunities and better facilities in urban compared to rural areas contributed to growing urbanization. Abu-Lughod (1986), for example, describes a region in transition, with few big cities (Cairo, Alexandria) but “signs of the encroaching metropolis” (p2) evident in the factories, storage depots and the like dotting the landscape. Eckelman (2002: 385) notes the magnitude of growth in the urban population, to the extent that whereas in 1900, less than 10% of the Middle East population lived in cities, by 1980, the figure was 47%. Typically, growth has been concentrated in a few major cities in each country.

Urbanization, like sedentarization, has had complex and varied implications for family life. Whilst it may have contributed to the splitting of rural families as some of their members migrated, the trend has often been for relatives to live, if not together, then in close proximity in the cities. Janet Abu-Lughod (1972) describes how the typical migrant, on arrival in the city, stays at first with a relative or friend from his village, then finds lodging in a neighbourhood occupied by others from the same region. Households within a residential quarter often claim personal ties and common interests, not only of kinship, but also of common origin, ethnicity, factional alliances and client/patron relations, resulting in a complex variety and mix of traditional social ties and linkages between domestic and extended family (Eckelman, 2002). Given the social mobility in the region, and the complexity of social and economic relations, Eckelman (2002) follows Ibn Khaldun (d.1406) the Arab social historian, in warning against too simplistic a distinction between villagers, pastoral nomads and city-dwellers, noting the “over-lapping nature and complementarity of the categories” (pp45-46).

Alongside these social changes, Eckelman (2002) notes another change: an overall trend throughout the Middle East toward separate housing for each nuclear family and a strengthening of the conjugal bond, with wives becoming more dependent on their husbands in nuclear households, but at the same time acquiring higher status, a greater role in decision-making and more involvement in their husbands’ activities. As noted previously, this is not to claim a universal, linear transition from extended to nuclear

families, as the “traditional” family could actually take many forms, and a variety of individual and community level factors interact in complex ways to influence family practices.

Nevertheless, there are signs that family and kinship structures are changing. Whilst the study by Goode (1963) was still able to characterise the Arab Islamic family as an extended family system, made up of married couples, their unmarried sons and daughters, and married sons and their wives and children (Goode 1963:89), Katakura (1977:150-151) in her study found the non-nuclear family to be the exception. Altorki (1986:32) remarked upon the increasing flexibility of living arrangements accommodating several generations of the same family, and the overall reduction in contacts between married couples and their parents. Fay (2003), charting the transition of an elite Egyptian family from the extended to the nuclear form, rejects stereotypical explanations of such change based on modernization and Westernization. Instead, she suggests a conscious attempt by elite women to valorize the conjugal family in order to strengthen their position, in response to the loss of social and economic power induced by the rise of the modern centralized state.

The complexity and ambiguity of family discourse is well illustrated by Cuno’s (2003) analysis of the very public transition to monogamy among the Khedival house of Egypt, which was perceived by Western observers as a significant departure from the “traditional” model of concubinage and by local commentators as closer adherence to traditional Muslim family values.

According to Al-Haddad (2003) some studies predict that the extended family will disappear altogether. A study in Riyadh revealed 31% of the families in that city were extended families, while 69% were nuclear families. This data indicates that there is a trend of transformation toward the nuclear family; however, it is a slow trend that does not match the volume of urbanization. Moreover, the family structure does not conform to Elliot’s (1986) claim that the nuclear family always constitutes a unit apart from the remainder of the community. Throughout the region, there is evidence that “cultural notions of personal and kin relationships vary considerably...from rural to urban settings, and among different educational and socio-economic categories of society”

(Eckelman, 2002, p143), but such relationships remain strong. Cohen (1965), describing the domestic arrangements of a “*hamūla*” (kinship network) of Arab families on the Israeli border observed a complex web of patrilineal, affinal and matrilineal lines, as well as relationships based on neighbourliness and social or economic co-operation. Similarly, Geertz (1979) in an urban residential quarter in Morocco, observed ties based on kinship, close proximity, shared resources (a communal water fountain) and responsibilities (upkeep of a mosque) which combined to sustain intense contact. Geertz also noted that while, for the educated middle-class living in modern housing, it might be difficult for relatives to be immediate neighbours, strong familial ties continue to be expressed in patterns of visiting. Altorki (1986) made a similar observation in Saudi Arabia.

As the above discussion has shown, in Saudi Arabia, as in the Middle East in general, there are many variations in household composition and relationships that are not due simply to tradition or modernity, but to multiple factors, including domestic cycle and economics. Nevertheless, we might broadly agree with Al-Haddad (2003) in seeing Arab Gulf families, such as those of Saudi Arabia, as in a transitional stage that carries many features of both the Western nuclear model and the traditional extended family model. Hence, we are dealing with a nuclear family characterized by extended relations.

These extended relations continue to play an important role in social and political life. The traditional method for reaching and legitimizing group decisions in Arabia is through consultation (Ar., *shura*) among those within the group whose opinions are considered important. From consultation emerges consensus (Ar., *ijma`*), which is binding for all members of the group. Within the extended family, the principal consensus makers are senior members or elders, and such roles are taken by male family members (Long 2003). In certain aspects, however, senior women may also participate in family consultations and consensus making. From texts in the Qur'an and the Sunna (Prophetic traditions of the Prophet Muhammad), comes the belief that God would never permit a consensus of the Islamic community to be in error, and consensual decision-making is still the norm in Saudi Arabia, whether in family, government, or business decisions. Lancaster (1997) in Saudi Arabia and Abu-Lughod (1986) in Egypt both illustrate such mechanisms. Lancaster (1997) notes that among the Rwala, sheikhs

had no formal coercive power, but maintained leadership through their skill in achieving consensus and representing the tribe to state authorities, access to information and success in maintaining a reputation for managing both people and resources in the best interest of the tribe. Abu-Lughod (1986) reports similar skills and qualities on the part of the community leader with whom she stayed during her fieldwork, and describes a social contract in which status differentials are conceived in terms of protection and dependency, rather than domination and subordination. Nevertheless, as Eckelman (2002) comments, similar arrangements have at other times been characterized as tyranny, depending on the degree of involvement with outside power and resources.

The extended family in Saudi Arabia has a considerable impact on politics. In the West, Saudi Arabian political life has often been characterised as an absolute monarchy with no public participation. To be sure, it is not democratic in a Western sense, but neither is it absolute, due to two principal constraints on the ruler. First, the constitutional system of Saudi Arabia is based on Islamic law, and the ruler is not above the law. Second is the consultative nature of decision-making. Esposito (1988) describes the political process in seventh century Arabia, at the dawn of Islam:

“Tribes were led by a chief (Ar., shaykh) who was selected by a consensus of his peers - that is the heads of leading clans or families. These elders formed an advisory council (Ar., majlis) within which the tribal chief exercised his leadership and authority” (cited from Long, 2003).

Then, as now, the political leader was as much consensus-maker as chief executive. The other participants in consensus making were, generally, the elders (male) of the extended families and clans (Altorki 1986:51). Saudi Arabia is not a country of individuals ruled by a single, absolute monarch, or even an autocratic royal family ruling over a country of individuals. It is a system whereby the patriarch of an extended royal family rules with the consensus of the leading members of a nation of extended families. The current appointed Saudi Consultative Assembly (Ar., Majlis al-Shura) is a modern institutionalization of a tradition of consensus extending back at least to the seventh century. There has been recent talk of making it an elective body, and if it continues to evolve, there is a possibility of its duties being expanded to include

formulation of enabling decrees for government operations. However it evolves, it will be a reflection of an extended family structure and the Islamic values of Saudi society. In addition to politics, the extended families also contributed an impact on economy and commerce. With oil revenues, the public sector now dominates the Saudi Arabia national economy, but extended families still dominate most of the largest business firms in the private sector (Altorki 1986:29). According to Al- Haddad (2003), although the number of nuclear families has increased, especially in the new urban areas, and certain characteristics of nuclear families are apparent, such as economic independence or independent residence, these features do not negate the affiliation of nuclear families to their extended families, both at the relational and the ideological levels. My aim in describing these mechanisms and processes is not to claim any single interpretation or that any ideal is necessarily and always realized in practice. Rather, I intend to acknowledge the existence of certain ideals and forces in Saudi society which, for good or ill, influence decision-making and exert forms of social pressure and control at a variety of levels, and which are likely to shape family and community practices. The implications of this situation for care of the elderly will be examined in the next chapter.

2.6 Summary

Demographic ageing has been shown to be a global phenomenon, with a growing elderly population and declining youth cohort presenting challenges in many countries, regarding availability of resources, personal and institutions (formal or informal) for elderly care. However, old age is a difficult concept to define, and one which arouses controversy. Old age can be defined by chronological, biological or psycho-social criteria, and be denoted by a confusing array of terms. “The elderly” could therefore encompass people in a wide range of different physical conditions and social circumstances. Often, however, the perception of the elderly is of people who are frail, infirm or disabled, no longer economically active, and increasingly disengaged from society. This is, however, only one perspective. As we have seen, the idea of old age is to a great extent socially constructed.

In the Islamic perspective, traditionally, the elderly are considered entitled to care and respect from others. Ideally, they should be cared for by their families, and where this is not possible, e.g. if they have no children, or the children are in economic hardship, the responsibility devolves on the extended family and the wider community. Only as a last resort, is care provided by the state. The distinctiveness of this perspective was emphasised by reference to an alternative discourse proposed in the West by Hockey and James (1993), who claim that since the industrial revolution, the primacy of work has resulted in the marginalization of those outside the workforce and, hence, the infantilization of the elderly. This is not to claim that all elderly people in the West are dependent and marginalized, any more than all those in Islamic societies are happily cared for and respected within their families. My aim, as I have explained, was to illustrate the implications that ideologies and attitudes in relation to the elderly can have for their social roles and care.

Finally, I examined the family, as the social context of much elderly care. Many writers, both Western and Saudi, contrast two basic family “types”- the extended and the nuclear, and perceive a linear transformation from one to the other. What the literature shows, however, is that there is no single family type. Families are, and always have been, affected by a complex interplay of social, cultural and economic factors. Nevertheless, it may be fair to say that recent decades have brought an accelerated pace of change and in Saudi Arabia there are academic and political concerns about the rates of change, the perceived “threat” to “traditional” values and the implications for the social and economic stability of the state, which lead to family discourse being framed in a particular way. Whilst ideological concerns may have over-simplified the picture, it is nonetheless true to say that social change is bringing a transition in family structure in Islamic societies like Saudi Arabia, with urbanization and social mobility resulting in larger numbers of nuclear families than was formerly the case. In the next chapter I will develop this theme further, discussing current trends in Saudi family life and social care, and showing how forces of globalization, modernization and social change are affecting age and gender roles, and changing the pattern of care for the elderly.

Chapter Three

Globalization, Social Change and Care of the Elderly

3.1 Introduction

In the previous chapter, I introduced social constructions of age, the elderly and the family, to set the context in which the needs of the elderly and arrangements for their care are determined. In this chapter I examine changes in Saudi society and their implications for care of the elderly. Moreover, I show how these trends are associated with globalization and argue that social and economic policies at national and supranational levels have created and reinforced the redistribution and internationalization of care work. In particular, I shall show how a neoliberal economic restructuring, in the guise of adjustment policies, welfare state restructuring, and immigration and emigration policies, has helped give shape to the “international division of reproductive labour” (Parrañas 2001, cited in Misra and Merz, 2006). While capitalism has always relied upon the unequal division of reproductive labour, based on gender, class, race/ethnicity, and nationality, the increased mobility of workers has exacerbated the global nature of these processes. Care work is an area in which these inequalities have been increasingly apparent.

Whilst there have always been divisions and inequalities in who is doing care work, and who is not, this has been reinforced by the “globalization of care work,” whereby care has been distributed and redistributed in an international system where immigrant workers provide care in wealthier countries (Misra and Merz, 2006). These developments can be seen as part of a wider pattern of social change in recent decades, which has affected incomes, gender roles and social structures such as the family, as I shall show in relation to Saudi Arabia.

This chapter, therefore, is divided into three main sections. In the first, I discuss elderly care in Saudi Arabia, to show how the forces of social change, which co-exist in tension with traditional social values, are reflected in patterns of care for the elderly, including

increased reliance on migrant workers from poorer countries in Asia. In order to set these changes in the context of worldwide trends, in the second, I briefly highlight changes in employment patterns as a feature of the global economy. In the third, I show how these forces are played out specifically in the unequal distribution of care work, by gender, class and nationality.

3.2 Care for the Elderly in Saudi Arabia

From the preceding chapter it has become apparent that while Saudi Arabia has strong traditions of social responsibility rooted in Islamic values, in practice, the forces of modernisation are bringing changes to patterns of residence and lifestyle.

The oil rich Arab states, of which Saudi Arabia is one, have been significantly affected by the impact of globalization, which has increased income inequalities among regions and countries. Richer countries, demanding and able to afford more goods and services, are attracting migrant workers from poorer countries-including large numbers of women, engaged in care work (Kurian, 2004). This section examines how these forces have affected the pattern of elderly care in Saudi Arabia. First, it discusses traditional social roles related to age and gender, and then examines the phenomenon of social change and its impact on care for the elderly in Saudi Arabia.

3.2.1 Traditional Social Roles

It has already been noted that Saudi Arabia is a patriarchal society, maintaining a respect for age and seniority. The extended family as a form of social organisation is one that accords to its elderly members a significant role, as Field (cited from Al-Kheil, 1991) describes. She says that the contribution of the elderly to the family is extensive, and as a result they are treated as wise instructors or expert counsellors, for the practical experience they have obtained through their lives. They have contributed, through their skills and experiences, to the evolution and development of their families and the group in general. Where an elderly person becomes unable to carry out his or her work responsibilities because of physical weakness, he or she will never lose others' respect

and will continue to be looked up to. The family are responsible for taking care of the elderly person; he or she will keep on living with them until the end of their life. It is customary that the rich help their poor elderly relatives financially, to prevent them suffering the humiliation of begging others for assistance. In addition, this increases a family's "good reputation"; important since interfamily conflict, especially when known to the community, injures its reputation (Altorki 1986:16).

Whilst this may be the ideal or theoretical position, in practice, the position with regard to elderly care has been and (as will be seen) continues to be more complex and is tied to theoretical and practical construction of gender roles. Gender, like family, is a discourse interpreted to reflect and serve a variety of ideological positions, and Saudi historians and sociologists – and indeed, the Saudi government in its development plans – tend to speak in monolithic terms of "the Saudi woman", ignoring particularities of age, class, residence and so on.

In the conventional depiction of the internal organisation of the family, a man has the position of the head and has overall control. In fact, it is normally the eldest male member of the extended family who occupies this position. Traditional gender roles in Saudi society share a number of common characteristics with other societies – particularly, though not exclusively, traditional ones, the most notable being the division between the public and the private spheres. The man's role is outside the home, as family provider, protector, and manager. He also takes care of the demands of internal discipline within the family. The Qur'an says:

"Men are in charge of women, because Allah has made the one of them to excel the other, and because they spend of their wealth" (Qur'an 4:34).

A woman's responsibilities lie within the family. The eldest woman is regarded as the centre of the family organisation but within each circle the relative central position is enjoyed by 'that woman who constitutes its core' (Khurshid Ahmad 1974:29). With regard to this, the Qur'an says:

“And they (women) have rights similar to those (of men) over them, according to what is equitable, and man has a degree (of advantage) over them, Allah is Mighty, Wise” (Qur’an 21:228).

In practice, the division of labour between the sexes, and the extent of constraints on and seclusion of women, vary according to a number of factors. Abu-Lughod (1986) in Egypt and Lancaster (1997) in Saudi Arabia, both describing *bedu* communities, note the importance attached to women’s activities; Lancaster (1997) describes women of the Rwala as “in structural terms” equal partners with men (cited in Eckelman, 2002, p77). Abu-Lughod (1986) describes *bedu* women as traditionally having a number of important roles in the household: weaving cloth for clothes and tents, growing crops and processing them for food consumption. Moreover, the simple blanket divider between “male” and “female” areas of the tent still allowed for a flow of information and conversation, enabling women to be active participants in household decision-making, despite their seclusion (which Lancaster (1997), in relation to the Rwala, characterised as a measure of women’s extreme importance to the society). Paradoxically, sedentarization and economic prosperity restricted the role of women, as separate rooms replaced the more fluid division of the tent and involvement in the cash economy replaced many of women’s traditional contributions with bought goods. In this way women’s work was peripheralized and they became more dependent on men. The increased likelihood that neighbours and visitors would be non-kin imposed a requirement of greater vigilance, which curbed women’s freedom of movement, restricted their networks, and resulted in men’s and women’s worlds becoming more separated. Abu-Lughod (1986) notes that it was men who travelled to the nearby sheep-market, village and town to engage in trade, while women were more restricted. However, the *bedu* contrasted their own strict gender role with those of the (non-*bedu*) “Egyptians”, who were more lax in matters of segregation. Moreover, even among the *bedu* themselves, gender roles differed with age, older women having more freedom. Similarly, Hildred Geertz (1979), writing of a “conservative” setting in Morocco, noted differences in women’s roles and behaviour. The higher their status, the less they were seen in public, but there was considerable variation between generations and according to women’s age and marital status.

Whilst such examples demonstrate that gender, like “family”, is expressed differently, dependent on a variety of contextual factors, it is nonetheless true to say that Islam sees the roles of men and women as different and complementary. This is reflected in care for the elderly where, typically, women – often daughters or daughters-in-law- provide the day to day physical and emotional care, whereas a son's contribution is more likely to be financial. Such a situation was reflected in Abu-Lughod’s (1986) account of the Awlad ‘Ali, where sons provided support and a home, while daughters provided care (although if they married “outside”, they would leave the community and may have little chance even to visit). This traditional division of roles does not mean that Islam undervalues women; indeed, the coming of Islam did much to enhance women's position in the Middle East. Traditionally, married women do not assume their husband’s surname, and if they are divorced or widowed, may be reunited with their own families (Altorki 1986:81). The Qur'an and the Sunna, the basic sources of Islamic law, provided for women to inherit, hold and bequeath private property. In the seventh century, these women’s property rights were revolutionary, and were not adopted in the West for many centuries. It should also be pointed out that any difference in roles of family members towards care of the elderly may not be solely attributable to Islam, but also reflects principles of tribal organisation, in that a woman is not incorporated into her husband’s lineage, but women, irrespective of marital status, are entitled to support from blood kin; thus, a woman is secure if she has adult sons (Abu-Lughod, 1986).

In Saudi Arabia, which adopts a conservative interpretation of Islam, gender segregation is more strictly preserved than in many other Muslim societies. Although women are expected to remain segregated from men, other than close relatives, they are allowed to be economically active, if this does not conflict with their family responsibilities. For urban women especially, segregated health and education systems provide opportunities for women in medicine and teaching, and in many other areas too, they are active in providing services for women – from tailoring, to women-only sections in banks and business organisations. Saudi women now own in their own right a considerable amount of the national wealth – in securities, real estate, and ownership of shops and other businesses. Restrictions on their physical mobility have not impeded them from prospering in Saudi Arabia's free market economy (Long 2003), although women’s economic independence remains restricted by the norm that they should not live alone

(Altorki 1986: 83). Moreover, Eckelman (2002) observes that in the Middle East generally, the higher the involvement of women in non-domestic economic activities, the more open the social roles they can play. The greater involvement of women in economic activity is part of a web of social change that increasingly affects patterns of care for the elderly. These changes will now be explained in more detail.

3.2.2 Continuity and Change in Saudi Arabia

Al-Mutlag (2003), drawing on social change theory, characterizes Saudi Arabia as a society in transition. He notes that sociologists, applying Hegel and Marx's ideas of thesis, antithesis and synthesis, interpret social change as a conflict between the thesis, "traditional forces", and antithesis "new forces", which may lead to synthesis, "new forms of social life" that differ from both the old and new forces. This is happening in Saudi Arabia through the force of urbanization, which has been experienced through the transformation of technology, expatriate skills and internal migration with no slums, because of oil wealth (Al-Mutlag, 2003). However, such transition is a lengthy and uneven process, and tends to be manifested in what Ogburn (1922) called a "culture lag", in that infrastructure and technology may change very rapidly, while social life changes more slowly. Old and new faces may, therefore, exist side by side. Indeed, as Parsons (1951:503) stated:

“... even in a relatively stabilized society, processes of structural change are continually going on in many subsystems of the society, a complex social system is not either stabilized or changing as a whole, but in different parts and different respects, always both”.

However, because of the interdependence between elements of a culture, rapid change in one part requires readjustment in others. As will be seen later, for example, in Saudi Arabia, changes in education and work are bringing adjustment in family roles, particularly those of women, which have implications for care of the elderly. Nevertheless, the social heritage and value system in traditional societies do not necessarily adapt fully to the changes in material culture. Consequently, new material

conditions may coexist alongside traditional cultural values. This is the case in Saudi Arabia.

Saudi Arabia is currently experiencing social change at an unprecedented rate, driven by oil wealth and the government's commitment to modernization. In the past fifty years, the Kingdom has spent billions of dollars on the social, physical and economic infrastructure, including modern education, transportation, communications, health care and sanitation (At-Tuwaijri 2001; Long 2003). The information-technology revolution has had an impact on society, finally eradicating the physical isolation that has historically shrouded Saudi Arabia, which never experienced the cultural assault of direct Western colonial rule and still managed to retain an essentially closed society.

As a result of the economic transformation, demographics have changed dramatically. Modern health care has contributed to a population explosion. Urbanization, too, has changed the face of the country. In the 1960s, the population lived predominantly in small towns and villages. Jeddah, then the largest city, had a population of about 250,000, and Riyadh about 200,000. The new urban centres with their work, social and educational opportunities attracted an influx of migrants from the nomadic and rural population. Thus, within a short period from the 1970s to the 1990s, the urban population increased while the number of Bedouins decreased (Al-Mutlag, 2003). Today, the great majority of Saudis live in urban areas; Riyadh now numbers over 3.5 million, and Jeddah over 3 million (Al-Tuwaijri 2001:64-5; Al-Thaaqib 1986). As people left their home areas, they took with them their nuclear family members, leaving the extended family behind. They also began to be more economically independent, relying on their own skills and abilities, rather than the communal effort and economic interdependence that had characterised the rural, agriculture-based communities (Saeed, 1990). Even after moving to the cities, members of Saudi extended families still tend to live in close proximity to each other wherever possible, and when not, they socialize with other family members a great deal. In addition, many families retain homes in their hometowns as well as where they work (Al-Tuwaijri 2001:63-7).

Thus, Saudi Arabian society is currently caught between competing forces, pulling in opposite directions; between individualism and collectivism, nuclear and extended

family. The effect of this transition is an increasing trend of what Beck (1999) calls “individualization”. In his definition, “*Individualization is a structural concept, related to the welfare state; it means institutionalized individualism*” (Beck, 1999, 2:9). Beck (1999) attributes the individualization process to “*the exhaustion, dissolution and disenchantment of collective and group-specific sources of meaning*” (p74) which has led to all the work of cultural definition being expected of or imposed on individuals; increasingly, individuals have to understand, interpret and deal with opportunities, risks and uncertainties that were once dealt with within the family, village or social group.

As a result of this process, old certainties, about the meaning of family, marriage and parenthood are being eroded; such meanings have become matters for negotiation (Beck and Beck-Gernsheim, 1995). Individualization (Beck and Beck-Gernsheim, 1995) releases men and women from prescribed gender roles; at the same time, it imposes a new imperative, that if they are not to suffer material disadvantage, they must exploit mobility, education and the labour market to advance their interests, perhaps even at the expense of commitments to family, relations and friends. Thus, a contradiction is emerging between the demands of the labour market and the demands of relationships. Such trends are manifested in the Saudi context in a number of ways.

As a result of social and economic development, the social structure of the family has changed. According to Saeed (1990) one of the impacts of social mobility and education has been a decline in the influence of the elderly, whose life experience is accorded less respect by the new generations. The population explosion has dramatically lowered the median age, which is now 15 years old. At the same time, life expectancy has risen with modern health care, and elders are not relinquishing their leadership roles as soon as they once did. These trends have helped create a generation of young people who are increasingly frustrated in seeking to create meaningful lives of their own, and they are not always willing to listen to the elders. Also among the changes to family and kinship system noted by Arab writers is the new phenomenon of spinsterhood. This has been attributed to a number of factors, in addition to the decline of polygamy: the loss, through migration, of the strong family and community relationships through which marriages were traditionally arranged; greater inequalities of wealth, leaving fewer opportunities for rich women to marry within their social class, the greater involvement

of women in education and work, and the escalating cost of the dowry (Al-Mutlag, 2003). Another factor is that some Saudi men who travelled abroad, especially to more 'Westernized' Arab countries such as Egypt, Syria and Lebanon, married women from these countries and brought their wives back to Saudi Arabia. This increased the number of local women who were left without marriage- who, in local parlance had "missed the train" (Al-Badawi, 2000). The new spinsterhood has a variety of implications. On the one hand, it might be thought that it will mean more unmarried daughters who are available to (and expected to) look after ageing parents. On the other, the need for these women to pursue economic independence may reduce the supply of informal carers. Moreover, in the longer term, there will be an increasing number of women who have no offspring to care for them in old age.

Increasingly, too, the distinction of traditional gender roles is becoming blurred, and this affects the way in which families function (Altorki, 1986). Interesting evidence of this role is provided by the contrasting findings of two studies by Abobaker, cited by Doumato (2000). In a questionnaire, conducted in 1980, 70 per cent of the sample of male university graduates said they would not want to marry a college graduate, nor did they want their wives to contribute in the household budget, since they perceived this as a threat to their authority. In contrast, in a more recent study by the same author (cited in Doumato, 2000) many men considered an educated wife as a vital asset in a potential marriage, as she can contribute to the income of the family.

Several specific government policies focused on women have contributed to change their role, notably the promotion of female education, since the 1960s. The number of women studying in Saudi universities doubled between 1983 and 1993, then doubled again in 2000 (Doumato, 2000:22), by which time women outnumbered men in higher education. These education policies have resulted in Saudi women's increasing involvement in non-domestic activities, drawing growing numbers of women away from the home.

The availability of education has done much to change the position of women, who are less frequently passive figures in the family, and more often participants in the family income, decision-making and planning for their children's future (Saeed, 1990). In

addition to increasing women's negotiating power within the family, education has given them greater mobility, as many now go out daily to school and work (Al-Sanbary, 1994). Thus education, urbanization and modernization have placed women in areas of public space, traditionally reserved for men (US Library of Congress, 2007).

Technology is helping this trend. Satellite television and internet access have allowed Saudi society not only to observe others in Western nations, but also to see changes in neighbouring Arab countries. Saudi women see Omani women as members of parliament and Qatari women as university deans, and are increasingly demanding to take their own places in the public sphere (Hamdan, 2005).

Moreover, economic changes leading to greatly reduced per capita income have induced many young wives to take up employment outside the home. Since the early 1980s, the dramatic reduction in government revenues linked to fluctuating oil prices led to a retrenchment of government expenditure. A number of goods and services formerly provided by the state have been privatised or restructured with a view to privatisation, leading to a reduction in the state's provision of public sector employment, decreases in subsidies for education, and a fall in per capita GDP from US\$18,800 in 1981 to US\$6,700 in 1995 (Doumato, 1999: p510). In the last few years, boosted by increased oil production, the growth rate in national GDP has recovered, averaging 3.1% between 2005 and 2009 and reaching 3.8% in 2010 (Richard Schuster, 2011) and GDP per capita has increased to reach an estimated US \$21,685 in 2009 (Global Finance, 2011). Nevertheless, with increasing privatisation and deregulation, Saudi citizens now have to pay more realistic prices for goods and services (such as electricity and telecommunications) that were once heavily subsidized. These pressures have encouraged Saudi women to enter private sector employment to supplement the family income (Silvey, 2004). Whilst women's labour force participation is still low by international standards, estimated at between 5.5 and 8 per cent of the total workforce (Silvey, 2004:14) the growth in numbers of women workers in absolute terms has significant implications for many families. In some, husbands assume duties in the household that were unthinkable a generation ago (Al-Taaqib 1986: Al-Tuwaijri 2001). However, many men are still unwilling to contribute in this way, or are prevented from doing so by their own work responsibilities. Women's absence from the home,

combined with the continuing construction of domestic work as women's work, contributed to a growing need for assistance with such responsibilities (Silvey, 2004). Families with two working parents may now rely more on the traditional role of grandparents and other elderly relatives to provide childcare whilst they are at work; but what happens when these elderly relatives themselves need care?

One answer to the problems of care for children and elderly is employment of domestic labour, either local women from poorer backgrounds or, more commonly these days, migrant workers. In Saudi Arabia, migrant workers have historically compensated for gaps in the indigenous work force in many fields, not only in care work. In 2000, foreign migrants were said to constitute 55 per cent of the labour force (ESCWA, 2001, Pakhiasamij (2004), quoting Saudi Ministry of Labour statistics, reports that in 2003 there were approximately seven million foreigners in the Kingdom, almost a third of the population. Expatriate labour across all occupations and skill levels accounted for around two thirds of the workforce overall, and 95 per cent of workers in the private sector. The majority are employed in low-status areas such as domestic labour. Foreign workers normally enter the kingdom on a service visa, sponsored by an individual or company. The visa and residence permit must be renewed after two years, and every four years thereafter (Pakhiasamij, 2004).

Since Saudi society is wealthy, the majority of families (often middle and upper class) have one or more housekeeper and driver. This may solve a lot of problems, especially with the elderly, where the housekeeper and the driver perform the domestic jobs that would otherwise have been done by the sons and daughters (in-law). Although employing a helper can lead to domestic tensions, for some, housekeepers appear to fulfil a companion role. The problems of the elderly and their adjustment to old age can be alleviated by employing other people to do some of the domestic work, since research also indicates that it is important for elderly people to remain active and feel independent as long as they are able. I remember from my childhood when my mother was taking care of my elderly grandfather, who was in his eighties and suffering with Alzheimer's. My grandfather was a trader by profession, so in order to keep him active and encourage him to feel independent, my mother organised a small 'shop' in the house. The driver assisted him and kept a watchful eye over my grandfather. The

neighbours would come and buy things from him. My mother would keep the stock and fill the shelves. He was happy and active and was keen to continue 'trading'. However, as his condition deteriorated, the driver and the housemaid were involved in his personal care under the watchful eye of my mother.

Whilst this was a positive experience, some Saudi writers (Faleh, 1983; Al-Thaaqib, 1986; Al-Tuwaijri, 2001) have criticized what they see as a trend for working women to reassign a number of their "roles and obligations" to third parties. Moreover, the employment of migrants, in particular, has become a hot political and social issue. In a United Nations population survey (UN 2004) Saudi Arabia was reported as viewing immigration levels as too high and wishing to reduce the number of foreigners residing in the country. In the past decade or so, in common with other states in the region, the Kingdom has embarked on a policy of indigenization of labour in an attempt to address the high rate of unemployment, particularly among youth and to capture and reinvest income that would otherwise be remitted abroad (Shah, 2005). So called Saudization measures have included a ban on, or phasing out of foreign workers in certain professions (Shah, 2005) and the introduction and enforcement of gradually increasing quotas of Saudi personnel in companies of a certain size. However, smaller companies are harder to regulate. Moreover, the government recognizes the continued need for foreign labour in certain sectors, including nursing, due to the shortage of trained Saudi personnel. The lack of scrutiny of domestic and care work, which are not covered by indigenization legislation, may help to explain the large number of foreign workers in these fields.

A new trend has also emerged for responsibility for the elderly to be shared with the state. In Saudi Arabia, as we have seen, social care in Islamic law is based on a system of social solidarity, which states that the responsibility of providing care to the needy falls on society. According to Islam, the responsibility of providing for the needy individual's requirements falls first upon the immediate family members, and if the family is unable to provide these needs, then the community and eventually the state.

In striving to adhere to the teachings of Islam, however, Muslims in today's society face various practical challenges. Recognising the present changing trends in family

structure and lifestyle, the Saudi government has sought, through the media, to remind citizens of the fundamental Islamic teaching on caring for one's fellows. The preferred approach to social welfare is not to establish public centres to look after the elderly, but to encourage families, neighbours and communities to provide individually and as a group for the needs of the elderly according to Islamic principles.

An important mechanism through which Islam ensures provision for the elderly and the other needy is through Zakat, an obligatory charge paid annually on surplus wealth. The rules of Zakat were established in the early days of Islam, fourteen centuries ago, and are still upheld today. The levy applies to wealth acquired from the produce of the earth; wealth accumulated in the form of gold, silver and money; business inventory (goods owned for sale) and livestock. The amounts due are collected by a designated state institution, which administers the proceeds for charitable purposes in accordance with traditional eligibility criteria. Zakat can be used to benefit eight purposes or categories of people: the destitute, whose means are half or less of their basic needs, the poor, who are better off than the first category, and do not have to beg, but can not make ends meet; the staff appointed to collect and administer the Zakat; missionaries working for the propagation of Islam; slaves and prisoners of war; debtors (including those inheriting the debts of a deceased person); Islamic education; and travellers. Elderly people might benefit under one or more of these categories, depending on their circumstances, and it may be distributed as cash or in kind.

Nevertheless, to meet the changing needs of their societies, most Arab governments, Saudi Arabia included, have begun in recent years to establish state-run and funded care centres, run on Islamic principles. These aim to meet both the biological needs of the elderly, for food, occupation and clothing, and their social needs, based on international paradigms (Abdullatief, 2000).

In Saudi Arabia, the first elderly care centre was established in 1934 in the holy city of Mecca, offering accommodation to the needy to prevent them from begging. There are now 10 homes, in various cities throughout the Kingdom.

The services provided by elderly care centres are available to any Saudi man or woman aged 60 years or over, who is unable to work and take care of him/herself, and has no family member able to care for him/her, subject to medical and social reports. Men and women are accommodated separately. Among the facilities provided, at least in theory, are medical care, opportunities for handicrafts and hobbies, and religious, social and cultural activities (Ministry of Social Affairs and Labour, 2001). A major role in the staffing of care homes – whether medical or ancillary staff, is played by migrants, given the shortage of Saudis willing or qualified to work in this field. As noted previously, nursing is one of the fields of employment exempted from localization legislation for this reason. Recruitment is handled by private companies holding contracts for this purpose, whose agents sign-up would-be migrants in their home countries, arrange the necessary documents, allocate accommodation and administer pay; in other words, migrants are employed by the company, rather than the Home or the Saudi state.

Table 3.1 shows the number of social care centres according to the year of establishment.

Table 3.1: Location and Date of Establishment of Social Care Centres.

No	The name of the centre	The Area	Date of Establishment
	The Social Care Centre in Mecca	Holy Mecca	1934
	The Social care Centre in the Holy City	Holy City	1937
	The Social Care Centre for males in Riyadh	Riyadh	1953
	The Social Care Centre in Dammam	Sharkia	1973
	The Social Care Centre in Abha	Asser	1974
	The Social Care Centre in Aneza	Kassem	1976
	The Social Care Centre in Jauf	Jauf	1976
	The Social Care Centre in Taif	Holy Mecca	1988
	The Social Care Centre in Bauady Al-Wasser	Riyadh	1998
	The Social Care Centre for females in Riyadh	Riyadh	2001

Source: Alwaznh, 1999

Table 3.2 shows the number of people who benefited from the Social Care Services during the period of (1960-2002) A. H.

Table 3.2: Beneficiaries of Social Care Centres

Year	Number of Centres	Males	Females	Total	The Annual Average of the people who benefit from the centres
1960-1965	3	734	209	943	189
1965-1960	3	625	204	829	186
1970-1975	5	526	252	778	156
1975-1980	7	639	598	1237	247
1980-1985	7	1230	862	2092	418
1985-1990	9	2434	1454	3888	778
1990-1995	9	3005	1810	4815	963
1995-2002	10	3898	2493	6391	913

According to Rakhah (1999) the mean age of elderly residents of social case centres in Saudi Arabia was 73 for men and 77 for women. The majority were illiterate, most had never married or had lost their spouse through death or divorce and most had a low income.

A reading of the Articles regulating conditions of residence in the Social Care Centres prompts two observations. First, it is noticeable that most articles refer to “The old or disabled person”, suggesting that the service does not differentiate clearly between these categories. Second; there is strong sense of “institutionalisation”, for example:

Article 12- Every disabled person has a specific allocation of clothes and equipment. This allocation will be clarified in the internal laws of the centre, which will also clarify when it will be given and all the related regulations.

Article 13- The items allocated to each disabled person will be marked in order to be distinguished from the property of others. A disabled person is not allowed to use others’ allocations.

Article 14- All allocations will be distributed to disabled persons by the board of directors in the centre with the signature of the disabled person on the receipt documents. These documents will be kept in the centre.

This raises a question as to how far those centres are able to recognize and meet individual needs and whether residents may be ‘objectified’ rather than treated as unique personalities.

Another point worth noting is that, if the number of beneficiaries of the centres, shown in Table 3.2, is compared with the size of the elderly population (Table 3.3), the proportion accommodated in those centres is extremely small.

Table 3.3: Distribution of Saudi Elderly Population

Year	Aged 65+ (thousands)	Aged 65+ (% of total)	Aged 80+ (thousands)	Aged 80+ (% of total)
1950	107	3.3	7	0.2
1970	182	3.2	14	0.3
1990	372	2.3	41	0.3
2010	778	2.9	112	0.4
2030	2458	6.6	282	0.8
2050	5858	13	1180	2.6

Source: Al-Gabbani, 2008

Research evidence (Fahmi and Fahmi., 1999; Al-Sadhan, 2002), however, suggests that these centres are rarely, if ever, occupied to capacity. The low uptake of these services has been ascribed to inadequate facilities, lack of awareness of the availability of these services, and the social stigma attached to entrusting one's parents to such an institution.

In addition to providing social care centres for the elderly, the Saudi government encourages and regulates a number of non-profit-making organizations which provide services for the elderly. These fall into two categories: those which provide accommodation and those that do not. Among the former are Sihat Institution for Social Services and King Fahad Charitable Institution. An example of the latter is Prince Salman Social Centre in Riyadh, which provides medical, sport and entertainment, social and cultural services, as well as conducting research in the field of elderly care.

Despite these efforts, however, it appears that care for the elderly within the family, albeit with the help of paid, often foreign, employees, remains the norm. It has been indicated that an important factor in these changes is the reliance on migrant workers in the domestic and care fields. Saudi Arabia in this respect is both reflecting and contributing to a global pattern which, given the key role of these workers, would be worth exploring in more detail.

3.3 Globalization and Labour Migration

Ever since the 1970s, globalization has been characterized by increasing levels of labour mobility and international migration (Kurian, 2004). According to the International Labour Office (ILO) (2004), by 2000, some 175 million people were living outside their place of birth or citizenship. The same report suggests that women made up almost half of migrants and that, whereas in previous years women migrated to join their families, particularly those who had settled in developed countries, women are increasingly travelling alone as family income earners.

Poor women have been disproportionately disadvantaged by market reforms such as the International Monetary Fund's structural adjustment programmes. The results have been more women seeking work to sustain their families, more women who are unemployed, deterioration in working conditions and increased movement of women into the informal sector (Sparr 1994 in Kurian, 2004). Women also migrate for non-economic reasons, such as fleeing from domestic abuse and other patriarchal relations (Parreñas, 2001). All these factors have induced women to migrate, temporarily or permanently, to the more industrialized countries for employment.

Although this trend towards feminisation of migration has been highlighted by a number of scholars, Baldwin-Edwards (2005), however, notes the shortage of hard data on the phenomenon of female migration, and observes that UN stock data (albeit ending in 1990) do not show significant increases of female migrants in most countries of the Middle East. This, he suggests, may be because the greater part of immigrant labour in the GCC countries comes from India, Pakistan and Bangladesh, countries whose

emigrants are almost all male. Nevertheless, he acknowledges an increasing trend of recruitment of female housekeepers and caregivers, and it is notable that in Saudi Arabia, for instance, an estimated 92% of Indonesian migrants (often employed in the domestic and caregiving sectors) are women (Esim and Smith 2004:13).

Kurian (2004) reports an ethnic dimension to this migration. The most important source countries of female migrants, globally, are Sri Lanka, the Philippines, and Thailand, while the main destinations are Hong Kong SAR, Malaysia, Singapore and the Middle East. The oil-rich countries have attracted large numbers of foreign migrants on short term contracts from the 1970s.

In some sending countries, such as the Philippines, the government actively encourages this migration; not only does it ease the local unemployment situation, but the country benefits from the foreign exchange remitted by these workers (Kurian, 2004).

Meanwhile, in the wealthier, developed countries, as well as rapidly developing ones like Saudi Arabia, globalization has had a variety of impacts. Although the total wealth of the world has been increased and many people have experienced rising incomes (World Bank, 1996), income inequalities have increased, even in rich countries (Wilson, 2006). Regional disparities have been experienced in terms of changes in the organisation of the labour market, growing insecurity of employment, differences in the ability of regions to generate profit, and marginalization of rural areas. The global ideology of market freedom exacerbates such inequalities by reducing state safety nets. In the last two or three decades, the global triumph of liberal economies has had effects on public finances. The dominant model of economic policy implies the end of subsidies or protection for disadvantaged regions or sectors, cuts in public expenditure, especially welfare expenditure, and large-scale privatisation (Wilson, 2006). In this situation, vacuums in service provision are created, which migrants from the poorer countries move to fill. In particular, as Kurian (2004) notes, most female migrants are employed in domestic service or care work of various kinds. This is not necessarily to say they are all unskilled. While the majority of female migrants enter lesser-skilled work, this is only part of the picture. Not all migrants are unskilled or occupied in menial occupations; there are, for example, migrants who work as technicians, nurses

and doctors. However, there is a lack of data on skilled emigrants (Baldwin-Edwards, 2005), although Wickramasekara (2002:5) suggests that some countries lose up to 30 per cent of their university graduates in this way.

Skilled migration has been described as a heterogeneous phenomenon (Ireland, 2001, cited in Kofman, 2004), with men dominating within multinational organisations, science and IT, while women's migration is more commonly through the reproductive sectors of teaching, health-care and social work.

In fact, the focus, in discussion of female migration, on domestic and care work, may obscure the fact that a number of these women have high-school or even college education, as Kofman (2004) points out. However, the concentration of women migrants in the undervalued domestic work sector leads to their portrayal as unskilled (Kofman, 2004). Moreover, non-recognition of qualifications (especially from non-Western countries) and controlled entry into regulated professions combine to force many skilled migrants into subordinate positions within their professions, or into alternative, less prestigious sectors. As Pfau-Effinger (2009) points out, in a context of tight controls on migration, the relatively hidden and unregulated nature of private domestic work offers a useful survival strategy for migrants. This is one of the factors that have contributed to such work becoming a migrant niche (Kilkey, 2010).

The Arab Gulf Countries, including Saudi Arabia, have historically recruited both skilled and unskilled migrants to undertake a variety of jobs. Such recruitment was necessitated by the young population and small native workforce of these states, local skill shortages and unwillingness of locals to do certain work for cultural or other reasons. With increased education in these states, saturation of the public sector and a growing problem of unemployment, however, as noted above, these states have introduced localization policies to reduce reliance on expatriates. It has been suggested (Greg, 2002) that medium and highly skilled migrants will be vulnerable to this recent trend of naturalization of the labour force. In contrast, low-skilled migrants will continue in demand, due to their lower wage-expectation compared with locals (Baldwin-Edwards, 2005). Care work is one of the area in which such migrants are concentrated.

In the following section 1 consider in more detail how global social and economic forces are played out in the area of care work.

3.4 Social Inequality and the Distribution of Care Work

As noted previously, care work of all kinds is an area in which inequalities of gender, class and ethnicity are manifest. An area in which this is particularly evident is the gender distribution of care. Social scientists define gender as the social and cultural construction of sexual differences. These differences are reflected in the roles, responsibilities, access to resources, constraints, opportunities, needs and perceptions held by both sexes, which vary across different cultures and societies (Barnett 1988:158-60; Foster-Carter 1985). Economic forces, in particular, play a significant role in determining gender roles and responsibilities.

Care work both reflects and reinforces inequalities between the sexes. Patriarchal ideas about women's duties have contributed to the social construction of their role as caretakers. However, feminist research challenges the idea that this type of work is "natural" for women and argues that it is a matter of socialization. At the same time, patriarchal ideas place a low value on skills associated with women, such as nurturing. As a result, while women are held responsible for care-taking, as they are in Saudi Arabia, despite the current social transition, both unpaid and paid care work are acutely undervalued (Misra and, Merz, 2006).

Many care services are regarded as having no economic value when provided in the context of a non-waged relationship (such as within the family) or are regarded as having relatively low value when offered on the labour market (Kurian, 2004). The problem of valuation of care work is related to the intangible nature of much of the offering, and the fact that often it is 'given' outside a market exchange relationship. Care given to promote the health and welfare of others can be divided into two categories: tangible services such as cooking, cleaning and nursing, and intangibles such as love, attention, warmth and affection (Kurian, 2004). The first kind is amenable to valuation, but several different approaches to valuation exist. The first is the global

substitute method- the cost of hiring someone to do the work; the second is the specialized substitute method - the value assigned to a specialist in each of these tasks; and the third is the opportunity cost - the wage foregone by the carer who spends time on care that could otherwise be spent earning in the waged market. Nevertheless, many of these tasks are given a low value on the market. The domination of the market model of economic activity marginalizes non-market work, such as women's unpaid care work in the household. Indeed, the work is regarded as inferior because women do it (Kurian, 2004). Consequently, even when it is performed in the waged market, it is associated with low value, and low paid; Saudi Arabia is no exception, as will be seen in later chapters.

