Older Adult Men and Women in Palestine:
Towards a Better Life?

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Introduction

In a society where older adults constitute less than 5% of the overall population, it is little wonder that attention is directed, for the most part, to the younger generation. As in most other developing countries, well over half the 2.5 million Palestinians in the West Bank and the Gaza Strip are less than 18 years of age, a fact which has no doubt contributed to the increasing marginalization of older adults and the elderly.

Palestinians, in common with other peoples of the East, have traditionally revered their elders and both older men and women were held in high esteem. But this was not to last. The terrible events of 1948 all but destroyed Palestinian society and culture. As people were uprooted from their land and families torn apart with the violent creation of the state of Israel, the elderly could no longer benefit from the traditional extended family system. This marked the beginning of an arduous journey that would take the Palestinian elderly along treacherous terrain, often in foreign lands, besought with hardship, anxiety, uncertainty and agonising longing for the younger loved ones who went far and wide in search of a better life.

Fifty years later, a new generation of elderly Palestinians continue to struggle for a better life, but with a glimmer of hope with the emergence of a fledgling Palestinian entity. In 1994 responsibility for health, education and social services, among others, was transferred to the Palestinian Authority (PA) after almost three decades of Israeli administration which systematically restricted development of public services. Since then the PA has been engaged in attempts to restructure these services, as they had been on a decline. To compensate for deteriorating public services, Palestinian non-governmental services proliferated often in defiance of Israeli restrictions.

Few of these services targeted older adults and the elderly, as they were not considered a priority. To put this segment of the Palestinian population in the forefront, accurate data were required to convince Palestinian officials of the rights and growing needs of the older generation whose proportion to the overall population, though slight, was steadily increasing. There were few studies to begin with and those that were previously implemented in the West Bank and Gaza showed deplorable living conditions and grossly inadequate services of

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any kind (Giacaman, et al, 1991; Sansur and Kevorkian, 1992).

This prompted such Palestinian non-governmental organisations such as Aid to the Aged in Jerusalem to launch a comparatively large scale field study on older men and women (the cohort that actually lived the traumatising effects of 1948), focusing on illness-related disability, its consequences and its implications on family and society. This study was conducted in collaboration with the Medical Research Council at the University of Cambridge, UK, and funded by the European Commission. It was based on the assumption that Palestinian elderly people, being financially and socially disadvantaged, and lacking in services tailored for their needs, would be more vulnerable to chronic disabling conditions.

Methodology

After a small pilot study intended mainly to test the research instruments and the reactions to the interview, a total of 1,700 older adults and elderly people ranging in age from 55 to 98 were interviewed by 11 trained field researchers. The respondents were randomly drawn from samples stratified to achieve representation of different groups and sectors within the population. Thus three types of communities were included (Urban, rural, refugee camp), men and women, Christians and Muslims, and five age groups starting from age 55.

The interviews were based on a questionnaire which inquired about demographic aspects, socio-economic status, availability and utilisation of health and social services, self perceived physical and emotional health, the level of primary and secondary activities of daily living (ADL), and cognitive functioning using a simple culturally appropriate test based on the Abbreviated Mental Test (AMT) which was administered at the beginning of each interview to determine the need for proxy interviews. The more disabled respondents in the sample were revisited a year later for in depth qualitative interviews to determine the quality of family care and needs within the family.

The sample was proportionally distributed across the northern, central, and southern West Bank Regions which included three major cities, Nablus, East Jerusalem, and Hebron representing the urban population, three refugee camps, and 15 villages representing the rural population.

Picture Credit: Delphine Garde

Results

Socio-Demographic Data: Women were in a slight majority (51% to 53% of the sample) in all but the oldest age group of 75 years and older where men were in a slight majority. Over 70% of both men and women were married at the time of the interview and living with spouses in the same household. The widowed comprised a little over 24%. The greater majority of respondents in the widowed, separated, divorced, and single categories were women. Seventy four percent of the women in the sample could not read or write compared to almost 29% of the men, with illiteracy rates increasing linearly with age.

Nine percent of all the respondents were fully employed at the time of the interview, 90% of whom were men, while over 7% were in part-time employment, 82% of them were men. In contrast over half the respondents in the sample had never had paid jobs at any time in their life and 75% of them were women. Fifteen and a half percent of the entire sample relied on their present paid work for their livelihood, and 9.5% relied on regular welfare from different sources (PA Ministry of Social Affairs, Israeli Social Welfare as in East Jerusalem only, UNRWA as in the camps, and Palestinian NGOs). The majority, over 54% received financial support from their children and other close relatives. The greater majority of the respondents who relied on welfare or their children for their livelihood were women with greater dissatisfaction from income expressed by the respondents on welfare. In all almost 55% of respondents expressed dissatisfaction and concern that their income was insufficient to cover basic needs such as utility bills and health care.

Self-Perceived Health and Health Service Utilisation: Almost 61% of the sample were in possession of health insurance (Private, Governmental, and UNRWA), with almost equal proportions of men and women. The proportion of the health insured increased among the older age groups as did the use of governmental, insurance paid health services, more so among older women. However 53% of all respondents preferred to seek private as opposed to governmental medical care, regardless of governmental health insurance, mostly because they claimed that treatment required was not available through the insurance. This explained the relatively elevated proportion of respondents who expended considerable amounts from their income or saving on health care (30% to 40%), especially buying medicines not available through the insurance.

Women spend more on their health than men

Multiple medical consultations and hospitalisations over the course of 12 months increased significantly with advancing age and more among women than men. This suggested greater health problems among women and the older age groups. Indeed women demonstrated significantly more health complaints compared to men. For example, 40% of the men in the sample complained of recurrent headaches compared to 51% of the women. Of the respondents who complained of painful joints including arthritis and back pain, 34% were men and 66% were women. Only in sensory difficulties were the complaints of men and women similar with slightly more men than women complaining of hearing difficulties.

Married respondents living with their spouses and, to a lesser degree, single respondents (those who never married), consistently showed better self-perceived health, than widowed, separated and divorced respondents, as well as the less educated and those who never worked. In all of these categories women were in a majority. Self reported health indicators, as measured in a translated and validated Short Form (SF) 36 Health Survey Scale, included physical, social and emotional functioning, energy and vitality, pain perception, and change in health perception (Jenkinson, et al, 1996). In all of these indicators women scored significantly lower than men suggesting poorer self-perceived health. On the other hand, both Palestinian men and women demonstrated poorer self perceived health than their European counterparts in the same age categories (Sharples, et al, 1998), but detailed statistical comparisons could not be made because of differing methodologies.

Mental Health: One of the more significant gender differences were observed in mental health indicators most notably in depression and cognitive functioning. Approximately 60% of the female respondents scored within the depressed range according to a translated and validated version of the Geriatric Depression Scale, compared to 40% of the male respondents. Furthermore, respondents living alone and those living with relatives other than their own children (the greater majority of whom were women) showed the highest scores for depression. Depressive symptoms also increased linearly with advancing age for both men and women.

Depression was significantly correlated with self-perceived ill health and cognitive dysfunction ($r=0.43$, $p<0.001$). Sixteen percent of the respondents showed moderate to severe cognitive dysfunction, most of whom had to be replaced by relatives for the interviews. Symptoms of depression were observed among these respondents but even more so among the 20% who showed mild to moderate cognitive dysfunction. While cognitive dysfunction increased linearly with advancing age, 76% of all those with moderate to severe dysfunction were women.

Disability: All physical and mental health indicators were significantly correlated with the level of activities of daily living (ADL) demonstrated by the respondents and measured as indicators of functional disability. Only about 8% of all the

respondents were dependent on others for primary ADL (eating, washing, dressing, indoor mobility and other basic self-help skills), while up to 28% were dependent on others for instrumental or secondary ADL (shopping, preparing a meal, and outdoor mobility). Dependence in both primary and secondary ADL increased linearly and significantly with advancing age while older men were significantly more independent in both primary and secondary ADL than women ($F[1,1168]=71.7$, $p<0.001$).