Saudi Arabia is characterised by a strong belief in family values and accompanying expectation that that women would act as family care givers, and Wilson (2006) has described in the Canadian context how such values can lead to underestimation of the need for support services. This discourse, he found, spilled over onto paid care givers, who were perceived as doing what could be expected of a daughter, or doing simple housework. As a result, care work suffered from low pay, lack of training and low social esteem, with adverse consequences for the quality of care.

Care work also reflects inequalities of class. As Misra and Merz (2006) argue, economic resources determine who provides care as well as the quality of the care families receive. Those who employ care workers may not recognize their own homes as work places but there are clearly class and power differentials between care workers and employers. While there are variations in the class levels of both employers and care workers, the class differences between employers and workers drive the system. Indeed, "a crucial determinant of the extent of employment in paid domestic labour in a given location is the degree of economic inequality there" (Milkman et al. 1998, p. 486 cited in Misra and Merz, 2006). Immigrant care workers, while subordinate to the families they work for, may experience improved financial ability in their own countries, and may even employ care workers for family members left in their home countries, creating complicated hierarchies of privilege, or global care chains (Parreñas 2001).

Class interacts with gender, especially in the gender relations between women who supervise care workers and the workers themselves (Misra and Merz, 2006). The lives of both women caregivers and women employers are influenced by gender inequality. Women workers face the gendered devaluation of care work, which leads to its being low-paid and often performed in hazardous working conditions; they may even be subjected to sexual harassment and sexual abuse. Meanwhile, women employers exploit the inequality by hiring domestic workers to help them balance their own conflicting social roles (Misra and Merz, 2006).

Both women care workers and employers may suffer role conflict due to a sense that they are violating idealized gender norms (Misra and Merz, 2006, Parreñas 2001). Women employers, when they employ other women to provide direct care for their family members, whilst hoping that the women they employ will provide high-quality care, may also fear that these workers will usurp their position in the family's affections. At the same time, women care workers also violate gendered norms when they provide care for other families, rather than their own. These women may criticise their employers for choosing not to care for their families, while they themselves are forced to break these norms in order to provide crucial financial support for their families. Parreñas (2001, p78), describes this system: "The hierarchy of womanhood – involving race, class, nation, as well as gender – establishes a work transfer system of reproductive labour among women, the international system of caretaking." Yet, while it is important to understand how inequalities shape this system, it is equally critical to view the international division of care from a wider political and economic context, to understand the way neoliberal economic globalization and state policies shape the pattern of care work and in the process reinforce these inequalities.

3.4.1 The Political Economy of Care Work

Over the last several decades, the neoliberal economic strategy has become prevalent as the driver of policies worldwide. According to this ideology, economic growth requires a market unfettered by state protections. Therefore, labour markets should be deregulated, and the state should pull back social safety nets and protections. Without

state interference, neoliberals argue, the market should work more effectively (Misra and Merz, 2006).

In the context of this worldwide economic growth and revival of protective measures, several forces have contributed to an increased demand for care services worldwide, in both welfare and non-welfare states. First, increased revenues in the Gulf States as a whole, resulted in increased incomes and growth in consumerism, creating new demand for goods and services. Second, the economic growth of the Asian 'Tigers' attracted an influx of migrants from poor countries. Third, the restructuring of care services for children, the elderly and the infirm in the industrialised countries in recent years has resulted in cuts in services and personnel, making existing services more expensive or not available to consumers (Kurian, 2004).

Neoliberalism affects the international division of care by shaping the contexts of the countries both sending and receiving immigrant care workers. In many developing countries as part of the withdrawal of the state and state support for care, care work has been passed back into the private sphere, where women are expected to subsidize the economy with their caring work (Sparr 1994). The fear of unmanageable costs arising from population ageing has been widely used as a justification for restructuring or attempting to cut back on welfare. At the same time, as Phillipson (2007) notes, the social infrastructure of welfare states is being targeted as a major area of opportunity for global investors, and the World Bank has called for a greater private sector role in providing such services. The WTO, also, has urged members to rethink their commitments in health and social services. Whilst the position of Saudi Arabia is somewhat different, as it has no history of a welfare state, accession to the WTO may bring pressures which affect future plans and policies on state expenditure and so counter any trend towards state care provision.

In both sending and receiving countries, neoliberal economic restructuring has increased income inequalities, leading to a system where more wealthy families rely on care provided by women from poorer countries. In many developed countries, the restructuring of the welfare state and reduction in state support for workers has forced women to look for alternative ways of meeting their family's care needs, and cheap

immigrant labour helps to fill the gap (Michel and Mahon 2002). Meanwhile, in developing and poorer countries, neoliberal structural adjustment policies, often imposed by international lending agencies such as the International Monetary Fund and the World Bank, have resulted in serious curtailment of welfare programmes, throwing responsibility for care back on the family, although the forces of modernisation may also create conditions which are not conducive to provision of care by family members. For example Borraro, Herrera, Poliuka and Malay (2007) in the context of Latin America and the Caribbean, suggest that structural adjustment policies in these countries have weakened their ability to meet the growing need for chronic and long term care services. They also argue that the globalisation of industry, business and western values may be contributing to a shift in living arrangements and cultural values. This in turn has the effect of undermining traditional relationships between the generations and the sense of obligation to care for the frail elderly within the family.

Another impact of structural adjustment is the deregulation of labour markets, leading in turn to lower wages and less attention to health and safety. Under these conditions, more workers migrate to wealthier countries in hopes of greater economic opportunity (Misra and Merz, 2006). Income inequalities within and between countries and regions create a number of pressures for elderly people, whether in terms of poverty or by disruption of social networks when younger people migrate to wealthier regions or countries (Phillipson, 2007). Saudi Arabia's position in this context is interesting. On the one hand, as noted above, it has no history of a welfare state, due to the cultural assumption, reported in Chapter Two, that care (whether of children, the elderly or those suffering from disability) is essentially the responsibility of the family. Nor has the Kingdom been the target of structured adjustment impositions. In this sense, the demand for the care is not related to a retrenchment of previously existing services. On the other hand, Saudi Arabia's wealth has made it an alternative destination for migrants from less prosperous countries. Moreover, as we have seen, the pursuit of modernization, economic liberalization and engagement in the global economy and the aspiration to join the leading developed nations within the next decade or so, have brought social changes affecting the ability or willingness of families to care for their own members. These include women's education and work outside the home, the consumer society and changing values and roles. The dynamics of the demand for care in migrant-receiving

countries such as Saudi Arabia are explored in the next section, in order to see how Saudi Arabia fits into the global pattern.

3.4.2 Neoliberalism and Care in Migrant-receiving Countries

Migrant involvement in care provision has become a common feature both of welfare states, and of non-welfare states such as Saudi Arabia, although for different reasons. In welfare states, while neoliberal ideologies have not destroyed the social welfare policies of wealthier nations, they have encouraged a greater emphasis on market-based solutions and a reduction of the state's role in care provision (Michel and Mahon, 2002). Welfare state restructuring has led to a decline in both social spending and social care services (Jenson and Sineau, 2001). Whilst welfare states have not always deeply cut social welfare spending, they have adopted various measures such as restructuring welfare programmes, including greater decentralization, changes in the welfare mix (benefits, leave, and service measures), and a focus on strategies emphasizing privatization and marketization (Daly, 2001; Mahon and Phillips, 2000). States have increasingly privatized care, relying on non-profit and voluntary carers, while also applying market mechanisms to state-provided care (contracting out services and care provisions and withdrawing state support from certain provisions) (Knijn 2000). For example, while many welfare states provided and subsidized high quality elder care and childcare, more recently there has been a move towards subsidizing care that families negotiate or withdrawing completely from care provision. These changes have led to more manifest and significant inequalities between families, as wealthier families are better able to cope with the impact of the state's withdrawal. The situation differs among countries, of course, with countries that have more generous state benefits and greater wage equality less reliant on large numbers of immigrant domestic workers. Milkman et al. (1998, p493 cited in Misra and Merz, 2006) note that in Sweden, the numbers of women domestic workers are excluded from the census, because they are so small. This may reflect more equal wages. Care work allows more highly educated women to enter the workforce and substantially increase their household income. Whilst middle class women benefit from the ability to pursue their careers, low-paid workers perform the caretaking and housekeeping tasks these women used to provide (Kurian, 2004). Thus, a flexible and cheap labour force of immigrant women workers enables

reproduction in wealthy countries to continue in the face of cuts in state provision of social services.

In Saudi Arabia, as a non-welfare state, where state provision of care services has always been very limited, a similar role is played by such a labour force, as the forces of modernization are creating new or increased demand, as noted in the earlier section on social change in the Kingdom. Where less care is provided by the state and families face social and economic pressures, the demand for low-wage care workers is higher (Misra and Merz, 2006). Indeed, Parrañas (2001, p33) notes a correlation between low welfare provision (as in the case of the U.S. and Southern European countries) and high rates of foreign domestic work, while nations where welfare institutional support for families is more widely available are less likely to rely on immigrant care workers. Other literature, too, highlights high levels of migrant involvement in care work in non-welfare state countries, both substituting for and supporting family care. However, no clear picture emerges as to the relationship between availability of informal care (which is traditionally high in Saudi Arabia, for instance) and state spending on elderly care. For example, Haynes et al. (2010) investigate the idea that the countries with higher levels of family contact have less government spending on long-term elderly care. They compare country variations on such spending in relation to ratings on “familialism” - a construct composed of data on family contacts and activities (e.g. marriage rates, household size, frequency of contact with adult children) that give an indication of the likely availability of informal family care in countries. No uniform association was found between higher expenditure on care and lower levels of family activity, although the countries spending the lowest proportion of Gross Domestic Product (GDP) on care were more likely to score above the household on familial indicators, while countries spending more than 1 per cent of GDP on care were generally less likely to meet such criteria. There was, however, considerable diversity and it was concluded that in the countries investigated, public policy was not necessarily a substitute to assist those isolated from family care. Indeed it was suggested that “*a culture which sees family relationships as important can also be a culture which recognizes the case for state support of the family*” (Haynes et al., 2010, p81).

Nevertheless, at present, for a variety of reasons, it appears that domestic and care work has become very much a migrant niche, in both Eastern and Western countries, and in both welfare and non-welfare states. According to McGregor (2007) the scale of the international influx into care has been such that in some societies (she focuses specifically on Zimbabweans migrating to Britain) migration and care work are virtually synonymous. Bloch (2005) found that among Zimbabwean migrants in Britain, care work was the largest single occupation category.

In this way neoliberalism has contributed towards an international division of care work. According to Heyzer and Wee (1994, pp. 44-45 cited in Misra and Merz, 2006),

“The shifting division of responsibility between the State and the family for the social reproduction of everyday life has, thereby, been transformed into a trans-national division of labour between middle class women and working class women. This results in hidden savings for the governments of the receiving countries, because the need for adequate state investments in child care, care of the handicapped, care of the elderly and other social services is instead provided for by the income subsidy of middle class professional women and by the labour subsidy of relatively low-paid female migrant workers.”

At the same time, neoliberalism has weakened worker protections and wages, so that middle and working class families have difficulty supporting themselves. Hiring low-wage care work allows more highly educated women to enter the workforce and substantially increase their household income.

However, it may be questioned whether employment of migrant workers can provide a long term solution to the problem of care provision. This is because of the difference in age structure between the world's richer and poorer countries. As Sayan (2002) points out, fertility reductions in richer parts of the world, together with longer life expectancy due to better health care and working conditions, mean that these countries have a higher ratio of elderly to working population. Whilst there is much talk of migration as a means whereby developing countries fill the labour shortages in countries with 'greying' population, he points out that migration on the scale that would be required is

unlikely to be accepted. Japan, for instance, would need 10 million immigrants per year until 2050, just to maintain the ratio of workers to pensioners it had in 1995. With the conflict between, on the one hand, the increasing demand for affordable care solutions and, on the other, suspicion and resentment of immigrant populations (see for example Kofman, 2005), both economic and social dilemmas are raised which are far from being resolved.

3.5 Summary

As this chapter has shown, social changes, such as the forces of globalization and economic liberalism prevailing in the last few decades, have had significant implications for the elderly and their care in Saudi Arabia, reflecting social and economic forces worldwide. The traditional norms and values of Saudi Arabian society laid stress on showing respect and providing care for the elderly (Najeeb: 1980). Consequently, the older members of the family were normally taken care of in the family itself, being treated as wise instructors or expert counsellors (Al-Kheil: 1991). The family, commonly the extended family type, and social networks provided an appropriate environment in which the elderly spent their lives. The advent of modernization, industrialization, urbanization, occupational differentiation, education, and growth of individualism has eroded the traditional values that vested authority with the elderly, leading to decline of respect for elders among members of the younger generation. Although family support and care of the elderly are unlikely to disappear in the near future, care of the elderly is changing as Saudi Arabia develops economically, and modernizes in other respects.

Despite these social changes the situation in Saudi Arabia is in favour of continuing the family as a unit for performing various activities. Increasingly with the economic and social changes, Saudi Arabia is attempting to maintain its traditional values by purchasing productive labour in the form of foreign domestic workers. This trend is encouraged by the migration of people within and beyond economic blocs, particularly those from poorer countries, like the Philippines, in search of work.

A significant minority of elderly people, moreover, are now cared for in state-run social care homes or residential charitable institutions, again staffed to a large extent by foreign migrants. Questions arise, however, as to the quality of care in those institutions, and the increasing financial burden that they represent for the economy. Clearly, the rapid growth in the number of older population presents issues, barely perceived as yet, that must be addressed if social and economic development is to proceed effectively. It is hoped that the present study will contribute in this respect by highlighting key factors in the care of elderly women and challenges facing their carers, in both family and institutional settings. The following chapter outlines the methods adopted in order to fulfil the research objectives.

Chapter Four

Methodology of Research

4.1 Introduction

As indicated in Chapter One, the purpose of this study is to investigate issues around the care of the female elderly in Saudi Arabia, in a context of socio-economic change. In order to fulfil the objectives set out previously, it was necessary to gather data, not only on the day-to-day practicalities of care, but also on the thoughts, feelings and experiences of those involved - the elderly women, their families, and staff involved in their care. I aimed to understand how care decisions were made, the dynamics of the relationships between cared-for and carer, the benefits and challenges in the care relationship, the quality of life for the elderly person, and the support received and /or needed by carers. My approach throughout has been guided by a feminist stance which implies, amongst other considerations, self-awareness and reflexivity about my role as a researcher and my relationships with my participants (Hesse-Biber and Yaiser, 2004). This chapter explains the choice of methods for conducting this inquiry, and the manner in which they were executed.

The chapter is divided into eight sections. First, the research paradigm and approach will be discussed. Then, the research location, target population and samples will be introduced. Section 4.4 will focus on the two main techniques used for data collection: participant observation and semi-structured interview, explaining the rationale for use of each technique, and the procedures employed. Section 4.5 will explain procedures for gaining access, section 4.6 will discuss data analysis techniques, while section 4.7 will consider validity and reliability issues. Ethical considerations will be discussed in section 4.8.

4.2 Research Paradigm and Approach

The choice of appropriate research methods depends on the ontological and epistemological assumptions underpinning the research, that is, ideas about the nature of "reality" and the means by which knowledge of it can be gained.

Writers on research methodology identify two basic ontological positions. One is that there exists an objectively defined reality, independent of the observer; the other is that what we call "reality" is socially constructed as a product of individual perception (Burrell and Morgan, 1979). These positions are termed 'realist' and 'idealist', respectively.

The realist and idealist ontologies are associated with different approaches to gaining knowledge. The realist position is associated with a positivist stance, which assumes that 'reality' can be measured, generalized and predicted. The role of the researcher is as the objective analyst of tangible phenomena (Remenyi et al. 1998). It is essentially deductive, proceeding from theory formulation to data gathering and hypothesis testing (Creswell, 1998). The alternative stance, phenomenology, which is linked with the idealist position, holds that humans are related to "reality" through their lived experience of it; the human world is always an experienced world. It cannot be objectively described but is interpreted in the light of the individual's specific historical, cultural, ideological and gender-based understanding. From this perspective, the aim of research is to understand the meanings that people give to their experiences. It is inductive, proceeding from data gathering and analysis to the generation of theory.

In this research, I took an idealist and phenomenological stance. Whilst I acknowledge that some aspects of old age are objectively measurable—for example, chronological age, or the existence or absence of conditions such as disabilities, heart failure, or dementia, these data alone are insufficient to generate an understanding of old age. As I indicated in previous chapters, old age is also a socially constructed concept, related to population structure, economic resources and cultural expectations as to the social roles appropriate to various age groups. My aim is to examine the lived experience and meaning of old age in a particular social setting, and attempt to interpret the discourse surrounding it.

My focus of interest, essentially, was the way in which elderly women and those involved in their care experienced, interpreted and structured the care arrangement and its impact on their lives (Burgess 1984:3), and the ultimate aim is better to help people by ‘understanding their nature, needs and aspirations’ (Katakura 1977:6). In so doing, I sought to understand the meaning of events for people in particular situations; focusing upon the way in which participants interpret their experience and construct reality (Berger and Luckmann, 1967; Alasuutari 1995). Ultimately, the aim was to study the situation of the female elderly in Saudi Arabia from the participants' point of view, participants being defined to include not only the elderly women themselves, but also the carers whose attitudes and practices shape the situation of the elderly women.

In line with the phenomenological understanding of the importance of gender, I felt it would be advantageous to apply feminist research methods because of the patriarchal nature of the Saudi society. Feminist researchers have paid specific interest to women researching other women (Oakley 1981; Finch 1984; Cornwell 1984). These accounts emphasise the ease of rapport and the empathy of gender as well as the dangers of “objectifying your sister” (Oakley, 1981; p49). They criticize the way positivism privileges the researcher over the researched, as the “knowing party”, transforming the research subject into an object (Hesse-Biber et al.; 2004; Sprague and Kobryniewicz, 2004). Oakley (1981) particularly questioned the morality and validity of prescribed, objectifying interviewing practice when a feminist interviews women- a context where the purpose of the interview

‘has changed dramatically, from a data- collecting instrument for researchers to being a data- collecting instrument for those whose lives are being researched’ (p49).

Feminist researchers seek, not a universal “truth”, but partial and context - bound truth that can be assessed through relationships with research participants (Hesse - Biber et al.; 2004).

Drawing on her experience of researching the transition to motherhood in *Becoming a Mother*, Oakley (1972) illustrates the way "making possible the articulated and recorded

commentary of women on the very personal business of being female in patriarchal capitalist society" (Oakley 1981; 49) required her willingness to engage with the participants, answering their questions, and making personal disclosures.

As Oakley (1981: 58) particularly reminds us, *“personal involvement is the condition under which people come to know each other and to admit others into their lives”*.

Having said this, I am also aware that, as Ribbens (1989, cited in Sprague, 2005) notes, research subjects may not even want to know personal information about the interviewer. As evidence, she cites Oakley’s (1981) data; more than three quarters of the questions asked by her interviewees were requests for general information, not personal disclosures. Moreover, investigator self-disclosure carries the risks, both of restricting opportunities for respondents to talk, and of increasing social desirability bias, when the respondent tailors her response to the beliefs, values and feelings of the investigator (Reinharz and Chase, 2002).

Awareness of such pitfalls, however, does not negate the fact that the feminist approach emphasises the potential for mutuality between the researcher and the researched. Grimshaw (2001) notes the development of informal, non-hierarchical working methods in which knowledge is generated through a process of sharing and empathy, based on the shared experience of womanhood. An important consideration in this respect was my own experience as a woman in Saudi society, which informed my understanding of what I observed and heard in the field. This is because, as Callaway (1992) suggests:

“a deepening understanding of our own gendered identities and the coded complexities of our being offered the best resources for gaining insights into the lives of others” (p50).

Researchers such as Oakley (1972) and Finch (1984) show how their common experience of womanhood gave them access, when interviewing mothers, to views that a man would be unlikely to obtain. Similarly, as a woman and a mother, I found common ground with the participants in the study, which may have influenced their disclosures and my interpretations. It is expected that interviewees will speak

differently with someone whom they see as ‘the same’ than they do with someone they see as ‘the other’ (DeVault, 1999:100-101, cited in Sprague, 2005:123). Meanwhile, the value of reference to one’s personal experience in making sense of participants’ information is attested by Ferguson (2000, cited in Sprague, 2005) whose personal experience helped her to recognise the way certain aspects of physicality were edited out of the memories of female respondents when talking about their youth.

Finch (1984) warns, however of the “*real exploitive potential in the easily established trust between women, which makes women especially vulnerable as objects of research*” (p81). Sprague (2005) makes a similar point. Feminist research implies a need to be aware of such effects and, as far as possible, protect participants from betrayal. What is required is not an intimate relationship, but an adequate rapport based on listening and sensitivity to the dynamics of power and privilege (Reinharz and Chase, 2002).

Another concern is that too great a reliance on an assumed sisterhood or commonality of experience may lead to the neglect of important aspects of the lived experience of participants, and of their relationship with the researcher.

One should beware, moreover, of assuming a universal concept of ‘woman’, as researchers’ characteristics such as race and social class affect research (Hesse- Biber et al., 2004; Bhavnani, 1993). Edwards (1990) warns of the danger of assuming a sisterly connection, and asserts the importance of openly acknowledging the existence and implications of social/ethnic differences, for example - a factor that was salient in this study when interviewing care home staff and housemaids, often Indonesian or Filipina, who were relatively disadvantaged in Saudi society. As a native Saudi, educated and from a well-connected family, I had to be sensitive to the potential impact of social differences between myself and my participants.

Maynard (1994) nevertheless comments that there are dangers, too, with excessive focus on ‘difference’; since cultural differences are not absolute, the similarities as well as the diversities need to be acknowledged. Moreover, difference is limited as an

analytical tool, because it cannot, on its own, account for power. The focus should not be on difference per se, but on the social relations which surround it.

A leading principle in feminist researching is that, when studying other women, the researcher should recognize their institution: their relationship to the domestic and wider power structure (Roberts 1981; Graham 1983). In particular, the difficulties of interviewing couples and the dominating behaviour of men in couple interviews have been noted (Chandler, 1990).

This research did not entail couple interviews, due to the segregated nature of Saudi society. This made it socially unacceptable for me to have close contact with men outside my own family circle. Nevertheless, it was important for me to remain critically aware of how prevailing social norms influenced both my own behaviour as a researcher, and the thoughts and behaviour of the research participants. Feminist research demands reflexivity, which Hesse-Biber and Yaiser (2004: 115) describe as ‘the process through which a researcher recognizes examines and understands how her social background, positionality and assumptions affect the practice of research.’ It demands awareness that the researcher, like the participants, is a product of society and its structures and institutions; hence, her beliefs, background and feelings become part of the process of knowledge construction. Reflexivity also requires that the researcher’s own social location and identity is made visible to both the research audience and the participants (ibid).

The methods chosen to fulfil the research objectives in the light of my phenomenological, feminist stance will be explained in later sections. First, however the research location and participants will be introduced.

4.3 The Location

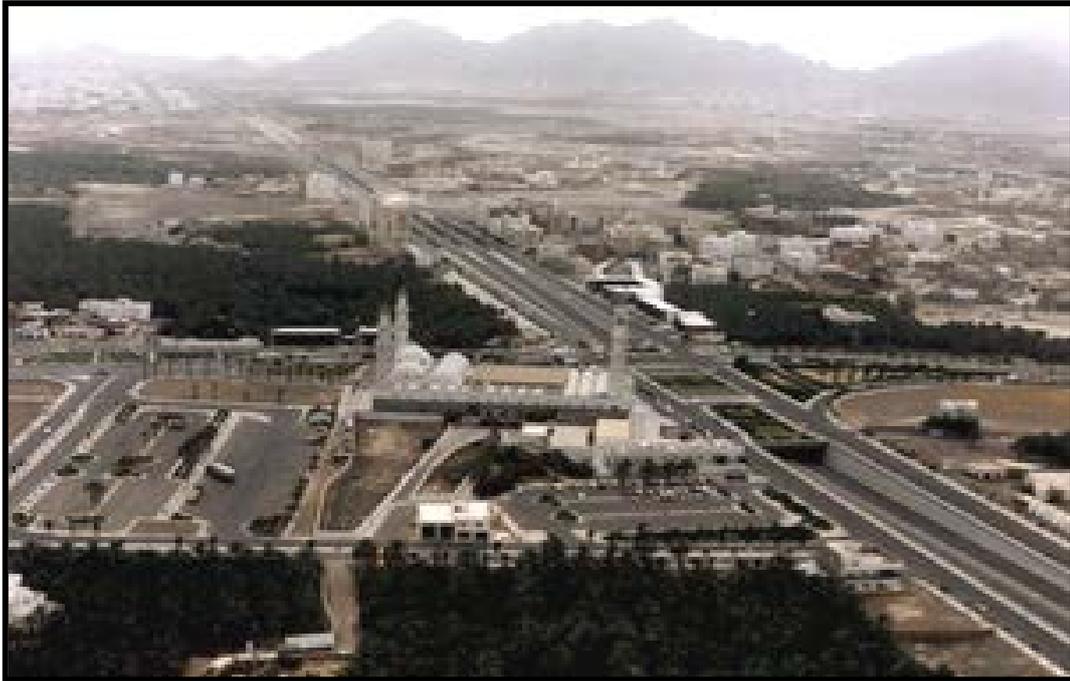
The research took place in Al-Madinah Al-Munawarah (Medina). The kingdom of Saudi Arabia is divided into thirteen provinces, each with a governor and each being further subdivided into seven counties inclusive of the Provincial Capital and, spread across them, 62 boroughs. The province of Al-Madinah Al-Munawarah is located in the

west-central part of the Kingdom, in the area known as Hijaaz. Of the provinces, it ranks third largest in terms of size, and fifth as regards its population, which was 1.46 million in 1993 (Ministry of Economic Planning 1993). The province measures approximately 600 kilometres from north to south and about 500 kilometres from east to west (Murshid 1995:17). The city is 620 metres above sea level, at the meeting point of longitude 39 36' east and latitude 24 28' north. It covers an area of about 50 square kilometres. The area has a hot continental climate, affected by the Mediterranean in the north and by the seasonal climate in the south, characteristics which, as will become apparent later, contributed in influencing the social life and well-being of my participants. Temperatures range between 36-45 degrees Celsius during the summer months and between 15-20 degrees Celsius during winter. Figure 4.1 shows the location of Medina within the Kingdom of Saudi Arabia, while an aerial view of the city can be seen in Figure 4.2.

Fig. 4.1: A map of the kingdom of Saudi Arabia



Fig. 4.2: The modern city of Al-Madinah Al-Munawarah



4.4 Target Population and Sample

This study was concerned with the female elderly (aged over 60 years), their families and carers, whether the elderly were cared for within the family setting or in a state care home. As this was an in-depth phenomenological study, the sample was necessarily small. Moreover, it was purposively selected, as the aim was not statistical generalizability, but detailed understanding of individual cases. As Patton (1990: 169) explains: *“the logic of purposive sampling lies in selecting information – rich cases to study in depth”*.

According to Van Maanen (1981), the selection of key informants depends on the researcher’s judgement. Informants can be selected on the basis of race, age, sex, socio-economic background and appearance, as these factors will influence relationships. Van Maanen states that the researcher should consider establishing relationships with a number of informants as it is doubtful whether sufficient individuals are acquainted with all aspects of a cultural setting (Burgess 1984:75).

In selecting participants, my aim was to include women living with their families, as well as living in a care home, and to explore their situation from multiple perspectives, including those of relatives and formal or informal carers, who were closely involved with the elderly women on a day-to-day basis and contributed significantly in shaping their experience of age and being cared for. I therefore studied seven elderly women living in their families, including relatives and housemaids in the families concerned. Five of the women concerned were those who had been included in my Masters research in 2005, in order to follow up their situation and build on existing relationships to facilitate access (see section 4.5). Two other families known to me also participated. The sample was inevitably small and selected on a convenience basis, due to the difficulty, for a researcher, of gaining access to homes in a culture that values privacy. In the care home I collected data for 20 elderly women (of whom five were interviewed directly: data on the others were collected from members of staff or patient records, with permission). I also interviewed 31 members of staff in the home, including a doctor, a physiotherapist, the care home manager, nine Saudi staff, and 18 non-Saudi staff. The distinction between Saudis and non-Saudis was made because the former were permanent staff, with higher status in the organization, whereas the latter were contracted migrant workers. However, since the aim was to research these people in total context, the sample cannot be reduced to this small number. Moreover, by interacting in the Medina care home, I was able to observe relations among many more elderly (the number of residents was 45), carers and relatives.

4.5 Data Collection Methods

In view of the phenomenological nature of this project, a qualitative approach was appropriate. The term qualitative research has been used by sociologists such as Filstead (1970), Bogdan and Taylor (1984), and Bogdan and Biklen (2003), to refer to a series of research strategies: participant observation, and in-depth, unstructured or semi-structured interviews (Burgess 1984:2). Using the qualitative method allows a researcher 'to get close to the data' and provides opportunities for them to derive their concepts from the data that are gathered (cf. Glaser and Strauss 1967; Strauss and Corbin 1998:11).

On the other hand, Halfpenny's critique (1979) claimed that qualitative method is perceived as subjective and speculative. Nevertheless, qualitative research has been vindicated by researchers such as Okely (1983) who conducted participant observation among Traveller Gypsies. Most of her subjects, like those in the present research, had enjoyed little or no formal education and were largely illiterate. Through description of places and events, and interactions with dozens of people, she was able to gain insight into experiences and values that were not recorded in writing and would not be accessible through survey methods.

The sociologist, John Lofland (1971), has suggested that there are four people-oriented requirements in collecting qualitative data. First, researchers should get close enough to the people and situation being studied to personally understand in depth the details of what goes on. Second, they must aim at capturing what actually takes place and what people actually say: the perceived facts. Third, qualitative data must include a great deal of pure description of people, activities, interactions, and setting. Fourth, qualitative data must include direct quotations from people, both what they speak and what they write down (cited in Patton, 1990). The following paragraphs explain the choice of the data collection methods to fulfil Lofland's criteria, the rationale for each, and the way they were implemented.

4.5.1 Participant Observation

The main method of collecting data, particularly in the care home, was participant observation. Participant observation is a useful method of obtaining information about current lifestyles. It involves long term observation and involvement with those being studied to the extent that the researcher comes to understand their culture as an insider. The researcher gains access to meanings and learns first hand about situations in the participants' own language (Burgess 1990). Peil also suggested,

“Much must be learnt by observing what people actually do and how they do it. As a research method for social scientists, observation involves more than just looking at what is going on. Because our subjects can talk and therefore explain their behaviour, observation includes listening and asking

questions, and often participating in activities of the group to get first hand experience of what daily life involves” (Peil, 1982, p. 158).

However, it entails far more than interviewing. This method often gains insights and develops interpersonal relationships that are virtually impossible to achieve through any other method (Gall et al., 1996). Participant observation is useful for extending the range, relevance and reliability of the data obtained, as the information available to a participant observer is deeper and wider in scope than that observable by someone who remains a foreigner, marginal to the community. Observation over a period of time enables a rich picture to be built up, of complex social relationships, and what Bruner (cited in Okely 1994a) called the lived experience of everyday life experiences.

This method also enhances the validity and reliability of the research, because it is more likely to reflect the needs and interests of society members than a survey completely devised from outside. The observer investigates activities, relationships and values as defined by the people being studied, rather than in terms of abstract concepts which may be irrelevant in the local context (Peil, 1982; 159-160). Okely (1994a) claims the researcher can never claim to have the same experience as those being studied, as observation is influenced by their own experiences and interpretations. Nevertheless, researchers can gain ‘knowledge beyond language` (Okely, 1994a) by using all the senses, sight, taste, sound, touch and smell and the relationship built up between the observer and participant.

Okely (1994a; 2007) provides rich examples of the learning that can be obtained through the senses. In her work on the elderly in rural France (Okely, 1994a), for example, she discusses at length the meanings attached to the appearance, aroma and taste of food: the expression of hospitality through the offering of snacks; the bonds celebrated and affirmed in a social club's six- hour feast; the social meanings of the bourgeois wine versus the farmers' cider; the disappointment of institutional food to palates accustomed to fresh local produce. In the same article, she expounds on the ways in which commonalities of physical experience, such as images of particular scenes or performance of certain tasks, provided points of reference between the researcher and the researched, which contributed in the formation of relationships and

the construction of shared meanings. Elsewhere (Okely, 2007: 65) she draws on examples of anthropological studies in Europe, Asia, and Africa, to illustrate the role of “bodily interaction and sensory learning” as “a foundation for the production of written text”

Burgess (1984) identified nine dimensions of observation data, which he illustrated with reference to the study of a school. Here, I adopt his idea to illustrate how these dimensions were applicable in studying a care home for the elderly, or the situation of the elderly women cared for in a family setting (see table 4.1).

Table 4.1: Dimensions of Observation Data

Features identified	Example
Space	Identification of the layout of bedrooms, communal areas, offices, bathrooms etc in the care home, or of bedrooms, living rooms and so on in the family home.
Actors	The people involved in the situation: residents, staff, and visitors, in the case of the care home, or relatives, housemaids, friends and neighbours in the family setting.
Activities	The various related activities of people in the setting: e.g. watching TV, feeding, administering medication.
Objects	The physical elements present, for example furniture and its layout, mobility aids and recreational objects, decorative and personal items.
Acts	Actions of individuals.
Events	The particular activities of individuals in, for example, meal times, an outing or social activity, such as the Eid celebration.
Time	The time sequence in the care home or

	family home; mornings and afternoons, prayer-times, meal- times, visiting.
Goals	The activities people are attempting to accomplish in particular situations. Differences between different people in the same situation, e.g. between an elderly person and a nurse or relative.
Feelings	Emotions in particular contexts, e.g. jealousy, frustration, joy, anger.

Adapted from Burgess (1984).

I include this, however, only as an indication of the kinds and range of information that was collected, and not to imply the use of any pre-planned recording system or set of categories. As Agar (1980: 112) commented, "Since you do not yet know what is significant, you do not know what to record". Okely (1994 b) recalls the valuable advice given to her, to record "*everything ... even the colour of the carpets*" (p7).

What is important and meaningful may not be clear until after the event, when apparently random impressions can be viewed in the context of the totality of material gathered. Okely's description of the process of writing up her research on Gypsies demonstrates how reflection and intuition grounded in experience enabled her to make sense of quantities of originally unclassified accounts, and how in the process brief jottings and casual remarks assumed a significance that could not have been envisaged at the time. If the researcher records only what is assumed, based on prior theory or other rationales, to be relevant, much valuable material could be lost.

Hence, to facilitate acquisition of "*knowledge beyond language*" (Okely, 1994a), a flexible and unstructured approach was appropriate. I did not use a checklist, as I did not want the observation to be biased by prior assumptions as to what would happen or what was relevant. I aimed to observe physical facilities, interaction between elderly people, their families and carers, and indications of attitude, such as boredom,

frustration and so on. Notes were made on anything that appeared to be of interest, in a research diary maintained throughout the period of research.

A possible criticism of observation as a research method is that observation may change the behaviour of the participants. The presence of an observer changes the situation. For instance, care staff may be particularly concerned to present a good image in front of a visitor by paying extra attention to residents, or speaking differently to relatives. A researcher has to be aware of these risks. However, my aim was to interact with participants in a natural and non-threatening way, to reduce such risks as much as possible. Moreover, since I was in the care home on a day-to-day basis for several weeks, people were not able to keep up a “front”. Furthermore, by using multiple data collection methods, including interviews with a variety of people (see section 4.4.2) and documentary evidence, I was able to gain contextual information which helped in interpreting the typicality or otherwise of what I observed.

The exact timing of observation was determined by the need to balance the aim of observing and recording as much as possible with practicalities such as official procedures and travel requirements, and ethical considerations, for example, not causing undue disruption to the care of the elderly or inconvenience to families. To a considerable extent, therefore, arrangements had to be guided by my judgment and awareness on entry into the research setting. During a total period of five months, from 1st July 2007 to 12th October 2007, and from 5th December 2007 to 2nd January 2008, I made rounds of the care home every day in different time slots, in order to capture various aspects of the home’s routine. Sometimes visits were made without prior warning (albeit within the agreed framework of my access arrangements), in order to guard against the possibility of settings or activities being “staged” for my visit. I was present at meal times, and helped residents in doing their hair or choosing their clothes. I attended Eid celebrations and outings, ran errands for residents, and made small gifts. In all these ways I became a regular and welcomed participant in the life of the institution, and captured the routines and disturbances, pleasures and frustrations of day-to-day living there. In the family setting, visits were made by prior arrangement, to talk to family members and housemaids involved in care. During these visits, I took the

opportunity to observe the facilities in the family home, and relationships between members.

4.5.2 Interviews

Interviewing is a qualitative approach and the most widely applied technique in social inquiry. Some social scientists regard interviews as a combination of conversation and observation (Holstein and Gubrium, 1998). The interview is based on a ‘sustained relationship between informant and the researcher’, which is what gives it greater depth than other research methods (Borg, quoted in Silverman, 1993: 95). Interview is a strategy that is widely used in descriptive research (Borg, 1991). It can be an effective way of obtaining views when the sample is small (Gall et al., 1996). One advantage of interviews is that people are usually more willing to talk than to write (Gillham, 2000). Another is the opportunity it provides to understand people’s experiences.

“Qualitative interviewing explores the shared meaning that people develop in work groups” (Rubin & Rubin, 1995; 8).

Interviewing provides the opportunity for the interviewer to explore the reasons for a person’s responses (Keats, 2000). In-depth interviewing aims at eliciting the special features which need to be understood through conversation-like interaction. It is rather like ‘walking a mile in someone’s head’, an expression which gives a sense of how complex it is, although apparently straight-forward (Patton, 1990; Wengraf, 2001). Depth means getting a thoughtful answer based on considered evidence and getting full consideration of a topic from different points of view.

Another advantage of interviewing is that the interviewer can observe the surroundings. The interviewer may also obtain additional information from the way the interviewer answers the questions, e.g. her or his body language (Laboviz, 1996).

For these reasons, the interview is considered as an important technique in social sciences in general and in sociology in particular (Patton, 1990). Comparing the merits

of interview with questionnaires, Gillham (2000) portrayed the interview as providing in-depth information about the phenomena under investigation, whereas the questionnaire confines respondents to the pre-determined options contained in the schedule, which may prevent them from expressing their actual views. Face-to-face interviews have the highest response rate and permit the longest set of questions. Okely (1994a), however, highlights the limitations of the spoken word in conveying experience and comments that

“spoken utterances, especially the brief and seemingly banal, made greater and profounder sense when placed in a broader, learned context” (p1).

This is why the interview is only one of the methods used in participation, and why it was used in this research to complement observation data, or where prolonged observation was not possible (for example in some family settings) rather than as a sole or dominant mode of inquiry.

There are many different kinds of interviews. Based on the degree of structure involved, interviews can be classified as structured, semi-structured and unstructured.

In the structured interview, the respondent is asked a series of pre-established questions with pre-set response categories. All respondents receive the same questions in the same order, delivered in a standardized manner. There is little room for variation in response (Punch, 1998).

In the semi-structured interview, the interviewer first asks a series of structured questions and then probes more deeply, using open-ended questions in order to obtain more complete information. This approach provides a combination of objectivity and depth and permits gathering of valuable data that could not be successfully obtained by any other approach. As Borg and Gall (1993: 442) put it, the advantage of a semi-structured interview is that it is *“reasonably objective while still permitting a more thorough understanding of the respondent’s opinions and the reasons behind them.”*

The unstructured interview is used as a way of understanding the complex behaviour of people in an inquiry. It is sometimes called an ethnographic interview. This approach, which may be like a conversation in day to day interaction, is able to produce rich and valuable data through prolonged and intimate discourse. However, specific training to develop that skill is needed (Punch, 1998).

I thought that a structured interview would not meet the needs of this research, as it would unduly restrict the respondents' replies and might lead to valuable insights being lost. The aim was to understand respondents' thinking and behaviour, and they needed to be able to answer in their own terms. At the same time, a wholly unstructured approach might lead to time being wasted in digressions that did not serve the purpose of the research. I decided, therefore, to adopt a semi-structured approach, in which, as recommended by Richardson et al. (1965), flexibility could be retained to vary the wording and order of the questions according to the nature of the respondents, while keeping the objectives of the study firmly in mind and ensuring that they were fully addressed.

In order to guide the interviews, schedules were designed, composed of open-ended questions to allow the free flow of information with minimum influence from the interviewer. Four schedules were used: two for the elderly (one for those in the care home and one for those in the family setting), one for informal carers and relatives in family settings, and one for staff in the care home (see Appendix 1).

Qualitative interviewing aims to capture the richness and complexity of the subject matter and explain it in a comprehensible way. Nevertheless the richness needs to be designed into the pattern of questions, as "*One of the goals of interview design is to ensure that the results are deep, detailed, vivid, and nuanced*" (Rubin and Rubin, 1995, p.76). For this reason, the interview schedules were designed to enable respondents to answer in their own terms about what was important to them, while giving me flexibility to probe for additional information on matters of interest. Active probing by the interviewer has been advocated by numerous researchers. Even at a time when the standardized interview was the norm, Rose (1945) (reprinted in Fielding, 2003) urged researchers to go beyond standard schedules, arguing that "... when the subject's

attitude must be fully known, then the interviewer must take an active role” (Rose, 1945, reprinted in Fielding, 2003; 49).

Penelf (1988, reprinted in Fielding, 2003) describing and analysing the interview practice of researchers from the French Institute of Statistics and Economic Studies, reports that

“Skilled interviewers who were highly engaged in their work (those who always asked for more accurate or precise answers, probed responses and had mastered the questionnaire) often got the same degree of engagement and interest from respondents” (p364).

Foddy (1995, reprinted in Fielding 2003) lists a range of probing techniques that researchers may employ, including

“echoing or repeating the respondent's answer as an invitation for elaboration; pausing or remaining silent to give the respondent time to add any further thoughts; making direct requests for clarification; summarising what the respondent has said to stimulate confirmation or correction; confronting the respondent with apparent contradictions in the answers given; and using verbal and non-verbal reinforcements to encourage respondents' responses” (p53).

By using such techniques, I aimed to explore thoroughly respondents' ideas, feelings and experiences.

In conducting the interviews, I made every effort to develop a friendly, relaxed environment in order to build respondents' confidence and so encourage deeper responses (Borg and Gall, 1993) and also to avoid imposing my views and values (Gall et al., 1996). Special care was needed in interviewing migrant workers in the care home, some of whom could speak neither English nor Arabic. In these cases I employed the services of a Filipina nurse and an Indian physiotherapist (their colleagues) as interpreters. I acknowledge that this may have influenced what respondents were willing

to disclose, and I had to be sensitive to the dynamics of the relationships between colleagues when making such arrangements. Another consideration with this group was their unwillingness to speak freely in the presence of (more senior) Saudi staff, due to fears that speaking “out of turn” might jeopardize their contracts or result in formal or informal sanctions against them. I therefore made sure the interviews were conducted in a private room, free from interruption.

In the family setting, I interviewed, where possible, the elderly woman, the family member mainly responsible for care (usually the daughter or daughter-in-law) and one or more housemaids. Interviews were conducted in the home, at times convenient to the participants. Care was taken to conduct interviews separately, to avoid coercion or influence among participants, with two exceptions. In one case, two daughters-in-law who shared care work were present together, and their interaction added much interest to the interview. In another case, an elderly woman insisted on being present while I spoke to her housemaid, and I had to respect her wishes. Clearly, in the family home, privacy could not be guaranteed; despite my best efforts, there remained the possibility that an interview could be overheard or interrupted, particularly as traditions of hospitality led family members to enter to offer refreshments. Moreover, for housemaids in particular, there is the possibility that their responses could be influenced by fear and power relationships between them and their employers. Throughout the fieldwork I tried to be critically aware of such possibilities, to be alert to the atmosphere in the house and the manner of the interviewee, and to be reflexive in my interpretations.

Interviews were tape-recorded, with respondents’ permission, except in two cases where respondents appeared uncomfortable. In these cases, notes were taken, as unobtrusively as possible and expanded immediately after the interview, while the memory was still fresh.

4.6 Gaining Access

The main problem encountered when undertaking any research is that of access (Alty and Rodham 1998). Access has been linked with important elements of building

rapport: 'establishing trust and familiarity, showing genuine interest, assuring confidentiality and not being judgmental' are paramount (Glassner and Loughlin 1987:35). Access has been described as an initial phase of entry to the research setting around which a bargain is struck; a process in which the researcher's right to be present in a social setting may need to be continually renegotiated (Lee 1993:122, Okely 1983:40-44). Assurances of confidentiality may demonstrate a researcher's trustworthiness, while a promised report may cause participants to feel they will also gain something from the research (Alty and Rodham 1998:277).

When I was doing my Master's research, I took a letter from the university to present to the care home in Medina, explaining my proposed research, which enabled me to gain access. My authorisation was still valid for further study. My attempts to visit the home, however, were initially thwarted by the officials as I was required to obtain permission from the Ministry of Social Security, which was based far away, in a different part of the city of Medina. There, the officials gave me some documents and some statistics, but I was not given permission to visit the care home.