Discussion

General Health Profile and Gender Differences: Gender and age appear to be the two most powerful variables affecting health and disability with age exerting a stronger effect. However, age and especially gender are interrelated with socio-demographic variables which have also been found to be related to health and disability. Multi-variate tests of significance demonstrated that when age and gender effects are held constant the effects of such variables as income satisfaction and the presence of health insurance on the various physical and mental health indicators are much reduced. Only the educational level, retained its significant effect when age and gender were separately held constant ($F=33.6$, $P<0.001$ with age held constant, and $F=342.6$, $p<0.001$ with gender held constant). Thus gender, and particularly age, have the greatest effects on all the physical and mental health variables with educational level also affecting health but to a lesser degree.

Despite the powerful gender effects on health observed in this study, there seems to be an increasing indication that poor health, or at least a poorer self reported physical and mental health profile and related disabilities, are associated not so much with gender per se, as with the socio-economic and educational disadvantages and powerlessness associated with being female in a patriarchal, traditional, male-dominated society. This is in addition to the ill effects of ageism (Thompson, 1995), and the deterioration in physical and mental health that may occur with increasing social isolation which may be observed among both elderly men and women. Such isolation has been observed more frequently among women who, significantly more than men, tend to be single, divorced, widowed, or living alone in poverty with less access to adequate health care.

Despite the fact that slightly more men than women use private health facilities, women spend more on their health than men. This is due to the finding that there are significantly more women making multiple visits to the doctor in a month than men, and more women hospitalised several times a year than men. Both hospitalisation and medical consultations increased in frequency with advancing age, suggesting a deterioration in general health with advancing age. This places a greater burden both on families and health facilities, particularly PNA facilities. Multiple use of health facilities and multiple hospitalisations are observed more frequently among the respondents belonging to groups of lower socio-economic and educational levels which places an even greater burden on both family and state.

However, it has also been observed that self reported health was poorer among people who had fewer carers at home - people who have lost their loved ones through death, separation, divorce and whose life circumstances have changed dramatically, or those who live alone unsupported. Respondents still living with their spouses, especially when their children are around, appear to be the best off physically and mentally. But here again the effect of age cannot be ignored as these tend to be younger than the widowed respondents. On the other hand, respondents living alone did not demonstrate a poorer self reported health profile; in fact many showed a better health profile (or at least complained less) than those living with relatives and even their own children.

While losing one's spouse is a major stressful life event and one that understandably often brings about deterioration in general circumstances and health, it seems to affect men and women differently. Widowed Palestinian women, for example, lose their main source of household income with the death of their husbands who would usually control all aspects of the family's finances. Inheritance laws also don't favour the wife so that she becomes at the mercy of her son(s) and their financial situation and the extent of their care and benevolence towards her. If they are non-existent or abroad, the situation may be much worse.

Divorced and marital separation is also traumatic and especially so in a conservative society where such events are still frowned upon and where, for the woman, it is much worse. Such life events create severe disruption and confusion and deplete, the woman especially, not only of income and security, but possibly also of her social support system. Hence the poorer self reported mental and physical status of the divorced and the separated. But owing to the small size of this group, further investigation is warranted before final conclusions can be drawn.

For a Palestinian older man widowhood can be very traumatic but in a different sense. Although he may not be working any more, he still retains his authority as the head of the family and, therefore, financial difficulties are much less than for women. However, owing to his previous long dependence on his daily needs (primary and especially instrumental activities involving cooking, cleaning and washing) on his wife, he may find himself feeling totally handicapped even when no disabilities are involved and especially if no daughter or daughter in-law is available to help. Of course the situation becomes worse where disability is involved. For example, an elderly disabled man may have a harder time finding help in the bathroom as he may be too embarrassed to allow women other than his wife to assist him. Nevertheless this did not come out too clearly in the results and since the greater majority of those who were widowed, separated and divorced were women, then it can be

assumed that the situation is generally much worse for the woman than the man.

Better off people enjoy a more comfortable existence. Even if no family support is directly available, they can afford to obtain outside nursing or domestic help and, therefore, perceive themselves as less handicapped. Furthermore, their daily lives may well be less demanding and, consequently, they do not perceive a big loss in functional ability. In villages and refugee camps, bathrooms and kitchens are often located outside the main living area of the house creating greater difficulties for those who are too ill and disabled to gain access without assistance. Furthermore, life in the villages remains, especially for the older generation, governed by the demands of seasonal agricultural work and farming and the hard manual work that goes along with that. This includes tilling the land, sowing, reaping and harvesting, picking and pressing of olives, (a major task in the autumn especially in the northern and central regions), food preservation, baking bread, and fetching of water. Such tasks are rarely undertaken in West Bank cities. Hence the acute sense of handicap when ill health and disability prevents a person from engaging in such habitual and traditional tasks which are not necessarily linked to one's main employment.