Researchers who want to conduct a study must also (to put it delicately) exploit their networks. Okely (1994a) for example reported the value of social networks in her study of elderly people in rural France:

“News that I was friends with certain individuals in a village brought unexpected entrée with poorer and non-bourgeois members of the town's club for the elderly: 'Once we heard that you were a friend of Madame G, we knew you were alright'” (p11).

With this in mind, I similarly attempted to draw on my personal and family connections. Everyone who might possibly know someone, or know someone who might know someone, was contacted and asked if they would give introductions, vouch for me, and help me. Luckily, my sister-in-law is a lecturer at the college of Teacher Training. One of her passions is social work. Some of her students had formed a group called 'Happiness', which organises fun days for orphans and old people. I got my chance to visit the care people's home with this group, in December and January 2006/07. My

family's good name allowed access for the future and helped facilitate rapport and enhance the trust of the participants. For example, the care home manager noticeably warmed towards me when a visitor spotted a family resemblance and identified me as Mrs _____'s daughter. Others knew of my uncle, a prominent local citizen who runs a well known hostel for the poor. In another case, the cooperation of one participant was secured because of a family connection; her husband was a relative of my own husband. As Cassell (1977) states, it is essential to establish a relationship which overcomes the 'social chasm between those who study and those who are studied' (Cassell 1977:412). Furthermore, it is common for informants to concede that 'this is a thing we normally don't divulge to outsiders, but since it is you we shall give you all the necessary help' (cf. Nukunya 1969:19). This is especially important in Saudi society, where it is customary to view strangers with suspicion. Thus, without a good rapport, transparency would be difficult to obtain and information would be partial (Katakura 1977: xiv).

Personal connections also proved important in gaining access to elderly people living in a family setting. The combination of the holiday season followed by the month of Ramadan, and the intense privacy of Saudi homes, made it difficult to find families who were willing to participate. I was able to gain access only to a small number of families, through the mediation of friends and relatives.

4.7 Approaches to Data Analysis

There are four main types of qualitative data analysis, of varying degrees of structure, as follows:

1. Quasi – statistical, e.g. content analysis (Weber, 1990). The analyst selects units of measurement (single words, phrases, or themes) and categorises them, then counts the number of instances of each, found in the text. In this way, qualitative data are converted into quantitative form (Collis and Hussey, 2003). Content analysis is based on a positivist ontology and epistemology which are inconsistent with the interpretive stance, and neglects the possibility of words and expressions having different meanings for different people (Krippendorff,

1980). It was therefore unsuitable for this study. More recently, the idea of content analysis has been broadened to include qualitative approaches such as discourse analysis and ethnographic content analysis, which take content as emerging through a process of context-informed analysis. This type of content analysis falls into the ‘editing’ rather than the quasi- statistical category.

2. The template approach: this is similar to (classical) content analysis, except that it uses a guide or codebook, although this may be revised a number of times as data emerge, and the data are interpreted qualitatively, not quantitatively. This approach, too, was rejected for this study, as the use of a guide, even if one could be found or developed, would tend to bias analysis by pre-conceived notions of what would be relevant or meaningful.
3. Immersion / crystallization – researchers immerse themselves in the subject for lengthy periods and produce an account of their findings through analytical reflection and intuitive crystallization of meaning. Whilst this approach offers the greatest level of freedom for the researcher, it appears rather vague and might, more than other approaches, expose the research to challenge on validity and reliability grounds (these concepts, as applicable to qualitative research, are discussed in the next section). I therefore rejected it for this study.
4. Editing – e.g. grounded theory (Glaser and Strauss, 1967); general analytical procedure (Miles and Huberman, 1994; Collis and Hussey, 2003); Editing methods are grounded in the phenomenological paradigm. The researcher searches the text for meaningful segments, cutting, pasting, arranging and interpreting, to arrive at the “interpretive truth” (Crabtree and Miller, 1992:20) of individual experience. This was the approach selected for this study, as it provides a high degree of flexibility and freedom of interpretation, yet at the same time retains a sufficient degree of structure (and is described sufficiently clearly in methodological literature) to provide useful guidance to the researcher. This increases the likelihood that all relevant points are covered, and helps to reduce bias introduced by the researcher.

The language of most of the interviewees was Arabic, so the interviews were conducted in Arabic. The starting point for analysis was tape-recordings and field notes. Listening to these recordings and re-reading my notes provided an opportunity to gain familiarity with data. However, the manipulation of data was in written form. The recordings were transcribed, after which I began the purposeful reading of text, searching for patterns and attempting to link the experiences of people with their social situation. The aim was to discover common themes, variations and possible sources of variation in needs and relationships. In order to identify common themes in the experiences of the women who were interviewed, sections of text were categorized under the broad topic areas that originally structured the interviews, with further categories and sub-categories developed as appropriate in order to capture the richness of the data and reflect emergent issues.

4.8 Validity and Reliability

The traditional positivist criteria of validity and reliability are problematic in the context of qualitative research (Guba and Lincoln, 1989). In the positivist paradigm, internal validity is concerned with the accuracy of the information obtained, and external validity with its generalizability beyond the immediate research context (Creswell, 1998). Excessive preoccupation with the former can reduce external validity, because it necessitates stripping away the context, producing results only valid in other contextless situations (Guba and Lincoln, 1989). Moreover, it is argued that internal validity can have no meaning in a paradigm that rejects realist ontology. The outcome of the research is not a set of "facts", but of meaningful constructions created through interaction between myself and the participants. In this situation, validity is best understood in terms of how well the research reflects the experience and perceptions of the participants (Miles and Huberman, 1994).

Drew et al. (1996) suggested a number of validation measures that could be applied, such as cumulative validation - a study can be validated if supported by other studies. Another method is Communicative validation - this involves checking the accuracy of the data, judging the authenticity of the research and may involve external auditors (Sarantakos, 2005). According to Sarantakos (2005), qualitative research has good

validity because the data are closer to reality than with quantitative research, and reflect the opinions and views of the researched. Flick (1998) suggested that in order to judge the validity of interviews, several points should be considered, such as whether the content is correct, or whether it is socially appropriate, and whether it is sincere. The interviewer should be aware of any restrictions or bias which may cause the interviewee to respond in a restrictive way.

In this research, the credibility of the findings as a reflection of the participants' experience was achieved by a combination of strategies, supported by writers such as Guba and Lincoln (1989), Creswell (1998), and Miles and Huberman (1994). One was the use of triangulation, whereby the researcher looks at the degree of convergence between data obtained by different methods or from different sources. In this case, this was achieved by combining observation and interview, and by exploring the experiences of different interest groups: elderly women, their relatives, and carers. Another source of validity was the prolonged engagement between researcher and participants during the research. Some researchers advocate a third approach, "member checks" (Guba and Lincoln, 1989), in which categories and themes developed in the course of the research are taken back to participants, who are asked whether the conclusions are accurate (Creswell, 1998). This approach, they argue, offers a safeguard against bias introduced by the researcher, and gives respondents a chance to correct errors of fact and interpretation, increasing the confidence that the conclusions reached reflect some "truth" as perceived by participants. Such a practice, however, is demanding of time on the part of both researcher and participants (Mauther and Doucet, 1998) and for the latter, may be more of an imposition than a source of empowerment (Patai, 1991). Particular problems arise where the respondents do not read in the language of the research (Wolf, 1996) as in this case, where most of the participants were unable to read English. It can also be argued that there may be ethical implications, if the analysis undermines a worldview that a participant has worked hard to sustain for her own emotional safety (Sprague, 2005). There is also the dilemma of what the researcher is to do if she encounters significant disagreement from the participant. How much "textual authority" (Borland, 1991, cited in Sprague, 2005:147) should the respondent have? In the light of the difficulties raised, therefore, member checks as such were considered impractical. Nevertheless, based on my familiarity with

the culture, I recognised that offering a copy of the findings to anyone who wished to see it would be appropriate for other reasons - to show my respect for them and recognise the value of their contribution, and to demonstrate my openness, so they could see I was not an official “spy” and had no hidden agenda which could harm them. Participants appreciated the offer, but in practice assured me that since I had been open in recording and note-taking and they had watched the process, they felt no need to check the outcome.

The traditional concept of reliability, too, needs to be reconceptualised for qualitative research. Reliability in the classical sense refers to the capacity of a measurement to produce consistent results. According to Sarantakos (2005), if a method is reliable it should produce the same results when repeated. There is internal reliability when the results can be replicated within one site and external when results can be reproduced in other sites. Qualitative researchers, however, prefer the concept of authenticity to reliability. According to Silverman (1993; 10), ‘Authenticity, rather than reliability is often the issue in qualitative research’. In qualitative research, issues of replicability and consistency are not as relevant as in quantitative research, because attitudes and opinions change over time, so different results may be obtained. Indeed, change is central to the development of interpretations between researcher and participants (Guba and Lincoln, 1989). Patton (1990) argues that reliability is the consequence of validity in a study, so that the measures taken for ensuring validity should demonstrate reliability also. Others propose specific reliability criteria for qualitative research, such as dependability (Guba and Lincoln, 1989). They suggest this can be demonstrated through an audit trail, in which the whole research processes is documented and traceable, so that the data sources and the processes involved in data management and interpretation can be confirmed. Drew et al. (1996) advocate a similar approach. However, this must be balanced with data security and confidentiality; for example, interview transcripts can be given a code number, and pseudonyms used. There is also a limitation with the audit trail approach when applied to observational studies where much of the data is unwritten, consisting of sensory impressions and memories which lie in the person of the researcher herself.

While, in this project, care was taken to retain all materials used - letters, e-mails, documents, recordings and transcripts of interviews, field notes etc, to ensure as far as possible the transparency of the research process to supervisors and examiners (albeit without disclosing informant identities), these records cannot tell the whole story. To the extent that the research embodies my own subjectivity, the dependability of the final report can best be demonstrated through my critical reflections on the research procedures, my own role, and the conclusions reached. Such reflections will be found in the final chapter of this thesis.

4.9 Ethical Considerations

Karhausen (1987:25) describes ethics as a philosophical discipline primarily concerned with the evaluation and justification of norms and standards of personal and interpersonal behaviour. As the Association of Social Anthropologists (ASA) points out, social research has implications for the participants, the researcher, research colleagues and the discipline, and various other interest groups in the wider society in which the research takes place (ASA, 1999). Researchers, therefore, are often faced with competing duties, obligations and conflicts of interest (British Sociological Association, 2002). Ethical problems facing social researchers have changed over time, and will probably be more difficult to resolve in the future. The intimate role relationships which put people in closer contact than in previous moments of social science demand greater sensitivity, authenticity and discretion from researchers, and create problems with managing confidentiality and anonymity (Lincoln, 1995). When interviewing individuals, one enters another person's social world, and sometimes establishes friendships characterized by caring, sharing and nurturing. A contradiction can arise when accounts of personal experiences are represented in the text as abstract, theoretical and sociological.

The ethical guidelines of the ASA (1999), British Sociological Association (2002) and Social Research Association (2003) all contain detailed and similarly worded advice on researchers' duties to participants and others involved in or affected by the research, which were followed in this study. In particular, use was made of a 14-point standard

protocol or checklist for checking ethical considerations, offered by the Social Research Association (2003). Some of the key issues and dilemmas are discussed below.

Informed consent is a central issue of professional ethical codes and guidelines (Punch 1986:36; Daly et al. 1992). Inquiries involving human subjects should be based on the freely given informed consent of participants. With this in mind, participants should be informed of any matters that may significantly affect their willingness to participate, such as the purpose and anticipated outcomes of the research, the arrangements for data security and so on (ASA,1999). Often this is done by providing written information and obtaining a signature on a consent form, but this is not always possible, for example with non-literates. In such cases, oral explanations and affirmations must suffice. For consent to be meaningful, participants must have the mental and legal capacity to give it. In this project, for example, care had to be taken to ensure that elderly people fully understood the nature of their participation and consideration given to possible dementia. In interviewing care home staff or housemaids, it was important to be sure that they were not being coerced by their employers. Consent was treated as a process, not a one-off event (ASA, 1999). Hence, participants had the right to withdraw at any time.

In obtaining consent, however, and in research generally, there is a dilemma as to how truthful the researcher must be. Cassell (1988) argued that in order to achieve the objective, the investigator's approach must, of necessity, involve certain falseness. Motives must be concealed: the researcher cannot say, 'this research is designed to expose your misbehaviour' (Cassell 1988:90). Questions of truth and lying pervade all that is said or left unspoken in research situations as well as in social life generally. According to Bok (1978), there are numerous choices: to lie, equivocate, be silent, or tell the truth. In addition, she states, in the absence of special considerations, that 'truthful statements are preferable to lies' (1978:30).

Another key issue is the protection of respondents' anonymity and privacy. The privacy rights of subjects may be compromised by the professional rules of a discipline to provide confidential information as evidence to support analyses and interpretations. Researchers could find themselves caught in cross-cutting ties of allegiance and

loyalties, and faced with a dilemma for which there is no satisfactory solution (Hill, Glaser and Harden 1995). There is a tension between the desire for rapport and the obligation adequately to protect the subject's right to privacy. The objective of fieldwork research is the disclosure and publicising of the findings, not to conceal information. The researcher may be torn between doing what they feel is 'right' by the subjects, based on intuition and empathy, and what should be done: they are consciously aware of the need to uphold ethical norms and do no harm, and their obligation to the discipline to provide an interpretation of a people and their practices (uncensored and complete) that could contravene moral imperatives (de Laine 2000:30). For that reason, names and addresses of people are not disclosed. The use of pseudonyms to disguise individuals, groups and research sites is common and mandatory practice in social sciences to protect the privacy of individuals (Lee 1993:185).

Whilst every effort should be and was made to ensure the privacy and anonymity of respondents, there are times when total concealment of identity is not possible. It is difficult, for example, to disguise institutions and office-holders, and sometimes a particular configuration of attributes may identify an individual (ASA, 1999). This was a strong risk in the care home, since it is the only institution of its kind in Medina. Whilst specific respondents are not named, there are some whose roles might identify them. In these cases, participants were reminded of this risk (British Sociological Association, 2002), and no reference is made to such roles, without the consent of those concerned.

A major concern in any social research is to avoid harm to the participants. Researchers have a responsibility not to cause participants embarrassment and upset from having spoken to them (Lee 1993:185; Akeroyd 1991:97; Finnegan 1992:226). The researcher is obligated to ensure that people know the information they convey could become data for uncensored public disclosure. Even if not harmed, participants may feel wronged by aspects of the research process, for example, perceived intrusion into their private and personal worlds, the raising of false hopes, or anxiety caused by the research (British Sociological Association, 2002). In the present research, an important consideration was not to intrude on or damage relationships between participants, for example between elderly women and their families. Moreover, I had to be sensitive to the physical and

emotional well-being of participants by, for example, respecting the need of an elderly woman to sleep, refraining from pressing points that appeared to cause distress, ensuring that my observations and actions did not disrupt feeding or treatment routines, and so on.

Researchers who engage in closer, more intimate relations in social research inevitably encounter problems that could be harmful to themselves as well as subjects. In the present research, for example, I knew from past experience that in the care home, elderly residents were accommodated alongside some who were mentally ill, whose behaviour could be unpredictable and even abusive. I was therefore guided by staff as to any precautions that should be taken.

As this discussion has shown, research ethics is a complex area. Problems of ethics cannot be avoided: as Bronfenbrenner (1952:453) suggests, 'the only way to avoid violating principles of professional ethics is to refrain from doing social research altogether'. However, by following the ethical guidelines referred to above, I sought to obtain valuable information by fair and honest means, and to fulfil my obligations both to my academic discipline and to the well-being of my participants.

4.10 Summary

This chapter has described, and explained the rationale for, my philosophical stance and methods adopted to fulfil my objective of exploring issues in the care of the female elderly in Saudi Arabia.

I started from the premise that old age is in many respects a socially constructed concept reflecting cultural norms and expectations. As such, I sought to obtain a deep, rich and contextualised understanding of the lived experience of elderly women and their carers, as perceived and interpreted by those involved. Moreover, I was guided by a feminist stance that sought mutuality with my participants, tempered by self-awareness and reflexivity. Consistent with my philosophical and ideological approach, I explored the experience of cared-for and carers in both domestic and institutional settings, through

participant observation and semi-structured interviews, conducted over a five month period. In an attempt to ensure and demonstrate the credibility of the research, I have employed triangulation, not only of methods, but also of data sources or perspectives, and prolonged engagement with participants.

The outcome of this prolonged immersion in the research setting, and the process of data collection, analysis and interpretation informed by constant critical reflection yielded deep and wide-ranging insights into the ways in which participants perceived their circumstances, roles and relationships, which I report in the next three chapters. I begin in chapter five with the experience of elderly women in a care home, and address the first three research questions, concerning the factors influencing the care decision, the way the elderly women perceived their role and family situation, and the multi-dimensional implications of their admission to the Home.

Chapter Five

The Elderly Women in the Care Home

5.1 Introduction

When new residents are admitted to a care home, their life is shaped, not only by the new people they meet, but also by the material conditions that determine how their daily needs will be met (Hazan,1992), for example the physical structure of the home, the services provided and the daily routine. As Hockey (1990) points out, such residents must conform to the institutional division of time and space. In this chapter, the first of two concerned with life in the care home, I try to capture the flavour of this new life and its meanings for residents, drawing on my observations, as well as many interviews and informal conversations with residents and staff. I begin with a general description of the setting in which the elderly women pass their days and nights and which shapes many aspects of their experience, both physical and psychological. I go on to consider the factors influencing the decision to admit the women to the care home and to explore the women's perceptions of their identity and role in the family, before and after admission. I describe both the care home routine, and a number of special events by which I saw the routine brightened, the links with the outside world briefly renewed. Finally, I discuss the experience of illness and death which, for most residents, will be their means of permanent exit from the care home.

5.2 Description of the Setting

Before discussing the way of life in the care home and the situation of the elderly women who live there, it would be worthwhile to provide a broad description of the building, its location, layout and facilities. My aim in so doing is to contextualise the discussion that follows; to sketch the 'scenery' in which the events described later took place and aid understanding of the practical and emotional issues faced by residents and carers, in which the setting played an important part.

5.2.1 General Overview of the Building

The female care home is located in the middle of the city centre of the old Medina. It is in a compound with high walls and a big metal gate for entrance. The gate is opened by security guards, who confirm the identity of visitors and whom they wish to meet. As you enter you face the administration building, and the big glass window of the office of the manager of the Care Home. In this situation, the manager, like the matron in the British care home described by Hockey (1990), has visual control and can be said to mediate the relationship between the home and the outside world. This arrangement is reminiscent of the notion of the panopticon developed by Foucault (1995), building on the ideas of Jeremy Bentham. The panopticon is a design for increasing security (originally in the incarceration of mental patients or convicts) through effective surveillance, achieved by the arrangement of cells in a circle surrounding a central observation tower. The central idea of the panopticon is the systematic ordering and controlling of human populations – whether prisoners, schoolchildren, medical patients or workers, through the restraining influence of (potentially) constant observation by a powerful authority. Behind this building there are another four buildings; one is for visitors, one is the kitchen, another building is for the men's section and the fourth is for the women's section. I conducted all my work in the women's section, as segregation of the sexes is maintained in this compound.

The purpose –built building, which was erected in 1958, is made of concrete. The women's section consists of four blocks, arranged round a central courtyard. These blocks, which house the residents, are named Flat 1, Flat 2, Flat 3 and Flat 4. The courtyard area is covered at each end by a wooden roof, providing shade in the summer and creating an outdoor recreational space for the elderly (see **Picture 1**). Beds and tables are set out and a portable air conditioner is set up at each end. In addition there is a drinking water dispenser at each end of the area. However, since the area is extremely hot in summer and cold in winter, in practice, the recreational value of this space is very limited. At the time of my main fieldwork, I noted the absence of any greenery to soften the harshness of the concrete and give the residents something attractive to look at. A number of interviewees among the care home staff similarly commented on the absence of a garden. One (CHS 2) explained how green land had been sacrificed to extend the buildings.

“Last year, this area was cultivated land surrounded by big trees. The Ministry provided this centre [referring to an outbuilding at the far end of the yard] with entertainment facilities but they do not use it because they are elderly. A princess donated funds for improvement of this building, so they removed all the green land.....”

She went on to comment, *“Patients prefer trees, green land. This place is bare.”*

Another interviewee (CHS 7) thought the removal of the trees had been precipitated by their attracting harmful insects. Whatever the reason, the drastic impact on the elderly women’s environment was the same.

By the time of my second visit, a year later, however, I noticed some changes. Recently, green basil plants have been planted along the long sides of the rectangular courtyard border, to improve the view. At each corner of the yard is a palm tree surrounded by green- painted concrete seats (See **Picture 2**). In addition, there is an umbrella made of bamboo on each side of the court yard. The outbuilding at the far end of the yard has recently been extended to include a large building and a kitchen and an events area.



Picture 1: Outdoor seating area

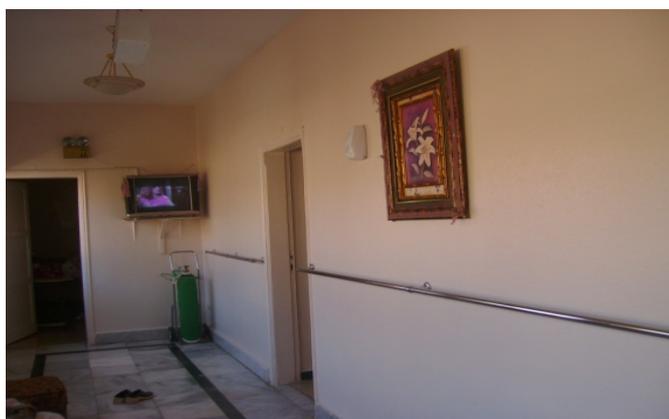


Picture 2: Palm tree and concrete seating

5.2.2 Inside Layout

Flat 1

As shown in **Picture 3**, the first building has a long corridor with a television mounted on the wall at the end. It has six small rooms and one large room, and three toilets and bathrooms. Four of the small rooms are for the elderly, one room for the staff, one room for the social worker, and the large room is for the Chief Supervisor. There are two toilets next to each other and two sinks outside, two chairs where the elderly women sit while being showered, and two shoe racks. In addition there is a separate toilet for the supervisor.



Picture 3: Corridor of Flat 1 Reception room with TV on end wall

Chief Supervisor's room

The door opens to the supervisor's desk, behind which there is a leather office chair (**Picture 4**). Behind the chair is the safe. There are also three modern leather sofas which together seat nine, covered with throw-overs. In the middle there is a coffee table with decorative pieces on top; a vase, a tissue box, and traditional serving plates for sweets (**Picture 5**). At the bottom end of the room there are two filing cabinets. To one side there is a computer and a modern desk and a chair. The room is very luxuriously furnished. I understand the decorative pieces are the Supervisor's personal property.



Picture 4: Chief Supervisor's desk



Picture 5: Chief Supervisor's room: seating area

Staff room

There is an old fashioned traditional seating arrangement around the two walls (a set of long, very low cushions with back-rests), one large table for tea and coffee, a small fridge in the corner, and one fitted store cupboard against the fourth wall. As can be seen in **Pictures 6 and 7**, new long curtains have been fitted recently.



Picture 6: The Staff Room (1)



Picture 7: The Staff Room (2)

Social Worker's room

This is a small room, depicted in **Pictures 8** and **9**. As you enter, there is a photocopying machine, and a cupboard with glass doors for files, an office table and a leather office chair. Next to it is another small wooden cabinet with glass doors and a two-seater sofa. New long curtains have been fitted recently.



Picture 8: The Social Worker's Room



Picture 9: The Social Worker's Room

Residents' rooms

Three of these have identical furnishings. Each room contains two single medical beds, (almost all residents are in shared rooms), built-in cupboards, an air-conditioning unit and two bedside tables. New long curtains have been fitted recently. As can be seen in **Pictures 10-12**, the rooms are small and basic, with a very institutional appearance which the new curtains do little to soften. There is no space for walking, sitting or occupation of any kind. There are televisions mounted above the door, but these have been disconnected, as the patients are blind, bedridden and with psychiatric needs. In fact, in the care home as a whole, I noted 22 televisions, one in each of 18 bedrooms, one in the dining room, and three in hallways- one in each of three of the flats. However, only six of these were operational.

The other resident's room is slightly different because the resident has insisted on the additions. The resident in question had a somewhat privileged position, as a long term resident who worked outside the home. The television mounted over the door is still connected. She also has a cassette recorder and a fridge. This room has been carpeted, and has the traditional Arab seating arrangement on the floor, with a mattress and an

arm rest. In addition there is a cupboard for her books, as this resident reads a lot. Although there are two medical beds, the resident insists on being on her own.



Picture 10: Flat 1: Resident's room



Picture 11: New curtains in a resident's room



Picture 12: Typical layout of a resident's room

Toilet and Bathroom

As shown in **Pictures 13** and **14**, these have a toilet, bidet and a bathtub unit each. Although they were purpose built for the elderly at that time, in today's terms they are not fit for purpose, as the design does not accommodate the equipment currently used for the elderly. The bathtubs are redundant now, as the residents find it difficult to get in and out of bathtubs. Instead, staff use portable medical commodes to seat residents and bathe them in comfort and safety.

It can be seen from the pictures that the bathrooms are rather bleak, utilitarian places, and show signs of wear and tear. On one occasion, as I was on my way to the toilet, a resident told me to be careful, because she had seen a rat inside the toilet some time previously. When I informed a member of staff, I found this was indeed the case, and the staff were well aware of the problem. Apparently, efforts had been made to kill the rats, but I was told that large numbers of them were living under the ground, in the drain, and my informant attributed this to the age of the building.



Picture 13: Residents' Bathroom



Picture 14: Residents' Bathroom

Shower facility

The residents sit on medical commodes (see **Picture 15**) and water is brought in a bucket and poured over them with a jug. There is no privacy for the residents.



Picture 15: Commode Chair used for showering residents



Picture 16: Corridor and entrance to shower area

Flat 2 and Flat 3

All seven rooms in each building are for the residents only, and rooms are similar to those described above. However, the large room (shown in **Picture 17**) accommodates five residents and there is no staff room. It can be seen from the picture that the five-bedded room are very cramped, providing nothing more than sleeping space.



Picture 17: Five- bedded room

Flat 4

This is the Medical building. It contains a large corridor, in which there are a medical check up bed with a partition screen, three oxygen tanks, wheelchairs, and scales to measure height and weight (**Picture 18**). There is a chart of the skeleton, posters on healthy food and information on keeping healthy (**Picture 19**). The building also has three large rooms, one for the chief nurse, one observation room and one physiotherapy room. It has three toilets.



Picture 18: The corridor of the Medical Building



Picture 19: Health and nutrition posters in the Medical Building

Chief Nurse's room

The room, shown in **Pictures 20** and **21** is very similar to the Supervisor's room in flat 1. The door opens to the chief nurse's desk, behind which there is a leather office chair. There are also three modern leather three-seater sofas, each covered with a throw-over. In the middle there is a coffee table with cultural decorative pieces and flowers on top. At the bottom end of the room there are two cupboards for files. There is a fridge for medicines. There are several wall hangings. There are short red curtains at the windows and rugs on the floor. The room is very luxuriously furnished. I understand the decoration is the Chief Nurse's personal property.



Picture 20: General view of Chief Nurse's room



Picture 21: Desk area of Chief Nurse's room

Observation room

As you enter there is a filing cabinet for patients' medical files, a safe and a fridge for medicines. There is also a steel locker for psychiatric medicines, an office table and chair, an autoclave for sterilisation, and a fluorescent screen for viewing X-rays. There is one cupboard with sliding doors, in which medicines are kept. This can be moved around. There is another cupboard for uniforms and abayas (outdoor cloaks) and shelves for sheets and pillow cases. There are two fixed cupboards for medical equipment of all kinds, two modern hospital trolleys with shelves, two standing blood pressure monitors, two ordinary blood pressure monitors, one old fashioned steel stroller, two old fashioned air conditioners, two medical beds, two oxygen cylinders, three suction machines, and one modern digital thermometer. New long curtains have been fitted.



Picture 22: Medical room: beds and clothes cupboard



Picture 23: Medical room: general view



Picture 24: Medical room: showing X-ray, sterilizer and sofa/refrigerator for medicines



Picture 25: Medical room: Medicines and First Aid equipment

Physiotherapy room

As you enter you see three medical beds, with equipment for exercising, a hot pack machine, one rotating arm machine, walkers, and information charts on the wall (See **Pictures 26** and **27**). Opposite this is a new extension for the chief physiotherapist (**Pictures 28** and **29**), in what used to be a storage area. It now has a desk and chair and a two piece settee, new hydrotherapy equipment curtained off for privacy and three air conditioners. Also attached to this room is a toilet for the chief physiotherapist's use.



Picture 26: Physiotherapy room (1)



Picture 27: Physiotherapy room (2)



Picture 28: Hydrotherapy area



Picture 29: Physiotherapist's desk

Laundry room

Behind the above room is the laundry room, where clothes are washed and ironed. There are three washing machines and two dryers (**Picture 30**) and one big machine for ironing clothes (**Picture 31**). The room gives out onto an open area for airing clothes in the sun (**Picture 32**). There is an area for hanging clothes and a big table on which the folded clothes are placed after ironing (**Picture 33**). I also noted a sewing machine, which attracted my attention. I asked the member of staff present, “Who uses this?” She answered, “Me; I can sew and repair patients’ clothes, including men’s clothes”. The Supervisor told me that the machine had been provided especially when it was found that the member of staff in question had sewing skills.



Picture 30: Washing machine in laundry room



Picture 31: Ironing machine in laundry room



Picture 32: Drying area adjacent to laundry room



Picture 33: Freshly laundered clothes

Receiving room

This used to be a dining and kitchen area. As can be seen from **Pictures 34** and **35** below, it is a very big room which can accommodate about 50 people, and is well decorated. It has the traditional Arab sitting arrangements on the floor and has carpets in the middle. Patients get together here for parties.



Picture 34: The receiving room (1)



Picture 35: The receiving room (2)

Dining room and Kitchen

This is the new extension, which has improved the outbuilding which had not been used for a long time. The extension is the new kitchen (**Picture 36**) which leads into the dining room (**Pictures 37 and 38**) and a washroom. This leads to a corridor, off which are five rooms. The first room has been converted into a classroom where the residents have Quran classes (**Picture 40**); the next room is for storage of winter clothes and bedding, the third room is for storage of summer clothes and linen and shoes of varying sizes, the fourth room for storage of tissues, nappies and toiletries (**Picture 44**), and the fifth room is for cleaning materials (**Picture 45**); off this is a large room where currently 12 medical beds and mattresses are stored for use when residents from other centres come to visit this institution (**Picture 41**). Apparently, such exchange visits between centres are one of the strategies employed to give small groups of elderly women (those considered in sufficient physical and mental health to enjoy the trip) a change of scene.



Picture 36: The kitchen



Picture 37: The dining room, outside meal times



Picture 38: Dining tables covered, ready for dinner



Picture 39: Kitchen with refrigerator and juice chiller



Picture 40: The Quran classroom



Picture 41: Spare beds for visitors from other care homes



Picture 42: Stored Oxygen and quilts in dining block



Picture 43: Wheelchairs stored in dining block



Picture 44: Stored nappies etc



Picture 45: Stored cleaning materials

5.2.3 Significance of Physical Environment

The description above reveals some distinctive features of the care home's physical environment, which resonate strongly with similar description of homes in the UK (Hockey, 1990) and Israel (Hazan, 1992). As in Hockey's description, it can be seen that the use of space for washing, eating and relaxing is different and separate for each institutional category. Not only is there a distinction between staff and residents, but also between different categories of staff; the chief supervisor (like Matron in Hockey's example) has her office, while other staff have the staff room. Thus, in a sense, the Chief Supervisor is distanced from her charges-both the elderly women and their carers. The Medina home also manifests the same "*peripheral homeliness*" described by Hockey (1990, p90); the Chief Supervisor's room with its coffee table, ornaments and rich furnishings contrasts with the simplicity - almost austerity - of the residents' rooms. The latter present a depersonalized environment in which, as Hockey (1990) describes, "*Any transformation of the living accommodation into a personal space must be wrought by the resident themselves*" (p99). The importance of personal possessions as reminders of the resident's former life and representations of her identity was attested by Okely (2000) in her moving account of her mother's experience and the absence of such possessions in most of the residents' rooms in this care home was striking. This may, however, reflect not so much any deliberate depersonalization on the part of the care home, as the poverty of the women's former domestic contexts, such that they had few possessions of personal value to bring. Hazan (1992) described a similarly impersonal (although more modern and luxurious) setting in a Jewish old age home as like a hotel or office building. In this case, as in the home described by Hockey (1990) and the Medina care home, the uniformity, functionality and impersonality of the buildings stand in ironic contrast to their labelling as "Homes". The surroundings, in fact, give a strong impression of medicalization of care. Not only is a whole building devoted to this, but the residents' rooms, with their medical beds and basic locker facilities, look more like hospital wards than bedrooms. As will be seen in the discussion that follows, many of the elderly women did indeed have medical conditions and infirmities that required treatment. Nevertheless, there are various aspects of the setting, such as the lack of privacy, the disconnected televisions, and the fact that attractive curtains were fitted only recently, after I had drawn attention to the bleakness

of the environment, that suggest – perhaps unwitting – neglect of the social dimension of care. The medicalization of care was in fact part of a discourse in which residents were characterised as ‘patients’ – a theme to which I shall return.

This, then, is the setting in which elderly women in the Home are cared for. The question now arises, in what circumstances was the decision made to have an elderly woman admitted to the Social Care Home, and what were the factors influencing the decision? These issues will be explored next.

5.3 Factors Influencing the Decision on Care Arrangements.

Of the twenty elderly women whose cases I followed particularly (see profiles in Appendix 2), the great majority had been admitted to the care home by a family member – husband, sibling, son, step-son or son-in-law. It was generally a male relative who made the request, consistent with men’s role as the primary decision-makers and authority figures in the Saudi family. Although it was not always clear from the case files, it is likely that the women had been living with the relative concerned at the time, since women are culturally dependent on and under the protection of men. A woman who is divorced or widowed, for example, may take up residence with a brother or grown up son. Certainly, there were a number of cases who were known to have been cared for within the family, sometimes for a number of years, before the decision was made to request admission to the care home. One resident, K----- (CHR 9), for example had lived for many years with her brother, who continued to support her for many years after she suffered some kind of seizure (attributed by the family to a neighbour’s curse; it is not clear whether there was an identified physical cause). After his death, the responsibility for her care was for a time assigned by family agreement to her sister, until the latter, who was asthmatic, could no longer cope. Two other cases had similarly been supported financially and cared for by brothers.

Where a woman had borne children and her offspring had reached adulthood, one or more of these might take on the responsibility of caring for their elderly mother. Indeed, I heard of one case where a divorced woman with children had been admitted to the care home by her husband; when the children reached adulthood, they took their

mother out of the care home and gave her a home with them. Such a determined effort, by offspring who might easily have accepted the status quo that had been created by others, before they were of age, is testament to the importance of family ties in Arab-Islamic culture, and the perpetuation in some families, at least, of traditional family values.

It was not always easy, however, for sons and daughters to provide care, particularly if they were married, when conflict might be experienced between in-laws. One of the elderly residents, for example, had a son who was willing to give her a home, but she rejected his offer because she did not want to be 'controlled' by her son's wife. One can perhaps see here a reflection of the reality that although a son might provide a roof and financial support, day-to-day personal care is likely to devolve on his wife, reflecting the typically gendered division of labour. One member of staff (CHS4) told me about a case that had attracted her attention:

“Her son came to visit her for the first time in seven years. I was here. He had got married and came to introduce his wife to her. After two months, he came to get her out to stay with him in his house. He was thinking that she was affected by her medicine and could not talk well. He brought her back [at her own request] after only two days because she was worried and refused to stay in his house. I asked [her], ‘Why did not you stay in your son’s house?’ [She] replied, ‘My son’s wife was scared of me. She put the food in front of me without speaking and went away, then my son took [the plate] back to the kitchen. She put me in a separate room when she received her friends. When her family visited her, she left me sitting with dates and coffee, away from them!’”

This account well illustrates some of the difficulties that might sometimes occur between a woman and her relatives, even if they were willing to have her at home, especially if care was provided through the medium of a spouse who had no emotional tie to the elderly woman. This couple provided for the woman's physical needs- she was given food, somewhere to sit, a roof over her head- but she was unhappy because she felt lonely and disrespected. Because her emotional needs were not met in her son's house, she preferred to return to the care home. Presumably, there, she was assured of a

certain amount of company. Moreover, relationships in the care home would not be subject to the same expectations as those with her son and daughter –in-law, and so perhaps there was less chance of disappointment.

It was also interesting to note that the care decision would depend on whether the potential carer was a son or a daughter, as a married woman would be expected to bow to the wishes of her husband; hence the case of AH (CHR 8), who was admitted by her son-in-law, although her daughter evidently missed her mother and perhaps would have been willing to care for her at home, were it not for the conflict of responsibilities. One of my interviewees (CHS1), telling me about this case, adopted a censorious attitude, reflected in her emotive language: *“Her daughter threw her in a social care home without mercy”*. However, the account of the case given by this same interviewee suggests that the daughter had been put in an impossible position:

“Her daughter’s husband told her, ‘choose me or her’.....Her daughter said to her husband, ‘I choose you!’ So she admitted her mother here.....”

Certainly, the daughter’s tenderness towards her mother during her regular visits did not present the image of a woman “without mercy”. This case illustrates all too clearly the pressures on women in a society which expects them to care for their elderly parents and stigmatizes them if they fail to do so, yet also expects them to be submissive to their husbands and stigmatizes divorce. The woman’s son-in-law apparently forced the decision to admit her to the social care home, but it was the daughter who bore the blame.

If no spouse, sibling, son or daughter was available to provide care, the responsibility for an elderly woman might devolve to a more distant relative – a nephew or in-law, for example. Two of the women whose cases I observed had been cared for by nephews. SS (CHR 1) had lived with her nephew, after she was widowed. Another woman, N. (CHR 3) had lived in a private poverty home or “alms house” funded by rich people for several years, but a nephew, seeing that the home could not provide an adequate standard of comfort and privacy, had removed her and taken her to live with him until he became unable to provide the continuous nursing care she needed. Two other

women, M.D. (CHR 10) and SM (CHR 18) had each lived for some years with a sister-in-law, who had continued providing the care they had originally given on behalf of their husbands, the women's brothers.

As these cases show, the eventual admission of the elderly woman to the care home does not necessarily mean that the family ties had completely broken down, or that social responsibility is no longer a force in the Saudi society, although traditional values may compete with other pressures. An outstanding example of the traditional Islamic approach, whereby social responsibility spreads out in ever-widening circles from the immediate family, is provided by the unusual case of AB (CHR 16). AB had been widowed by her first husband and divorced by her second; she had no children. When she became infirm, her care was undertaken by a neighbour, who not only prepared meals for her, but even provided a servant to attend to her needs.

Thus, some women, at least, had benefited from family and community support for some time before being admitted to the care home. Their admission was in many cases a last resort, when alternatives were not available or had in time been no longer considered viable. A number of factors seemed to have been key in the decision to apply to the social care home: medical, economic and social.

5.3.1 Medical Factors

All of the women I observed had a variety of medical conditions requiring supervision and/or medical treatment. Of the twenty cases observed, for example, six had diabetes, in some cases diet-controlled and in others requiring medication. Six had impaired mobility or were totally immobile. Several were incontinent. One woman had been admitted following a stroke. There were a number of cases of impairment or loss of vision due to cataract. However, with the exception of the woman who had suffered a stroke, the residents' notes did not make clear whether or to what extent the physical conditions described had been a factor in the women's admission. In some cases, these conditions may have appeared or worsened in the years following admission. However, it is worth noting that in a study in the UK by Allen et al. (1992), cited in Victor (1997),

the main reason for entry to residential care was acute deterioration in health (e.g. stroke) or generally deteriorating health status. Admission in such cases was usually suggested by a carer or professional health or social worker and was often so rapid as to leave limited opportunity for the exercise of choice.

In addition to physical health problems, there were several mental health issues, although in some cases it was not clear how far these had existed at the time of admission. Surveys in the West have shown a high prevalence of psychiatric disorder among elderly people in sheltered accommodation and hospital; a third of residents in old people's homes have significant cognitive impairment and a third to half of general hospital patients aged 65 or over suffer some form of psychiatric illness (Gelder et al.: 2007). Perhaps not surprisingly, given the age of the residents in this study, a large number were said to be suffering from senile dementia. There were also four women among the twenty focus cases labelled 'mentally retarded', four said to be schizophrenic, and two suffering from (unspecified) mental illness. Quite apart from the question of the suitability of housing mentally well elderly and mentally ill residents together (a theme to which I will return) these figures warrant further comment. Whilst I cannot challenge medical diagnosis, I was interested to observe that some members of staff – even qualified nurses - seemed to be unable to differentiate clearly between different categories of patient, in particular confusing senile dementia and “mental retardation”; some used the terms almost interchangeably. It is possible, therefore, that some of those who were described as 'mentally retarded' were in fact suffering from senile dementia or another dementing condition such as Alzheimer's. In most cases it was not clear from the women's files what kind of assessment they had undergone or what diagnostic criteria were used. According to Gelder et al. (2007) psychiatric assessment of elderly people is likely to take longer than with younger cases, requiring more than one interview and in the case of suspected dementia relying on informants to verify the extent to which the impairments are affecting the patient's capabilities and safety. It is likely to extend beyond the strictly medical to include the wider psychiatric situation, including carers and other involved people. Moreover, physical and laboratory examinations are important because of the greater prevalence of organic disorders as a cause of psychiatric symptoms in the elderly. If such detailed and thorough assessment had not been carried out and given the lack of specialist training of many care home

staff (I shall discuss this further in Chapter Six), there is a very real possibility that some women were 'labelled' rather than diagnosed, and so the actual mental health status of some residents may be in doubt.

Another possible explanation for the unexpectedly high proportion of women described as mentally retarded might lie in the practice of 'disposing' of a mentally handicapped daughter through an arranged marriage. Historically, in Saudi society, marriages were arranged by the families of the prospective bride and groom, with the aims of controlling female sexuality (a family's honour was seen to be in the chastity of its women), securing property – for example through first-cousin marriage – and forging alliances. The couple would not spend time together, or even meet, until the wedding ceremony, during which the bride would be veiled, as customary in the presence of men other than close relatives. Among conservative Bedouins who cling to old traditions a girl may be 'given' in marriage by her father, to a man who will not see his bride until the wedding has taken place, and her mental incapacity comes to light only when her husband has already committed himself. Such girls may be kept in the household and bear children, but they may also be vulnerable to divorce or, if widowed, may be unable to care for themselves and unwanted by other relatives. GA (CHR 13), for example, was described as mentally retarded and unable to take care of herself on widowhood. The vague and confused labelling of some residents may also reflect a general failure in Saudi society to distinguish between mental retardation and mental illness, which is evident in the fact that services for the mentally retarded consist of beds in various mental hospitals (WHO 2001).

Also surprising was the proportion of women described as schizophrenic. In only one of these cases was the illness described as starting in childhood, although in other cases it is not clear whether the problem was not diagnosed until later. Schizophrenia usually begins in early adulthood or middle age and new onset after 60 years of age is rare. Among the features of the late onset form, however, are female predominance and association with sensory deficits and social isolation (Howard et al., 2000), both of which characterised many of the care home residents. Moreover, some elderly suffer from schizophrenia-like and paranoid disorders which according to Gelder et al. (2007) have been a long standing source of debate and terminological confusion. In future

versions of the International Classification of Disease and the Diagnostic and Statistical Manual, a distinction (based on symptom profile and risk factors) is to be made between later onset schizophrenia (applying to those with onset between the ages of 49 and 59 years) and very –late- onset- schizophrenia-like psychosis, covering psychoses of the type arising after 60 years of age (Howard et al., 2001). Patients with very -late-onset- schizophrenia-like psychosis are said to form approximately 10% of admissions to psychiatric wards for the elderly, according to Gelder et al. (2007, p500). They do not indicate which societies are referred to, but claim an “international” perspective for their manual. In other settings, however, prevalence is difficult to estimate due to the tendency for many sufferers to keep their experiences to themselves, and to the difficulty in distinguishing between this condition and psychotic symptoms associated with dementia or severe depression (ibid). However, it has been reported (Chaleby, 1987) that schizophrenia seems to cluster in families in Saudi Arabia, due to consanguinity.

It is interesting to note, also, that life events and difficulties have often been proposed as precipitants of schizophrenia, although there have been few satisfactory studies (Gelder et al., 2007) In this respect, it may be significant that in this study in some cases, mental health problems (whether described as schizophrenia or more vaguely labelled ‘mental illness’) were said to have first been manifested following distressing life events, although no explicit connection was made between them. For example, DA, described as schizophrenic, had been married and had a child who had died. Her illness first manifested itself in the early years of her marriage. However, in the absence of a clear chronology or more detailed information, it is not clear whether or not this may have been connected to the loss of her child. In another instance (CHR 15), the woman was described as schizophrenic, but it is interesting to note that the onset of her illness followed her divorce; moreover, she had a son who was jailed for drinking alcohol, which added to her stress.

Interestingly, in none of the cases observed was there a diagnosis of depression, although Gelder et al. (2007) indicate that the incidence of depressive disorders in the elderly is considerably higher than that of dementia. Prevalence is said to be higher among women and among older people living in adverse circumstances (Bechmann et

al., 1999). Rates of depression depend on the setting; Koenig and Blazer (1992) reported incidence ranging from 0.4 -1.4 per cent in the community, to 15-20 per cent among nursing home residents. These variations may, however, to some extent reflect co-morbidity with other psychiatric (Devanand, 2002) and physical (Gelder et al., 2007) disorders, particularly those with a vascular basis.

Care home files indicate that those women described as mentally ill were prescribed psychiatric medication; there is no indication that any of them had ever received other forms of treatment, such as counselling. This is consistent with Al-Sabaie's (1990) report that mental health practice in Saudi Arabia is medication oriented. This may to some extent be due to cultural factors. The closed Saudi family system, with its rigid boundaries, is said to preclude the therapeutic advantages of family or group therapy. Moreover, the cohesion and closeness of the extended family, while providing protection of its members, also increases their sensitivity to disharmony in the larger family system (Al-Sabaie, 1990).

The reliance on medication contrasts with Western practice where, although drug treatment is common for schizophrenia, drug treatment of behavioural and psychological symptoms of dementia is recommended to be a last resort, following treatment of any underlying physical cause (such as infection or pain) and modification of the person's environment or behavioural intervention. Gelder et al. (2007) for example refer to sensory stimulation (e.g. aromatherapy, massage), social contact (e.g. one-to-one interaction, pet therapy, or stimulated contact e.g. videos), exercise and structured activity programmes. None of these approaches to treatment were observed, in the care home.

Before leaving the subject of mental health it is interesting to contrast the observation in the care home of a high reported incidence of psychiatric disorders with Al-Sabaie's (1990) reports of the small representation of the elderly among users of psychiatric services in Saudi Arabia in the community in general. He attributes this to a shorter lifespan and to the Islamic teachings regarding support for old people. However, the findings in this study challenge Al-Sabaie on both counts. Many of the women in the care home had reached a good age. Moreover, Saudi life expectancy is not particularly

low; in 1995, the total life expectancy was estimated at 71.4 years (WHO, 2001) and as indicated in Chapter Two, women's life expectancy tends to be higher than men's. Regarding the suggestion that religiously-motivated care for the elderly reduces their need for psychiatric services, again, this study offers another perspective. It could be that the mental health needs of the elderly have gone unrecognised simply because they are elderly, and the elderly 'identity' takes precedence, or that age makes available another route for removing a difficult individual from the family and community.

5.3.2 Poverty

Another salient issue in the care decision was poverty, either of the elderly woman herself, or of family members who might otherwise have provided care. In at least five of the twenty cases examined in detail, close investigation of the women's histories suggested that poverty had contributed to the decision to admit them to the care home, whether or not this was explicitly stated in their files. In the case of CHR5, M, for example, the reason for admission was officially stated as old age and inability to care for herself; but elsewhere it is indicated that she had no income or property. CHR9, K, was in a similar position. CHR13, G, was described as in need of financial support. Her brother made a meagre living from fishing, which did not enable him to support his sister adequately. In another instance, the woman, CHR17, was one of two wives, each having a separate house. The husband earned 2,700 SR (equal to about £441) per month as a security guard, which was not enough to meet his family needs, let alone pay for a private attendant for his septuagenarian wife, who had senile dementia.

5.3.3 Childlessness

Whatever the physical, mental and economic situation of elderly women, the biggest single factor in their admission to the care home was their having no children who could care for them. Eleven of the twenty women studied were in this situation. A couple had never married, perhaps because of their mental incapacity; some had married but not borne children, and others had had children who had died. It has been explained in a

previous chapter that in Saudi culture, the primary responsibility for the care of the elderly traditionally rests with their offspring, and so women who have no surviving children are vulnerable, lacking the expected means of support. One woman acknowledged this, telling me wistfully, “*If God had given me a boy, I would not be here. My sister had children...*” (CHR 3). It is notable that this woman wished she had had a son, rather than a daughter, even though the literature in the UK for example, Finch (1989) indicates that it is overwhelmingly daughters who perform day to day care activities. This can be explained by the family roles in Saudi society, whereby a son would support his mother financially and provide care (at least of a basic physical kind) through the medium of his wife, whereas a daughter would leave the family home, whereupon her contribution would depend on the goodwill of her husband, as described by CHS 4.

5.3.4 Family disruption

In view of the importance of family in Saudi society, and the expectation that family members will care for their elderly, the disruption of normal family relationships, for example, through divorce, widowhood, death or incapacitation of a former carer, or removal of family members from their place of origin, can have devastating effects. No less than twelve of the women I observed had suffered from one or more of these life changing events, examples of which have appeared throughout the preceding narrative.

An unusual and extreme case of family disruption was that of A M. (CHR 11), an 86-year-old woman described as “Lost and Found”. She had apparently been found by police, alone and confused, in Prophet Mohammad Mosque. They had brought her to the care home temporarily, until her family could be located. A newspaper appeal for her family to come forward brought no response, so she was officially admitted. AM had previously lived with her daughter in Jeddah. She claimed that the daughter had taken her to the mosque and abandoned her deliberately. At the time of admission, AM presented with multiple bruises; it was not clear whether these were the result of a fall or of ill-treatment. She was also thin, anaemic and very hungry; she ate greedily during her first month at the home. Subsequent to her admission, she had recovered physically

and was no longer anaemic. However, she was depressed because she wanted to return to her home region (in fact, in 2007, a visit was arranged for her; she travelled by plane, accompanied by an attendant and a social worker). She generally kept to herself in the care home. However, her daughter was eventually located and visited her regularly.

Family disruption also appeared to play a significant role in the admission of a number of other women, who were neither elderly, nor physically infirm, nor without relatives. Indeed, half the women in the care home had been admitted for reasons other than old age. According to the doctor attached to the care home, the social care home accommodates several categories of residents : elderly; mental health cases that are not considered dangerous; “Social cases”, very few in number, women who are admitted to the home rather than be left on the streets, for their own protection and that of society; reformatory; and rehabilitation. At the time of fieldwork, the home actually contained, in addition to the twenty elderly cases, eighteen mental cases and one social protection case. Women in the latter two categories were younger than those admitted by reason of old age- in some cases, very much so, and some had been admitted while very young. Although such cases are not the main focus of this study, I feel it appropriate to include some examples here, for two reasons. First, these cases shed light on the institutional structure and nature of social care in Saudi Arabia, and the societal attitudes by which such arrangements are shaped. Second, those women, accommodated as they are, alongside the elderly, not only in the same institution but sometimes even sharing bedrooms with them, impinge on the lives of the elderly women in many ways. Their presence has practical and psychological impact on the elderly, on their own cases and on the care home staff who must try to manage the different needs of these groups and meet the conflicts that occur between them.

In some cases designated ‘mentally ill’, it was not clear to what extent the psychological problems manifested had been the cause of the admission and how far they had been caused, or exacerbated, by being in the home, especially in cases where admission to the home appeared to be a means of dealing with socially difficult situations. A good example is the sad case of H, a young woman of 29, who drew my attention when I heard her recite some verses of the Holy Quran. She chose the story of Joseph, whose brothers were jealous of him and cast him out. There was such sadness in her voice, and

she began to cry. The supervisor explained that the young woman identified with Joseph, because she felt she had been similarly abandoned by her family. Later, I learned more of her story. She had been admitted to the home at the age of sixteen, supposedly on the grounds of mental illness, but in fact, it appears she had been raped and in the absence of any counselling or support had become anxious and depressed. The relatives who had been responsible for her after her father's death had tried to seize her inheritance by reason of her 'mental illness', but had been prevented from doing so by the authorities. She had been admitted to the Medina Care Home because, at the time, her mother was resident there, supposedly due to 'psychological problems', but the details are vague. Subsequently, however, H's mother had recovered and left the home to marry again, leaving H behind. CHS 9 described the poignant scenes that ensued on one occasion when H's frustration at her situation overcame her:

"H packed her two bags to leave this place. She was very sad and lonely. She stood outside her room from morning till evening, waiting to leave. Then the staff persuaded her to stay here. She tried to call her uncle but no response (The interviewee was visibly upset describing this scene, and kept gesturing with her hand to show her frustration)..... Her relatives refused to have contact with her. Her sister did not visit her. Her mother was a patient here, then she married and moved out and she didn't ask about H".

H was very suspicious of other people, fearing that they wanted to take advantage of her sexually. Indeed, when, after a journey, I gave her the small gift I had brought back for her, she became uncomfortable, asking why I had brought it and wondering what I wanted from her. I observed that this woman had lost interest in personal hygiene and had to be cajoled into taking a bath. She could also be aggressive towards other residents. She had not always been in such a state, but had deteriorated day by day. She had attempted suicide twice. I noticed that all the staff pitied her, and treated her differently from other residents, for example taking her out to choose her own clothes (normally, clothes were ordered by the staff and issued to residents at regular intervals). They hoped by such means to give her the feeling of being a young woman with hope for the future. Their kindest efforts, however, could not hide the reality that, as a vulnerable young girl, she had been traumatized and the psychological damage had been

compounded by the shock of abandonment and years of institutionalization. I can never forget her words, *“I have lost my life here with these elderly”*.

Another woman for whom residence in the social care home was an unsatisfactory solution to a social problem was the so-called “special case” or “social protection case”. The social protection case was a young widow. When she was a girl, her father and brother had forced her to marry an old man, who later died. Her father was wealthy but had forced her into a succession of such marriages, keeping the dowry for himself each time. She had one son who lived with his father’s family and another, five years old, who was under her care. His father had died and left money for his maintenance, but the woman’s brother, who had power of attorney to administer the fund, gave her only 100 riyals (about £17) a month. When her family tried to make her marry again, she refused. They beat her so severely she was admitted to hospital, after which the authorities admitted her to the social care home for her own protection. Her young son was living in the home with her. The situation was a source of tension for all concerned. The little boy’s noise and activity disturbed the elderly residents. Meanwhile, I observed a great change in his mother’s behaviour. Initially quiet and restrained, she became frustrated and irritable. *“This place will turn me crazy”*, she told me. These two cases can be seen as evidence of the lack of other forms of state support in Saudi Arabia for vulnerable women and indeed as a reflection of the vulnerability of women in general in a patriarchal society. Such vulnerability had resulted, certainly for these women, but for many of the elderly, too, in care decisions being made without their participation or against their will. As will be seen in the next section, this decision could have significant impact on the women’s sense of self, and of their role within the family.

5.4 How do Elderly Women Perceive Their Role in the Family?

How has it Changed?

In the social world, we subsume ambiguity, reinforce predictability and so create stability in the social order by assigning individuals to identity categories (Jenkins, 1996). The sense of self is associated with roles (such as wife, parent...) to which various expectations are attached, which in turn influence how individuals expect to experience aspects of their identity (Killingbeck, 2007). For women in particular, Evers

(1981) suggests that their identity continues, throughout life, to arise out of the quality of care which they provide within the home. However, admission to residential care is 'the experience of individuals no longer able...to live out the requirements of their former social roles' (Hockey and James, 1993 p110). Consequently the women in the care home had faced or were facing a period of demanding change and loss. Bereft of their former identities as domestic carers, they exhibited pride over their previous status and in some cases bitterness over their changed circumstances.

A number of the women looked back with nostalgia to their earlier life, before they had entered the home. Most of the women had been married at some stage- some still had a living husband, while others had been divorced or were widowed. Recollections of family life revolved around husband, children (not always the women's own; in polygamous households, for example, a woman might form a close bond with her husband's children by other wives) and in a few cases, siblings.

Some women liked to recall the affection in which they had once been held, as in this unusually intimate (it was rare for the women to be so sexually explicit) account given by one resident (CH19) of her married life with the man she described as 'like Sheikh Qabila' (the leader of the tribe);

“Believe me, my husband never beat me in all my life, he loved me so much. When he came in from his work, I'd ask him, “What kind of food would you like? From my mouth or from my (she pointed to her private parts)?” Then my husband replied, “Your mind is fixated on sex.” Then I gave him his meals, and then he went to sleep. When he woke up I served him coffee and dates. (Clapping and singing) Pour the coffee and give it to the brave man. (Starts crying). When my husband passed away, my life changed for the worse. I miss him”.

In this case, the woman was widowed before her advancing age and ill-health could put a strain on the marital relationship. In other cases, however, women had suffered the experience of being committed to the home by their husbands. Understandably, however difficult life was, and whatever the reason for the decision, the woman

concerned would see this as a betrayal and rejection; *'I loved my husband truly, but he didn't love me; he brought me here'*. (CH 15).

Whether or not they had children of their own, looking after children had been an important part of life for many women; it had not only provided affection, but had also given them a sense of usefulness. For a woman who was unable to have children, caring for the children of co-wives could provide an outlet for their maternal instincts and enable them to feel valued contributors to the family. One woman (CHR 19) described how, when she did not produce children, her husband married a second wife, then

'I stayed with them in their house and looked after their children, especially his youngest son. When their mother was very ill and taken into hospital, I took care of her children. I slept surrounded by their children'.

Such a situation could cause some strain, at least between the co-wives: *'Their mother told me one time, 'You have a bad smell', and then I explained to her, 'Yes it comes from your children's smell'*. Nevertheless, this woman recalled real affection for the children, especially her favourite step son, towards whom she had been very protective: *'When he went to the mini-store, I followed behind; because I was afraid someone might hurt him'*.

Another of the elderly women, who had married but borne no children, had lived with her brother and brought up her nephew, these bonds, again, giving her a valued role in the family and a purpose in life.

For such women, admission to the care home represented the loss of the life, relationships and roles they had once had. In some cases, as has been seen, admission to the care home was the result of such losses; they had been admitted following the death of a spouse or sibling. In others, it was the admission itself that appeared to have brought about an abrupt breaking of previous relationships as family members, for various reasons, did not visit regularly, and some did not visit at all. Hazan (1992) describes a similar process of isolation from family among residents of a Jewish old-age home. Several women showed yearning for their families. I observed one resident, for example, harassing staff from early in the morning, to call a relative to visit her;

residents who received a visit would sometimes tell their relatives, 'I'd like to get out', or would beg to return home, and could not understand why their requests were refused.

Residents of the care home showed a variety of ways of responding to their feelings of abandonment and rejection. One woman, (CHR 19, quoted earlier) adopted a tone of stoical resignation: 'I have to be happy by any means'. More common, however, were expressions of defiance and counter – rejection. One woman, for example, had for some time been repeatedly asking to see her daughter, but when the daughter eventually visited, the elderly mother felt her daughter was ungrateful and had abandoned her. In turn, she rejected her daughter and from then onwards, refused to speak of her. One can only imagine the hurt hidden behind the proud and intransigent facade. Another woman, similarly hiding her hurt behind a proud exterior, voiced her defiance openly: *"I don't need my family since they threw me in here. I'm proud to be by myself"*. (CHR 3).

In this regard, it is worth pointing out that social norms influence how (or whether at all) emotions are expressed and that among the Bedouin, direct public expression of love, hurt and so on are not socially acceptable, such expression being associated with weakness and dependence, as well as an unseemly publication of what are deemed to be essentially private matters. Abu-Lughod (1988) demonstrates such behavioural norms in her description of life among a Bedouin community in Egypt.

Not only was the admission to the care home difficult for the women because of the roles and relationships that had changed or been lost; it could also be seen as the breach of an unspoken social contract. As I discussed in Chapter Two, Islam has traditionally taught that children owe a debt of gratitude to their parents for their care and sacrifices, and have a duty to care for them in later life, in return. This sense of the duty owed to parents was keenly felt and expressed by some members of the care home staff, and was not confined to Saudis. CHS 3, from India, expressed her recognition and acceptance of such values when I asked her if she thought the residents of the care home had needs that the staff could not meet:

"Yes, the need for the beloved ones, the near and dear ones, and the children they gave birth to with so much pain, whose needs were met and who were given everything they wanted. And then at last when the time

came when these parents needed their children, they refused them and cast them aside”.

Islamic societies are not alone in facing conflicting pressures, as a result of which younger people are increasingly finding alternative solutions to the issue of elderly care. Walker and Warren (1996) in the UK reported the difficulties faced by family members trying to balance elderly care with children and jobs, or perhaps having to travel between their home and that of the elderly relative. At the individual level, however, such pressures were irrelevant in the face of the sense of personal betrayal, when a woman who had spent her life caring for others was not cared for by them in return: *‘Look, after all I did, they put me in this place.’* (CHR 19).

Admission to and residence in an institution marks the inhabitant with the social stigma of being unwanted, with significant implications for their self-perception and relationships (Hazan, 1992). Understandably, then, it could be painful for a woman to accept that the relative on whom so much love and care had been expended had been instrumental in ‘sending her away’ to the care home, and one way of dealing with this was denial. It was unthinkable that the beloved son had put his mother in the care home, therefore he couldn’t have done it; it was someone else’s decision. I saw this reaction clearly exhibited by an elderly woman, referred to previously, who had cared for her co-wife’s children and been particularly attached to one boy, whom she spoke of as her own son. Although at times she appeared to be aware of the truth and told me, *‘I don’t know why my eldest step-son put me here in the social care home,’* at other times she insisted that the arrangements had been made by others, without her step-son’s knowledge.

‘‘If my son knew my present situation, he couldn’t tolerate knowing I was here, he’d never allow this to happen, but it’s because they hid it from him, because they were getting tired of looking after me’’. (CHR 19)

This is not to say that all family bonds were broken when a woman was admitted to the care home. Some of the residents were regularly visited by sons, daughters, nephews and nieces; similar interactional ties and exchanges between residents and their prior social environment were noted in a home for Jewish elderly by Hazan (1992). One son frequently visited his elderly mother, and kissed her respectfully, although the woman

concerned was blind, hard of hearing and with impaired memory and did not recognise him. Another resident was visited twice a month by a nephew, who brought her toiletries, sweets and chocolates and anything else she asked for and also gave her money- SR200 or more (around £33).

In another case, a married daughter who lived in another region, far from Medina, visited every three months. She clearly missed her mother (it had been her husband's decision to have the lady admitted to the home) and showed great tenderness and affection towards her. The woman was not easy to deal with; she had senile dementia, was restless and irritable and sometimes refused her food, but her daughter would sit with her for an hour or two patiently feeding her the sweets and drinks she had brought. In another case, after one of the residents had received a visit from a niece and nephew, she greeted me excitedly, eager to tell me all about it and in particular, to show off the new trousers and scarf they had brought her, in a colour and design unique to her home region. She kept touching them and told me proudly about the distinctive design. Even such happy times, however, could be tinged with sadness, because they raised hopes that might not be fulfilled – “...*they promised to come and visit me again, but you know that's only a promise like in the past.*”(CHR 9).

In other cases a visit would leave a patient agitated and 'out of sorts', perhaps because it aroused memories of happier times, bringing forceful reminders of the life 'out there' from which the women were now largely isolated. When I went to visit one resident, for example, her attendant told me, '*She is in a bad mood because her sister visited her last week and it's upset her.*' Another resident who had been admitted after a stroke, which left her paralysed and unable to speak, following a brief visit by her son (he stayed only a matter of minutes), could not voice her feelings, but her agitation was manifested physically in an increase of the Parkinson's tremor in her left hand.

Clearly, admission to the social care home had been a devastating blow to some of the residents, and for all it marked a change in their roles, relationships and sense of value and self-efficacy, despite the efforts made by some relatives to maintain contact. Their age, infirmity and presence in the care home gave them new identities as 'elderly' 'patients' and even 'victims', reflecting the way in which the constitution of any

identity entails a marking of boundaries to establish exclusively what it is not. This process unites the construction of a series of binary opposites, such as woman/man, old/young, healthy/sick etc. which are articulated within the discursive power relations prevailing in the society at large (Killingbeck, 2001). The residents' situation can also be interpreted in the light of Butler's (1990) assertion that identity is less a matter of 'being' than of 'doing' through the 'performance of roles that are pre-scripted by society'. Butler's view can be criticised as neglecting the individual and denying agency, but it does allow account to be taken of the crucial role of social interaction and the way social experience contributes in legitimating or rejecting identity.

A key point that has emerged in social theory in recent years, moreover, is the extent to which identity is 'performed' through the body (Butler, 1990); the body is the canvas through which identity is read and legitimised through society (Killingbeck, 2001). From this perspective, it can be suggested that the elderly women's physical limitations, among other factors, had prevented them from continuing to perform according to their previous 'scripts'- roles which were valued by the women and valued in their society- and forced to adapt, not only to new roles, but to ones that were less favourably perceived. Similarly, Richard Zaner (1982, cited in Bowden, 1997, 113) describing his experience of chronic illness, describes the resulting distortion of relations with others, the humiliation of dependence on others, and the loss of a crucial sense of self; his illness is experienced as an attack on his personhood. Bowden (1997) suggests that such feelings are deepened in institutional settings, where a patient's private experience becomes a public object. Whilst infirmity had its own impact in changing identity for these women, the impact was exacerbated by their roles as women in a patriarchal society.

In patriarchal societies, as Thompson (1995) notes, ageism and sexism combined to bring about a shift in the sense of identity of elderly women, as ageing has implications for the extent to which old women can conform to the societal image of womanhood. They lose both the physical attractiveness considered desirable in a woman, and also their prescribed role of caring for the family. When the woman needs care herself and becomes the cared-for, this role-reversal underlines the woman's "failure" to conform to her ascribed role.

For all these women, whatever their age, physical and mental condition, and family circumstances, the decision- in every case made by others on their behalf- to admit them to the social care home, had a variety of consequences- medical, economic, social and psychological, which I aim to draw out in this chapter and in later discussion. A useful “way in” to these explanations is to begin by looking at the structure and atmosphere of the care home routine; a “day in the life.”

5.5 Care Home Routine - A Typical Day

Day to day life in the care home followed a regular rhythm. A major role played in the structure of the day was played by prayer times¹; the five daily calls to prayer were relayed into the home by loudspeaker from outside, and these provided fixed points in the daily routine around which other activities were fitted. However, women’s ability to observe the prayers varied according to their physical and mental capacity. Some could not perform the rituals actions of kneeling, bowing and standing in a prescribed sequence, due to physical infirmity, but remained seated or lying. Others, because of age and senility, could no longer remember the words of the prayer, but in some cases tried to participate by mumbling their own words. Those who were incontinent and wearing ‘pampers’ were unable to pray because they could not attain the required condition of purification. Islam makes concessions for those who, through age, illness and mental or physical incapacity are not able to participate fully in prayers. Nevertheless, these women who were less incapacitated participated to the best of their ability, and for those who were still mentally aware, the prayer routine would be a familiar anchor, a point of continuity with their former lives.

Other fixed points in the daily routine were provided by the performance of particular services. Consistent with Hazan’s (1992) findings, there were certain basic services in

¹ Prayer is one of the five Pillars of Islam and Muslims are required to pray five times a day, at specified times. Since these times are calculated with reference to the movement of the sun, the exact times differ slightly day by day, with considerable variation over the annual cycle. The prayers are: Fajar (before dawn); sunrise; Dohar (noon); Asar (mid-afternoon); Meghrib (dusk) and Asha (sunset).

which all residents participated: food provision, cleaning (living quarters, laundry and where necessary personal) and medical care. The day began at around 4 or 5 am with the Fajar prayers, followed at around 7.30 am with the serving of breakfast, generally consisting of bread (brown for diabetic patients and those needing to reduce their weight, white otherwise), traditional soft white cheese, Cheddar cheese, beans, boiled eggs and milk. Breakfast, which was sent on a large kitchen trolley from the men's kitchen, was served more informally than lunch and dinner; I saw residents sitting around on the ground to eat.

Later, at around 9.00 am, tea and biscuits were served; savoury crackers for the diabetic patients and sweet biscuits for the rest. During the course of the morning, the attendants then made their rounds, washing and showering residents and changing the nappy-like incontinence pads which were known generically as pampers. Another snack, of fresh fruit, was served at around 10.30 or 11.00 am. Two types of fruit were distributed each day. Patients with no teeth were given juice, while others were given whole fruit, which they ate under the attendants' supervision.

The main meal of the day, lunch, was served at around 12.30 or 1.00 pm after the Dohar prayer; it could sometimes be late if ready-prepared food had been ordered from outside, or if there were visitors. All staff were present at lunch time. The meal generally consisted of soup, meat or chicken with rice, vegetables and salad (consisting of cucumber, tomatoes and green leafy vegetables, seasoned with lemon and salt).

In the afternoon, another round of cleaning and changing took place. Many residents had a nap. A few attended a Quran class. Following the Asar prayer, another snack was served mid-afternoon. The Maghreb prayer took place at around 6 p.m. Following this, at around 6.30 or 7.00 p.m. the staff did their medicine round, to ensure that all patients were calm and settled before bed-time. The day finished with the Asha prayer, immediately followed by dinner, served at 8.00 p.m. This consisted of "light" and "heavy" foods on alternate days. "Heavy" meals were similar to lunch. "Light" meals consisted of bread, yogurt, cheese, tuna, preserves and the like. On one occasion, for example, I recorded a light meal of cheese, bread, fruit and juice, which were issued to

patients in their rooms. Generally, residents were settled in bed for the night at around 9.00 pm.

A striking feature of the care home routine is the dominant role of meal and snack times. Food appeared to play a number of roles in the life of the care home residents, apart from its basic function of meeting bodily needs. Meal and snack times were the fixed points which provided the structure of the daily routine. They provided sensory highlights of colour, taste and aroma; although having said this, not all residents were satisfied with the food in this respect, simply because this, like so much else was routinized, served according to a fixed pattern, X on Monday, Y on Tuesday, and so on, with little variation, except for certain festivals (which I shall discuss later), or when food was bought in from outside. One resident expressed her pleasure in being bought a 'mahshi' (stuffed vegetable) by a visitor, as a change from the institution's food; Okely (1994a: 2007) similarly noted the contrast, for elderly French residents, between institutional food and the tasty home cooking to which they had previously been accustomed. Such offerings from outside could be a link with a previous life; Lewis (2007) noted the importance of such familiar tastes and textures to Kurdish refugees living in the UK, in the preservation of personal identity. There was also a social function, since generally the ambulant women gathered together in the dining room to eat. Hazan (1992) similarly notes the attraction and interest that meal times provide for old-age home residents and remarks on the way relations between residents and management are reflected in residents' assessment of the taste and quality of the food.

The serving and eating of food might also be a point of close contact between residents and carers, especially for those residents who needed assistance with feeding. At its most basic, the relationship was a "nursing" one, whereby staff prepared and, if necessary, administered the food according to each resident's physical needs. A social worker explained that food is prepared according to each resident's needs, for example mincing or pureeing for feeding with a spoon or by syringe, and this was confirmed by my own observations.

I also noticed, however, interesting indicators of the psychological relationship between residents and carers. I remember the surprise I felt when I heard one elderly woman, at

mealtime, call for her “mother”. Since I knew a woman of such an age would not have a mother still living, I asked an attendant what she meant. Was she confused, perhaps, and wandering in her mind? No - it was explained to me that it was quite common for these elderly women to refer to the carers as “mother”, a term that seemed to capture poignantly the reversal of roles experienced by these women, who were now dependent on others for their basic needs.

This, however, brings me to perhaps the most interesting and important role played by mealtimes in the lives of the care home residents. For some women, at least, they provided one of the few available opportunities to assert themselves and exercise agency. They could not choose their meals, which were provided according to a set menu. However, they found other ways of asserting themselves. Some would refuse to eat. One used to take food and hide it in her bedside cupboard (as the staff discovered when they found cockroaches in her room; from then on they regularly inspected her locker and removed mouldy and rotten food). The phenomenon of transfer of food from the dining room to the resident’s room, where it may be eaten or become mouldy and be thrown away, was described as common by Hazan (1992). A possible explanation of this behaviour may be seen in the psychology of old age (Gelder et al. 2007), for example, dementia, depression or anxiety disorders, or the senile squalor syndrome (Diogene’s syndrome) characterised by severe neglect of self and surroundings and sometimes syllogomania (the hoarding of rubbish). Such conditions may have physical causes or may be associated with stressful life events and isolation. However, I interpret this behaviour (as did Hazan, 1992) as an attempt by residents, in response to the negation of personal identity in an institutionalised setting, to rebel by means of acts of non-conformity. Women could also exercise some limited choice in their selection of foods from the buffet-style serving table, and in doing so might come into conflict with staff that saw them as patients and tried, with the best of intentions, to control what they ate. On such occasions, meal-time could become something of a battle-ground.

One patient, for example, loved to eat rice and refused to eat vegetables or salads. She was about 5 feet tall and weighed 97kg. The doctor had advised her to lose weight by reducing her carbohydrate intake, eating vegetables and salads and doing some exercise, but she refused. When anyone tried to prevent her eating large helpings of rice, she

would shout and curse for days until she eventually calmed down and was reconciled with the member of staff in question. On one memorable occasion I witnessed the scene that resulted after one of the staff on duty advised her to take only a small amount of rice. While dinner was being served, they exchanged more words, both cursing each other until the resident threw a very hot chicken breast at the worker; it landed on her chest. Embarrassed, ashamed and angry, the worker gave up her efforts. I later heard that when the worker went home to change, she found a piece of chicken that had stuck to her clothing. The following morning, the supervisor asked the psychiatrist to check the resident in question. The psychiatrist advised that it would be better to let this resident eat freely as she wanted, rather than make a scene that would agitate and upset her and disturb all the other staff and residents. From this time, the resident avoided the worker who had upset her. She spent most of her time sulking in her room. At subsequent dinner times, staff recalled this incident and were wary of this resident.

Like mealtimes, the showering/ changing routine also afforded insights into conditions in the home, and the relations between residents and carers. Ten attendants were involved in the showering/changing process, each attendant being responsible for four patients. After the shower, attendants dusted the patients with talcum powder, soothed dry skin with Vaseline, and sprayed the women with lemon-scented toilet water.

In theory, residents were showered twice a day but in practice I noticed that a full shower was given only two or three times a week, with more perfunctory cleaning at other times, perhaps because of the poverty of facilities and resultant difficulty of bathing/showering. This is reflected in the following dialogue, which took place in a patient's room during the morning rounds, when the supervisor and I entered room when a patient was being washed:

“Supervisor: Why don't you take this patient to a bath?”

Attendant: (appearing embarrassed). She had a shower yesterday, so I'll just wipe her body today.

Supervisor: Did you change her pampers today? How many times did you change it?

Attendant: Twice

Supervisor: That's wrong; you should change it every time she needs it, especially when she has passed a stool''.

I felt the supervisor was trying to create a good impression and to hide the fact that this was normal practice.

The above exchange also reflects a matter that I found to be problematic throughout my time at care home, the issue and change of “pampers”, worn by the bedridden and some others who were incontinent. Early in the fieldwork, I accompanied the chief nurse on her rounds of residents’ rooms. As soon as we entered the first room, the unpleasant odour was apparent. The staff nurse present hastily sprayed the room with air freshener and explained that the smell was caused by the patients having their pampers changed. It seemed, however, that the real problem was that, whether due to shortage of pads or to neglect, patients were not changed often enough. Hockey (1990, p18) similarly noted the ‘*ominous presence and smell*’ of residents’ urine and faeces in a British care home.

On another occasion, while I was discussing some cases with the supervisor in her office, we were interrupted by a member of staff who came to report that there was a bad smell in the section because the men’s section had not supplied the necessary pampers. The supervisor brusquely told her, “*Go and see to it yourself*”, as if she did not like the employee to talk like this in my presence.

Given the apparent difficulties with the supply of pampers, such that residents were routinely changed twice a day, but not necessarily according to need, I was astonished to find that pampers were distributed free of charge by the home, to a number of outside cases.

Shower and changing times, like meal times, constituted a relatively fixed point in the life of the residents. Between these activities, which were governed by the care home staff, were periods of unallocated time, which the residents might occupy in a variety of ways. However, for the most part, I saw little in the way of recreational activity. Some women spent most of their time watching TV. Although most of the televisions in the

care home were disconnected, those in the dining room and receiving room, to which the ambulant women had free access, were connected. A few would occasionally play music and dance or sing and recite poetry. In Bedouin society as Abu-Lughod (1988) has shown, poetry and song have an important place as a legitimate indirect means of expression of emotions that cannot be articulated in normal conversation. As such, they provide a kind of coded emotional discourse with family and friends who share the same cultural frames of reference, as well as a valuable “safety valve” or coping mechanism for the performers themselves. Similarly, I felt some of the women in the care home used songs in this way, as a means of self-expression – as in the case of CH 19, cited in section 5.4, whose singing about serving coffee to a “brave man” was part of a memory of a happy marriage. When the weather was mild, I also noticed residents sitting or strolling in the garden. Such activities however, were spasmodic and not organised by the Home; they depended on the residents and their visitors.

The only regular organised recreational activity I witnessed in the care home was the adult literacy (Quran) class. Every afternoon, some volunteers came to teach the residents Arabic reading and writing, and the Holy Quran. The idea was to maintain a link with the outside world and enhance the women’s self-esteem. One afternoon, I went to the care home with the specific intention of finding out about the Quran class. Two teachers came to take the class, which was held at 4:00 p.m. in the dining room. I asked one of them why the class was being held in the dining room. She answered:

(Laughing): “Why does this surprise you? This is a dining room and at the same time a classroom. Oh, where do you find a place like that?” (More seriously) “The fact is we have no rooms at all and if there’s a new admission I do not know what will happen”.

Also I observed a Quran lesson, during which the teacher recited verses, which her audience repeated after her.

These classes were important to the residents for a variety of reasons. It is important to recognize that most of these women would have had little or no formal education; having grown up in the years before education for girls was established on any real scale in the Kingdom (although a few informal classes were available, formal girls’

schooling was not introduced until 1960). This in itself would greatly constrain the recreational activity available to women; it was rare, for example, to find one who owned books and regularly read for pleasure. The Quran class gave some women, for the first time, basic skills in reading and writing.

Their Islamic faith was also important to the elderly women as a coping mechanism, by which they found some comfort in the face of feelings of loneliness and rejection. Moberg and Tavas (1965, cited in Hazan; 1992) reported the importance of religious activity in adaptation to the problems of old age. Such activity provides comfort in the face of illness, suffering and imminent death, and also provides opportunities of social interaction and channels of communication (Morres, 1960 in Hazan; 1992).

With relatively little to interest and entertain them during the day, it is not surprising that the elderly women were content to sleep early, soon after the evening meal. For this reason, only two members of staff were assigned to the nightshift, coming on duty at 10.30 p.m. and leaving at 7.30 the next morning. I found surprising the apparent assumption that the residents needed so little attention at night time; in my perception the night shift seemed to have more problems than the day shift, more risk and danger. I tried several times to visit the care home at night, but I felt afraid because the residents' behaviour was so different. For example, I heard that Z, a resident with whom I had a good relationship, saw ghosts. I was sceptical, assuming that the staff were telling stories to tease me. One evening I visited Z at sunset. The first member of staff I asked to accompany me refused, but another agreed. As soon as I touched Z's hand she started and complained, "*You frightened me*". She added, "*There are four ghosts sitting under my bed, frightening me*". I explained, "*I am Nada. I have come to visit you as I promised*". However, she would not be reassured. She repeated, "*Every night they come and they do not let me sleep*", and continued to mumble, becoming quite delirious. I admit to feeling afraid; I had to control myself by reciting some verses from the Quran in order to bring my feelings under control. I subsequently learned that impaired sleep, delusions and hallucinations can be symptoms of dementia (Gelder et al., 2007). However, I saw no indication, in the care home, that the staff recognised this, or that Z received treatment for any underlying physical cause of her nocturnal disturbances.

As this section has shown, the day –to-day life of women in the care home was bound by routine, with few opportunities to make choices or express individuality. The imposition of routine time-schedules, where meal-times and room cleaning, for example, occur at fixed times, independent of the wishes of the residents, is described by others, for example, Hazan (1992) and Hockey (1990). Other activities (in the Medina home, for example, Quran classes and outings), though not universal or compulsory, similarly take place within an organised framework. Thus, a considerable part of residents' daily schedule is dictated by the institution, corresponding to what Fontana (1976) and Hazan (1992) respectively called objective and external organisation of time. During my time in the care home, however, I did witness a few events- parties, religious festivals and outings- that provided welcome highlights and breaks from routine, and I turn to these next.

5.6 Special Occasions

Parties and special events, as Lewis (2007: 159) suggests, provide a ‘‘physical manifestation of community’’ through food, clothing and the like. They also provide an escape from daily boredom, stress and social exclusion. Although she was writing of refugees, her comments seem equally pertinent to life inside the care home. During my time there, I witnessed several special occasions: a party to celebrate the achievement of the Quran class, the rituals and celebrations surrounding Ramadan and the two Eid festivals, and even simple outings into the surrounding area. These events stood out as highlights in a life otherwise marked by routine and relative isolation.

The first such event was the party held for the Quran class. As soon as I came back from the UK, I returned to the social care home in Medina. The manager welcomed me with a warm embrace and kisses; I met the chief the nurse there. She told me, ‘*We hope that you will attend a party we are holding here today, for the end of the illiteracy eradication course*’. The party was to be held at 5:00 in the afternoon. We were busy preparing the certificates for the teachers. Some staff went shopping to purchase food and gifts. When I did my rounds of the residents, one of them came to me and told me happily, ‘*There's a party today, please bring us a cake.*’

I went home and baked a cake, big enough for everyone. At 5:00 o'clock, I went to attend the party. The patients and employees, including the supervisors, were all wearing new clothes. Happiness shone in their faces. The hall was covered with a new carpet. I noticed that all of the air conditioners in the hall were operating, a small fountain was playing, and some patients were wearing make-up. It was a good atmosphere. Tables and chairs had been arranged nicely. The food was already set out on the table, so I put my cake on it too. Then a song was played over the internal broadcasting. There was a table full of different kinds of gifts for all the residents, including the paralyzed one, who attended this party happily. The patient attendants were wearing their native dresses, not their everyday uniform. The party began with the residents who had learnt the Quran by rote marching in, accompanied by Islamic music, and the audience clapped enthusiastically. At this moment, I saw the happiness of every patient expressed in their eyes. They were also shy, because the eyes of the audience, including the staff, the Quran teachers and a press reporter, were focused on them. Then, they took their seats. The programme started with a recitation of the Holy Quran by a patient, and then the microphone was passed from one patient to another as each recited a verse from the Holy Book. Meanwhile I noticed a blind resident raising her hands and making a supplication. The recitation was followed by the presentation of certificates and gifts. The manager of the course gave a speech, promising that the group would continue their efforts for the year, building on this good beginning. A journalist who was present introduced herself to me. She asserted the importance of the mass media in the process of enlightenment of society, and that they should urge people to remember these forgotten elderly women by visiting them and communicating with them to improve their situation. I invited everyone to go to the table for dinner. The residents ate all kinds of food with a good appetite and the cake was finished very quickly, except for a small remaining piece, then the guests departed, one by one.

5.6.1 Ramadan

Ramadan (the holy fasting month - the month of repentance to Allah for bad deeds, peace, forgiveness, unity, and mercy) lasts for 29 to 30 days. In 2007 it started on September 13. The home served special foods for fasting patients. They served heavy

foods at 2:00 to 3:00 am, followed by a cup of tea. When the call for Morning Prayer was heard from the mosque, every fasting person had to stop eating and drinking and everyone went for prayer. At 7:30 am, it was time for the non fasting patients to eat their breakfast. Sixteen of the 40 residents could fast, and the rest were non-fasting because of the exemption given to the elderly, mentally retarded, and sick. A few elderly women wanted to keep the fast, and became very angry if they knew that it was Ramadan and they were being prevented from fasting. In these cases the Medical Doctor, the nurses and the supervisors tried to convince them not to fast because of their illness. Even of the 16 fasting residents, some of them could not continue fasting for whole month, because some (about five) were still menstruating, and on these days they could not fast. At 1:30 lunch was served for non-fasting, followed by their cup of tea and biscuits at 3:00 pm. Then at sunset, when the call for prayer in each mosque was clear everywhere, the fasting residents and all the followers of Prophet Mohammed broke their fast. There was a feeling of a joy, of continuous supplication to God, and satisfaction in the heart at doing good things for the sake of Allah. The foods were very light, such as dates, yoghurt, some little Arabian sweets, bread and water. The non-fasting patients were also given some of this food. This breakfast was followed by the sunset prayer and supplication. At 8: 30 pm, dinner was served for everybody, fasting and non fasting, and was followed by a prayer. There are long prayers that can be recited by anyone expert in memorizing the verses in the Holy book but the patients, of course, could not do these. The same daily routine was followed throughout the Holy Month of Ramadan.

5.6.2 Eid

The end of Ramadan is marked by several days of feasting and celebration called Eid, a high point in the Muslim calendar. The care home staff exerted every effort to make this a special time for the residents and to follow the traditional rituals. For days before Eid, for example, the chief Supervisor ordered all the patients to have their hair hennaed in preparation for the coming Eid. All the attendants, supervisors and the patients were gathered in the hall for the application of the henna. Most of the patients cooperated; only about four refused. It is a traditional Saudi custom, on special occasions, such as weddings, or Eid, to apply henna to the hair and to the palms, arms, and feet for

beautification and to express happiness. Some patients expressed their gladness. There was satisfaction on their faces, and they smiled, but some showed no feeling or reaction. The attendants, even the cleaners, emergency workers and even the medical team like nurses, dental hygienist, and physiotherapy technician cooperated together to help in applying hair henna for the residents. Some patients pasted this henna innocently on their dresses, and on their chairs. Some henna dripped onto the ground from their hair. Some attendants raised their voices to control the residents and especially to get the psychiatric patients to sit still. There was laughing, smiling, and joking among them. The hair henna remaining after the patients had been decorated was given to any of the attendants who were interested. The Indian and Bangladeshi workers loved henna too, like Saudis, but the Filipino and Indonesian people were not interested to use it themselves, although they loved to look at it. After five hours they washed each patient's hair with plain water and shampoo. Some patients could not wait for five hours; they became bored and washed it, after only two or three hours. Some workers also wanted to wash their hair immediately because they wanted to finish early. Some of them prevented their patients from lying down on their beds to avoid the pillows and sheets being stained with henna. Grey and white hair looked beautiful after the henna, as it was turned to red. Everyone exclaimed, "*Wow! It's so beautiful!*"

The following day, at 8:00 am, the chief supervisor phoned the nurses' room and asked as a favour for the help of anybody expert in gift wrapping. A Filipino nurse replied, "*After I've seen to my work, I'll come and bring some workers who are good at it.*" An hour later the nurse asked her companion nurse to take care of the patients for a while, so she could go to the chief supervisor's office to talk with her about gift wrapping. The experts in gift wrapping were the Filipino women. They did different designs nicely. The supervisor and her staff were delighted. They wrapped gifts for all the patients and for all the attendants and other staff; pictures 46 and 47 show the baskets and parcels of sweets and gifts prepared and purchases from a local jewellery store. While they were wrapping, they made jokes, they were so happy helping together, hand in hand. These gifts were to be given on the first day of the Eid.



Picture 46: Eid Celebrations – preparation of gifts



Picture 47: Eid Celebrations- purchases from the jewellery store

The Eid was fast approaching. On October 9th, two days before the festival, the chief Supervisor arranged for henna to be applied to the residents' palms, feet, and arms, if they wanted it, but no-one was forced if they did not like it. Again they gathered together in the same place in the hall. The henna was applied by the attendants and everyone who was interested to do so, headed by Chief Supervisor. She sat down on the middle of the group. The henna application took much longer than the hair henna because of the intricate patterns involved (see Picture 48 and 49). The Indian workers were the experts in this, so they took charge, and were very popular for their designs. After lunch at 2:30, the henna was removed by washing with plain running water. The residents' nails were carefully brushed because the dried henna stuck to the nails and skin. Some designs were stunning; those on the patients who had been restless came out less well, but were still quite attractive. I gave fancy rings as Eid gifts to all the residents and some workers. As I went around the residents to put the rings on their fingers, most of them were happy and hugged and kissed me and expressed their thanks, but some of them were unaware of what was happening.



Pictures 48 and 49: Examples of henna ornamentation

October 12, 2007 was the first day of Eid. After the prayer in the prophet’s Mosque, the workers came on duty at 8:00 am. All the residents, wearing their new Eid dresses, were sitting together in a row in the hall. A computer had been set up to display Eid Greetings (See Picture 50). In the middle of the hall was a big table covered with a new tablecloth. Plates of chocolates and Arab sweets were arranged on the table. I took a big cake as a gift for the residents, and put it on the table with the rest of the sweets. The chief supervisor and her staff conducted the festivities. Gifts were distributed to all the patients and to the attendants, cleaners and laundry women.



Picture 50: Eid Greetings displayed on computer screen



Picture 51: Cake and sweetmeats set the out for the Eid celebrations.

The principal of the Quran class was attending the celebration, and distributed certificates to the residents and attendants who attended the class. Aside from the cake, I gave 50 Saudi riyals (around £10) to the foreign attendants and cleaners, because I had seen how they struggled with their small monthly salary. I placed each 50 riyals in an

envelope with a small card, expressing my warm greetings. Arabic songs were played continuously and some patients danced. Music and dance have been characterized by previous writers (Miller, 1991; Lewis, 2007) as representing a moment of freedom and individuality. Lewis (2007), writing of refugees, suggests how important such activity may be in lives otherwise marked by powerlessness, and it may be suggested that it fulfilled a similar role in the lives of these elderly women.

One young patient, around 30 years old, was not participating in the celebration. She was wearing her old dress, very irritable, and talking to herself. When I asked the nurse about her, she replied,

“It’s because she asked her uncle to come to pick her up. She wanted to spend her Eid with her family but her family ignored her. The supervisor kept calling them to ask them to take her to their home, but the family did not cooperate. That’s why she got violent now.”