It is, perhaps, for this reason that the Physical Functioning dimension of the SF-36 health scale stood out so prominently and differed so significantly among regions, areas of residence, gender, educational level, employment, income, and marital status.

The SF-36 Physical Activity Scale inquires about limitations in such activities as lifting heavy objects, domestic chores, bending and stooping, walking long distances, washing and dressing. These are essential activities in general and even more so among rural people who rely more on walking and engage in more strenuous physical work. And since domestic chores are prominent in this scale, it is not surprising that women, more than men are only too aware of any such limitations. In addition to physical functioning, social functioning also stood out as a more sensitive scale regarding gender and all the other factors mentioned above.

Social life includes visiting relatives and friends on a regular basis and this is highly valued among the gregarious Palestinian people, women more so than men. Hence when ill physical and/or mental health affects this important aspect of life, women probably feel the effects more than men do especially in the villages and refugee camps and among the lower socio-economic and educational level groups. Social life is rich in Palestinian society and an important aspect of every day life no matter what the individual's background, as well as an important indicator of physical and mental health especially in this part of the world.

Women lose their main source of income with the death of their husbands

The apparently poorer self assessed health in this sample (compared to European samples) may be a reflection of considerably less advantaged socio-economic circumstances and life style, and a harsher environment where basic factors for comfortable living are vastly inadequate. This is in addition to lack of economic security, and different attitudes towards health. Such attitudes may well be responsible for a lowered threshold for self-perceived poor health and greater socially acquired dependence on loved ones in old age which seems to be more pronounced among women in the sample.

Health and Social Service Availability, Cost, and Utilisation: The very elderly and the majority of women in this sample, being more financially disadvantaged, rely more on health facilities of a charitable character and on governmental services covered by Palestinian health insurance mostly paid for by their children or welfare. However, place of residence also appears to play an important role in the type of health service utilised.

Outside East Jerusalem, residents of refugee camps registered with UNRWA have the highest proportion of health insured respondents and the highest users of UNRWA health services the majority of whom are women and the very elderly. Paradoxically, however, it was these residents who complained more of lack of financial means to cover health costs and who also included the highest proportion of respondents who had multiple consultations with the doctor in the month preceding the interview and multiple hospitalisations during the year.

One-time medical consultations were more frequently observed among city residents. Here proximity of the larger health facilities, and more specialised physicians contributes to a greater frequency of one-time medical consultations that serve more as primary, preventative health care. Furthermore, people with better access to health care are also among the better-off financially. These are more often found in the West Bank cities than in villages and refugee camps. In addition (although not investigated in detail in this research), results do indicate the possibility that the well off, residing mostly in the cities, have different perceptions of illness.

Given the results of the health profile, it is not altogether surprising that refugee camp residents showed the highest use of health facilities and hospitalisation as they showed the poorest self reported health profiles (physical and mental) in comparison to city and village residents. These are the respondents who expressed the least satisfaction in many aspects of their lives, particularly financial and it is among these respondents that the highest proportion of disabilities were found.

Hence it can be comfortably concluded that refugee camp

residents especially women and the very elderly, have a poorer quality of life than either city or village residents and have a poorer perception of their health. But caution here is warranted; refugee camp residents have been living on welfare for more than half a century and, the older generation in particular, has come to expect free services all the time and some may be in the habit of exaggerating their plight to obtain assistance of any kind. Nevertheless, the physical aspects of refugee camps with their overcrowded, cramped conditions and poorer sanitation in comparison to cities and the healthier atmosphere of the villages, cannot be ignored; these are conditions which also tend to favour ill health and lack of emotional well-being.

It also cannot be overlooked that Palestinians on the West Bank still express a lack of faith in governmental health services and there remains the notion that one tends to get a better medical service if it is paid for. While residents of refugee camps may have lost this notion, those in the villages certainly haven't. It is there where the largest proportion of private health facility users are to be found. This, however, may have come about more out of necessity than choice, for in many villages there are still no governmental health services but private clinics opened by doctors from the same or a neighbouring village.