Then I asked her, “What we can do for her now?” She replied;

“Just leave it now, we’ll just keep on watching her closely, she will be calm later but now, we can’t force her to do anything. I’ll just look for a good time, and then I’ll just talk to her. If I try more, she’ll push me.”

A foreign worker looked sad. When I asked her why, she replied,

“I miss my homeland and my family. On this occasion, I think they’ll be celebrating now in our house but they don’t know about my life here, I am alone, I am so sad.”

In the hall I saw more workers embracing, kissing their friends and saying “Sorry” for past wrongs and misunderstandings. There were tears, a mix of joy, sadness and forgiveness. Then I saw a worker serving Saudi coffee to all the patients in the hall. The Eid is celebrated for three consecutive days, but the first day is the main feast day. They

eat sweets throughout the Eid, but for diabetic patients, sweet foods are limited and controlled.

The other Eid in the Muslim calendar is to celebrate the pilgrimage (hajj) month. In 2007 this fell in December, and I was able to share the celebrations with the staff and residents of the care home. The week before the Eid of Hajj, the head supervisor was busy implementing her plan for the coming Eid. She had distributed to all the residents (via their attendants) new dresses for them to wear on the day of Eid. The dresses were ready made, in native Arab style. For two days before Eid, everybody was busy working together. Some were busy decorating the hallway, hanging colourful decorations; some were clearing out all unnecessary things, such as broken chairs. The day before Eid, before sunset, the supervisor ordered the cleaners to clean the care home. They washed the hallway and all the flats with soap powder mixed with disinfectant liquid. Everyone was so busy that some of them expressed their tiredness, but nevertheless, there was a feeling of joy. The Filipina staff were especially adept at decorating, since they were used to preparing for various celebrations in their country, and they worked cheerfully. On the eve of Eid, the attendants put out the dresses for the patients to put on at 4:30 am in the morning, when the spirit of Eid starts. A recitation of the holy book was played and could be heard everywhere.

At 6:30 am, the following day, the residents, employees and attendants, of all citizenship and races, were prepared for the festivities. They were in their best new dresses, and some of them were wearing makeup, or different hair styles. After the Eid prayer in the Prophet's mosque, the day staff came on duty to relieve the night shift. I was conscious of the feeling of love and forgiveness in the atmosphere. Some greeted the Eid by hugging and kissing their friends and co-workers; attendants hugged other attendants, employees hugged residents, and attendants hugged their patients. Arabic songs were played, and everyone danced. At noon time, the main foods served were meat from freshly slaughtered goat and sheep, since this is the Islamic custom and tradition and this day was a celebration in which Muslims throughout the world followed the ancient traditions. The spirit of their joy lasted until they slept.

On the next day, the staff and the residents again ate goat meat, prepared by their male chief cook. At 9:00 am., the supervisor prepared a salad of chick peas, chopped cucumber, salt and Arab spices. The meat was made into a shish kebab by combining minced meat with Arab spices. Chicken shish kebabs were also made. These were all cooked on a barbecue. The food was so tasty; everyone wished they could eat this every day. Goat meat is served for three consecutive days during Eid.

5.6.3 Outings

Apart from these Muslim festivals, other opportunities were made to vary the resident's routine by taking groups of them on short trips. One afternoon, I accompanied the residents on such an outing. The three Supervisors sent 13 walking and wheelchair patients to the garden, accompanied by five attendants and one nurse with her emergency kit. They took with them juice, biscuits ,cup cakes, water , crisps and four medium sized carpets for the patients who were not mobile to sit on. One young adult patient was so excited that the nurse suggested she should be left behind, as they might be unable to control her, and she might run away or make trouble during the trip, but one supervisor insisted she be included and promised to take care of her .She was very excitable inside the bus from the start of the trip. She talked to herself constantly, cursing, shouting and laughing. She sat next to the window. At one point, she suddenly opened the window and leaned outside, cursing, while continuing to fiddle with her head scarf. Some residents and staff scolded her, while others watched her, smiling and laughing. The nurse advised the supervisor to move this patient to a seat in the middle of the bus; to be sure she wouldn't jump out into the road. The driver complained and said, "*Who told you to bring this patient this time?* ". Everyone kept quiet. When we arrived at our destination, the patients got down from the bus one by one, carefully guided by the supervisor and the nurse. The attendants spread the carpets right away. The Supervisors counted the patients again and again. Two patients stayed in their wheelchairs and watched the rest. The hyperactive patient was gradually becoming calm as the nurse and a supervisor continued talking with her, and attracted her to play on a swing, slide etc. until she happily rode on a swing pushed by the nurse, and began to laugh, and then the supervisor felt satisfied. The garden had no toilet, so some patients

had to be guided by the attendants to a place where they could relieve themselves. They stayed in the garden for three hours, while the driver waited, sitting away from the women. During this outing, I saw the change in the faces of both patients and employees, which radiated satisfaction and pleasure.

A couple of days later, 16 patients with three Supervisors and six attendants went on an outing into the desert, which the original natives of the region love. From 10:00 in the morning, the chief supervisor was busy choosing and preparing the patients. Everything they might need had to be taken with them, as this was quite a long trip; the destination was about 60 kilometres away from Al-Madinah Al-Munawarah, more than 40 minutes ride by bus. They took slices of marinated chicken for a barbecue, and all the necessary kitchen utensils. There were two men with them, the driver of the big bus carrying the patients and the driver of a jeep which carried the supplies for the trip. On the way to the desert, everyone was happy, joking and laughing and playing their favourite Arabic songs and music. When the bus was parked, the residents got down one by one, guided by the attendants and supervised by the supervisors. The nurse had a complete medical emergency kit, and the psychiatric medicine which the residents were due to take. Then, some patients went strolling, but the employees overprotected the patients, as they were afraid they might get injured or get lost while walking and that the staff would be held responsible. Some patients refused to go strolling and sightseeing; three of them stayed in the carpeted area, sat down and continued eating their snacks and drinking juice. As with the previous outing, there was no public toilet in this place. The patients went to relieve themselves a short distance away from the group, behind a large rock. After the patients had eaten their snacks and performed the noon time prayers, the supervisors and the nurse took round Arabic coffee and sweets. Then they played music on a cassette recorder and everyone danced, both the employees and the patients, foreigners and Saudis. After about two hours, lunch was served: chicken barbecue cooked by the two drivers, and the readymade rice and salads brought from the care home kitchen. They served the patients first, then sent food to the drivers, then the attendants and the Saudi employees ate last. Tea was served later. Altogether they stayed in the desert for about five hours before returning to the Social care home. The patients and the employees all felt happy and satisfied with the whole trip.

5.7 Illness and Death

Many of the elderly women in the care home had chronic medical conditions, some were very old and for the majority, there was little or no prospect of their being moved to any other accommodation. Thus, as Hockey (1990) points out in her discussion of an 'old people's home' in the UK, the reality, even if unspoken, was that in most cases, the residence of the elderly women would end in their death. Indeed, Hockey suggests that underneath the homely appearance and the comforting rhetoric, the "real" business of such institutions is the management of death. She describes the residential home as "*a dying space concerned primarily with the slow process of deterioration*" (Hockey, 1990, p92).

In an interview with the doctor attached to the care home, I asked him whether the home was able to provide medical treatment for patients. He replied:

"This is social service. If medicine is not provided by the Health ministry we purchase it with the patient budget provided by our Ministry" (CHD).

He went on to say that in 95% of cases, health care is provided in the care home. In other cases, which require more care and modern equipment, patients were transferred to hospital. Regarding patients cared for in the home, he indicated that most medication is available but other medicines are provided by "*special methods*". "*By deduction from allowances?*" I asked. The doctor looked at me in surprise, and admitted:

"Yes this is the government's money. Some cases have 50,000 Riyals (about £8,500). Their relatives will receive it after their death, so it is better to spend money on their care".

Despite the attachment of a doctor to the home, in practice, he rarely checked the patients; in between rounds (which might be several weeks apart) he simply signed the patients' files. I met him for the first time when he was conducting a round to check the patients and took the chance to talk to him afterwards.

Me: "How often do you come to check on the women's section?"

CHO: Every day I visit the patients in this section.

Me: How strange, I've been here three weeks and I haven't seen you before.

CHO: [Laughs] Do you stay here all day?

Me: Yes.

CHO: [Laughs and quickly changes the subject] Well as you can see we are very busy, we are busy attending conferences on the elderly in the kingdom, especially the men in Medina and the women in Taif, we make programmes for visiting the holy place in Medina, we organise recreational trips and we give lectures on psychology and medicine."

In this situation, it was normally the nurses who first discovered a serious change in a patient's condition or a medical emergency, and had to decide on the necessary action. During my period as an observer in the home, two medical emergencies occurred.

One day, as soon as I arrived at the entrance of the ladies' section, I noticed that an ambulance car was parked outside the door. I peeped inside, but I could not see any facilities for emergency medical care, except an old fashioned orange stretcher without trolley and a small old fashioned oxygen tank. I wondered how they could protect the patient, in an emergency, on the way to hospital. In this situation the patient could die before arriving at the hospital. I pressed the door bell of the ladies' main door, and it was opened by a lady security guard, then I asked the emergency worker, "*Why is this ambulance car here?*" She replied:

"An elderly resident got ill yesterday, she can't sleep, she is in a critical health condition. So, were transferring her to the hospital in a hurry, by the ambulance car".

The driver helped to transfer the patient into the car. Then, I proceeded to enter the section. I asked the Filipina nurse on duty, how they managed with patients in emergency situations. She replied,

“Yes, it is very difficult to manage during emergency cases because of the lack of facilities. All we can do to help the patient is manual CPR [cardio pulmonary resuscitation] although there’s oxygen. Nowadays, all the medical facilities are modern, like for example oxygen attached on the ambulance wall ready to use and we have discussed this matter with the Head Supervisor. [By comparison] our ambulance is considered to be empty, it is just like an ordinary car.”

On another occasion, a nurse told me that at about 10am, a mentally ill resident had ingested about half a glass of undiluted Dettol, when the laundry supervisor let the patient attendant decant the Dettol into a patient's stainless steel tumbler. The patient attendant placed the tumbler on the table while she continued cleaning and washing the floor. Then, the patient, about 40 years old, took the tumbler and drank it. Upon noticing the incident, the attendant ran to report to the nurse right away, then the nurse took emergency measures and at the same time she called for the Doctor on duty. The doctor was out of the social care home; the nurse didn't know where he was. After 30 minutes, while the nurse took the necessary emergency action and prepared the patient to be sent to hospital, the Doctor came and transferred the patient. The patient looked fine, she laughed and smiled, ran and walked actively without any evident signs of abnormality, but there was a distinct smell of disinfectant on her breath.

In the hospital the patient did not cooperate and created a disturbance inside the emergency room (E.R.). She would not allow herself to be calmed by the E.R. gastroenterologist. She looked totally fine but the employees on duty were worried about the mistake. After 30 minutes of observation by the E.R. Doctor, he ordered the patient to be sent back to the social care home and advised that she should not have hot food for 24 hours and be put on a fluid diet for 48 hours. The social worker in the male section who was appointed as director on that day [Thursday] ordered that a warning be given to the laundry employee and the patient attendant responsible for the negligence. This case betrays the employees' ignorance and lack of education as to how to avoid such dangers.

In these cases, the patients survived, but in other cases, an emergency would have a less happy outcome. During my interview with (CHS), she told me how difficult it was to deal with the death of a patient. She recounted this example:

CHS: "One time, I'd just finished my round to check on all the patients and check their food, when they informed me that a patient was very sick. She'd been in good health, I couldn't believe it. I went quickly to check her. She was choking. We got the ambulance car quickly, but we couldn't do anything, she'd already died before she got through the gate.

Me: Did the ambulance car arrive quickly?

CHS: Yes, the driver came rapidly to transfer her to the hospital."

I wondered why they sent her when she had already died; maybe to avoid responsibility for her death? I think that she was telling me the truth, but the manager informed me that this patient died in hospital. It may also be, as Hockey (1990) suggests, that the 'home' is considered a place for the living, where death should be kept as a distance. Physical movement of the resident, in Hockey's case to a sick bay, and in this instance to hospital, metaphorically reflects the transition from life to death.

Another member of staff also talked freely about patient deaths. I asked her how frequently she had experienced such events:

"Many times, Glory to God, one year we'll have maybe three or four deaths, then maybe for two or three years there are none. Glory to God, sometimes deaths follow one after another in a single year" (CHS4).

She went on to tell me about some of the cases she had witnessed.

"Last Ramadan, you didn't see them, they were elderly cases. They were the same height, and thin. A. died at 10am on 14th Ramadan. They called me at 4.am. We transferred her to hospital where she died. She made a crisis situation here".

A. died at 10.am without complaining of pain. She requested me to call her family to visit so she could see them one last time, so I called her nephew (underage) and sister-in-law (an old woman in need of care) who came quickly to visit her before she died...At 10am on 15th Ramadan, I saw Z was coming back from the physiotherapy section, then within a few minutes, the staff informed me that she was vomiting constantly .As I was on duty, I ordered her to be sent by ambulance car, quickly . She died in hospital, after Asr (afternoon Prayer).

I asked her, “What did you do after you sent them to hospital?”

“We informed their families by phone. Their family received their bodies, prayed for them, and buried them. We had also a death case before Ramadan, Glory to God. Catastrophes follow in succession, like our patients, if one of them dies, it will be followed by others constantly. First ZK. Died, second A, third Z and finally at the end of this year AH. Who came from the Yanbu area.....she stayed only four months in the care home. We’ve had no death case this year, thanks to Allah’.

I asked her, “Has anyone been admitted and not been able to adapt to the situation, and died?”

“Yes, maybe A. who stayed only four months. Another case came from Taif I while was on vacation. She stayed only three weeks and died. She’d requested her family to transfer her to the Al-Madinah Al-Munawarah care home. Maybe she wanted to die in Al-Madinah Al-Munawarah’.

Just a few months after that conversation, I had first-hand experience of death in the care home, when FR, who according to her files was 132 years old, passed away. I was first made aware that she was in a critical condition, when I went one Tuesday morning to visit all the residents and staff of the care home to say my farewells, as my flight to the UK was scheduled for the Thursday evening. I found two nurses were at her bedside. The old woman was getting thin and refused to eat. They inserted a nasogastric line but she refused it and removed it. The nurses were alert, watching her. The Chief Supervisor and her staff frequently came into her room and expressed sadness. The

Doctor came and explained that F's health was deteriorating. She was given intravenous therapy and oxygen. The patient was talking well about God, asking for forgiveness and praising God for all his creatures. She talked politely to her attendant and recited some extracts from the Quran in a weak and old broken voice. This old lady felt content that her life was coming to an end. She said, "*My life is enough, I will be leaving soon. I am tired of waiting*". She talked to me slowly while she held my hand and repeated the same sentences to the workers who surrounded her bed. All the workers prayed for her. Before I left, I gave my telephone number to the workers and asked them to keep me informed of the patient's progress.

The next afternoon, at 4pm, the patient's vital signs weakened. A Supervisor called me to say that the patient was being transferred to Ohud Hospital. I put down the phone and called my driver to take me at once to the Hospital. I found the patient in the emergency room, while the nurse from the Social Care Home was talking to the Doctor on duty, giving the patient's medical background and handing a referral paper to the Doctor, with the patient's file from the Social Care Home. The emergency nurse was ordered by the Doctor to take some blood samples from the patient and give her oxygen. The patient looked well but the nurse from the Social Care Home explained that the patient's general health had deteriorated compared to the previous day. Now she wanted to sleep. After all the investigations, including the results of the blood sample and chest x-ray, she was found to be normal. According to the Doctor, she only had a chest infection. A Doctor came and ordered the nurse to bring F. to the CPR; the chest x-ray result was shown to the Doctor. After looking at it, the Doctor ordered an intravenous anti-biotic. One of the Doctors convinced the other to send F back to the Social Care Home, saying she was fine and only needed an anti-biotic injection that they could give there. The nurse Social Care Home tried hard to persuade the Doctor to admit F to the Hospital but he insisted there was no need. The nurse was disappointed, but brought F back.

The following day, at 9am I went to the Social Care Home and asked about F's condition. The nurse on duty said she was under close observation. Many nurses pride themselves on their ability to predict an approaching death (Pierson 2000). At 10pm the nurse on duty became concerned and directly called the Doctor to check the patient. She had deteriorated again. The Doctor ordered her to be transferred immediately to another

Hospital. They took her to the emergency room and after 15 minutes a Supervisor came and stayed with her until she died, giving her spiritual comfort until her last breath. It is customary among Muslims, if the patient is conscious at the time of death, to encourage him or her to recite the Shahadaa (the declaration of belief in the one-ness of God and in God's prophet, especially the final prophet Mohammed). Also it is customary to recite a certain chapter of the Quran, Surah Yasin, at the time of death (Hai and Hussein, 2000). Meanwhile, the assigned patient attendant came from her housing by taxi to visit her patient and was very distressed to learn that her patient was at the end of her life; she cried and cried. After five hours there, the patient was taken to the CPR room, where she died. Everyone in the social care home was terribly sad and the place was silenced at the loss of one of their number. They played a recorded recitation from the Holy book. The real grief I witnessed among care home staff at the death of this patient challenges Hockey's (1990) view that care home routine causes the passage of any one individual through the institution to have little impact and their absence or permanent loss to be made irrelevant. Whilst it is true that the routine of the care home is largely undisturbed, my observations are more in line with Kalish's (1985) report that nurses may form such deep relationships with dying patients that they grieve when the patient dies. Despite the "*veiled structures of separation and control*" (Hockey, 1990 p3) in operation, neither residents nor staff could "*keep death at a distance.*" (Ibid)

5.8 Summary

In this chapter, I have attempted to capture the flavour of life in the care home, looking at the material conditions of the setting, the circumstances surrounding residents' admission, and both daily routine and special events. In so doing, I have tried to understand how the elderly women construct their identity (or have it constructed for them) and how they respond to this new, normally final, chapter in their lives.

In many ways, the social care home appears to represent what Goffman (1961) called a total institution, in that all aspects of life are conducted in the same place and under the same single authority. This sense is reinforced by the features of the physical environment: the high walls, the institutional furnishings of residents' areas, the security guards and manager who mediate contact between the home and the outside world.

Residents are to some extent cut off from this world, not only by their own frailty and lack of mobility, but in many cases by the paucity and irregularity of links between residents and their relatives.

A recurrent theme was the lack of children who might otherwise have provided care, although this was only one among a number of medical, psychological, social and economic factors influencing the admission decision. Whatever the reason for admission, the elderly women experienced the loss of previous, valued roles, and the social construction of a new identity as the unwanted, abandoned elderly, and “patients”. These identities were constructed and enacted in the care home routine: the enforced submission to others’ division of time and space, the impersonal rooms, the routines of feeding, cleaning and medication, the characterisation of care staff as “mothers”. At the same time, glimpses of a woman’s former self would survive, despite their bodily weakness and dependence, and would sometimes be expressed through individual preferences in food, fondness for attractive clothes and adornment, dancing, poetry, jokes and some robust and earthy conversations. Paradoxically, such marks of individuality were often best expressed in “community” moments- the parties, rituals and celebrations shared by residents and staff.

Death, too, was characterised by a paradoxical blend of the personal and the institutional. The sick and dying were routinely transferred to hospital and separated from the relatively well. Nevertheless, I saw evidence of genuine emotion among the staff at the passing of one of their charges and women who had died, even some time previously, were by no means forgotten.

In a later chapter, I shall compare the experience of these elderly women with that of women cared for in a family setting. First, however, I shall explore another side of life in the care home- the background, working conditions and attitudes of the staff that provide care.

Chapter Six

Care Providers in the Care Home

6.1 Introduction

The daily lives of elderly women in the care home are in many ways shaped and coloured by the carers responsible for their needs. It is they who structure the day, provide physical services such as feeding, washing, dressing and health care, and through their attitudes towards the elderly set the tone and ethos of life in the care home. The care provided can be affected by the adequacy of staffing levels in relation to number of residents and by the motivation, experience, skills and attitudes of individual carers. This chapter, therefore, investigates how care is provided in the care home, and by whom.

The chapter begins with a profile of the care home staff (see also Appendix 3), in terms of their roles, gender, age, ethnicity, motivation for working with the elderly, and training and experience in this field. Attention then turns to the attitudes of staff towards the elderly women in their care, and the dynamics of the care relationship. Finally, consideration is given to the problems and challenges faced by the care home staff, and to sources of support available to them, all of which impact on the quality of care they are able to provide.

6.2 Who Provides Care?

The care home staff can be broadly divided into four main categories: professional medical/nursing staff; patient attendants (not medically qualified, either in Saudi Arabia or their home countries but providing personal care); administrative staff, and ancillary staff such as security guards, cleaners and laundry workers.

In the “professional” category were a doctor, three physiotherapists, a psychologist, a dental hygienist, two social workers and four nurses. The doctor was the only male

member of staff. Saudi tradition, as noted previously, demands segregation of the sexes, and in accordance with this norm the elderly women were cared for almost exclusively by staff of the same sex. Medical care is, however, one of the few areas where it is accepted that necessity may require contact between the sexes. In practice, nevertheless, such contact was limited, except in cases of medical emergency, as indicated in the previous chapter.

Considering the frail health and multiple disabilities of many of the elderly women, as well as their categorization by staff as “patients”, it is interesting that there were few nurses. This may be related to issues of training and qualification, which will be discussed later. For the most part, daily care was performed by patient attendants; there were about 20 of these, around half of whom would be on duty at any given time. It was these women who washed the residents, changed their “pampers”, helped with dressing and feeding, and so forth. These arrangements reflect the distinction, pointed out by Twigg (2006) between social care and medical care, social care being “those aspects of the patient that medicine leaves out or prefers to assign to other, lesser professionals (p20). Bathing, dressing, toileting etc are bodily tasks, but related to a different view of the body from that presented within medicine.

Administratively, there were four supervisors, a chief supervisor or manager, and a secretary. Ancillary staff included four cleaners, three laundry workers and their supervisor, and four security guards. It is interesting that the home employed as many security guards as it did nurses. However, it should be understood that in Saudi culture the role of security guards, especially in women’s institutions, differs somewhat from the Western conception. Saudi norms place great value on privacy, particularly of women; therefore, an important function of security guards is to preserve privacy and seclusion by acting as gate-keepers, mediating contact with the outside world, for example taking in newspapers and post.

“In the mornings I am very busy. Every moment I open the door to receive a paper and take it to the section managers” (CHS 6).

The security guard I interviewed (CHS 6), however, appeared to have a rather nebulous role which included elements of personal care and patient control. She was not allowed

access to patients' medical information, because of her status, but she was aware of the broad distinction between ordinary elderly and mental cases. With the former, she helped with routine tasks such as feeding and hair-dressing. However, with mentally-ill residents, she played more of a controlling role. She told me, she had sometimes had to intervene when residents become violent:

“S___ and A___ share a room. They became excited and were hitting each other.

I separated them by force; it's difficult to face quarrelling mental cases”.
(CHS 6)

Thus, as can be seen, the care home employed a number of staff, who performed a variety of roles towards residents, depending on their position. However, although there were broad boundaries between medical and social care, these were somewhat fluid, especially among “non-professional” staff. Indeed, as Twigg and Atkin (1994) point out, such boundaries are constructed in various ways and subject to change with time and circumstances. Moreover, in the Saudi care home both these positions, and the nature of care given and difficulties faced, were associated with several other factors, such as carers' age, ethnicity and migrant status, motivation, training and experience. These factors are accordingly considered in this section.

6.2.1 Ethnicity and Migrant Status

Historically, Saudi Arabia has depended heavily on foreign workers in a variety of roles, and as noted in Chapter Three, an increasing trend has been the employment of migrant workers in domestic and personal care work. The staffing at the care home reflected this trend. Only about a third of the staff were Saudi, two were Egyptian, two Indonesian, six Indian and nine from the Philippines. This situation is consistent with Kurian's (2004) assertion that there is an ethnic dimension to care work, with the Philippines as a major sender. Saudi Arabia has been identified as the most frequent destination for overseas workers from the Philippines (Johnson, 2010). However, in other Eastern and Western countries, too, domestic work is a migrant niche, as Danis (2009) reports in Turkey. Throughout Europe, domestic and care work are increasingly

outsourced (and particularly to migrants) as women increase their labour market participation (Lutz, 2007; Kilkey, 2010). In fact, in the UK, Kilkey (2010) finds a similar outsourcing of “male” domestic chores such as gardening, repairs and maintenance and painting and decorating, in response to time pressures experienced by men attempting to balance work and family. She reports the increasing “migrantization” of such work and elsewhere (Kilkey, 2010a) describes the handyman sector in the UK as increasingly dominated by migrants from Central and Eastern European States. Thus, the Saudi reliance on migrant workers is in line with global trends.

A clear occupational grouping along ethnic lines was observed. The administrative staff (manager and supervisors) were all Saudi, as were the social worker and all but one of the nurses. The Egyptians and three of the Indians occupied professional /technical roles: the doctor, physiotherapists and dental hygienist. All the more ‘lowly’ roles of patient attendant, cleaner, laundry worker and the like were occupied by foreign migrants, the majority from the Philippines. The only Saudi occupying a non-managerial, non-professional role was the security guard, CHS 6. However, she held a trusted position, and as the longest serving member of staff commanded a lot of respect. The hierarchy of status (and, hence, pay, as will be discussed in a later section) between nationalities, related to education, was similarly noted by Danis (2009) in Turkey.

6.2.2 Motivation

When I asked care home staff how they came to be in their current employment, their answers provided fascinating insights into the variety of forces and motivations that had led to their working with elderly women. Moreover, clear differences emerged between Saudi and non-Saudi staff.

For a number of the Saudi staff, working in the care home was a natural progression from qualification in nursing, social work or administration (the issue of training, qualifications and experience will be discussed in more detail in the next sub-section). This is not to say that these staff had a specific wish or intention to work with the elderly (few expressed any such feeling), but that they submitted general applications to

the Ministry of Social Affairs and were assigned to their positions. For example, a member of the administrative staff, CHS 4, told me:

“I was appointed by the Social Affairs Ministry. First I worked 4 years, and then I received my first promotion to a rehabilitation centre where I stayed 5 years. After a second upgrading I transferred again to the social care home.....”

Two Saudi interviewees spoke of moving into care work after problems with their previous employment; in one case willingly, in the other, less so. The former case was that of a trained nurse who had begun her career working in a general hospital under the aegis of the Ministry of Health:

“I worked as chief of nursing in ----- hospital, Health Ministry. Due to special circumstances, I resigned (the Health Ministry tried to force me to transfer to another hospital; I refused, I preferred to resign). I stayed for a short while at home without work, but I couldn't stay without work, so I offered my papers to the Social Affairs Ministry. They accepted me to work in the social care home (CHS 7).

In the other case, CHS 8, the woman had clearly been transferred against her will. In her previous post, she had complained about breach of the terms of her contract and a ministry official had arranged her transfer:

Me: ‘Did you request to be transferred here?’

CHS: No, there were differences between me and the management so the deputy ordered me to work here because it's the same company and to avoid me making problems for them” (her face darkened with anger when she recalled her situation).”

For two other interviewees, their working in the care home was the result of using family connections to find employment:

“My father was the director of a care home; he helped me to work in this company” (CHS 2)

“Frankly, my uncle----- was a director of a care home. As soon as I got my secondary school certificate, he got me a job here, thanks be to Allah” (CHS 9).

The implication was that for these women, work in the care home was a matter of chance and circumstance, rather than any career plan or sense of mission. Had they had no ‘wasta’ (“pull” or “connections”), or had their relatives worked elsewhere, they might have remained unemployed, or entered some other field entirely.

Only three of the Saudi employees spoke of being motivated to enter care work out of particular sympathy towards the elderly. For example, CHS 3, whose sociology degree qualified her to work with the elderly, young people or in the field of family problems, preferred to work with elderly people:

“I don’t know [why] – maybe because the elderly are weak and [I want] to care for them. It’s the age of [needing] sympathy, we must treat them kindly and respectfully”.

Another employee told me, *“I came to visit them one day. When I saw the patients I felt sad”* (CHS 10). She had consequently offered her papers to the recruitment company and obtained a position. Nevertheless, she had initially been unhappy in the work and had actually left the job for a while, returning a year later. Her initial unhappiness was attributed to a variety of factors. She was distressed by the plight of the elderly, she was initially shocked and uncomfortable dealing with the realities of incontinence, dementia and so on (Walker and Warren, 1986, report similar feelings as a source of strain among informal carers in the UK); and as a company employee, she was low-paid compared to her Ministry colleagues. Moreover, the work was unrelated to her previous education and experience (she was an Arabic language graduate). A year after leaving the care home, however, she had decided to give the job another try. Since then, she said, *“I’ve got used to this work”*.

If few of the Saudi workers expressed any specific motivation to work in the care field, and with the elderly in particular, this was still more the case for the non-Saudis. Most of these were economic migrants, forced by family circumstances to seek work outside their home countries- whatever the nature of the work. Misra and Merz (2006) report a similar economic drive to migration. Many of these women spoke tearfully of family poverty, often exacerbated by the infirmity, absence or death of the father, and of their responsibility to help provide, not only for ageing and sick parents, but also for younger siblings. For example, a Bangladeshi woman told me:

“After the death of my father, we had so many financial problems, so I decided to come here to Saudi Arabia. I have an older sister who’s married, but she cannot help my mother. My younger sister and my brother are studying at university, so I need to arrange money for them ---I am here to provide their sustenance, their food and everything they want” (CHS 19).

Another woman, a Filipina, sobbed uncontrollably as she described a life of paternal neglect and grinding poverty:

“My father married more than four times after my mother and neglected us - my mother was too weak to control him. There are 10 of us children left by my father. My brothers and sisters were suffering, crying with hunger. They hadn’t even enough clothes. They needed milk, but we gave them water in their feeding bottles, without even sugar to flavour it..... My mother was getting thin” (CHS 23).

Such accounts appear to support the stereotypical view of the victimhood of foreign migrant workers, a view criticized by, for example Williams (2005; 2009). In fact, for many of these women the decision to migrate in an attempt to improve their circumstances was a proactive move on their part; these women, although disadvantaged, were agents too. Moreover, as will be seen later, I learned of instances where foreign migrant workers had continued to exercise agency by asserting themselves against unfairness and exploitation. Nevertheless, the fact remains that the main reason given for working in the care home was economic and as subsequent

narratives demonstrate, the migrant workers were significantly disadvantaged compared to their Saudi colleagues.

For these economic migrants, the essential concern was to find work where they could earn a better salary, rather than to work in a specific job or sector. Indeed, some had contracted themselves to the recruiting company without knowing what kind of work they would be expected to do, or had even been promised some other kind of work, and the reality was not always welcome:

“When I came from India I thought this company was in a hospital and I would be a cleaner but when I found out it’s a social care home and we have to look after these people, I got very tense and I stopped working, but when they sent me to Medina my conditions made me change to work again and now I’m adjusted” (CHS 14).

For a number of women, the choice to work in Saudi Arabia, and specifically in Medina, was significant, for religious reasons (all were Muslim; non-Muslims are not allowed to work in Medina, which has a special status as one of the two holy places of Islam). Several women spoke of feeling privileged and “safe” working in Medina:

“In this place I have peace of mind, that’s why...I chose Saudi Arabia because this is an Islamic country...” (CHS 16)

Similarly, Danis (2007), investigating the situation of Iraqi, Christian migrants working in Turkey, found employment in Christian households to be perceived as relatively “safe” by their families. Both cases illustrate how religious identities help migrants to sustain membership in multiple societies (Levitt, 2003). Hondagneu-Sotelo, 2007) found religion to be significant, also, to Asian, Latin American and Middle Eastern migrants to the USA. For those migrants, religion was salient in their lives prior to and after migration. In contrast to the Saudi situation, migrants to the USA faced religious diversity, but churches, temples, mosques and so on were a major institutional point of entry for immigrants and religious practices were often strengthened through immigration and were key in solidifying ethnic identities. Religion provided material and social resources, and an arena for civic participation. Similarly, religion enabled

migrant workers in the Saudi care home to participate to some degree in the society they had entered.

This was particularly important for the Filipinas who, as minority citizens in a predominantly Christian country, reported having faced discrimination which had added to their economic hardship:

“As Muslims it’s hard for us to get jobs because we are under the Christian government, they prioritize Christians rather than us” (CHS 16).

“The Muslims in our country are a small minority. We don’t have much chance to work in a hospital right away; besides the big number of nurses in the Philippines..... the priority is non-Muslims (CHS 28).

For an impoverished minority population in a predominantly Christian country, moving to live and work in an affluent country as part of the religious majority had particular significance, offering those migrants an alternative Muslim status, as Johnson (2010) also found. My interviews also revealed how religion informed these workers’ orientation towards, experience of and attachment to this location; they derived both “spiritual solace and cultural capital” (Johnson, 2010) from living and working in Medina.

For such women, the opportunity to work in a location held sacred by Muslims provided a form of consolation that helped to make the economic necessity of leaving home and the demands of their duties more bearable. As one woman told me, *“That is why I remain patient, because of this holy land” (CHS 26).*

There were, nevertheless, a small number of migrant workers who reported a conscious decision to work in the care field, and these indicated that they were motivated by a desire to be of service. Two Indian workers, CHS 11 and CHS 12, reported such a wish – *“I came here to serve people to the best of my ability” (CHS 12)*, while CHS16., a Filipina who had originally wanted to serve her countrywomen, *“especially women in rural areas – pregnant women who can’t afford to go to hospital because of their financial problems”*, had made a virtue of economic necessity

by transferring her desire to serve others to her new situation: *“Thanks to Allah that he gave me the chance to serve the elderly people.”*

Others, too, expressed sympathy and even affection for the elderly women in their care (carers’ attitudes towards the elderly women will be discussed in a later section). Nevertheless it was noticeable how few of the carers, Saudi or non-Saudi, reported a deliberate choice or preference to engage in care work generally, or care of the elderly in particular. This was in some cases related to the institutional arrangements for employment. Employees had signed up with an employment agency (in the case of all foreign and some Saudi workers) or applied for employment under the Ministry with little knowledge of or control over the posts to which they would be allocated. Another factor was probably the low status of such work (the issues of deskilling and occupational status will be discussed in the next section) which made acceptance of such work a necessary economic strategy rather than a conscious career choice.

6.2.3 Training and Experience

Carers reported very varied periods of experience in care work, which to some extent corresponded with their ages. The staff represented a wide spread of ages, the youngest being two laundry workers, CHS 22 and CHS 23, who were in their late teens, and the oldest being the security guard mentioned previously, who was about 60 years old. Three women – the manager, a supervisor, and one of the nurses, were in their mid-40s. The remainder was divided almost equally between those in their 20s and 30s, with no clear pattern of association between role and age.

The younger women had been in their jobs for periods of two or three years, or even less in the case of the teenage laundry workers while the elderly security guard had worked in the care home for 26 years. The service tenures reported suggested that most of the staff were appointed in their early to mid-20s. In only about a third of cases was this following formal training; all but one of the Saudi workers and just four of the foreign workers had formal qualifications in some way related to their work. Those in administrative roles had received training in areas such as business, computers and management, while professional/technical staff had relevant qualifications – for

example physiotherapy, or general nursing training, which they felt to be sufficient to equip them for this current roles.

“I did not face any difficulty working with elderly people due to my contact with patients in hospitals” (CHS 7);

“My complete nursing education is more than enough for my training in this field” (CHS 28).

None, however, had trained specifically to work with the elderly – indeed, one woman’s degree was in the area of kindergarten work!

This last example can perhaps be seen as a reflection of the tendency to “infantilize” the elderly who like children, are seen as vulnerable, passive and dependent with only marginal social status (Hockey and James, 1993). More explicit evidence of such a view was observed in the attitude of some carers towards their charges (Chapter Five), challenging Hockey and James’ assertion of the (Western) cultural specificity of such practice. Another explanation is offered by Twigg (2006); that the intimate care needs of the elderly – the need for help with washing, dressing and toileting – transgress normal social boundaries and undermine the recipient’s status as an adult, since these things are normally only done for babies.

As for the non-Saudi workers, only the Indian workers (two physiotherapy technicians and the dental hygienist) and one Filipina nurse had relevant qualifications. Many of the others indicated that they had trained “on the job”, although this training occurred more in the form of ad hoc advice from senior colleagues, rather than a systematic training programme.

“Our senior workers and the nurses demonstrated how to care for the elderly people: they explained and showed us how to feed toileting and other daily activities. The Doctor also sometimes during his rounds advised us to treat the patients gently and to give them the proper hygiene” (CHS 21).

“I got my training here through my colleagues and the nurse who advised us on how to feed, bath and deal with them and sometimes the doctor taught us the correct way of handling the residents but the Agency didn’t train us”
(CHS 27).

The situation in the care home contradicts the commonly-reported finding of downward occupational mobility among migrant carers. McGregor (2007) reports the deskilling and loss of status experienced by Zimbabweans working as carers in the UK. In Zimbabwe they had been students, skilled workers, professionals (e.g. teachers, accountants) and entrepreneurs. However, tightened immigration controls and economic measures such as the ending of free bursaries or nursing for nursing training had gradually shut down strategies by which they could regularise their status, and forced many of them “underground” to seek work by any means. Thus, McGregor (2007, 807) notes *“the effect of trapping a post of skilled people in Britain who are unable to use their skills.”*

Parreñas (2001), exploring the position of migrant Filipina domestic workers, describes a more complex process of “contradictory class mobility”, whereby workers experience simultaneously a decline in their social status and increase in financial status. Her interviewees considered domestic work as a de-skilling process and lamented the failure to utilize their educational achievements, which led to a great sense of loss. At the same time, the inequalities of regional development were such that even educated skilled professional women could not earn enough to meet their needs; for example, to buy a house. Thus, they secured material security for themselves and their relatives in the Philippines at the expense of downward mobility in other countries.

Other employees made no mention of even such limited training, but relied on their experience of caring for elderly members of their own families, consistent with Wilson’s (2006) comments on the lack of training, related to low status, for work that was regarded as only what could be expected of a daughter. ‘Social care’ needs are thought to be simple, day- to- day needs that do not require trained staff (Twigg, 2006) and, moreover are suited to woman’s nature. Thus, care work is “naturalised” as a basic function and a female characteristic, rather than requiring skills. For example, CHS 21 told me:

“I used to take care of my grandmother when she lived with my mum. I combed her hair, gave her a bath and talked to her until she died last year”.

Indeed, two such women expressed the view that caring for the elderly did not require training as it was a matter of “common sense”.

“This work is easy and needs only common sense and to be careful. I treat them like my grandparents” (CHS 23).

“Actually I have no training formally, but I think it’s not so much a deep issue because it is common sense work” (CHS 26).

Such views appear to be common in the care field and have traditionally pervaded care-related work, even the more formal, skilled and institutionalized sphere of nursing. For example, Bowden (1997: 106) describes nursing as *“a practice that is learnt through practice”* and draw attention to the similarity, in this respect, between professional caring relations and informal caring displayed in mothering and friendship relations.

Nursing care has traditionally drawn on conventional social constructions of women’s nature and roles, reflected in the strict separation of nursing functions from the (originally) male medical sphere. Reverby (1976, cited in Bowden, 1997, 30) describes how, in the early years of nursing professionalization in the USA, regular nurses (as opposed to superintendents) were recruited from women *“used to household work”*.

Such perceptions all contribute to the low status (and, hence, low pay) of care work; interestingly Kilkey and Perrons (2010) observe how the masculinization and perceived “skilled” nature of ‘handyman’ type domestic work, by contrast generates higher wages than for feminized domestic labour.

Thus, the care of the elderly women in this institution owed little to any formal training in the particular needs of the elderly, and more to the goodwill, adaptability, common sense and sympathy of their attendants. This raises the matter of the attitudes of carers

towards their charges, and the nature of the relationship between them, to which I now turn.

6.3 Attitudes of the Carers and Dynamics of the Relationship

During my time in the care home, I was interested to observe the interactions between residents and staff and I also asked interviewees directly about their feelings towards the women in their care. Several staff described a transition in their attitude over time and reported that when they first came to work in the care home, their overwhelming reaction had been one of fear. This can be explained partly by simple ignorance, as one interviewee admitted:

“This is the first time I knew there were people like this in our society ---I’d never seen them until I came to work here” (CHS 5).

Another factor, however, was a feeling that there must be something “wrong” or “unpleasant” about these people, or why were they here? Because institutional care of the elderly runs counter to the traditional values and expectations of Saudi society, some staff had found it difficult to accept that the women had been admitted, unless there was something untoward in their condition, behaviour or personality:

“On the first day of my work here, I felt fear, terror. I didn’t expect my work to be like that ... I was afraid of the atmosphere, everything frightened me. I asked myself why these women were here, why their families threw them in here, what was their problem?” (CHS1).

Eventually, however, with the guidance of colleagues or simply through the effect of time and familiarity, they had adjusted to the work, and many showed real affection for their charges, which was often reciprocated; as a long- serving member or staff told me:

“I treat them like my sisters, Like A- when I go out to work she gets sad, lonely and out of sorts. H also comes to visit me every day; she loves me so

much. I tell them, if they make a mistake, I'll protect them. I don't let anyone hurt them" (CHS 6).

The feeling of protectiveness expressed by this attendant characterized many of the relationships between staff and residents, the latter being - rightly or wrongly-perceived in a wholly dependent role. In many cases, of course, the elderly women were dependent, by virtue of their physical frailty or mental condition and this appeared to arouse sensitive, nurturing feelings on the part of their carers.

"I think tender loving care is the most important thing to give them --- we need to give our love to them as much as we love ourselves" (CHS11).

Many carers derived a sense of satisfaction from their work, similar to that reported in the UK among family carers; Walker and Warren (1996) found that London residents interviewed in relation to Neighbourhood Support Units project mentioned a sense of reward from the happiness and appreciation of the older person's enjoyment of closeness and feelings of satisfaction.

There were, however, a variety of feelings and motivations: underlying the willingness of staff to care affectionately for the residents. Interviewee CHS 16, quoted above, for example, went on to express recognition that she owed her salary to these people, but also expressed a religious motivation: *"We are working not just for the sake of people, but for Allah."* Indeed, a number of interviewees expressed a sense that the affection and care they gave the residents was in some sense the fulfilment of a religious obligation, informed by a sense that as they treated others, so in turn might they one day be treated and that they would be judged in the hereafter.

Still more frequently mentioned, however, was the feeling of being drawn to the elderly residents because they reminded the carers of their own elderly relatives. Several interviewees referred to similarities between the elderly women and their own mothers or grandmothers and for migrant workers in particular, having left their own relatives behind, the elderly women became, in a sense, surrogate family: *Working with the elderly reminds me of my mother, because I miss her so much (CHS14).*

Some of the Saudi workers, too, formed quasi-familial relationships with the elderly woman and I learned of two notable instances where members of the staff, having their own homes and families nearby went beyond the normal carer-patient relationship to include the elderly women in their family circle.

“They are like my grandmother; they talk like her. I take them to my house as [if they were] my aunt and let them stay for two days or a week. I was brought up in my grandmother’s house, so I like to deal with the elderly” (CHS 4).

“I love these patients like my parents. I bring my children here to let the patients feel a family atmosphere and teach my children to respect them” (CHS10).

A strong component of these affectionate and compassionate feelings towards the residents was pity for their situation as “abandoned”. I noted in Chapter Five the censorious attitude expressed by some members of staff towards the families who had admitted their elderly relatives to the home, and a recurrent theme in the interviews was the expression of sorrow for the plight of these women, who were clearly construed as victims.

“I treat them according to my human nature- everyone must respect humanity. These patients had an important role in our society, so I have to consider them---it’s not fair to admit them to a miserable place” (CHS 7).

“Human nature urged me to care for the patients because I felt they need my sympathy and compassion--- The majority of the elderly in the care home have psychosomatic illness, feelings of loneliness, frustration and isolation. The responsibility for this lies with the family that threw them in this place. I must reduce their feeling of insecurity and anxiety by sharing my love and respect [because] they’ve lost contact with the world around them” (CHS 3).

Whilst the two staff quoted above were able to analyse and articulate some rationale for their feelings, another more simply expressed her distress and incomprehension in the

face of these elderly women; “*Every time I see them, I feel so distressed; sometimes it makes me cry*” (CHS 22).

This member of staff went on to contrast the situation of these residents with those in her homeland, Indonesia where, she claimed, the elderly are loved, respected and always cared for by their families. Similarly, McGregor (2007) reports that among black Zimbabweans working in homes for the elderly in Britain, care for the elderly was viewed largely as a family concern and they initially found the idea of such homes shocking. Most of her interviewees were highly critical of the way the British society treated its elders and “*many thought families who put old people in homes were abdicating their moral responsibility by ‘discarding’ or ‘dumping’ their parents*” (McGregor, 2007, 808). I have no doubt of the sincerity of the Indonesian staff member quoted in the claims she made; such may well have been her own experience. Nevertheless, it is worth remembering that many of the migrant workers in the care home had left elderly relatives behind – relatives who, while still living in the family home, were suffering real poverty and hardship. Such cases remind us that sometimes economic aid was secured at the expense of loss of personal contact, and for the workers, as for residents’ families, sometimes difficult and painful decisions had to be made.