The men were generally better looked after than the women because the majority still had their wives

Distance (except for respondents in the central villages some of which are isolated) and costs of transportation to and from health facilities were not so much of a problem for the greater majority of respondents. It was more the cost of health care and treatment from which more people complained and this is not surprising when, as reported earlier, older Palestinians on the West Bank spend an average of 40% of their savings and 30% of their income on their health, while in some areas well over 40% complain of lack of money to cover health costs. This suggests several issues at hand: a poor health status and associated disabilities requiring constant medical care, reduced income and/or low levels of savings, and/or a larger proportion of private health facility users than ought to be for an older segment of the population.

Furthermore, even among the insured, there are people who continue to believe in the merits of private medicine as mentioned above, while certain costly medication, usually prescribed for chronic conditions through the health insurance system, is often unavailable and has to be bought from private pharmacies. On the other hand, specific medical interventions may also not be available in the PA health system and has to be sought privately at considerable costs to the patient or his family.

It can be deduced, therefore, that health care in general is available and accessible to the majority of the respondents interviewed in this investigation, but that the more specialised medical care, that directed towards conditions, illnesses and disabilities specific to old age, is not accessible to the greater majority.

Besides specialised health care, social care outside the family is quite scarce. For the more than 99% of the elderly who are living in their own communities and not in institutional care, there is little that can be offered. Only the central region offers a tiny percentage of its older people home-based nursing and social assistance on a regular basis and these are to be found in East Jerusalem. There are some programmes offered by private Palestinian charitable organisations in the city of Ramallah, but the latter was not included in this investigation; only the villages and camps of the district were included and these had no community-based services for older people. Day centres and clubs are also very much lacking everywhere and a sizeable proportion, with men in the majority, expressed the need for such facilities.

The use of various health and social services by older people was not related to educational level, or income. If anything, those who used health services more often were among the poorer more disadvantaged groups who, paradoxically included less health insured respondents than those from higher socio-economic and educational levels. Therefore, there seems to be a link between quality of life and the use of health services with people who are less satisfied with their lives making more demands on the health system. There appears to be a general trend where the more privileged of older adults, with better living conditions, also have better access to preventive health care thereby reducing incidence of long-term illness, disability and tertiary care.

Disability and Living Conditions: Results of Follow-Up Qualitative Interviews: One year after completion of interviews for the main data collection phase of the investigation, a group of 100 elderly men and women, representing about 6% of the entire sample, were revisited. Their selection were based on the results of the primary ADL scale which assessed all the respondents in the first phase. Only those respondents whose scores indicated dependence were selected and they amounted to a total of 128 people.

Of the 100 respondents the field investigators managed to revisit in the northern and central regions of the West Bank, 24 had passed away during the year; they were 14 women and 10

men whose ages ranged from 70 to 99 years. According to their families, most died from sudden cardiovascular or cerebrovascular accidents, but many died from complications of diabetes. As many as 20% died alone in their beds with no family or friends around them.

The 76 men and women who were living during the second interviews were all very ill, the majority with multiple serious conditions usually including hypertension and diabetes as well as poor vision; most had deteriorated during the course of the year since the last visit which more than half could not recall. Sixty one percent of these people were disabled of whom 23% had two or more disabilities involving movement, with at least hearing and/or visual impairments. Visual impairments only, resulting in total or partial blindness, accounted for 25% of this sample, hearing impairments 10% and physical disability involving movement amounted to 32%. All of these disabilities resulted from years of chronic illness: physical disabilities resulted mostly from CVAs, limb amputations due to diabetes, severe osteo-arthritis, and extreme frailty. The greater majority, however, were CVA or stroke patients who had either diabetes or hypertension or both.

Many of the visual impairments were complications of diabetes or because of primary and secondary glaucoma or cataracts. Ten percent suffered from total dementia.