Whilst attitudes towards the elderly residents were often expressed in general terms, arising out of a perception of their common frailty and victimhood, this is not to say that the elderly women were viewed or treated as an undifferentiated mass. Perhaps inevitably, some staff admitted that they warmed to some residents more than others, and that there was some favouritism in their behaviour. For example,

“N is close to me. I fulfil all her requests, or she sends her worker to call me if she needs something--- maybe I visit her more than other patients, I sit with her more” (CHS 9).

In fact, I observed that most interviewees preferred some residents to others. Generally they preferred to deal with the “normal elderly” than with the mentally ill residents and clearly, relationships with the more lively and responsive residents were found more rewarding.

In total contrast to the prevailing expressions of affection, solicitude and compassion, there were, nevertheless, as observed in Chapter Five, instances where the behaviour of staff towards residents lacked the “human touch” and appeared to be governed more by a sense of duty – care without warmth; the distinction that Perrons (2000) makes between ‘caring about’ and ‘caring for’. It is widely acknowledged in the care and ethics literature that there can be different kinds and levels of care. Bowden (1997) refers to a distinction between “taking care of” and “caring for and about”, referring to instrumental and ethical activities respectively. However, she challenges such distinctions, citing evidence of a blurring, in practice, between the instrumental and expressive roles in nursing. From this perspective, nursing involves the “emotionally engaged attention as an ethical activity that depends on responsiveness to the unique particularly of another person” (Bowden, 1997, 109).

Tronto (1989) distinguishes “caring about” from “caring of ” according to the focus of caring; from this perspective, “ caring about” refers to a generalized concern for less concrete objects, while ‘caring for’ implies a specific, particular objective and in Tronto’s view *“involves responding to the particular concrete, physical, spiritual, intellectual, psychic and emotional needs of others”* (p103). Her contention is that, broadly speaking, men “care about”, while the work of “caring for” devolves on women. The former is an attitude or feeling; the latter involves action.

Held (2006) finds the distinction between “caring about” and “caring for” more complex, since ‘caring for’ may or may not involve caring for the sense of liking, as well as that of performing the activity of care. At the same time, people who care strongly “about” something are likely also to engage in some related activity. In relation to care activity, she acknowledges a broad consensus that care involves work and expenditure of energy, and that *“engaging in the work of taking care of someone is not the same as caring for them in the sense of having warm feelings for them”* (Held, 2006 : p30). Nevertheless, referencing the work of Nel Noddings, she suggests that *“close attention to the feelings, needs, desires and thoughts of those cared for”* (p31) is central to caring for someone.

Whatever the terminology used, the essential point to be made is that the care-workers I observed varied greatly in their engagement with and empathy for the elderly women in their care.

Some members of staff were particularly detached. I observed, for example, that the physiotherapist did not even know the residents' names. In fact, she herself had little "hands on" involvement with the residents, relying heavily on her assistants. Such behaviour was criticized by some colleagues:

"My only comment is that in dealing with the residents, they don't talk to them enough to make them laugh; they keep themselves busy with other jobs like maintenance, cleanliness and grooming" (CHS 25).

The brisk impersonality shown by some staff in their dealings with residents may have been a result of tiredness and the pressures of a heavy workload. It may also have been a means of emotional self-protection. I have previously commented on the real distress shown by staff in the event of patients' deaths and I well remember a migrant worker whose eyes welled with tears at the thought of leaving her charges behind, despite her yearning to return home. However, one interviewee offered another, surprising explanation - that particular attentiveness to individual residents was discouraged by the home's management.

"For example, a patient is upset, so part of your job is to talk to her. Then what amazes you is that later, they [the management] criticize you for talking to her. [they say] you spoiled her" (CHS 28).

It might be suggested that such a stance might be intended to protect both residents and staff from the tensions that could arise in response to perceived favouritism; as I noted in Chapter Five, the elderly woman, in their desire for attention, were prone to resentments and jealousy. I experienced it myself; if I lingered to talk to one resident or comb her hair, another would become agitated and clamour for similar attention. Such behaviour may have been either the cause or the consequence of the tendency, noted in previous chapters, to "infantilize" the elderly. For example, when I asked the Chief Nurse about how the residents are treated, she told me that they treat them as children and went on to explain that this meant giving them care, sympathy and tenderness. She

also pointed out that she was careful to treat all equally, in order to avoid arousing jealousy among them. Yet if this was the case, why were some staff permitted to take residents out or bring their families to visit? There seemed to be no consistent policy in such matters.

Before leaving this section, I must mention some more incidents reported to me where attendants' treatment of residents was not affectionate and caring, or even dutiful if impersonal, but apparently violated the trust reposed in them, with serious consequences. My informant, discussing cases of injury to residents, told me:

“Sometimes it’s by accident because their skin and bones are very fragile at their age, but sometimes it’s from the patient attendant’s negligence and sometimes I feel that some of them did [hurt patients] intentionally” (CHS 28).

She went on to describe the case, some years previously, of a resident who had on three occasions sustained fractures of fingers. At first the staff attributed the injuries to the woman's osteoporosis, but after the third time they became suspicious and reassigned her attendant to the laundry. After that, there were no more injuries. On another occasion, she had witnessed an attendant, escorting a mentally retarded resident to the toilet, pulling her by the hair instead of holding her arm *because “she obeys me if I hold and pull her hair” (CHS 28)*. I myself observed one instance of ill-treatment of a resident. While making my rounds, I observed that when an attendant approached one resident, the woman hit her. The attendant forgot herself and hit her back. When I asked her, *“What are you doing?”* she replied with a laugh, *“I’m only pretending, I’m joking with her.”* Still, I wondered, if an attendant would hit a resident in front of me, what might she do with no-one to observe? I learned that strict sanctions were applied in cases of proven neglect or ill-treatment. Fines were imposed by the employer, and in serious cases, the employee would be dismissed. Indeed, one or two members of staff told me that the fear of being held liable for any mishap to residents was an added pressure in their work. Cases of real negligence or ill-treatment, distressing as they were to witness or hear about, appeared to be thankfully rare; most of the care workers I observed and spoke to appeared sincere in their desire to promote residents' well-being in difficult circumstances. The problems I observed were attributable more to lack of

training, staff shortages and inadequate working conditions than to ill-will. Nevertheless, a variety of constraints faced by the care home staff did indeed affect the quality of care they were able to give the residents. In the next section, I highlight some of these issues.

6.4 Problems, Constraints and Sources of Support

The conditions under which care staff work might be expected not only to have practical implications, but also to affect the morale of the staff. Such practical and psychological effects might in turn affect the quality of care provided. I therefore felt it important to ask staff about any aspects of the work they disliked or constraints they faced, and also any sources of support that might help to alleviate such problems.

Overwhelmingly, the major source of discontent, mentioned by all but a handful of the staff I spoke to, was the low salary. In this respect significant factors were not only the role of the individual but also their status as ‘Ministry’ or ‘Company’ employees. CH 33, a social worker employed by the Ministry, for example, earned 6,000 SR per year; CHS 28, a nurse employed by the company, earned 1,995 SR, while patient attendants and auxiliary staff, all company employees, typically received as little as 500 SR. Moreover, there were differences between Ministry and Company employees even in equivalent positions.

“The Ministry salary is better than the Company salary; my salary is 2685 SR after various deductions. The salary of a Ministry employee is more than 3000 SR” (CHS 8).

A number of employees expressed dissatisfaction with pay on the basis that it did not fairly reflect the hours and effort they expended in the work or, in the case of professional and technical staff, the qualifications and experience they brought to the job *“Our salary doesn’t give the value for our situation and experience. It’s not the value of our service here...” (CHS 11)*. Not only this, but long-serving staff had been working for years at the same rate of pay without any additional allowances that might have gone some way to compensate for the low salary, and made it easier for them to afford a reasonable standard of living. As CHS 28, a registered nurse told me.

“The first [thing I don’t like] is my salary if 1995 riyals. When I compare to nurses in a hospital, with 4,500 riyals, I feel so bad..... Many times I have asked, but they can’t change my contract. Imagine working for 14 years without a salary increase, without housing allowances, without bonuses” (CHS 28).

Interestingly, it may be that the Kingdom’s reliance on expatriate workers has contributed to affect the wage rates of their Saudi colleagues also; Shah (2005) claims that the abundant supply of Asian workers has resulted in stagnation or even decline of wages throughout the region; for example he reports that pay rates for workers in domestic service have not risen significantly in over 20 years, despite the higher cost of living. In these circumstances it is hardly surprising that employee morale was affected: as one interviewee declared; *“If the management increased my salary, I might work with full interest to develop and serve the patients better”* (CHS 12).

The low pay attached to care work is, of course, not confined to Saudi Arabia. Kurian (2004), Wilson (2006) and Misra and Merz (2006) among others, have noted how the low status of care work is reflected in low remuneration.

If the Saudi company employees were struggling financially, the plight of foreign workers was worse. Kurian (2004) reports a similar disparity. Not only were they predominantly employed in the more menial and hence lower-paid positions, and disadvantaged as company rather than ministry employees, but they did not even receive the full amount of the salary stated in their contracts, because various deductions were made. A standard deduction mentioned by most of the foreign workers, was the cost of the ‘iqama – the work permit/identity papers without which they could not legally work in the country. Some employees indicated that there were further discrepancies between promised and actual salary, which they did not understand, although they felt the effects all too clearly, as expressed in the following comments made by a patient attendant from the Philippines:

“My salary is 520 SR but the company only pays me 470 SR. I don’t know why they do that. The identity card is also deducted from our salary, 500 SR a year, and we get no food allowance. Then we have to buy personal

necessities like lotion, shampoo, soap, napkins our clothes. So try to imagine it for yourself” (CHS 18.)

One foreign employee told me she had not realized, at the time of signing the contract, just how little she would be paid, because she did not understand the exchange rate between the Saudi riyal and the currency of her own country. For most of these foreign workers, however, the fact that they had initially been willing to sign contracts for such low salaries is a reflection of the dire economic circumstances that had forced them to seek work abroad. They had hoped, by leaving their countries of origin, not only to alleviate the situation at home by providing for themselves, but also to contribute further by remitting whatever they could save to support family members left at home. The reality, however, was that on their small salary, they could hardly support themselves, let alone help their families. Thus, to the financial hardship was added psychological stress:

“I worry about loved ones and guilt at being unable to do more for them. When my mother asks for money and I don’t have any money for food for my brothers and sisters, and when she told me four of them got sick at the same time, I was so worried., I couldn’t sleep and eat...” (CHS 23).

Another employee, CHS 27, from the Philippines, told me she often spent her vacations in Saudi Arabia because she couldn’t afford to fly home; thus her low salary contributed to prolong the absence from her family. Her country woman, CHS 26, indicated that she was ready to leave, but was deterred because to do so was not just a matter of setting aside money for the flight; there were also social obligations to be fulfilled, which were beyond her financial means:

“I’m just waiting to save enough to buy some small gifts for my relatives, friends and neighbours. I feel ashamed to go to my country without anything to give them” (CHS 26).

A supervisor informed me that the employees’ conditions were so poor that some employees in the past had even taken the risk of seeking other work, without permit, in order to obtain a higher salary.

In addition to dissatisfaction with salary and its impact on their personal lives, staff also expressed dissatisfaction with working hours and leave. Again, there were differences between Ministry and company employees. The former were permitted 'emergency' days off, and 45 days holiday each year. The latter had less holiday, were under pressure to continue working even when unwell and in the case of foreign workers, had to work long contract periods without returning home. As one Indian employee told me:

“Since we are so far from our families, the company should cooperate with us; at least we should be able to visit our own country once a year, but we get leave only once in three years”. (CH 13)

A common complaint was the long duty hours worked under the two-shift system in operation; twelve hours, rather than the eight hours one employee told me she had been promised by the company at the time of her recruitment. Several staff commented that a twelve-hour shift was too arduous and I was left under no illusions as to the toll this took on the workers:

“Twelve hours on duty is too big a burden; we can't look after ourselves..... We have no time to cook and wash....we are too tired after twelve hours duty to do anything else” (CHS 14).

Indeed, I heard of instances where staff were required to work for longer even than their basic twelve-hour shift, due to staff shortages:

“For example when there's a party for the patients, since there are only two of us company nurses, we're forced to work for more than 24 hours duty” (CHS 24).

Clearly, in terms of pay, hours and conditions of service generally company employees were disadvantaged compared to ministry staff, and were very much at the mercy of the company holding the contract at any given time. This was highlighted in my conversation with CHS 6, a long-serving Saudi worker, who had worked under three different companies and compared conditions between them. For example:

“M operated three shifts. The number of workers was more than with S, so the employees didn't have too much work, not like now. If any company

provided three shifts and the full number of workers according to the contract, the work would be fine” (CHS 6).

On the other hand, N had not paid its workers monthly but only every two or three months. Moreover, they were not paid in cash, but in the form of credits for use in various shops. This not only restricted employees’ choice, but also prevented them sending money home. The companies also imposed severe restrictions on workers’ movement;

“The company didn’t allow them to make Omra and Hajj, or go to purchase their needs. On the other hand A sent them on Omra and Hajj in groups, and let them go shopping. S sends its workers to make Omra and Hajj” (CHS 6).

Johnson (2010) and Pingol (2010) similarly reported migrant workers’ experience of restriction and confinement, working long hours and not being permitted (as single women) to rent their own flat or move freely outside it. Pingol (2010) reports how women are confined in controllable spaces and their movements controlled and monitored. She describes, for instance, the dependence of hospital workers on company buses, provided to take them shopping on designated days. Such restrictions would be a significant source of frustration for women coming from locations such as the Philippines, where even as Muslims, they were accustomed to considerable freedom of choice and movement – hence their ability to leave home to take this work. Whilst Johnson (2010) found that married women who migrated with their families were less constrained, as at least they had someone to perform the roles of guardian and chauffeur, most of the migrant workers I encountered had come alone, and so were subject to oppressive company restrictions.

Apparently, conditions under N had aroused such discontent that the employees had eventually gone on strike. My informant thought this may have been a factor in the termination of the company’s contract. As this example shows, migrant workers do on occasion assert their agency in support of their rights. Similarly, in 2005, more than 1000 Bangladeshi workers protested outside the Bangladesh embassy in Kuwait, due to non-payment of salary by the cleaning company for which they worked (Shah, 2005). More recently, *Immigration Matters* (2010) reported a strike by more than 200 Filipino

construction workers in Saudi Arabia, in protest at delayed payment, lack of overtime pay and unsafe working conditions, all of which contravene the Saudi Labour Law. However, such actions may be more difficult for care workers because of their relative isolation and small number in any one institution, and for women in particular because of the restrictions on their movements. Moreover, they may be constrained from taking action by a sense of duty to the women in their care. Among the women I observed and interviewed, despite the many complaints about their low pay and other hardships, the prevailing response seemed to be to adapt and cope as best as they could.

Although most of the complaints I heard were around terms and conditions of employment, a number of respondents also criticized the facilities in the care home. One employee, for instance, was critical of the small size of rooms, which posed practical problems in her work:

“I don’t like the small size of the residents’ bathrooms.... I think the size of the bathroom should be as big as patient’s bedroom, and the bedrooms should be bigger than they are now. Sometimes I bump myself while giving a bath” CHS 27).

Another made more sweeping criticisms of the design, layout and facilities of the home, which she felt were unsuitable for its purpose and the needs of the residents:

“This residential home needs to be rebuilt, specially designed for the elderly, with a full range of equipment for the convenience of these poor elderly people” (CHS 28).

I also heard comments regarding cumbersome bureaucratic procedures that created obstacles in the care of the residents, for example:

“In the past it was easy to provide medicines for patients. Now the Ministry puts barriers in the way of issuing it. First we send a written request to the rehabilitation pharmacy. It takes a long time to get the medicine” (CHS 7).

Not everyone voiced criticisms explicitly, however one interviewee for example remarked:

“I would not talk about the Ministry or the company; our management provide what we need to help the patients, especially Mrs. K [the manager]”(CHS9)

Nevertheless, I perceived a certain reluctance in her manner. By answering only with reference to the immediate management, she avoided overt criticisms of the powerful agencies that control the home and its employers and I sensed that this was a conscious, diplomatic evasion on her part. One of her colleagues was more direct in drawing a distinction between different kinds of facilities; those provided directly for the benefit of the residents themselves, and those of the staff:

“Yes, I think the government provides everything for the patients, they have a lot of things, which are good enough for their life, but no-one thinks about us, the attendants. They should provide facilities for us, too, so we can give full services happily” (CHS).

As in so many other ways, here, too, the foreign employees were disadvantaged, as in addition to any shortcomings in facilities at work, they had to contend with the discomforts of the unsatisfactory accommodation in which the company lodged its employees. Buildings were in poor condition, rooms were overcrowded, and there was a lack of even the most basic facilities. The following comments, made by an Indian and two Filipina employees, clearly illustrate the problems these young women faced on a daily basis.

“Our accommodation is bad. There are eight of us in one room. Not enough gas stoves and cylinders etc” (CHS 15).

“There are four ladies in one room. We have three toilets for two shifts. Sometimes we have problems with the water and often the gas cylinder is empty so how can we cook?” (CHS 20)

“It’s so crowded, and a very old house, but what can we do? We have to put up with it. Sometimes the gas cylinder is empty. One time we came on duty with an empty stomach because there was no gas to cook our food on when we got home. Then when we told the project manager he scolded us and said, ‘Why did you use up the gas so quickly?’” (CHS 21)

I observed these conditions myself, although I learned that, when the Chief Supervisor had asked the care home director for permission to visit company employees’ accommodation, he had initially been reluctant, saying *“What business does she have with the employees’ house?”* I suspect he might have been embarrassed at the prospect of the workers’ conditions being revealed to a stranger. Nevertheless, permission was eventually granted and, one afternoon, the Chief Supervisor and Chief Nurse accompanied me to the company women’s accommodation. When the car drew up beside the house, I looked around the neighbourhood and my immediate thought, based on long experience in Saudi Arabia, was, *“This is not a safe place for the women.”* Then I looked at the house itself, an old, two-storey building that looked like a family house; no-one would suspect it was a company housing. When we entered the house, our noses were assailed by the smell of onion and other - distinctly unpleasant – smells. The place was a mess. Such conditions are hardly conducive to employee morale; indeed, it is hardly surprising that one employee told me she preferred to stay in the workplace, because at least she could find food and pleasant company there; in her lodgings, the grim living conditions simply exacerbated the distress of her homelessness.

The inadequate or erratic cooking and washing facilities also raise issues of health and hygiene. A worker who comes on duty without having eaten will be physically weakened and prone to loss of concentration, while inability to wash and shower properly or do one’s laundry poses clear risks of transfer of infection.

These unsatisfactory living conditions are but one example of what appeared to be a prevailing neglect, not only of workers’ comfort and psychological well-being, but also of basic health and safety. I have already reported, in the previous section, instances where residents’ safety was compromised by the quality of care, but staff, too, faced a

variety of risks. Working with mental patients and dementing elderly exposed them daily to threat, abuse and, not infrequently, actual assault.

“When the mental cases see your fear, they’re encouraged to do anything. S has hit a lot of workers.” (CHS 4)

“When H becomes agitated, she’ll hit anyone. One time I was sitting with two workers in a corridor when S came suddenly and hit me on the face. I try to keep away from her” (CHS 5).

Many of the employees I spoke to recounted instances of being hurt in this way. Whilst some risk must be inevitable when working with confused patients, it seems to me that the risks were compounded by a combination of factors: the housing of mental patients alongside the ‘normal’ elderly, staff shortages, lack of training, unawareness of (and hence, perhaps, failure to treat) physical and psychological causes of delusion in the elderly, and the anger and frustration endemic among the residents.

In addition to such risks, employees were also exposed to risks of accident and injury by the conditions of their surroundings. For example, a patient attendant told me that some months previously she had fallen on a slippery bathroom floor, fracturing her foot; moreover this was the second such accident she had experienced. One has to question why lessons have apparently not been learned from such incidents and improved safety precautions and procedures put in place. If staff cannot be sure of their own safety, what of their frail and less nimble elderly charges?

Clearly, the care home staff faced enormous problems, which affected them practically and personally and which could affect the quality of care given to the residents. Nevertheless, the picture was not one of unrelieved misery. Despite or indeed because of the problems they faced, many interviewees spoke warmly and appreciatively of the support they received from superiors and co-workers. Advice, friendship, the support of supervisors and even some forms of material assistance helped staff members to cope with their work and made life generally more bearable.

Several interviewees commented on the spirit of friendship and collegiality prevailing among the staff. In some cases, these bonds were strengthened by a common origin – CHS 16, for example, singled out for special mention her fellow Filipinas. More often, however, they were ascribed to shared goals and team spirit.

“To live, work as a team.....We are from different countries but we cooperate with each other. Everyone is very kind and helpful” (CHS 4).

It also appeared that religious fellowship was a factor in the bonds between co-workers. As indicated in section 6.2, all were Muslims and their faith had been a significant factor in their decision to work in Medina. Consequently, as one worker told me. *‘We live here like one big Muslim nation.’* Religious faith may also have been a factor in the help provided to migrant workers by their colleagues. As Hondagneu-Sotelo (2008) reports in the US context, religion (such as the Muslim notion of charity) provides a moral justification or motivation for action - what Smith (1996, in Hondagneu-Sotelo 2008, p19) called *“transcendent motivation.”*

These ties of collegiality in the workplace extended also to friendships outside work: *‘I love to sit and joke with my friends, eat and go out together’* (CHS 20). Such relationships were particularly important for immigrant workers who, as I have already indicated, faced both financial hardship and emotional distress. For them, the friendship and support of colleagues could indeed be a lifeline, as one young Indonesian woman told me:

“I always feel tense and what makes me feel better is when I talk to my friends and laugh sometimes- otherwise it would be very difficult to stay here” (CHS 18).

In fact migrant workers also relied heavily on their Saudi colleagues, particularly the better – paid ministry staff, for various forms of material assistance that helped to supplement their meagre salaries. One Saudi employee expressed sympathy with the plight of these workers and explained how the Saudi staff, to the extent possible within the regulations, tried to alleviate their conditions.

“They are poor, they work 12 hours a day ... their house is very bad... Regarding salary the contract they signed is 750SR. They’re surprised here to get only 500SR because the company deducts ‘iqama and housing costs. So we deal with them kindly. We cannot change their situation because this is the system of the company ... We try to provide their food...we provide their clothes” (CHS 7).

One of the Filipina attendants told me her colleagues had even donated winter blankets to provide some additional comfort in the poorly equipped company accommodation. The value of such assistance was clear in her heartfelt outburst:

“Thank God for the ministry staff for helping us a lot. If not for them, maybe we couldn’t survive our long stay here’”. (CHS 14)

Some of this material support had in fact been institutionalized by the current manager, who had introduced a number of new measures to improve conditions for her staff within the limits of her authority. One of these was to allow them to use surplus supplies officially provided for the patients. This was perhaps not technically within the regulations, as there were fixed allocations of food, clothing, bedding and so on for each patient. However, food in particular, was often over-supplied, given the low calorific need of those elderly, often inactive residents, and the wasteful alternative would have been to dispose of the left-overs. As the manager explained:

“In the past they threw extra food into the waste bins, but me, I allow the workers to eat it rather than throwing it out, because their salary is small ... I allow toiletries like soap, perfume, Vaseline and cream to be used for the workers if there’s a surplus. It’s considered as used materials; the company provides them monthly according to contract.” (CHS 1)

This was in fact only one of several ways in which the care home manager supported her workers. Several of them expressed their appreciation of her flexibility with regard to work schedules and her willingness to listen to and implement their ideas. She herself expressed her belief that even uneducated people could sometimes offer good

ideas, and she cited the example of a worker's suggestion to streamline the serving of meals during Ramadan. Since some residents fasted and others because of their physical condition did not, the home had been operating two completely separate meal schedules, imposing a heavy burden on staff, who were themselves fasting and so inclined to feel tired and weak. When one of the workers suggested a way of merging the timetables to reduce the number of meal services required each day, Mrs K had seen the sense of the suggestion and been happy to implement it. Some of her subordinates mentioned other instances of similar support, for instance when one employee's suggestion for an outing had been accepted. I gained some insight into the reason for employees' warm feeling towards Mrs. K when I was talking to one of the Saudi employees. It appeared that Mrs K had been promoted 'from the ranks', and her experience had given her insight into the needs of her staff. Moreover, she had not lost her fellow-feeling with colleagues after her promotion. As my informant told me:

“She hasn't changed because she was one of us. She doesn't deal with us like a manager because she worked with us before, so she felt what we feel. She's made things better for us and the patients” (CHS 5)

Thus, as this section has shown, the picture of life for the staff of the care home is a very mixed one. Certainly, there were many problems, which were faced disproportionately by company, and especially immigrant employees. The latter faced the practical and psychological effects of real hardship: a pitiful wage, long gruelling shifts, separation from loved ones and poor quality accommodation, to add to the shared problems of bureaucratic constraints and inadequate facilities. These conditions certainly had adverse impact on the health and morale of employees. Nevertheless, the gloom was brightened by moments of warmth and laughter with friends, by team-work and collegial support, and by the support and the understanding of the manager. Such benefits went some way to alleviate the burden on the employees and perhaps enabled them to provide better care than might otherwise have been the case.

6.4 Summary

This chapter has examined the characteristics, motivation and attitudes of the carers attending to the elderly residents of the care home in Medina, and the conditions in which they work. All these factors have impacts on the ethos of the Home, and the quality of care provided.

Carers were, with the exception of doctor, all female, and included both Saudis and migrant workers, particularly from the Philippines. The main motivation for the latter to seek work in Saudi Arabia was economic hardship. In a sad double irony, however, not only had these workers had to leave their own ageing parents to care for the Saudi elderly but also, their low wages made it difficult to visit or fulfil financial obligations to their families of origin.

Not only did few of the carers express any specific motivation to work with the elderly, but many had little specific training to enable them to do so, relying on their instincts, religiously motivated compassion, and experience of living with and caring for elderly relatives in the past. For migrant workers in particular, the elderly residents became, in a sense, surrogate family. Attitudes expressed towards the care home residents were generally respectful and affectionate, and there was a strong element of pity associated with the perceived victimhood of the residents, who were seen as having been abandoned by their kin. Nevertheless, I also heard of, and on one occasion witnessed, instances of impatience and ill-treatment.

Such instances, however, were mercifully rare; on the whole, care home staff acted, if not with professionalism, then at least according to their own values of humanity and service. In this, as in so much else, two overriding factors served as coping mechanisms that enabled carers to make sense of their situation and adjust to its demands: the friendship and support of colleagues, and the solace of religion. The latter, in particular, gave meaning to the work of both Saudi and migrant employees. The transcendent image of Medina as a holy city and the sense of performing a religious duty helped staff to resolve the ambivalences involved in day-to-day work of a kind some had never expected or intended, and which for most was fraught with emotional and practical challenges.

From this portrayal of elderly women and their carers in the Medina care home, I now turn to the experience of their counterparts in the family setting, which forms the subject of the next chapter.

Chapter Seven

Care of Elderly Women in the Family Setting

7.1 Introduction

For women in the family setting, as for those in the care home, quality of life is affected to a great extent by their material conditions, and by the attitudes and behaviour of the people around them. For some, this will be a smooth transition from or continuation of previous arrangements. For others, advancing age or the onset of illness may necessitate new living arrangements or bring a change in the family dynamics as the former carer becomes the cared-for. In this chapter, I present the experiences of a small number of elderly women cared for within the family setting, in an attempt to capture the interplay of care within family life and relationships, and the impact this has on both the women and the family members and paid help who support them.

I make no claim that the cases presented in this chapter are “typical”. The lack of a research culture in Saudi Arabia, together with the strong norms and values related to the privacy of women in particular, make access to the Saudi home extremely difficult, except for members of the householder’s own intimate circle. I therefore had to rely heavily on my personal social network. Inevitably then, the women whose stories are told here are distinct in terms of residential location and social class. Nevertheless, I include them because, however limited a spectrum of Saudi society they represent, they provide valuable insights into the conditions that make elderly care in the family setting feasible, the facilitating factors and challenges, and the implications, both practical and emotional, for elderly women and their families, of such arrangements.

In presenting the women’s stories, once again I am guided by the research questions set out in Chapter One. Thus, after a brief description of the care setting(s), I explore the reasons for the current living arrangements, the women’s perceptions of their identity and role within the family, and the implications - practical, psychological and social –

of the care arrangement. I then turn to the carers, whether relatives or employees, in order to answer the question, “Who provides care?” in terms of demographic characteristics and motivation. I discuss the expressed and observed attitudes of those individuals towards the elderly women in their care, and the challenges they face in performing their caring role.

7.2 Description of the Setting

Seven elderly women and their families (see Appendix 4 and 5 for profiles) were visited at home during the course of the research. Constraints on the length of the thesis preclude detailed descriptions of all seven settings; moreover, there is a risk that such a description would enable certain houses and, hence, the resident participants, to be identified. In this section, therefore, I try to capture the flavour of the settings in general, reserving more detailed description for the only house in which I was allowed to take photographs.

7.2.1 General Features

All but two of the households visited occupied part or all of a “villa”. The term villa in Saudi usage refers to a large, modern detached house built of materials such as concrete, in contrast to the smaller mud-brick “traditional” house. Whereas the traditional house is often single-storey, a villa has two, three or even four storeys. A family may occupy the whole villa, it may be shared with other family members (for example, parents on one floor, a married son and his family on another); or – particularly in the case of a three or four-storey building, the top floor may be rented out as a source of income. I did not observe any such instances among the families visited, but I did observe cases where a villa was shared between family members, with parent(s) and adult offspring having their own apartments. In each case, the villas were set in extensive grounds with attractive gardens. Although these were walled, to protect family privacy, the space between the walls and the house, and the pleasant gardens, prevented any sense of oppressiveness.

On each visit, whether to a villa or, in the other cases, to a flat in a residential block, I was ushered into a spacious, comfortably furnished sitting room. Furnishings were typically a mixture of western and Arab influences – large, comfortable suites upholstered in leather or fabric, richly coloured and patterned rugs, throws and cushions, and small tables displaying lamps, ornaments, and family photographs, particularly of grandchildren. There were pictures on the walls, or framed Quranic texts in their beautiful curving script, which gave an atmosphere of both homeliness and spirituality. Additional colour was often provided by displays of houseplants, the fresh greenery sometimes being supplemented by artificial plants. A large TV set occupied a prominent position in every sitting room.

7.2.2 An Example

The only house where I was allowed to take photographs was the villa that FSR3, Mrs Fa, occupied with her older, severely disabled husband. This was a particularly large house, set in an extensive plot of land – indeed, a divorced daughter had a separate villa which had been built in the grounds of the main house.

Entrance Hall

Entry to the house is via a spacious and colourful entrance hall (**Picture 46**). Cool, cream walls are contrasted with a feature wall of rich red wallpaper and a colourful oriental rug. To the side are chairs in an antique French style. A staircase with polished dark balustrade leads to the upper storeys, while doorways off the hall give access to the family living space and guest salons.



Picture 46: The Entrance Hall

Living Room

The family living room is furnished with comfortable chairs and sofas in a floral pattern (**Picture 47**). In one corner, a lift has been installed to enable Mrs Fa's disabled husband to be brought downstairs in his wheelchair (**Picture 48**). The room is a homely, welcoming space with pictures around the walls and family photographs displayed on side-tables (**Pictures 49-51**)



Picture 47: Living Room



Picture 48: Living Room, showing lift to right-hand side



Picture 49: Photo of grandchildren



Picture 50: Photos of husband and son



Picture 51: Photo of father-in-law

Family Dining Room

Family meals are taken in a bright room, decorated in a warm terracotta shade. The room is dominated by the large, centrally placed table and chairs, while china and glassware are displayed in a large glass-fronted cabinet of matching dark wood (**Picture 52**)



Picture 52: Family Dining Room

The Guest Area

Mrs Fa loves to entertain and regularly hosts large family gatherings. In line with Arab and Islamic tradition, where there are guests of both sexes, men and women will gather separately. Accordingly there are two guest salons. One, the men's salon (**Pictures 53 and 54**) is a spacious rectangular room with walls painted in a cool, pale blue. Large, comfortable sofas line the walls (an updated version of the traditional furnishing style where large floor cushions or low divans would border the room) and a generously sized painted table is provided for serving tea and coffee. The other salon, the women's room, has elegant, wooden-framed chairs in a French style (**Picture 55**). There is also a guest dining room (**Picture 56**) with richly coloured, elaborately swagged and fringed curtains. The ornate suite comprises a large table and seating to accommodate at least twelve people, flanked by a sideboard and armoire for storage and display.



Picture 53: Men's Guest Room



Picture 54: Men's Guest Room



Picture 55: Women's Guest Room



Picture 56: Guest Dining Room

Main Bedroom

As the accompanying photographs **57-60** show, the furnishing of the main bedroom was to a large extent dictated by the old man's ill-health: a medical bed and oxygen machine, an adjustable chair, a cupboard piled with tins of his special food. Nevertheless, this was not a stark, sterile environment. Alongside the medical bed was a conventional double bed with padded headboard, there were several pictures on the walls, and the old man's feet rested on a colourful tapestry footstool.



Picture 57: Husband and Wife in Main Bedroom



Picture 58: Medical Bed



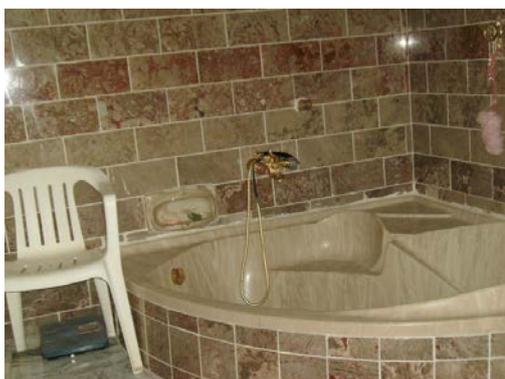
Picture 59: Main Bedroom



Picture 60: Main Bedroom (detail)

Bathroom

The bathroom too was colourful and comfortable, fully tiled in a marble-type finish (**Pictures 61-62**). One corner was taken up by a sunken bath with an integral moulded seat. Alongside, a patio-type chair provided a convenient place to sit. A carved and painted cupboard provides storage for toiletries and the old man's Pampers.



Picture 61: Bathroom



Picture 62: Bathroom Storage

Housemaid's Room

This room was large and comfortably furnished, with a T.V. and refrigerator, and all the furnishings were of good quality. Undoubtedly, this room was exceptional in its size and the standard of furnishings supplied, reflecting the house as a whole and the means of its occupants. Nevertheless, it is worth noting that in all the houses I visited, the housemaids had their own private rooms.

7.2.3 Significance of the Physical Environment

Most of the research on the influence of environment on the adjustment and well-being of elderly people has been carried out in institutional settings (Garland, 1990). However, Sixsmith (1986, quoted in Garland, 1990 p126) noted the “amalgam of subjective feelings and physical opportunities and constraints” representing the meanings and expressions of home. Factors identified by Scheidt and Windley (1985) in this respect include sensory stimulation, comfort, aesthetic attractiveness to the resident, a sense of attachment, and a degree of control by the occupier. In line with these

perspectives these settings have practical and symbolic significance that goes beyond the immediately apparent concerns of safety, comfort and convenience, important though these are for the elderly women and their families.

Probably the first point that strikes the visitor is that those rooms offer a high level of sensory stimulation. Whilst the walls were often painted in pale, neutral colours to increase the sense of space and coolness, everywhere else there was colour and texture – the shine of dark, polished wood, the creams, reds and browns of silken or velvety soft furnishings, the dark green of a potted palm, the silver of photo frames. Everywhere, there were things to look at, touch and talk about.

A second point worth noting is that, even though in some settings, a degree of adaptation to health needs had been necessary, these were first and foremost family homes and as such reflected a shared life. The elderly women were surrounded by objects to which associations and memories were attached: a widow's photo of her deceased husband, pictures of grandchildren sent by a daughter in another city, gifts from family and friends. Such items, reflecting and reaffirming the woman's status and identity as wife, mother, grandmother and friend, connected the women to their past, and to an extended network of relationships in the present. It is not surprising, then, that FSR 1, Mrs S, when invited to move with her son to his new villa had replied, "*I can't leave this house – I've got 30 years of memories of my family in this place.*" Another elderly woman, ESR 5, Mrs R, reporting her pleasure at returning home after an extended visit to a daughter, looked around her comfortable room with its familiar objects and told me, "*This is my paradise.*"

The emotional meanings attached to home, and the role of domestic objects in invoking these associations and preserving/displaying identity have been recognized by a number of writers. Okely (2004), discussing ageing in northern France, notes the importance of connections to the past and a sense of place, which can be provided by familiar objects such as photographs. Moreover, these selected images, often constituting an idealized formal display, not only connect the woman to her former identity(ies) but also represent the image of herself and her relations that she wishes to present to the world and invites others to share (Okely, 1994). Elsewhere, describing the last months of her

mother's life, she notes how photographs evoked reminiscence and a rare lucidity (Okely, 2000). The value of reminiscence to the elderly has been widely recorded; Coleman (1990) suggests that it plays an important role in adjustment in old age, helping the elderly to preserve self-respect by investing in images of themselves as they have been.

In such ways, consistent with the view of Saunders (1990), the physical environment in which the women lived represented "home" as a source of what Giddens (1984) calls ontological security – confidence and trust in the basic essential parameters of self and social identity. Beyond this, however, as Gurney and Means (1993) suggest, home is the location of loving and supportive relationships, and associations with important personal events and stages in the life cycle, and as such is a source of emotional security, as the comments of Mrs S and Mrs R, quoted above, so well illustrate. Perhaps of most importance, however, is that the objects in these settings were ones over which the elderly women had control. They could arrange the cushions to suit themselves, choose whether to watch TV and which channel, create their own display of ornaments and photos, and pull up a side table to serve tea. Even where physical assistance was needed, for example with carrying a tray, it was the elderly woman herself who called for refreshments to be served. Thus, women had a large degree of control over their environment, and through these settings were enabled to enact a variety of roles – a topic to which I shall return in a later section. First, however, I shall outline the women's living arrangements and the means by which these had been decided.

7.3 Factors Influencing the Decision on Care Arrangements

With one exception (FSR 5, Mrs R, who lived alone apart from her housemaid) all the elderly women in the family setting lived in some form of multi-generational arrangement, with adult offspring and grandchildren either in the same apartment/villa, or adjacent in the same building or its grounds. In many cases, the situation was not so much a conscious decision necessitated by the woman's age or ill-health, but a continuation of pre-existing living arrangements.

In three cases, the women were still living in the marital home. Two of these, FSR 1 (Mrs S) and FSR 2 (Mrs F) were widows, while the third, FRS 3 (Mrs Fa) was living with and caring for her older, frail and disabled husband. It is worth noting that in Arab and Islamic culture, responsibility for a widow devolves to her eldest son, although in practice other siblings will contribute in various ways (Altorki, 1986). In the case of the two widows mentioned, one or more son had remained living in or had moved back into the family home. In two other cases, the co-resident offspring were daughters, who each occupied a villa built for them on their parents' land, adjacent to the family home. Mrs Fa's daughter had been provided with the villa on return to her parents' home following an abusive marriage; her parents had protected her and negotiated with her husband's family to agree a divorce. The other case was that of FSR 6, Mrs A, whose daughter lived with her husband and children in the villa provided for her. She was the youngest of six siblings, three sons and three daughters, and was the one closest, emotionally, to her parents.

I found three cases where conscious decisions to change living arrangements had been made as a result of the woman's age and health, or other factors. In the case of FSR 1, Mrs S, although the existing living arrangements had lasted for some time, change was forthcoming and plans were being made for the succession of care. The son who currently had an apartment in the same building was planning to move into a villa, which would afford more space for his growing family. He had invited his mother to join them, but she had refused: "*I will stay here to the end of my life, and if you want to move you can go ahead.*" However, a second son was temporarily staying in his mother's apartment and it had been agreed that he and his family would move into the place vacated by his brother. Everyone concerned expressed satisfaction and even pleasure at this arrangement. The couple who were about to move admitted they would miss the elderly woman, but were happy that her continued care was secured. Mrs S. herself, although diplomatic in the presence of her daughters-in-law, later confided that she was looking forward to the change, not only because the couple who were moving "*will move to a better life, and that makes me satisfied*", but also because she felt a greater personal affinity with her other daughter-in-law:

“It’s so much better for me; I prefer the second woman, the wife of my eldest son, because she is understanding; we have the same nature, upbringing, background in life.”

In another case, a change in living arrangements had been forced by the elderly woman’s declining health (sadly, she passed away shortly after my visit to the family). Until she became ill, FSR 4, Mrs H, had lived independently, although her daughter lived close by. At the time of the research, she was 82 years old and suffering from severe respiratory problems. Her sons had become concerned about her health and, as a daughter-in-law explained,

“As I am a doctor, and my daughter helped her a lot, and since her house was far from here, her sons decided to have her stay with them. My mother-in-law accepted this decision.” (FSC 10)

Mrs H had spent alternate months with each (they lived in adjacent villas with only a wall between), while the daughter managed Mrs H’s own home. I was unable to talk to Mrs H about this arrangement, as her poor health prevented the interview, but the love and solicitude of her sons were apparent in their expressions and the anxious looks that passed between them when their mother had a coughing spasm.

In a third case, the change in living arrangements had been the result of the son’s circumstances as much as the mother’s. FSR 7, Mrs Ha, had depended on her only son since the death of her husband and had accompanied him to the city where he worked, around 200 km from Medina. However, she was unhappy there, so he resigned from his post in order to return to Medina, where they lived in separate flats within the same building and Mrs H often paid extended visits to her sister and step-daughter. When the son had the opportunity to study for a PhD in the UK, she accompanied him and she, her son and daughter-in-law, and their three sons all shared a large house on the outskirts of the city. Mrs H later became ill with rheumatism and severe asthma, and was largely bed-ridden; she died not long after the family’s return to Medina. Nevertheless, it is noteworthy that the deterioration in her health occurred some time

after the formation of the joined household; it was not the reason for the choice of living arrangement.

With the exception of Mrs H, Mrs Ha and Mrs A (FSR 6), who had kidney disease, all the elderly residents in family settings were in reasonable health. Certainly, they showed signs of ageing – one interviewee (FSC 1) described her mother-in-law as “tired” – but they were fairly mobile and mentally alert. Medical issues appeared to play little or no part in the care decision. Even in the cases where the women’s health had significantly deteriorated, this brought a change in the kind or extent of care, rather than precipitating the original decision to provide care. Moreover, while the comparatively good health of an elderly woman would clearly make her care within the family setting easier, in those cases where severe health problems developed, the additional burden had been one which the families concerned were happy to undertake. The main factors determining the care arrangements for all these women were not so much medical as social, specifically family composition, and economic.

7.3.1 Family Composition – the Importance of Offspring

As Froggat (1990) notes, family structure has a significant bearing on the ability of the family to respond to changes in the needs of its elderly members. This includes not only the number of family members and their relationships (both biological and emotional) but also the development stages of family members. For each of the elderly women included in this study, the most important single factor in their care and living arrangements was their having had children, and especially sons – and not only the mere fact of having children, but the closeness and affection between parent and offspring. All of the women had at least one son, who either provided accommodation or handled the elderly woman’s financial affairs, ensuring that bills were paid and so on. In three cases, FSR 1 (Mrs S), FSR 2 (Mrs F) and FSR 7 (Mrs Ha), a son’s responsibility for his elderly mother pre-dated his marriage, on which his wife immediately became a co-carer (the extent to which care was provided through the medium of daughters-in-law, and the way care tasks were divided will be discussed further in a later section). Whilst they had not necessarily lived with the elderly woman from the beginning (FSC 4, Mrs

F's daughter-in-law told me "*in the beginning my husband didn't force me to stay with her; it was our family situation*") the son's responsibility for his mother had been made clear. As FSC1, Mrs S's daughter-in-law explained - "*to be honest, he told me everything and I agreed with him.*"

Although, as stated earlier, care of the elderly mother is nominally the duty of the oldest son, in practice, care responsibilities are negotiated within the family. The notion that care arrangements are the outcome of implicit or explicit negotiations and understandings, both between carer and cared-for, and in the kin network as a whole is similarly reflected in the work of Finch (1989) and Finch and Mason (1993). A widow's choice as to which of her offspring to live with, or the assumption of responsibilities by one or more siblings, depend to a great extent on personal affinity. For example, when I asked Mrs S's daughter-in-law why her husband looked after his mother, rather than his older brother as might be expected, she told me;

"My husband's personality is very unique and open to her. He doesn't hide anything from his mother. The eldest son is very quiet and reserved..."
(FSC 1)

Altorki (1986:84) similarly notes the role of "compatibility of character" in an elderly woman's living arrangements.

It is also noteworthy that care may be divided among siblings. In the case of FSR 3, Mrs Fa, for example, financial matters were handled by a son:

"My second son arranges our budget. If he finds our account is negative, he deposits money again, and sometimes my daughter asks him to pay the phone or electricity bill" (FSR 3)

In addition, three sons helped her in caring for her disabled husband (for example, helping with lifting and turning him), while a divorced daughter helped in running the household. Similarly, in the case of FSR 6, Mrs A, her six offspring all contributed to

her care in various ways, although a married daughter (with the co-operation of her husband) played the major role.

Among the seven family care cases included in this study, I learned of only one case where a degree of family disruption affected care arrangements. This was the case of FSR 5, Mrs R, who saw less of her elder son than of her second son, because “*he has a problem with his wife*” – apparently the lady in question was not on good terms with her in-laws, and had caused tension between her husband and his sister. As a result, “*our relationship with my eldest son’s wife has been cut off*” – and it was noticeable that no photographs of this couple’s children were on display, in contrast to those of Mrs R’s second son and daughter. Nevertheless, Mrs R’s care was well provided for by the younger son, who visited every day and telephoned every night before bed. This case demonstrates the reality of Altorki’s (1986) assertion that the relationship between mother and daughter-in-law plays a significant role in care provision and may, indeed, be a determining factor in which of the offspring becomes the main carer. I shall have more to say about these important relationships in later sections.

7.3.2 Financial Status

A major factor in the care arrangement – if not the initial decision, then the degree of ease with which it could be managed – was the family’s financial situation. All the families discussed in this chapter could be described as middle-to-higher class, and relatively wealthy. Some, such as FSR 2, Mrs F and FSR 3, Mrs Fa, had inherited land or income, while another family owned a furniture store. The elderly women’s sons and daughters had received a good education and made a comfortable living in their various occupations (for example, one was an engineer, another a pilot). In the case of FSR 4 (Mrs H), not only her sons but also at least one daughter-in-law had professional status. The possession of ample financial means obviously played a major role in the ease with which multi-generational living could be accommodated, a degree of privacy and independence maintained, and the elderly woman’s personal and medical needs met. It enabled families to afford a spacious apartment or villa and in some cases, such as FSR 3, Mrs Fa, to provide separate but adjacent accommodation for a daughter; it enabled

families to employ at least one housemaid and, in the cases of FSR 4, Mrs H and FSR 6, Mrs A, trained nurses to assist and care for the elderly woman; and where necessary, it enabled families to provide specialist or adapted equipment (for example, a medical bed, or a reclining chair). Clearly, families of less financial means, living in smaller, older houses, and unable to afford live-in help or specialist equipment, would find the care of an elderly relative more difficult and might in some cases (especially given the absence in Saudi Arabia of systematic State support) be unable to provide adequately for the elderly woman's health and comfort. Indeed, Kosberg (1992) points out the strain on the family system when elderly care is associated with factors such as unemployment and overcrowding, while Wilson (1993) highlights the importance of financial means to buy goods and services that enhance quality of life for the elderly person.

7.4 How do the Elderly Women Perceive their Role in the Family? How has it Changed?

I have noted earlier in this thesis the importance of social roles and associated expectations in the construction and experience of identity (Killingbeck, 2007). Elderly women in the family setting viewed themselves in the context of a network of relationships, through which they enacted multiple roles; some old (wife, mother, housekeeper, employer); some relatively new (widow, grandmother, dependent) and all continuously modified and negotiated with changing circumstances.

For all the women interviewed, a major part in their sense of identity was their role as wife, whether currently or in the past. Only one of the women had a husband still living: FSR 3, Mrs Fa, whose husband was not only severely physically ill and largely bed-ridden, but also suffered from senile dementia. After a long and happy marriage – *“he’s the love of my life. We’ve lived together for 54 years now”* – she was devastated by his illness, but proud and happy that she was still his main nurse and companion. She had steeled herself to perform every unpleasant procedure – changing his Pampers, clearing his airway – *“because he is my love and when I do it I feel so satisfied...my conscience is completely clear for rendering my whole care, not failing to give my best for him.”* At

the same time, she acknowledged that the situation was becoming more difficult as a result of her own advancing age and deteriorating strength.

Other women were widowed, but for them too, the experience of having been a wife still figured largely in their sense of self and the deceased husband was a constant presence, both in their conversation and, symbolically, in the photographs that surrounded them. As FSR 5, Mrs R told me, with a sense of loss almost tangible under the stoical exterior, *“Thank God, I don’t need anything – but I miss my husband.”*

Whilst the role of wife might be ended abruptly by widowhood, the role of mother remained, but in changed forms as children grew up and moved away or brought their brides into the household, and gradually the carer became increasingly the cared for. As Altorki (1986) has commented, widowhood in particular brings a change in the family dynamics and a renegotiation of roles as the mother’s right to impose parental authority is restrained by the reality of her dependence on her son. Whilst in some cases a woman might still provide care for her offspring – as in the case of FSR 3, Mrs Fa, who had provided support and a refuge for her divorced daughter and still tried to avoid burdening her unduly – more often her role became more indirect, enacted through relationships with daughters-in-law and grandchildren. FSR 1, Mrs S, expressed her acceptance of the role of her daughter-in-law in her sons’ lives in the following words:

“I know their wives are very important in their lives and this makes me feel good. I tell them, “If these ladies are good for you, then you will be satisfied and this is the way of life”. I know this lady makes my son happy so why should I interfere? These wives give something to my sons that I cannot.”

Relationships with daughters-in-law were not always straightforward, however. On the one hand the elderly woman saw herself (and was seen by her family) as the teacher and advisor of less experienced younger women. Both Mrs S’s daughters-in-law, FSC 1 and FSC 2 commented appreciatively on her patience and understanding in teaching them recipes and helping them with chores they found difficult or distasteful. At the same time, comments by two of the women showed that they expected and appreciated

certain traditional virtues in their daughters-in-law, including a degree of deference towards themselves:

“My son’s wife...is obedient to me and a good lady...she knows our habits and traditions” (FSR 1)

“She is so good to me, and because of her, the whole house looks wonderful. She gives me whatever I need, the housemaids work under her supervision and guidance. She follows the duties of marriage perfectly.” (FSR 2)

In asserting these values, I suggest, they reconfirmed their own identity as “good wives” who knew how things should be done, as well as maintaining a measure of authority in the household. Similarly Pathak (1993), writing of widowhood in an Indian community, notes that elderly women, particularly those that have ruled a family, tend to be orthodox in outlook and to cling to their authority.

In addition to their roles as mothers and mothers-in-law, these women in later life had acquired a new role, as grandparents. All proudly displayed photos of grandchildren and spoke fondly of the affection between them. Mrs S and Mrs F both spoke of (and were witnessed) indulging their grandchildren – sometimes in defiance of their parents’ attempts to impose discipline, for example over bedtimes – and tolerating their mistakes and clumsiness. As Mrs F told me, *“I would like them to have fun and good times in my house”* (FSR 2).

In some cases, grandmotherly duties extended beyond indulging a visiting grandchild and an elderly woman might play a major part in the upbringing of her grandchildren. Mrs S, for example, had volunteered to care for her grandchildren in order to enable her daughter-in-law to go out to work. Moreover, even when the grandchildren themselves became adult, a woman could cling to her role. FSR 6, Mrs A, for example, was desperate to attend the birth of her granddaughter’s first child, although her poor health made such a journey hardly feasible.

The final role asserted by the elderly participants was as employer and household manager, guiding and directing the housemaids in their work. They appeared to enjoy being seen to make decisions and command obedience, if only in the clearing of a tray. At the same time they showed real kindness and generosity towards staff, in some cases (for example FSR 6, Mrs A) viewing them as companions as much as servants. FSR 3, Mrs Fa, had cared for her driver's wife during her pregnancies, and nursed his daughter when she had asthma. The values underlying such care were articulated explicitly by Mrs F,

“Good dealing is the key of life. This includes the housemaid, you have to respect them and don't make her look down to your feet – remember before God that she is a human being.” (FSR 2)

At the same time, another motivation might be suggested. These elderly women grew up and married in the days before employment of domestic labour became commonplace. They were used to looking after themselves and others, and to the extent possible, wanted to remain active and useful. It was a point of honour with them not to leave everything to the housemaid. By sharing responsibilities (*“I wash and she irons”*) they retained something of their former identity.

Thus, for these elderly women, while age imposed some limitations and brought some changes, it was a gradual transition rather than an abrupt change. They retained a strong sense of their identity as enacted through relations with others, and exhibited pride in their ability to hold on to traditional roles and values. This experience supports the continuity theory developed by Atchley (1999) which suggests that the elderly try to preserve and maintain internal and external structures by using strategies that maintain continuity. Atchley (1999) reported positive adjustment, resilience, high self-esteem and a firm sense of values among female retirees, who carried their former identities with them and continued to derive self-esteem from them. Ageing was for most experienced as a gentle slope, with continuity used to “create and maintain a personal system that provides direction and life satisfaction (Atchley, 1999, online excerpt not paginated).

In this respect, an important part was played by the women's physical and mental ability to "perform" identity (in line with Butler's (1990) notion of identity as "doing", rather than "being"), especially as for women, identity is to a great extent linked to the care they provide in the home (Evers, 1981). This enactment of multiple roles challenges the stereotypical view of the elderly as purely dependent recipients of services. Rather, the women here, consistent with the findings of Qureshi and Walker (1989) in the West, contributed to family life and the cares of others in a variety of ways: helping with personal care, childcare and housework, advising and counselling, and providing emotional support.

Such contributions can be seen as a form of reciprocity that avoids the stigma of role reversal, whereby elderly women "fail" to conform to their assigned roles (Thompson 1995) and they and their offspring face the awkwardness of the child "parenting" the parent (Froggat, 1990). The receipt of informal assistance builds up obligations, and, as Wilson (1995) argues, if these can be reciprocated, quality of life is enhanced. Informal help received by the elderly is "paid for" indirectly and reciprocated emotionally.

7.5 Implications of the Care Arrangement

In contrast to the care home, it is not possible to construct a single blueprint of daily routine for the elderly women in family care, due to the differences in their circumstances – health, number and location of children and grandchildren, and so on. Nevertheless, it is possible to identify some general implications of family care, both for the elderly women and for the relatives who took upon themselves the responsibility of caring for them.

7.5.1 Practical

At first sight, the most obvious impact of a family care arrangement was the practical assistance afforded to the elderly women, and alleviation of her responsibilities, by daughters and/or daughters-in-law. For example Mrs Fa's daughter managed the

household so her mother could concentrate on caring for her frail husband. Both of Mrs S's daughters-in-law spoke of assisting with household chores such as cooking, and when one remarked that their mother-in-law was sometimes reluctant to be helped, the other asserted the need to cajole or insist, in order to prevent Mama becoming "too tired":

"Don't say that she refused, you have to look for a way to change her mind...I know how to convince her...I say "can you show me how to cook it?" then she says "yes" until I slowly, slowly take the whole work from her" (FSC 1)

A closer look, however, reveals that, although the elderly women's burden was reduced, it was not removed altogether, nor did they want it to be so. Indeed, as noted previously, there was a degree of reciprocity in the care arrangements, with elderly grandmothers a major source of help with childcare for busy mothers. FSC 1, 2 and 4 all benefitted in this way.

7.5.2 Social

It was noted in an earlier chapter that among the instrumental factors identified by Steverink et al. (1998) as necessary for the well-being of the elderly are three social needs: for behavioural continuation, affection and status. All these needs appeared to be met to varying degrees and in various ways, in the family situation of the women visited. I have already discussed, in the context of the women's perceptions of their identity and family role, the way in which, with differing degrees of success, they strove and were enabled to continue with familiar behaviours and to exercise a position of some authority within the household, which affirmed their status and maintained their self-esteem. I also observed the close ties of affection prevailing between the elderly women and their adult off-spring – and in the cases of FSR 1, 2 and 3, grandchildren too (I shall return to this theme in a later section, when discussing attitudes of carers toward their elderly relatives). The presence of those relatives, whether as co-residents or visitors, provided diversion, conversation and companionship. Nevertheless, some of

the women lamented the fact that, due to their physical limitations, their social circle had shrunk to those few – however loved – family members, and their activity confined to the regular household routine. They welcomed my visit as providing the novelty of a new face, different conversation and news of the outside world, because “*every day’s the same.*”

Nevertheless, with the help of willing and understanding relatives, the social needs of even the most ill or disabled could be met. I was particularly struck by the efforts made by the son and daughter-in-law of CSR 7, Mrs Ha, to provide amusement and company for her. She had always been a sociable lady who loved to visit family and friends. When she accompanied her son, FSC 16, to the UK, she was removed from these contacts, and her activities were constrained by dependence on her son, the language barrier (Scrutton, 1999, notes this can be a cause of forced disengagement) and, later, ill-health. However, her family recognized her needs and made conscious efforts to provide diversions for her. As her daughter-in-law told me:

“Look, my husband doesn’t like to drink tea, it’s like medicine to him, but because of his mother, we’d pretend to drink tea and I made a cake. Then we sat together like a party to entertain her, because we knew she loved a gathering and she missed it” (FSC 15)

Moreover, they made a point of inviting friends home and introducing them to the old lady:

“Sometimes I collected all the Arab women I knew, and the younger ladies, to visit us in our house to gather with her. I tried my best to have a good relationship with any Arab people there [in the UK] for her sake. Then they exchanged phone calls and shared advice, which gave her good feelings” (FSC 15)

In this way, although housebound and virtually bed-ridden, Mrs H, as friend, counsellor and surrogate “Mum” to the young women of her daughter’s circle (who as overseas students were no doubt missing mothers, aunts and in-laws back home) was able to

maintain some continuity of role, receive affection and preserve status as a valued member of her new community. In this way, the prescription of Steverink et al. (1998) was fulfilled, even in what might at first have appeared to be unpromising circumstances.

7.5.3 Psychological

In section 7.2 I presented evidence that the elderly woman I encountered in family settings were to a great extent able to maintain their sense of identity and self-esteem by continuing to perform the roles “scripted” for women in Saudi society. Both through their activities and through reminiscence and clinging to iconic objects, such as photographs, they maintained their self-perception as good wives, mothers and housekeepers, despite widowhood and other changes of circumstance in old age. However, as Atchley (1999) admits, continuity is not a magic prescription for “successful” ageing. Old age may pose very real functional limitations, and render previous roles impractical or no longer relevant. In such cases, clinging to the past or having unrealistic expectations is unlikely to provide continued life satisfaction. Activity theory (Havighurst, 1972 in Scrutton, 1999, p128) suggests that to maintain a positive sense of self, the person must substitute new roles for those that are lost because of age, and the women in this study appeared to have done this. They gained satisfaction from their new roles as in-laws, grandparents, advisers and teachers of younger generations – all roles that were created by and enacted within the family setting. This in turn helped women to meet the developmental tasks which Life-course theories suggest are required for successful adjustment: adjustment to declining health and physical strength; adjustment to the death of a spouse or family members; adjustment to different living arrangements; and adjustment to the pleasures of ageing, such as increased leisure and playing with grandchildren (Havighurst, 1972). A fifth adjustment also mentioned, adjustment to reduced income, was less relevant to these women, due to the comfortable financial means of their families and the generous provision made for them by their offspring, as noted elsewhere. In general, consistent with the requirements suggested by Nilsson et al. (1998), the family setting afforded

those women close personal relationships and a sense of being needed, leading to a positive view of the past, present and future.

7.6 Who Provides Care?

In analysing patterns of care among elderly women living in family settings, it is necessary to make two distinctions. The first is the distinction between care-giving relatives (son, daughter, daughter-in-law) and employees (housemaid, nurse). The second is between types of care, bearing in mind Froggat's (1990) three-fold typology of family obligation: personal care, material/financial assistance and provision of a home (temporary or permanent). Although all three types of care were observed among the women included in this study, not all received every type of care (some remained in their own homes) and the different kinds of care were provided by different people. Material and financial provision, as well as accommodation, were family matters, while personal care was shared with paid employees. Below I enlarge on this division of care, the motivations of carers for engaging in this activity and, in the case of domestic employees – who were all migrants – their background and family situation.

7.6.1 Family Carers

As noted in previous chapters, there is an expectation in Islam, and in Saudi society, that the primary responsibility for care of the elderly lies with family members, beginning with sons and, if necessary, radiating out to other relatives and to the wider community. Consistent with this social norm, all the elderly women in the family sample received care and assistance of various kinds from their adult off-spring and daughters-in-law, who expressed, as one motivation for providing such care, a sense of duty. Although, for the participants in this study, the sense of duty was derived from Islam (*"I have to care for her, for God's sake"* – FSC 4), similar feelings are commonly reported in other cultures. Qureshi and Walker (1989) in the UK similarly found that family, and particularly children, were seen as the first line of assistance for elderly people and carers they interviewed expressed a sense of obligation to assist in this way.

A strong element of this motivation, for some family members, was a belief that “you reap what you sow” or “do as you would be done by.” For example, FSC 1, Mrs S’s daughter-in-law, expressed her consciousness that “*in the days to come I will be in her position.*” More explicitly, FSC 4, Mrs F’s daughter-in-law, told me:

“I have a duty to look after her, she is a trust...Then, if I have sons, if I treat her badly, my daughters-in-law will treat me worse later...”

This is not to say that affection was not also a factor (indeed, as I shall show in the next section, strong ties of affection were noted between elderly women and their families). Nevertheless, it illustrates the extent to which normative beliefs are internalized and play a role in ensuring care provision (Qureshi and Walker, 1989).

Within the family, there was a clear division of caring roles. Financial matters and, where necessary, provision of a home, were the contributions of sons, whereas it was daughters and daughters-in-law who provided personal care.

Regarding accommodation of the elderly parent, it has been reported previously that a home was provided for Mrs Ha (FSR 7) by her son, throughout her years of widowhood, as part of what he viewed as an inherited family responsibility. In the case of Mrs H (FSR 4) her sons provided a temporary home during her last illness. Whether or not the elderly woman lived in her son’s home, in every case, one or more sons provided and administered material and financial resources. For example, Mrs S’s daughter-in-law told me:

“Her sons contribute money between them and give it to their sister to buy whatever she needs” (FSC 1)

This role of provider is consistent with sons’ responsibility in Islam, as noted previously, but also calls to mind similar findings in the West (Qureshi and Walker, 1989).

In practice, however (and again as widely reported in the literature) day-to-day personal care was provided by female relatives, predominantly daughters-in-law, since daughters were normally married and had therefore moved away. Both FSC 1 and FSC 4, the daughters-in-law of Mrs S and Mrs F respectively, commented that because of the time spent together and involvement in day-to-day care, they knew the elderly woman better than her son and played a significant role in mediating the relationship between them.

“Sometimes, when I see her eyes expressing upset, I ask him, “What’s wrong with your mother?” He says, “Nothing, she’s fine.” After 11 years staying with her, I’ve come to know her more than her son. While he goes to work, I spend most of the time with her, eat and drink with her, so I know her better than anybody” (FSC 1)

“Sometimes when my husband happened to forget to greet his mother on Eid because of being very busy and tired from work, I remind him...” (FSC 4)

In these, as in other cases, long hours of companionship and shared participation in household tasks had created a bond between the mother and daughter-in-law which went some way to mitigate any sense of burden on the part of the daughter-in-law or uncomfortable dependence and loss of status on the part of the mother. Nevertheless, it can be understood why Altorki (1986) suggests that relationships with daughters-in-law may be a dominating factor in widows’ choice of living arrangements and the prospects for domestic harmony.

The relationship between the elderly woman and her family was, however, only one part of the care equation. All the participating families employed one or more members of domestic staff, as is increasingly common practice in Saudi Arabia (Al-Tuwaijri, 2001). I shall consider their role next.

7.6.2 Paid Help

All the participating households employed at least one, and in some cases two or three housemaids, while the families of FSR 4, Mrs H and FSR 6, Mrs A, additionally employed qualified nurses to meet these women's needs for more specialized medical monitoring and care.

Consistent with what has previously been reported regarding patterns of migration (Kurian, 2004) and specifically domestic workers in Saudi Arabia (Esim and Smith, 2004; Johnson, 2010 and Pingol, 2010), the women employed in these households were all either Indonesian or Filipina. For most, the motivation for migration had been economic. Some, such as FSC 5, who worked as a housemaid for Mrs F, were not well-educated. She told me she had finished the second year of high school then worked as a shop assistant. However, because “*you know, the economic level in the Philippines is bad*” and her father was a struggling farmer. “*I decided to travel here to Saudi Arabia for a better wage.*” Even a trained professional, FSC 13, a nurse employed to care for Mrs A, explained that she could earn more in Saudi Arabia than at home and, moreover, more in a private residence than in a hospital.

“The main reason [for migrating] is money. I need money; my husband is jobless and I have three kids in the Philippines...[My salary here is] 2,500 Riyals...I received 1,600 Riyals in the clinic, plus overtime, usually a total of 1,800 to 1,900 Riyals.” (FSC 13)

This nurse was very experienced in her field, having worked for a number of years in hospitals and clinics in Jeddah and Abha before her present job. She and the other nurses were the only employees with specific training related to elderly care. In the case of FSC 13, however, her work history had included experience in a number of hospitals and specialist clinics, and she clearly missed those more challenging environments:

“Sometimes I really miss the work in the hospital; because of having no nursing work I feel so bored. I just keep watching the health status of

“Mama”, and sometimes I feel that I will maybe forget the knowledge I’ve gained in the field of nursing” (FSC 13)

Similar fears of deskilling among qualified migrant employees are reported by, for example, Parreñas (2001)

Among the unqualified migrant workers, whose role was as general domestic workers rather than in the provision of intimate personal or nursing care, experience and tenure varied greatly, in some cases as little as one year. However two (FSC 11 and FSC 14) had long service tenure, pre-dating by many years the employers’ old age. These women had become “fixtures” in the employing households and, as will be seen in the next section, had become valued companions of the elderly women they served.

Consistent with previous findings on global care chains (Kurian, 2004, McGregor, 2007, Parreñas, 2001), the majority of these migrant workers had elderly relatives left at home and/or were married with children, thus having to balance the trade-off between the economic benefits of migrant employment and the loss of time available to care for their own loved ones. FSC 3, for example, had an elderly mother and very old grandmother at home in Indonesia, cared for by the mother’s youngest sister. However pressing the economic rationale for migration, such situations were a source of distress and feelings of guilt on the part of the migrating daughter. I was moved by the situation of FSR 13, Mrs A’s nurse, for example, who told me sadly:

“Sometimes I wish I could take care of my mother like I do for “Mama” and sometimes I cry about it when I talk to my mother and say I’m very sorry mother...”

Both natural bonds of affection and internalized normative beliefs about family roles were violated when economic necessity forced a migrant worker to abandon her own family to the care of others. In addition to concerns about parents, most of the migrant workers also had responsibilities related to husbands and children, in some cases in Saudi Arabia with them, in other cases in their countries of origin.

Only one of the housemaids was unmarried. In some cases, the housemaid's husband was also employed by the same family, as a driver. In one such case, the couple had actually met while in service and had asked their employers for permission to marry (the employers being effectively the woman's "guardians" in the absence of her own parents, who died before she migrated). She told me:

"When I wanted to marry our Filipino driver, I told them. Then the father and mother of this family, who stand for me as my parents, arranged our marriage, then they celebrated with a party, like a grand wedding, and everyone brought me a special gift. I couldn't believe that it happened in my life." (FSC 14)

In another case, the wife had migrated first and had asked her employers to help get work for her husband. "Madam" had accordingly sent a visa to enable her husband to join the household as a driver. Unfortunately the arrangement had not been a happy one and the respondent had eventually begged her mistress to send her husband – who was *"always making trouble for me"* – back to Indonesia, and they divorced. She had one daughter, who was married and living in Indonesia, and she appeared to accept the situation. For women with younger children, however, leaving them behind while working in a foreign country was a departure from traditional ideologies and norms of maternal care and (similarly to the experience of Latina migrants, reported by Hondagneu-Sotelo and Avila, 1997) involved a reconceptualization of the "mothering". As Hondagneu-Sotelo and Avila (1997) point out, solo mothering within the home is an ideal only possible where there is a certain level of economic security. In practice, women in less favourable circumstances have always worked, sharing mothering responsibilities with kin and friends in order to do so. With the long distances of space and time that separate transnational mothers from their children, preventing their provision of primary care, such women construct a new mothering identity as breadwinners; they fulfil their maternal responsibilities by earning the means to support their children and afford them a better quality of life. Where migrant mothers were separated from younger offspring, however, regular visits and gift-giving could not compensate for the sadness of separation.

Despite these personal conflicts of emotion and duty, it would be wrong, however, to portray these women solely as victims. They had in many cases made proactive choices and expressed satisfaction with the solutions they had found to the difficulties they had faced. In this respect, an interesting case is that of FSC 3, Mrs S's housemaid, who was working for her "illegally" having, as she put it, "*escaped*" while visiting Medina for Omrah (minor pilgrimage). In theory, as noted previously, domestic workers are not allowed to leave their original employer and sponsor without permission, but increasingly, some migrant workers are doing so, in order to demand higher wages. FSC 3, for example, told me her salary was 1,000 Riyals (a more usual figure, reported by other housemaids, would be 800 Riyals). Moreover, because she had acted independently, rather than through the organization set up to support Indonesian domestic workers, she was able to benefit fully from her higher salary, rather than pay dues (150 Riyals a month) to the organization. Silvey (2004) reports the existence of similar organizations, and a growing level of activism among migrant workers.

7.7 Attitudes of Carers and Dynamics of the Relationship

The broad distinction between family carers and employed domestic workers was reflected in the range of relationships observed among and described by the research participants and it seems appropriate, therefore, to discuss these two main types of relationship separately.

With regard to family carers, foremost among the attitudes expressed was a strong and deep affection for the elderly woman, recalling Kurian's (2004) claim that family care is high in emotional care. The loving relations of a close-knit family were captured beautifully in a vignette recalled with warm smiles by FSC 15, Mrs Ha's daughter-in-law:

"All of us sat on a single bed together - my husband, me, my mother-in-law and all my kids, then we realized and looked at each other, surprised. She said [mimicking Mrs Ha's teasing tone], "Oh, get off, you'll break the bed! Why are you crowding me? Go and sit somewhere else, there's plenty of

space”. Then we laughed together. We just wanted to get warm from her, to be close. She was so sweet it felt good to sit beside her.”

The affection expressed by relatives was widely attributed to the personal qualities of the elderly lady herself. Daughters-in-law particularly appreciated the forbearance shown to them as new brides, and the encouragement they received. FSC 10, Mrs H’s daughter-in-law, for example, described her mother-in-law as “*big-hearted and broad-minded*”, and recalled tearfully (the old lady had died a month before the conversation) how she had benefitted from her comfort and wisdom:

“I felt she was like my mother. When I was distressed, I told her my feelings and she advised me; her advice was always good.”

To a great extent, the giving of care was an expression of love, and of gratitude for the care previously given by the parent or the parent-in-law.

I also noticed a feeling of mutuality, a sense among the carers that they too had benefitted from the care arrangement. In some cases, this went beyond the apparent and tangible reciprocity of help with childcare and housework, to a more intangible sense that the elderly woman’s presence was in some way responsible for the general good fortune of the family. FSC 1, Mrs S’s daughter-in-law, told me:

“God sent us an open-ended blessing on our home, like giving us healthy children, plenty of food and my husband’s success in expanding his business. God has blessed us while she’s lived with us.”

Such feelings might be attributed to a self-righteous feeling of having done one’s duty, since care of the elderly is a religious obligation, the fulfillment of which would bring its just rewards. As expressed by this respondent, however, this “*blessing*” was a direct response to the prayers of the old lady herself:

“...because of the blessing of an old woman inside our house who is continuously praying, supplicating for us, there’s light in our home” (FSC 1)

These expressions go beyond the general sense of personal satisfaction and reward reported in family carers by, for example, Walker and Warren (1996) in their London survey, and clearly reflect the impact of internalized Islamic values in regard to the caring relationship.

This is not to claim, however, that relations between carer and cared-for were always smooth. Occasional glimpses were seen of the reality that care-giving can pose practical and emotional difficulties. Elderly women, especially when sick, could sometimes be challenging in their behaviour and forbearance was necessary: *“We have to understand her”* (FSC 12). Moreover, perceived favouritism on the part of the elderly woman, or unequal division of care, could cause jealousies and resentment – not necessarily towards the elderly woman herself, but among other family members. I shall consider these issues more fully in section 7.8 when I come to discuss challenges and support in the care relationship. First, however, I shall consider the relationship between the elderly women and the other carers – the paid nurses and domestics.

These carers too, expressed considerable affection for the elderly women in their care. These feelings were clearly linked in their responses to appreciation for kindness and consideration on the part of their employers. As FSC 5, a Filipina housemaid, explained:

“I love my job because they are kind and pleasant to me. She [the old lady] speaks to me softly and nicely, which makes me love them and be kind to them.”

A common theme was to speak of the employers as a rival or substitute family. Interviewees commonly referred to their employers in terms such as *“our mother”* or *“Mama”*, and while this may to some extent be a conventional form of reference, acknowledging the old lady’s status in the household, it seemed also in many cases to

reflect a sense of identification with the employing family. FSC 5, quoted above, went as far as to claim, *“My lady boss is like my mother”*. For women living away from their families, employers were indeed, as noted previously, effectively “guardians”, and the elderly women in these households had certainly taken seriously their responsibilities toward these workers – I heard of generous gifts of clothing to the housemaid and her children; of the matriarch advising and caring for her housemaid in pregnancy or nursing her sick child and even, as described earlier, arranging a marriage and wedding celebration. Moreover, elderly women expressed affection for their housemaids. FSR 5, Mrs A, said of the Indonesian migrant worker who had lived with the family for 23 years, *“She is my daughter, very dear to me”*, and went on to speak of her absolute trust in the woman concerned, *“even with my whole house when I travel.”*

Nevertheless, it was clear that, however strong the affection expressed between employer and employee, and however benevolent the employer, these were not equal relationships. As Moors (2003) points out in her review of migrant literature, these domestic workers are incorporated into the household, yet simultaneously excluded, their quasi-kinship having distinctly hierarchical features. The employees’ movements were constrained and although I heard of many instances of their being taken with the family on outings or “allowed” to visit relatives working in other households, the fact remains that these benefits were in the hands of the employer. The boundaries to the reciprocity in these relationships are well illustrated by the matter of Eid gift-giving. Whereas employers were all reported to give generous gifts to their employees at Eid, the giving was an act of benevolence or charity towards a subordinate, rather than a mutual exchange, and was not reciprocated. As FSC 11, Mrs R’s housemaid, told me:

“Oh! No...I am a poor woman to give her [gifts]. She doesn’t need it, she has everything.”

Clearly these relationships operated within boundaries accepted by both sides. Within this framework, however, these workers and their employers had negotiated a manner of co-existence that provided the elderly woman with both practical assistance and companionship.

7.8 Challenges Facing Carers and Sources of Support

It is reported (e.g. Qureshi and Walker, 1989) that caring for an elderly person is not an easy task; it poses practical difficulties and affects the dynamics of relationships within the family of the cared-for. Consistent with this view, I saw among the participating families occasional glimpses of strains and challenges that could face even the most loving and willing carers.

Given the lack of a welfare state in Saudi Arabia, care of an elderly relative could have significant financial implications. While loss of earnings of family members may be less an issue than reported, for example, in the UK (Parker and Lawton, 1994) since Saudi women's participation in the workforce is still low by international standards, there were direct costs in the provision of equipment and living aids. Three of the families involved in this study had faced such demands on their resources.

Elderly women could also be difficult in their behaviour. FSC 16, for example, recalled how his mother had become uncooperative with her medical regime and irritable with the housemaid who was trying to help her. He needed patience and ingenuity to pacify both sides; ostensibly taking his mother's part and cajoling her into accepting her medicine, but later mollifying the offended housemaid with a gift or outing, and calling for her understanding of his mother's condition. Qureshi and Walker (1989) similarly note the difficulties faced by families when age and infirmity seem to change the personality and behaviour of the loved one.

Other challenges, however, were more social and emotional. Whilst close or co-residence could be rewarding for both parties and bring reciprocal benefits, it could also be a source of strain due to conflict of needs and lifestyles. Different preferences in such day-to-day matters as bedtimes, the food served, tolerance of noise or entertainment of guests could be sources of tension. One of Mrs S's daughters-in-law, quiet and reserved by nature, spoke of her difficulty in accommodating the lack of privacy and the comings and goings of a highly sociable housemaid. Similarly, the elderly women themselves experienced strain, related to the younger generation's "new" ways – a similar issue arising in the adjustment of elderly people is reported by Coleman (1990). Sometimes

these conflicts were resolved by a simple agreement to differ; for each party to maintain their own preferences. For example FCR 1, Mrs S, insisted on maintaining her accustomed dietary habits:

“If they offer me modern foods that I don’t like, I tell them I prefer my native traditional foods – just leave me alone, don’t dictate to me or push me.”

Such differences were relatively easily reconciled, but in other cases, conflict of lifestyle could be more serious, with lasting consequences.

Caring could strain relationships, not only between the elderly women and the carer, but also between other members of the family. I observed several instances of jealousy between daughters and daughters-in-law, reflecting a variety of emotions raised by the caring relationship: the need to feel that love was returned and care rewarded, resentment of those who, perhaps, “should” have done more, guiltiness and regret at not having played an expected role. Mrs S’s two daughters-in-law, however pleasant and light-hearted their manner on the surface, betrayed some rivalry as each tried to assert her special relationship with her mother-in-law. Mrs F’s daughter-in-law, the regular, “live-in” carer, betrayed jealousy and resentment of the woman’s married daughter, who lived some distance away:

“I used to feel she treated me like a daughter but she soon changed her manner when her real daughter came to visit her for a second, although I deal with her throughout her life, and from this time I told myself, “I’m not her real daughter” (FSC 6)

Conversely, in the case of FSR 4, Mrs H, it was the daughter who showed jealousy of her sister-in-law, with whom her mother had lived her last months;

“She [the daughter] shouted in my face, “Why didn’t you tell me [mother was dying]? My mother lived with me all my life, and now you’ve prevented me from having her die in my arms, not yours”” (FSC 10)

In dealing with these practical and emotional challenges, family carers had two sources of support: the sense of religious duty and the contributions of other family members. Both of these have been highlighted in previous sections and so will not be discussed further here. It is, however, worth emphasizing again that there is no systematic, statutory support, through district nurses, community workers and the like, for Saudi families caring for an elderly relative.

Paid cares and domestic workers employed by these families faced different challenges. Although it can be inferred from the experience of the self-confessed “escapee” from another household (FSC3), that for some domestic workers, low wages and poor working conditions are among the challenges faced, none of the interviewees raised such issues related to their current employment. Rather, their concerns focused on problems of cultural adaptation and separation from their families. In the former category, for example, FSC11, an Indonesian housemaid, focused on Arab foods, and mentioned her dislike of preparing kouba (a mixture of spiced ground meat and bulgur wheat which may be shaped in various ways, into small balls, patties or lozenges) because she found it time-consuming and tedious. In the second category was FSC13, a Filipina nurse, who had left an elderly mother, an unemployed husband and three children in her country of origin. As described in a previous section, she spoke of her role conflict and sadness at being unable to give primary care to her own mother as she did to her employer. Nevertheless, it was interesting to note that some of the migrant workers insisted (even when interviewed privately and “free” to speak) that they faced no problems or dislikes in their work. This may be partly attributable to their working in relatively generous and considerate households. Another factor, however, was the support of family and friends; some had relatives working in the same household or nearby, and visits between members of the employing families provided opportunities for their employees too, to socialize. In this way they constructed a sense of community in their foreign home.

7.9 Summary

As noted in earlier chapters, it seems to have become commonplace in both Western and Middle Eastern cultures to perceive care of the elderly as a problem; to lament the supposed decline of family feeling and responsibility and to paint a picture of depression and isolation (Coleman and Bond, 1990; Al-Tahhan, 1999). Whilst it might be true that, due to social change, the pressures on and aspirations of women are changing and the availability of daughters and daughters-in-law as carers cannot be taken for granted, as this chapter has shown, many Saudi families still espouse the “traditional” value of filial responsibility and are finding ways of enacting it.

The participating families included only one case of a woman living “alone” (i.e. without co-resident family; she was attended by a housemaid) and various close or co-residence arrangements with adult offspring. Economic means, family structure and the quality of personal relationships were the main factors influencing the decision on living arrangements – in which the elderly woman was a full participant, if not the instigator. The elderly women were seen to be full of character, with strong values, self-esteem and sense of identity, derived both from the associations of their surroundings, and from a network of roles and relationships. Through their interactions with the physical environment and with family and employees, they asserted and maintained, despite some loss of strength and vigour, their former identities as wives, housekeepers and mothers, and adjusted to new roles as mothers-in-law and grandparents. Thus, their role at the heart of the family not only afforded them practical and financial assistance, but also appeared to be central to their psychological adjustment. Key to those relationships was a sense of reciprocity; these were not simply “cared-for, dependent” women, but women actively engaged in the life around them.

Turning to the carers in these settings, a broad distinction was drawn between family members and employed carers, each with their own motivations and attitudes, and playing various parts in the life and identity constructed by and for the elderly woman. Among both sets of carers, strong feelings of affection towards the elderly woman were expressed, associated with appreciation of the elderly woman’s personal qualities, a sense of both obligation and pleasure in repaying kindness received, and – on the part of

family members, a sense of filial respect and responsibility informed by internalized Islamic norms.

Nevertheless, the caring relationship was not without difficulties and challenges. It imposed financial costs on the family, it necessitated a degree of forbearance and compromise in adjusting to different lifestyle preferences; and it could strain the dynamics of the relationships among other members of the family. Foreign workers, meanwhile, faced the strains of adapting to the ways of another culture, and the pain of separation from loved ones in their home country.

As I pointed out at the beginning of this chapter, I make no claims that these families are typical, or that they offer a prescription for how elderly care should be provided. However, they do help to highlight some of the issues affecting the feasibility and outcome of the decision to care for an elderly woman within the family setting. These cases, and the institutional care cases presented in earlier chapters, are snapshots of points on a spectrum of care possibilities, which offer insights into social change in Saudi Arabia, and have implications for the theorizing of ageing and the provision of elderly care, which I shall highlight in the next, concluding chapter.

Chapter Eight

Conclusions and Reflections

8.1 Introduction

In the preceding chapters, I set out and explained my intention to explore how elderly women are cared for in both institutional and family settings in Medina, Saudi Arabia. The research took place in the context of a country in transition, with traditional values and social systems confronting new forces of modernity, with implications for social care: urbanization and internal migration, the move from the extended family to the nuclear family, the increased participation of women in the workforce and reliance on migrant workers. Such factors raise questions as to whether traditional values of family and community care of the elderly are breaking down and how the needs of a growing elderly generation are being met. In the present chapter, I draw together the research findings and offer some reflections on the research process and its outcomes. I begin by summarizing the findings already presented in Chapters Five, Six and Seven regarding the care settings, decisions on living arrangements of the elderly women, how the women perceive their role in the family and society, the care providers, their relationship with the elderly in their care, the challenges facing carers and sources of support available to them (research questions 1-6). In so doing, I also answer the seventh research question, concerning similarities and differences in the care provided in the two settings. Then, I reflect on the research process and my role as a researcher, and on the research contributions and implications. I discuss critically the limitations of the present study and offer some thoughts on how its contributions can be followed up in future research. In a final post-script I highlight some improvements that have already been made in the care home facilities and conditions, as a direct result of this research.

8.2 Similarities and Differences in Family and Care Home Settings – A Summary

In this section I highlight the key features observed in relation to the two research settings: the social care home and family setting in order to draw a comparison between them. In so doing, I am aware of the dangers of a simplistic polarization, particularly given the limitations of the research scope and sample (see section 8.5). Moreover, there were individual differences in both groups. Nevertheless, I feel such comparison is worthwhile as it helps to draw attention to issues faced by the women and carers in these particular settings. I leave it to the readers to judge how far these findings are applicable to other settings, based on the principle of transferability, rather than generalizability, proposed for qualitative research (Guba and Lincoln, 1989).

As regards the physical environment, it was noticeable that, particularly at the beginning of the fieldwork, the care home setting was bleak and impersonal, with little sensory stimulation, few objects to connect women to their culture and past lives, and little social or recreational space. In contrast, all the family homes visited were comfortable, and colourful, rich in association and vibrant social spaces where the elderly engaged regularly with family and domestic employees.

Decisions on living and care arrangements were influenced by three major issues: economic status, health and family structure. Whilst the women cared for at home were from middle to upper class families with ample financial means, were mostly in reasonably good health and had adult offspring able and willing to provide care, those in the care home were less fortunate. Many were from impoverished families; they exhibited a variety of physical illnesses and infirmities, and in some case dementia or mental illness; and a significant number were disadvantaged by childlessness or family disruption. They were not necessarily “victims” of uncaring families; rather, a combination of circumstances had in many cases made family care difficult.

In these conditions, elderly women were observed to construe their family and social roles in very different ways. Women in the family setting were undergoing a gradual transition as they continued to enact their familiar roles as wives, mothers and

housekeepers, albeit with increased assistance from others, and as roles “lost” (for example through widowhood) were transformed in the symbolic form of iconic objects and photographs, and compensated by new roles, such as grandparent. In contrast, the care home residents had experienced an abrupt, unwelcome change – no longer capable of performing (or allowed to perform) their accepted social roles and given new identities – constructed by themselves and others – as “patients” and “victims”. This major difference between the settings was accompanied by other dichotomies: the feelings of being connected with others versus abandoned/rejected, of being useful versus feeling useless, and of agency and reciprocity versus passivity – although as indicated in Chapter Five, some care home residents found limited ways to assert their identity through song and poetry and even through mealtime tantrums.

As a consequence of their care arrangements, women in both settings had their subsistence and medical needs met; the main difference was the financial implication. For women in the care home, these were provided with state funding, while families met all these needs themselves, sometimes at considerable expense, in the absence of any statutory welfare support. While these families had the resources to do so, many others would be less fortunate.

In both settings, care provision relied heavily on migrant workers, mostly from Indonesia and the Philippines. In family homes, sons (with legal/religious responsibility) and daughters/daughters-in-law (as actual providers of personal care) were assisted by housemaids and, in two cases, private nurses. In the care home, more than half of the staff, including a few medical professionals and all the patient assistants, were migrants. In both settings, however, the majority of the migrant employees had no training in elderly care. They had migrated predominantly for economic reasons, but in some cases among care home employees also expressed a religious motivation, encompassing both the desire to be of service and the desire to live in an Islamic environment. Religious motivation for caring was expressed by family members also, and internalized religious and social values were reflected in a strong sense of duty to provide care.

Both family and employed carers (in both settings) expressed considerable affection for the elderly women in their care. Among family-setting carers, this was attributed to the qualities of the women concerned, and gratitude for kindness received. There was a tendency, too, among migrant workers in both settings, to view the elderly women as substitute family, and replacement for parents and grandparents who were deceased or had been left behind in the country of origin. Despite these similarities, however, there were noticeable differences. Relationships in the family setting were more individualized, and characterized by greater reciprocity and mutuality; women in family homes were still contributing to family life, as babysitters, advisers and employers. It was noticeable that carers of these women expressed respect for them, whereas the dominant sense in the care home was pity.

Carers in both family and care home settings faced challenges. For families, these were two-fold; the cost of providing care, and the renegotiating and balancing of roles and relationships (adjusting to loss of privacy, allocation of responsibilities, jealousies among siblings and in-laws). In the care home, the challenges were mainly related to low pay and poor working conditions, especially for non-Saudis. In both settings, however, sources of support were similar: personal initiatives and relationships with others, whether family members or co-workers.

In a later section I consider the theoretical significance and practical implications of these findings. First, however, I reflect on the research process and my role in it.

8.3 Reflections on My Role as Researcher

As explained in Chapter Four, in conducting this research, I adopted an interpretivist/constructivist stance, in which I sought to gain deep and intimate understanding of the lived experience of elderly women and their carers, to see their world through their eyes and to reflect not only on physical realities but also on emotional meanings. For this purpose I employed qualitative methods; participant observation, combined with a flexible interviewing technique. In taking such an approach, I was taking a risk, as purely qualitative research is rare in Saudi Arabia. This

can be explained partly by the lack of a research culture and partly by cultural norms of privacy and a reluctance to disclose personal information or problems openly. The fact that, despite these constraints, I was able not only to gain access to family homes and to a social care institution, but also to elicit so much personal disclosure is a significant achievement. It shows qualitative approaches can succeed in the Saudi context, perhaps reflecting a gradual shift in attitudes and a greater mood of openness in the country.

At the same time, I had to invest considerable time and effort in gaining the trust of participants and building rapport with them, particularly in the care home, where I was at first suspected of being some sort of government “spy” (a not uncommon reaction to researchers in this culture). Gradually, however, particularly once my family credentials were established and the sincerity of my intentions clear, I was able to “get beneath the surface” of the situation and was rewarded with rich information. Over time, indeed, I came to be regarded as, and to feel like, an “insider”, and was increasingly able to engage more fully with both staff and residents.

This growing and deep involvement brought its own problems, however. An essential aspect of my paradigmatic stance was my willingness to bring my own subjectivity into the research setting, and it was impossible to avoid emotional involvement. In this sense I faced a tension between my role as researcher and my role as community member. As a researcher, I was in the setting to gather data and construct interpretations, and whilst I deliberately rejected the positivist pursuit of neutrality, I inevitably had to reflect on the extent of my involvement, whether this might distort the situation, and how far I should see myself as a change agent. Meanwhile, as a member of a collectivist society – and one relatively privileged by education, material means and social network, I faced a clear expectation from participants that I would provide immediate and tangible help. In this situation, my guiding principle was a sense of ethical and humanitarian responsibility to act where the well-being of others was at stake. To do otherwise would be to objectify my participants. Witnessing poor conditions and overcrowding that posed clear health and safety risks, were evidently damaging psychologically, and exposed women to assault from more unstable residents, I felt emotionally and ethically required to intervene by writing to my uncle, a member of the Medina council, who conveyed my concerns to the city’s governor. The improvements brought about as a

result (see the Postscript to this chapter) vindicated my action and indirectly benefitted the research as well (although this was not an intended or expected outcome), since it demonstrated to the care home staff my genuine concern for them and the women in their care, thus strengthening the relationship between us, and enhancing the openness of their disclosures. As I see it, research can never be truly value free, and I believe that my willingness to bring my own values and subjectivity into the research enhanced my understanding as a researcher and was ultimately beneficial to the participants and to the research purpose.

8.4 Contributions and Implications of the Research

8.4.1 Theoretical Implications

The findings of this study contribute in various ways to existing knowledge, whether by supporting or challenging prevailing views or by extending their application to a novel research context. The implications of the findings are in three main areas: with regard to ageing and the care of the elderly; with regard to social change and the family system in Saudi Arabia; and with regard to the experiences of female migrant workers.

With regard to ageing and care of the elderly, reference has been made to a number of theories of ageing, and the findings demonstrate that all have some salience in the Saudi context. Evidence was found of disengagement among some elderly participants, expressed in withdrawal, a preference for solitude and a disinclination to participate in communal activities. However, as noted previously, such attitudes were specific to the care home population and were not manifested among family residents. In four of the seven cases involved, this could be partly attributable to better health. Nevertheless, FSR6, with kidney disease, still enjoyed travelling to be near her favourite mosque, while FSR7, with the aid of her family, maintained an active social life as friend and adviser to younger Arab women living in the UK, even after she became bedridden. Thus, the differences cannot be explained solely in terms of health status. This lends support to the view of those critics of disengagement theory who argue that disengagement, far from being a natural or voluntary part of ageing is actually forced on

the elderly by society. In the case of care home residents, it was a response to both rejection and abandonment (actual or perceived) by family and community, and characterization by staff as passive victims. In contrast, among the family sample, more evidence was seen consistent with activity theory (the satisfaction gained from active engagement in household tasks), continuity theory (the maintenance of self esteem through continuation of valued social roles and identities, such as wife and mother) and adjustment theory (acceptance of physical limitations, adjustment to new living circumstances, new roles as grandparents and counsellors. At the same time, within each group, care home and family residents, there were individual differences. The care home experience was not solely one of disengagement, as demonstrated by the enjoyment some women found in poetry and dancing – which also reaffirmed former tribal and family identities. Nor was the family experience necessarily one of perfect adjustment. Elderly women found some aspects of modern life difficult or even rejected them; new roles brought tensions as well as pleasures; and despite the company of family, the complaints that “nothing ever happens; every day’s the same” reflected some miss-match between expectations or perceived need and day-to-day reality. Thus, while each of the theories of ageing goes some way to explaining certain aspects of ageing, none presents a universal description, or a blueprint for “successful” ageing. Rather than support any one theory, the findings suggest a more nuanced and contextualized view which recognizes how biological, economic and social factors interact to constrain or support adjustment and well-being in later life.

This brings me to my second theme, that of social change and the family system in Saudi Arabia. In previous chapters I quoted the views of Saudi writers who suggested that with economic development had come the collapse of the traditional extended family and a loss of family feelings and social solidarity (Al-Divayen, 2003; Al-Thaaqib, 1986; Al-Tuwaijri, 2001). The implication seemed to be that the “traditional” life and values were necessarily and always beneficial to the elderly and that the effects of modernity had been detrimental. My findings challenge these views. First of all, they show that the extended family system may have been modified, but it has not been eliminated. In the family settings investigated, adult off-spring were not necessarily technically co-resident with parents, but they tended to stay in close proximity (even in the same building or complex), to visit regularly, and to maintain a strong sense of filial

obligation. In such cases, the employment of migrant housemaids and nurses was not a substitute for family obligations, but a mechanism that helped sustain them. Their assistance was in turn reciprocated by various forms of practical and emotional support on the part of the elderly women. Among care home residents too, many had previously benefited from extended family in the provision of accommodation, financial support and personal care. Their eventual admission to the care home was not necessarily a reflection of broken social bonds, but of a more complex array of social and economic factors.

Not only do the findings challenge the view that the traditional family system and values have been entirely eroded, but they also challenge the view that traditional values have been entirely beneficial to the elderly. Again, the reality seems to be more complex. Certainly some internalized cultural and religious values appeared to play a part in encouraging family care of the elderly, and the respect and forbearance shown to them by their offspring. They also figured strongly in the compassion shown by many care home staff toward their charges. At the same time, it was seen that in other ways, cultural values, notably patriarchy, and associated social structures and expectations, contributed in disadvantaging some women. The emphasis on and privileging of the roles of wife and mother undermined the self-concept of women in the care home who could no longer enact those roles, or perhaps due to ill-health and/or childlessness had never been able to do so. The privileging of male authority resulted in women being admitted to the care home on the basis of decisions made by others, in which they had no part; even the basic comfort and dignity of sufficient and timely supply of Pampers depended on the management of the Men's Section. Most disturbing of all, abuse of male power had resulted in the institutionalization of women (the 16 year-old rape victim and the widowed "social protection case") who should never have been accommodated alongside the elderly and mentally ill. By uncovering and highlighting such cases, this study goes some way towards challenging certain discourses prevalent in the recent characterization of social change in Saudi Arabia. In this way, it is hoped it will be a step towards deeper understanding and more open discussion of the social changes facing the country, the effects on the family and social system, and how old and new values may be negotiated in ways that protect and support women, young and old alike.

Finally, I consider the contribution of the research to the understanding of female migration, which although not the major focus of the research, arose as an important theme due to the role such migrants play in the care of the elderly, whether in family or institutional settings, in Saudi Arabia. Here, three points emerge. First, the findings confirm that the motivation for migration was primarily economic, consistent with the prevailing view in the literature (e.g. Kurian, 2004). However, they challenge the view of migrants as victims, which a predominant focus on their economic disadvantage tends to encourage. Contrary to this image, the women I met in both family and care home settings were strong individuals who had made proactive decisions and taken risks in order to improve their situation, whether by the original decision to migrate or by “escaping” one employer in order to seek better wages elsewhere. I also heard reports of “company” employees striking in protest at unsatisfactory working conditions, and of a growing activism among domestic employees, represented by the Indonesian workers’ aid organization. It would seem that migrant studies need to take a more balanced view of the situation of female domestic migrants and explore the extent to which they are able to exercise agency, negotiate their role and to maintain a positive view of themselves and their life.

A second way in which the present findings add to the migrant literature is in the way they enrich the picture of global care chains by focusing specifically on elderly care, rather than solely child care; and on institutional workers as well as those employed in private homes. Yeates (2004), in her critique of global care chain literature, calls for such broadening of focus, arguing that “*childcare workers in contemporary, individualized care settings ... may not be typical / representative of all migrant care workers*” (p379). She advocates a revised framework which should include skilled and semi-skilled as well as unskilled workers; different family types; working in institutional as well as family settings, and providing different types of care. This study goes some way towards answering Yeate’s (2004) call. Among Saudi writers in particular, the position of migrant workers has attracted interest in recent years, and the discourse has been overwhelmingly negative, with a stereotypical view of modern women abdicating responsibility (predominantly for children) to foreign housemaids, with detrimental effects on children’s language development (due to the poor Arabic of

foreign workers) and morals (due to the import of alien cultural influences). This discourse overlooks the valuable role played by migrant workers as carers and companions of the elderly, both in the home and in institutions where their service is vital, given the shortage of Saudis in the nursing and care fields. In contrast, the present study contributes to a more comprehensive and balanced picture of the contribution of migrant women to care work in Saudi Arabia as a major receiving country, and of how elderly care is in effect subsidized by the labour of these women and (in family settings), the financial provision of the middle-class families who employ them. The picture emerges of a complex scenario in which migrant workers on the one hand, in institutional settings may be seen as replacing family care; on the other, in private homes, they contribute to sustaining traditional values of family and care responsibilities.

Thirdly, the present research findings contradict the common claim (e.g. McGregor, 2007; Parreñas, 2001) of deskilling and downward occupational mobility among migrant workers. Those migrants with professional training in, for example, nursing, dentistry or physiotherapy, were employed in their fields of specialization. The one partial exception, a private nursing attendant whose duties were relatively light and who feared that she would forget her skills, had been employed in Saudi clinics and hospitals but had chosen private work for financial reasons. This finding may reflect the uniqueness of the Saudi situation, where the present shortage of qualified locals forces recruitment of professionals from abroad and I do not claim to challenge the findings reported in other contexts. Nevertheless, by at least showing that there can be another side to the migrant experience, this research contributes to a broader understanding of variations within the global care chain picture.

Having considered the theoretical contributions of this research, I turn now to assess the practical implications of the findings for care of the elderly. It is worth highlighting here that this work was predominantly designed to inform policy and was empirical in nature.

8.4.2 Implications for Practice

Although the findings of this study relate to only one care home and a small group of families, they raise themes and issues which may have wider applicability, and provide pointers to some ways forward in the provision of care for elderly women in the Saudi context. A two-fold approach is indicated. First, assuming that, where possible, care in the family setting provides the optimum alternative for the comfort and well-being of the elderly, support services are needed to enable and facilitate the provision of such care. Whilst family care of the elderly is in line with Government policy and with social and religious expectations in Saudi Arabia, it must be recognized that society is changing and also that there are many circumstances which may make family care difficult. The availability of statutory and voluntary forms of support – economic, practical and social – could alleviate the strain on families of elderly women and postpone or even avoid the need for institutionalization. Second, where, for whatever reason, institutional care is the only alternative, thought should be given to ways of enhancing the quality of life of the elderly residents, promoting positive self-concept and adjustment, and encouraging continuity of relationships with family and friends.

To take first of all the family setting, it has been noted previously that some of the participating families had incurred considerable expense in the provision of living aids, medical equipment and professional care for the elderly spouse or parent. Moreover, poverty of the elderly women and their families was found to be a major factor in admissions to the care home. This suggests that some form of economic support for families caring for elderly relatives would be desirable. For instance, the introduction of a Carer's Allowance for low-income families would help to encourage family members to care for the elderly in their homes, and alleviate the financial strain of doing so. Other possibilities would be the free or assisted provision of necessary medical equipment and home aids (such as grab rails and bathing aids). Such assistance could be organized through the Ministry of Social Affairs and funded through the state budget or financed by the allocation of an agreed proportion of annual Zakat (wealth "tax") collections. While such grants and allowances would be a cost to the state, it should be considered that support for family carers would reduce the number of elderly requiring institutional

care. At the same time, by maintaining the family as the primary locus of care, such measures would be consistent with local cultural values.

It should also be recognized that migrant workers play a valuable role in sustaining traditional values and norms of family care. Brining domestic workers within the scope of the labour law would be a step towards safeguarding their rights in relation to pay, time off, visits home and the like, bearing in mind that many in the country are far less fortunate in their positions than those I interviewed.

In addition to financial assistance and domestic support, care-giving families and their elderly relatives would benefit from social and emotional support. Elderly women living with their families, while in many ways contented and occupied with their family roles, also lamented the lack of variety and diversion in their lives. Moreover, while these were clearly loving, close-knit families, willing to make sacrifices and adjustments for each others' comfort and happiness, the reality is that the caring relationship is never without difficulties. Different life-style preferences, disagreement over the care and discipline of grandchildren, loss of privacy, jealousies between "rival" carers, and challenging behaviour on the part of the elderly (especially when sick, or deteriorating mentally) could all be sources of strain, sadness and frustration. A possible source of stimulus and variety for the elderly and respite for their families would be the provision of day care facilities for the elderly. In this respect, the model of the recently opened Markaz al Amir Suleiman in Riyadh could usefully be extended. This is a combined day centre and clinic where elderly people and their families can meet others and take part in a variety of social activities, as well as receiving medical advice, monitoring and treatment. It was established as a more culturally-acceptable alternative after an initial proposal for a private residential home had been rejected as an unwelcome departure from the traditional norm of family care. Whilst the Markaz is a private facility whose services have to be paid for, it is possible that the idea could be adapted on a more modest scale (perhaps through charitable foundations and endowments) to provide day centres for those of more limited financial means.

As noted previously, however, although support may be provided to encourage and assist families to care for their elderly at home, there will always be cases where this is

not possible. There may be no relatives, relatives may themselves be elderly or disabled and unable to cope, or there may be other circumstances in which institutional care becomes necessary; the cases of the women in the Medina care home illustrated a complex array of factors leading to this option being taken, often as a last resort. In such cases, it must be recognized that the elderly residents have sensory, social and emotional, as well as physical, needs. The provision of an attractive, comfortable, colourful environment, and encouragement of the elderly to bring photographs and other items to personalize their rooms would provide sensory stimulus, aesthetic pleasure, and food for reminiscence. More comfortable and pleasant surroundings might also encourage relatives to visit more often.

As regards residents' psycho-social needs, an urgent priority should be to separate the elderly from the mentally ill. The present situation, in which women in the two categories are accommodated in the same "flat" and even sharing bedrooms imposes strain on both residents and carers. Elderly women are exposed to anti-social behaviour and even abuse at the hands of some mentally-disturbed residents, while staff struggle to balance their differing needs. Failure to separate these groups both reflects and perpetuates a prevalent ignorance and confusion about psychology of the elderly and mental health, and highlights the need for training in this area.

With a view to the positive adjustment of elderly women, the current tendency of care home staff to focus on loss, reversal and victimhood is not helpful. A wider range of activities and therapies for the elderly women could assist in the construction of a more favourable identity for them. Memory work that recognizes and draws on women's past experiences and roles can help to focus on the positive and build self-esteem, consistent with continuity theory. In addition, the teaching of new skills such as craftwork might provide not only an interest and sense of usefulness, but also an opportunity for renowned engagement with the wider society, for example through displays and sales of work.

Above all, there is a need for training of those caring for the elderly, whether in a professional or ancillary role. Given the lack of trained personnel, in-house training in geriatric care should be provided to current employees, and efforts made to recruit

people with appropriate training in future. Since nursing is one of the areas in which localization policies are not yet implementable because of the lack of trained Saudis, the establishment of a training institution to train young Saudis to care for the elderly would fill a current employment gap. Meanwhile, as long as reliance on migrant workers continues, consideration needs to be given to the way they are recruited and treated by the employing companies. Regulation or incentives to encourage the training of these workers and improve their living conditions would increase morale and would enhance their ability to provide good quality care.

Above all, it must be recognized that elderly women and their families are not an unindividuated mass. Social change and individual differences pose a variety of challenges for elderly care and create diversity of need. For many elderly women, family care will be preferable. For others, institutional care must be accepted as a legitimate option. Whatever the living and care arrangements, the priority must be the welfare of the elderly women themselves. With the right support, women in family or institutional settings can continue to live fulfilling lives as valued and respected individuals, in line with the Islamic ideal.

8.5 Limitations of the Research

Like any research, this study has been limited by certain inevitable constraints on its scope and implementation, which must be borne in mind when considering its implications. Foremost among those is the limited size and nature of the samples involved. For example, in order to obtain the depth of insight required, through deep and prolonged engagement in the investigated setting, only one care home was investigated. It is possible that other care homes across the kingdom will differ in the standard of facilities they enjoy, the calibre of staff recruited, and the quality of care they are able to provide to their elderly residents. Indeed, comments by care home staff that were familiar with the care home in Riyadh suggest that, at least as regards facilities, this was indeed the case. It is therefore not possible to make any assertions as to the typicality of the Medina care home, or to evaluate its quality in comparison with other provision.

Similarly, caution must be exercised in drawing conclusions regarding family care, based on the small number of cases discussed here, particularly as all seven families were middle to upper class, and so relatively privileged in terms of living accommodation and financial means. This limitation was inevitable, given cultural privacy norms and the consequent difficulty of gaining access beyond my own social network. Nevertheless, it must be recognized that many Saudi families are of more modest means and this can be expected to have a bearing on the ease with which they can adapt to the changing needs of ageing members.

Another constraint in conducting the research in both family and institutional settings is that it was not possible to interview some of the elderly women, due to their ill-health. In such cases, information about their circumstances and about their roles and relationships within the setting was mediated by others: offspring, daughters-in-law and household staff in the case of family residents, and nurses and care assistants in the case of those admitted to the care home. Whilst these third-party interpretations have their value, and were in addition supplemented by my own observations, direct access to the perceptions of lived experience of these women would have been desirable. At the same time, I was conscious of my ethical responsibility as a researcher to respect and safeguard the physical and emotional well-being of participants, and it would not have been appropriate to press for interview where this would have caused significant distress and discomfort to the woman concerned.

With regard to the migrant workers who played an important part in the care of elderly women in both family and institutional settings, the question inevitably arises as to how far they were able to give a full and frank account of their experiences, or whether they were constrained by concerns to placate their employers. In one of the family settings, for example, the elderly woman insisted on being present while her housemaid was being interviewed. In these circumstances, the housemaid would be unlikely to express any dissatisfaction she might feel about her living and working conditions – although in practice, my observation of the demeanour of the two women gave no reason to suppose that the relationship between them was anything other than as stated. Here though, another note of caution must be sounded, that while the migrant employees in those

“good” families were well-treated, enjoyed comfortable accommodation, and expressed great satisfaction with their circumstances, many others are far less fortunate. The experience of the housemaid who had “escaped” her former employees in order to find a better situation, and the reported existence of an organization to improve the lot of Indonesian domestic workers, remind us that the experience of many migrant workers in the kingdom is very different from that captured in family settings in this research.

Finally, I want to acknowledge the absence of a male perspective in this research. Although as a woman I was keen particularly to give a voice to elderly women and their carers, who have hitherto been overlooked in Saudi research, I recognize that in many cases, decisions affecting these women were made by men. In the care home, the decision to admit an elderly woman was made by a male relative, while decisions about the day-to-day running of the home, allocation of resources and so on were subject to the overarching authority of the Men’s section and its (male) manager, who declined to be interviewed. In family settings, as noted previously, care was, at least nominally, the responsibility of sons. Traditional attitudes towards unsupervised contact between the sexes made it difficult for me, as a female researcher, to gain access to men. I was indeed fortunate to find even two exceptions, the care home doctor, and the son of one elderly woman whom I was able to interview alongside his wife. Further insight into how male decision-makers perceive the needs of elderly women and rationalize their decisions would have been interesting. Unfortunately, however, for the reasons mentioned, the vast majority of research conducted in Saudi Arabia reflects a single-sex perspective.

While the above-mentioned limitations do not negate the value and achievement of this work, they do, however, remind us that what is reported in this thesis is only part of a large and complex picture, and that more work in this area is needed. Some thoughts on how further research can build on the contribution of this thesis follow.

8.6 Suggestions for Further Research

This thesis has broken new ground in the study of elderly care in Saudi Arabia, and opens up a number of possibilities for further research. Some suggestions are as follows.

Given that this research included only one care home, and my informants indicated the existence of at least one where conditions are very different, it would be worthwhile to carry out further studies in other similar institutions, either individually or in a comparative study. Such investigation would provide a clearer picture of overall care provision and the factors affecting it across the kingdom, and might provide further information on the impacts and relative value of specific facilities and practices, to inform future policy in this area.

Further research is also needed to broaden the understanding of care in family settings, to supplement and complement the findings from the limited sample included here. Given the difficulties of access to families posed by social and cultural norms in Saudi Arabia, several such studies in various parts of the kingdom and among different social classes may be necessary in order to build up a sufficiently comprehensive picture of how family systems are coping with the needs of the elderly in a rapidly changing society, and to determine more accurately what support they need.

Another necessary avenue for further investigation is the male perspective on elderly care in Saudi families and institutions; for example, the views of sons and sons-in-law or other male relatives with caring responsibilities, and of male decision-makers in the care homes and Social Affairs ministry. Given the constraints on access to male respondents by female researchers, this could be done in three ways: by male researchers; by female researchers through telephone interview or email, avoiding the need for face-to-face contact; or through the use of a related male (husband, brother or son, for example), trained to act as research assistant to gather data. The reverse strategy (the training of a sister or wife to enable a male researcher to obtain data from and about women) has been successfully employed by Saudi social scientists in the past.

More work is also needed on the families of women in care homes, in order to understand better how they make the care decision, how they view the care home, and their relations with both their elderly relatives and care home staff. Such research would further inform policy on support for the elderly and their families, and may be a basis for training in family work in the caring professions.

Turning to the secondary theme of this thesis, the role and experience of migrant workers involved in care provision, a more extensive survey is needed of workers involved in elderly care, since this area has received considerably less attention than child care and general domestic work.

It would also be of interest to follow up the surprising finding of this study, which contradicts the commonly-reported picture of downward occupational mobility among migrants, in order to identify more clearly how this may vary by region, country and occupational sector. On a related theme, it would also be of interest to explore further the exercise of agency of migrant workers, including their support networks and strategies for adjusting to and improving their situation in the adopted country. Such research would be a valuable counterpoint to the “migrant as victim” image dominating recent research and would deepen understanding of the experience of migrant workers in an increasingly globalized world.

8.7 Postscript

In conducting this research, my underlying motivation was interest in the well-being of the elderly and a wish to contribute towards understanding and improvement of their situation. I am therefore delighted to acknowledge that in response to the preliminary findings of this work, and through the agency of His Royal Highness Prince Abdulaziz bin Majed Al Saud, the governor of Medina, considerable improvement has been made to conditions in the care home, since the main fieldwork was conducted. A previously unused building has been converted to create a new kitchen, a new classroom allocated for the Quran classes, a salon created for social gatherings, the physiotherapy room extended and provided with additional equipment, and storage rooms reconfigured for

greater convenience. Moreover, after the distressing incidents I reported in Chapter Five, some residents were moved and the “social protection” case given a separate room. These are all very welcome steps in the right direction which, it is hoped, will be part of an ongoing transformation.

Elderly women are a growing but often invisible segment of society. In their younger days they were care givers rather than receivers, active in and for their families and communities. Now, the traditional sources of care face challenges from a variety of social and economic forces. Nevertheless, the help and support needed to enable elderly women to experience continued fulfilment and self-esteem in old-age should be seen not as charity to the dependent, but as an essential feature of a humane and interdependent society. If this thesis goes some way towards an enhanced understanding of ageing and elderly care, and improved support for elderly women and their carers, the time and effort expended in this fascinating but challenging journey will be worthwhile.

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Appendices

Appendix 1	Interview Questions
Appendix 2	Profile of Care Home residents (CHRs)
Appendix 3	Care Home Staff (CHS)
Appendix 4	Profile of Family Setting Residents (FSRs)
Appendix 5	Family Setting Carers (FSCs)

Appendix 1 Interview Questions

Questions for the elderly in families

- 1) What is your opinion about the family's/society's attitude towards the elderly?
- 2) What do you think about inter-generational relationships?
- 3) Who is responsible for your living needs (accommodation, food, finances, and housekeeping)?
- 4) How are your family ties?
- 5) Do you feel lonely, isolated or abandoned?
- 6) How do you evaluate your role in the family?
- 7) As a mother/mother-in-law how do you evaluate your relationship with your children/daughters-in-law and sons-in-law?
- 8) Where do you find yourself when it comes to decision making?
- 9) What is your view about reciprocity with friends and relatives, in terms of gifts, visits, affection, taking an interest in each other's lives and so forth?
- 10) With whom do you and your family spend feasts and special occasions?
- 11) What health, social, and psychological problems do you experience?
- 12) How is your relationship with your carer(s)/housekeeper(s)?

Questions for elderly in care homes

- 1) Tell me, how did you come to be here?
- 2) Tell me about yourself, your family and friends?
- 3) How do you like living here (self – other residents- carers)?
- 4) Is there something that could be done to improve your life?

Questions for informal carers and relatives in family settings

- 1) How did you become the carer for elderly woman's name]?
- 2) How do you get on together?
- 3) Is there anything you find difficult to cope with? If so, what?
- 4) What do you think are the positive aspects of your position now?

- 5) How could it be improved?
- 6) Do you feel supported in your role of caring?
- 7) What sort of help do you need, if any?

Questions for care workers in the care homes

- 1) How did you become employed as a carer in the care home?
- 2) Did you receive any training to care for elderly people? If so, what is it?
- 3) What aspects of your job do you like?
- 4) Which aspects of your job do you not like?
- 5) What do you think about the quality of life the home provides for residents?
- 6) Do you think they have needs that you can't meet?
- 7) Do you face any constraints in your work?
- 8) How do you think their lives could be improved?

Appendix 2 Profile of Care Home Residents (CHRs)

CHR 1

Date of Birth: 9-10-1934
Date of admission: 27- 4-1984
Age: 74 years old.

Reasons for admission:

Geriatric case, unattended.

History of social and health situation:

She had been married twice and had borne three children. All of them had died, as had her husband. After that she lived with her nephew, who looked after her. Because she had high blood pressure and was mentally ill, a member of her family decided to put her in the social care home. She was seldom visited.

Present Health Condition:

Controlled hypertension, osteoporosis, poor hearing, senile cataract, could not walk but could sit and lie down alone. No teeth up or down; loss of memory. Patient was cooperative; ate mashed foods with good appetite. She could not manage bathing and toileting alone. She was cooperative with other residents, with social workers and the health workers, calm and polite.

CHR 2

Date of birth: 7-2-1946.
Age: 63 years old

Reasons for admission:

Based on a medical report from a psychiatric hospital, dated 9-5-1992, the patient was diagnosed as having schizophrenia. She was an out-patient with irregular visits for

health check-up and had an old file dated 1988. Her health problems started in childhood. She had no follow up for 2 years, starting from 24-3-1990. She had poor hearing, which made her uncooperative.

History of social and health situation:

She had been sick from childhood. She had married three times and had two children, but her mental health problems led to divorce. Because of her mental illness, she used to run away from home. Her family visited regularly, especially her son, but she did not recognize him.

Present Health Condition:

She had controlled diabetes, was blind with senile cataracts in both eyes, and had poor hearing and loss of strength. She had impaired mobility and could walk but only with assistance, and was prone to fall down. She suffered urinary incontinence. Psychologically she was disorientated and showed inappropriate response and loss of memory.

CHR 3

Date of birth: 9-10-1934

Date of admission: 14-5-2006

Age: 75 years old.

Reason for admission:

She had been married but was childless. Her age and disability led her family to put her first in a private Quba home for the poor, funded by donations. She stayed there more than six years. Because this location could not offer her comfort, security and privacy, her nephew took her back to his house. After that he admitted her to the social care home because she urgently needed physiological and psychological care from an interdisciplinary team and nursing staff. Her family did not visit.

Present Health Condition:

She could walk with a crutch. She had a good memory, talked and could sit and eat unaided. She had had an operation [goitre] more than one year previously. She was depressed because of missing her family. She had a history of diabetes controlled by diet. Her mental health was good.

CHR 4

Date of birth: 3-7-1943

Age: 66 years old

Reasons for admission:

Elderly and unattended. According to a medical report from Madina Psychiatric Hospital dated 29-9-1985, she was diagnosed as having severe schizophrenia. She could not take care of herself.

History of social and health situation:

She came from an urban area. She was illiterate. She had married 23 years previously and had two sons, one of whom was a soldier; the other had died at the age of two years. Her husband worked in the health ministry. There was no one at home to care for her so he admitted her to the social care home. She preferred isolation and refused to take her part in social activities. Her husband visited her regularly. She was cooperative.

Present health conditions:

She was diabetic, controlled by diet, and under medication for her psychiatric condition. She could walk, received physiotherapy, had good eye sight, and had excellent hearing. She needed help with personal hygiene and her activities of daily living had to be supervised.

CHR 5

Date of birth: 5-3-1916
Date of admission: 5-7-1998
Age: 92 years old

Reasons for admission:

Elderly and could not take care herself.

History of social and health conditions:

She was married without children. Her husband was also a resident of the social care home, in the men's section. She had no property or income. She was bedridden and could not move in her bed. She received visits from her nephew.

Present health conditions:

She had senile dementia, was blind in both eyes, was physically frail, with osteoporosis and was doubly incontinent.

CHR 6

Date of birth: 1873
Date of admission: 30-5-2002
Age: 134 yrs. old (Deceased 2007)

Reasons for Admission:

Old age [senility], unattended.

History of social and health situations:

She was born in Makkah Mukarrama and had been married; her husband died 25 years previously and she had no children. She moved to Al-Madinah Al-Munawarah and lived in Robath, an alms house, 15 years ago. The Al-robath housing supervisor requested that she be admitted to the home as she had no relatives to care for her and she was very

ill and depressed; she kept crying, day and night. She received financial assistance from two charitable foundations. She was periodically visited by the supervisor of the alms house where she used to live.

Present health conditions:

She was completely bedridden, had senile dementia and was totally dependent. She could move her hands slowly but was not mobile. She had hypertension controlled by medication; her blood pressure was monitored 2 to 3 times a day. She ate pureed foods. She was doubly incontinent. She also had osteoporosis.

CHR 7

Date of Birth: 9-10-1934

Date of Admission: 18-1-2002

Age: 75 years old.

Reasons for admission:

Untended and right leg paralyzed after a burn.

History of social and health situations:

She was a widow and had one unemployed son. She was from the Khibar area, Her brother admitted her due to her physical, mental, psychological and social impairment. Due to her health condition (she had a history of epilepsy) she could not take care of herself alone. Sometimes she refused meals. She could walk slowly.

Present health conditions:

This resident needed to be watched carefully because of her epilepsy and proneness to fall. However, she could manage toileting alone and cooperate with bathing. She received physiotherapy, with which she cooperated. She seldom spoke and had to be encouraged to talk.

CHR 8

Date of Birth: 1924
Date of Admission: 10-5-1996
Age: 84 years old.

Reasons of admission:

Senility [old age]

History of social and health situations:

She was widowed and used to live with a married daughter. Her son- in-law admitted her to the social care home. She had no property. She was from the Jazan area, some distance from Medina. Her daughter visited her every three months.

Present health condition:

She had senile dementia, and was restless and irritable. She had osteoporosis. Most of the time she was shouting and wringing her hands. Her speech was unclear. She needed her food minced because of the loss of both upper and lower teeth. Her mood and behaviour were erratic; sometimes she refused her food and drink and abused anyone who came near her. At other times she was polite, kind and cooperative. She received psychiatric treatment and physiotherapy.

CHR 9

Date of Birth: 1926
Date of admission: 20-5-2000
Age: 83 yrs. old

Reasons for admission:

Old age

History of social and health situations:

She was a widow and childless. She lived with her sister in Yanbu, an area of Saudi Arabia about 200 kilometres away from Al-Medina. Her sister was also elderly and suffered from asthma so was unable to take care for her sister any longer. The resident had no income or any property.

Present health conditions:

She had osteoporosis, kyphosis and senile dementia. She was mobile. She was talkative and uttered malicious words when she got angry. She was aware of the things happening around her. She had good eye sight and hearing. She had lost all her teeth upper and lower, but she ate foods normally. She was free from any diseases and senile complications. She was urine incontinent.

CHR 10

Date of Birth: 14-1- 1926

Date of admission: 1989

Age: 84 yrs. Old

Reasons for Admission:

Because she was old and mentally retarded, one of her relatives had sent her to the care home.

History of social and health situation:

She was unmarried. Her brother, who used to take care of her, had passed away when she was aged sixty two and her sister-in-law, her brother's wife, then continued the responsibility of taking care for her. However, because of being mentally retarded, she wandered out into the dessert and refused to stay at home. No-one visited her in the care home.

Present health conditions:

She had senile dementia, hypertension and diabetes (both controlled with treatment) and was mentally retarded. She was bedridden and had osteoporosis. She had an old fracture at the neck of the right femur with internal fixation (the fractured happened in the social care home, about 7 or 8 years ago). She had senile bilateral cataract, stiffness and deformed joints, alopecia, right hemiplegic paralysis, poor hearing and vision. She ate minced food, having no teeth up and down. Her mobility was limited. She was doubly incontinent. She had no judgment and was disoriented.

CHR 11

Date of Birth: 6-2-1924

Date of Admission: 29-9-2004

Age: 86 years old

Reasons for admission:

"Lost and found"; the police in Prophet Mohammed Mosque found her in there and sent her to the care home temporarily, while they tried to locate her family. The Director of the care home published an announcement in Al-Jazirah newspaper dated August 13, 2005 asking for her family to come forward, but nobody claimed her so she was officially admitted by the Ministry of Labour officials.

History of Social and Health Conditions:

She had been married and had two children; one daughter and one son. She used to work as a security guard in King Khalid Committee Organization in Tabuk Area, and was provided with a room for her accommodation. She was well known to the people in the area, and she received donations from some of them. Her son also worked with her in the same organization. Later, her daughter who lived in Jeddah took her to live with her there. Her daughter visited her regularly in the care home.

Present Health Conditions:

She was depressed because she wanted to go back to Tabuk. She had senile dementia, left eye cataract, osteoporosis, poor hearing, and no teeth. She could walk slowly, but was doubly incontinent and could not perform her daily activities without an attendant. She loved to dance, and was well oriented and very clever.

CHR 12

Date of Birth: 1926

Date of admission: 6-2-2007

Age: 83 years old

Reasons for admission:

Before entering the care home, she had been admitted to the Ministry of Health Zulafy General Hospital after suffering a stroke. One of her sons asked the Medical Director in the Ministry of Labour to admit her to the care home in Medina for supportive nursing care. It was agreed to do so, due to the patient's age and condition.

History of Social and Health conditions:

She had two sons. She suffered a stroke while visiting her brother, who lived outside Medina. She was found unconscious and admitted to hospital as an emergency case. She received brief visits from her sons and other family members.

Present health Conditions:

She had senile dementia, was completely bedridden, and was diabetic with insulin therapy. She had suffered multiple cardio vascular accident resulting in aphasia, right hemiplegica and Parkinsonism of the left hand. She could eat minced, semi-liquid foods. She was doubly incontinent.

CHR 13

Date of Birth: 4-1-1927
Date of Admission: 2003
Age: 83 years old

Reasons for admission:

Elderly, in need of financial, physical, social and medical support.

History of social and health conditions:

She was very poor, a native of Umlodz, who had married at the age of 25 but widowed at 30. She was childless. She had a brother who was also poor and made a livelihood by fishing. She used to receive an insurance stipend of 5,400 Saudi riyals monthly before she was admitted to the social care home. She was occasionally visited by her brother and other relatives.

Present health conditions:

She had senile dementia. She had left hemiplegic paralysis and was completely bedridden. She had chronic schizophrenia and took psychiatric medicine. She had no teeth up or down and ate minced foods. Her neck was stiff; she had senile cataract and very poor hearing. She could talk but was incoherent.

CHR 14

Date of Birth: 28-4-1949
Date of Admission: 1998
Age: 60 years old

Reasons for admission:

She was schizophrenic; her brother admitted her to the social care home because she could not take care of herself and no-one in the family could take care of her.

History of Social and health conditions:

She had been married, and had one child, who had died. Her mental illness appeared two years after her marriage. She took Arabian herbal medicines but they had no effect. She had been admitted twice, the first time from 6-1-1988 until 12-10-1996, the second in 1998. Her brother had readmitted her. She was visited, but rarely.

Present health conditions:

She was mentally retarded and had chronic schizophrenia. She was diabetic, controlled by tablets and diet. She had lost the terminal phalanx on her little toe, left foot but she was mobile. She had senile cataract in both eyes. She was generally calm but sometimes restless. Her speech was limited, like baby talk. She was urine incontinent. She could eat normal foods, was cooperative and could dance slowly and sing.

CHR 15

Date of Birth: 21-5-1936
Date of admission: 31-1-1989
Age: 69 years old

Reasons for admission:

Mentally ill, social and financial problems.

History of social and health conditions:

She originally lived in Mauritania. After getting married, she travelled to Saudi Arabia and lived in Medina. She had a son and a daughter. In 1968, she and her husband divorced. She developed mental illness after her divorce and her condition worsened steadily. According to her husband, she had set fire to her house and tried to burn her children, so he had taken them away. Her son was jailed for drinking alcohol, which also affected her. She used to wander in the street. Her daughter provided a flat for her mother's accommodation, together with her aunt, but she ran away and returned to her old house. She was admitted to Taif Psychiatric Hospital and stayed 3 days; she had also been admitted in Medina Psychiatric hospital for 3 months. According to her

psychiatric report, she was not a danger to herself or to others. Her daughter had admitted her to the care home in 1988. Her daughter lived in Qatar, and visited only rarely.

Present health conditions:

She was schizophrenic and completely uncooperative. She was mobile, could walk slowly, and manage toileting, but was prone to fall down. She could bath herself unaided; left to herself she maintained poor personal hygiene. Her appetite was poor and she was thin with dry skin and lips.

CHR 16

Date of birth: 1931

Date of admission: 29-10-2000

Age: 78 years old

Reasons for Admission:

Elderly and unattended

History of social and health conditions:

She had lived in the Badr area, and had a child who died. Later, she married again to someone from Jeddah, who had divorced her a long time ago, and they were childless. She had a sister who had been living in the Yanbu area but they had no communication with each other and she never mentioned her sister. She had lived in her own traditional-style house and had been on good terms with her neighbours. After she became infirm her neighbour helped her to prepare food and provided a maid to help her. She received an allowance from the Ministry of Social Affairs. She had previously kept sheep but after she became incapable, they were all sold. She could not move well, was disoriented and no one could take care of her. According to the Board of Governor's report, since was an old widow and could not take care of herself, he recommended her admission to Al-Madinah Al-Munawarah Social Care Home. She had no family, but was visited by former neighbours.

Present Health Conditions:

She had chronic hypertension controlled by drugs, and controlled diabetes. She was completely bedridden. She could talk and respond, and was cooperative, but disoriented. She had no teeth and ate minced foods. She was doubly incontinent. She had cataract in both eyes. She also had osteoporosis.

CHR 17

Date of Birth: 28-9-1935

Date of admission: 7-1- 2005

Age: 74 years old

Reasons for admission:

Old age and financial insufficiency.

History of social and health conditions:

She had a daughter who was mentally retarded living in the same social care home. Her husband had another wife. Each wife had a separate house. The husband worked as a security guard with a salary of 2,700 Saudi riyals monthly, which was not enough for his basic family needs. She was anaemic on admission. She received more visitors than most residents, including her husband and close relatives.

Present health conditions:

She had senile dementia, and was schizophrenic and mentally retarded. She had senile cataract. She was disoriented, and her speech was incoherent.

CHR 18

Date of Birth: 22-4-1917

Date of admission: 4-1-2004

Age: 91 years old

Reasons for admission:

Old age and financial reasons.

History of social and health conditions:

She was a widow and childless, who had no source of income after her husband's death. She lived in her sister in-law's house in Al-Safra valley for 14 years before she was admitted. Because of her age and health condition she needed financial support and could no longer take care of herself. Her sister in law admitted her to the Social care home.

Present health conditions:

She had senile dementia, was completely bedridden with severe osteoporosis, totally blind in both eyes and had poor hearing. She had no teeth and ate minced food. She was doubly incontinent.

CHR 19

Date of Birth: 17-11-1910

Date of admission: 16-11-2007

Age: 100 years old

Reasons for admission:

Old age, inability to take care of herself, and no family members to take care for her.

History of social and health conditions:

She had been married, but was childless. Her husband had married three other women after her, and had children by them. She was widowed. Her husband's son by another wife admitted her to the care home because she had no-one else to care for her. She was only recently admitted and no-one had visited her.

Present health condition:

She had senile dementia and was disoriented. She was completely deaf. She could walk slowly but needed assistance. She had no teeth. She had cataract in her left eye and corneal opacity in the right eye.

CHR 20

Date of Birth: 26-3-1947.

Date of admission: 9-2-2003.

Age: 60 years old.

Reasons for admission:

Mentally retarded and also elderly. .

History of social and health conditions:

She was unmarried. She had lived with her only brother in a poor house in Alnakhil, a village near Al-badr. She received 5,200 R.S. yearly; her family income was poor because she depended on her brother's salary, which was 800 R.S. Her brother worked as a driver. She had no one to take care for her except her brother, who was an old man. She received occasional visitors, especially her brother's family.

Present health condition:

She was mentally retarded but very calm, and no danger to others. She did not take psychiatric medicine. She had recently controlled diabetes.

Appendix 3 Care Home Staff (CHS)

Staff Member	Nationality	Role	Age	Experience	Company / Ministry
CHS 1	Saudi	Manager	40s	20 years	Ministry
CHS 2	Saudi	Patient Attendant	20s	6 years	Company
CHS 3	Saudi	Social Worker	30s	4 years	Ministry
CHS 4	Saudi	Supervisor	late 30s / early 40s	4 years 8 months	Ministry
CHS 5	Saudi	Nurse	20s		Company
CHS 6	Saudi, black	Security Guard	60s	26 years	
CHS 7	Saudi	Nurse	about 45	23 years as nurse, 8 years with elderly	Ministry
CHS 8	Saudi	Supervisor	30s		Company
CHS 9	Saudi	Nurse	20s	3 years	Company
CHS 10	Saudi	Care Assistant	late 20s / early 30s	7 years	Company
CHS 11	Indian	Physio Technician	20s	9 years	Company
CHS 12	Indian	Patient Hygienist	27	4 1/2 years	Company
CHS 13	Indian	Physio Technician	23	3 1/2 years (2 years in Home)	Company
CHS 14	Indian	Patient Hygienist	32	9 years	Company
CHS 15	Indian	Physio Technician	late 30s	9 years	Company
CHS 16	Filipina	Patient Attendant	36	5 years	Company
CHS 17	Indian	Patient Attendant	late 30s	9 years	Company
CHS 18	Indonesian	Patient Attendant	early 20s	3 years	Company
CHS 19	Bangladeshi	Patient Attendant	late 20s	2 years	Company
CHS 20	Filipina	Patient Attendant	20s		Company
CHS 21	Filipina	Patient Attendant			Company

CHS 22	Indonesian	Laundry	18/19		Company
CHS 23	Filipina	Laundry	19		Company
CHS 24	Filipina	Patient Attendant	late 30s	2 years	Company
CHS 25	Filipina	Patient Attendant	early 20s	2 years	Company
CHS 26	Filipina	Patient Attendant	32	7 years	Company
CHS 27	Filipina		20	1 year 7 months	Company
CHS 28	Filipina	Nurse	38	14 years	Company

Appendix 4 Profile of Family Setting Residents

FSR 1 (Mrs S)

Social Situation

Lived in a spacious apartment with her second son and his family (wife and three children). Another son with his wife and child had a separate apartment in the same building. Two domestic workers helped in providing care. The older son was due to move to a larger house; it had been arranged that the younger son and his family would move in with Mrs S.

Medical Situation

Described as “weak” and “tired” due to old age, but still active. No major health problems reported.

FSR 2 (Mrs F)

Age 95

Social Situation

A widow. Lived in an apartment block, in which the whole floor constituted a “villa”, with separate suites for her son and daughter-in-law and for domestic workers. Following her husband’s death, she had brought up their son and three daughters, who were all married.

Medical Situation

Hearing-impaired (wore a hearing aid) but otherwise in good health

FSR 3 (Mrs Fa)

Age 68

Social Situation

Lived in a two-storey villa with her 80 year-old, bed-ridden husband, her divorced daughter and a housemaid. She had four sons and two daughters. The elder son was staying with his parents until his own villa was ready. The other siblings visited regularly. The couple were comparatively wealthy.

Medical Situation

In good health, but the main carer for her husband, who had become ill two years previously.

FSR 4 (Mrs H)

Age 82

Social Situation

A widow who had lived independently until her health deteriorated some months previously. She stayed alternate months with her two married sons, who lived in adjacent villas. The family employed two qualified nurses to look after her, and her general care was supervised by her elder son's wife, a doctor.

Medical Situation

Specific condition(s) not reported. Mrs H passed away in her daughter-in-law's arms a fortnight after my visit.

FSR 5 (Mrs R)

Age 74

Social Situation

Lived alone except for her housemaid. Two sons and a daughter, all married. The younger son visited every day and phoned every evening. The older son visited once or twice a week. The daughter lived some distance away, but visited periodically.

Medical Situation

Generally in good health – reported only occasional colds and flu.

FSR 6 (Mrs A)**Social Situation**

A widow from a wealthy family. Had six children – three sons and three daughters. Her main carer was her youngest (married) daughter, who lived in an adjacent villa.

Medical Situation

Kidney disease – dialysis twice a week. Hard of hearing.

FSR 7 (Mrs Hu)**Social Situation**

A widow, lived with her only son and his family (wife and three children). She had accompanied them to Yanbu, then to the UK.

Medical Situation

Asthma, rheumatism, an unspecified eye condition. Passed away shortly before study period.

Appendix 5 Family Setting Carers

Carer	Role / Relationship to cared-for	Co-residence	Nationality	Duration of Care or Co-residence
FSC 1	Daughter-in-law	Yes	Saudi	11 years
FSC 2	Daughter-in-law	No	Saudi	2 months
FSC 3	Housemaid	Yes	Indonesian	2 years
FSC 4	Daughter-in-law	Yes	Saudi	26 years
FSC 5	Housemaid	Yes	Filipina	
FSC 6	Daughter	Yes	Saudi	18 years
FSC 7	Daughter-in-law (and niece)	No	Saudi	
FSC 8	Housemaid	Yes	Indonesian	18 years
FSC 9	Housemaid	Yes		3 1/2 years
FSC 10	Daughter-in-law	Yes	Saudi	3 months
FSC 11	Housemaid	Yes	Indonesian	23 years
FSC 12	Daughter	No, but adjacent	Saudi	
FSC 13	Nurse	Yes	Filipina	1 year
FSC 14	Housemaid	Yes	Filipina	32 years
FSC 15	Daughter-in-law	Yes	Saudi	
FSC 16	Son	Yes	Saudi	