The remainder, nonetheless, deteriorated from last year and many of those not included in the above disabilities had heart conditions preventing them carrying out their regular social and domestic activities. Others were in constant debilitating pain, while many were either completely incontinent or had difficulties reaching the toilet in time. Only 10% of this sample showed and expressed improvement in their health and were able to get out of the house and be more independent than a year ago. All the rest were house-bound and some totally bed-ridden.

The majority were living with their children and grandchildren with either a daughter or daughter in-law to look after them and meet their basic every day needs. There were slightly more women than men among this sample and it was observed that the men were generally better looked after than the women because the majority still had their wives and usually wife and daughter or daughter in-law would be there for him. With women they would usually be widows. A typical scene would be a widow with either an unmarried daughter kept at home to serve, or an overworked daughter in-law who had to cope with disabled in-laws and at least four to six young children all living either nearby in the same building or, in some cases, in the same household which often consisted of two or three small rooms and an outside bathroom and kitchen.

Poverty was rampant. Few of those people were comfortable in their infirmity and old age. The majority were from villages and refugee camps where many of the homes visited were decrepit and unhealthy. They were devoid not only of modern amenities but, occasionally, of basic necessities such as running water and electricity. In at least three cases, the dwelling was nothing more than a dark and damp hovel where animals are normally kept.

Picture Credit: Anita Nassar

The people living alone were usually the worst off financially, physically and mentally. Their number not exceeding eight (8%), the majority were married but had lost their spouses and either had no children or their children were all living abroad and often neglecting to send regular financial remittances. Some had a daughter or son nearby who would visit (usually the daughter), and help with domestic chores and bathing. The best off of the people revisited were those who had the entire family with them (i.e. spouse, at least one son or daughter, and grand children).

The situation became worse with those living in a large family with too many grandchildren in crammed, overcrowded households, particularly in the refugee camps. In such situations a live-in son, usually married with several children, would assume financial responsibility for his family as well as his elderly parent(s). This responsibility is often precarious, depending on the availability of jobs either in Israel or the West Bank itself so that the income generated usually from work as a building or farming labourer, varies from week to week. Almost 90% of the elderly and their caring relatives expressed dire need for financial assistance.

Since many of the people interviewed were physically disabled, experiencing considerable difficulties moving around, the need for wheelchairs was overwhelming. Most did not have wheelchairs and had to be carried by their overburdened relatives. There were some who were even seen crawling on the floor to move from one part of the room to the other. A few had wheelchairs and too many were in bad need of repair or had to be replaced. There was also a great need for eye treatment and some required hearing aids which they could not afford. Above all there was an overwhelming need to cover the costs of medication. Although some may certainly be overmedicated by their doctors and, consequently spend more than they should, others had to stop the expensive medicines because they could not afford to keep buying them outside the governmental health system.

The social welfare system in the West Bank (PNA or UNRWA), aside from paying the insurance fees for at least one third of those interviewed, also afforded financial or in kind assistance mostly involving food commodities to a minority, not exceeding 10% of these poverty stricken, ill and disabled elderly people. Hence loud expressions of

While the overwhelming majority had health insurance either paid for by welfare or children, all expressed dissatisfaction because the medication they required for their numerous illnesses were often unavailable through the insurance and had to be bought at considerable costs. Most of these medications were for long-term treatment of such chronic ailments as cardio-vascular disorders including hypertension, diabetes, and arthritis, the medication of which are counted among the most expensive. Thus, financial assistance was required for medical costs which the insurance often failed to cover, and some required assistance to pay for the health insurance fee itself. Some of the health insured did not use the insurance because it was more convenient for both the elderly patient and his/her relatives to ask a private doctor for a home visit. This was common in some of the more isolated villages where transport was more difficult than elsewhere and where the governmental health facility was too distant or absent.

Picture Credit: Pierre Couteau

dissatisfaction were heard during the interviews. However, those who expressed the most dissatisfaction were not necessarily those who were without external assistance; many were from among those who were receiving help one way or the other. Dissatisfaction was often not directed against the system or life in general but against the carers themselves. Daughters in law helping an elderly man or woman where the spouse was deceased drew the loudest protests and grumbles with statements of discontent and disapproval expressed by both patient and carer. Daughters were much more tolerated and resulted in more satisfaction from the elderly but not necessarily from the daughter. Some went so far as to wish the parent(s) dead to be relieved from what they regarded as a heavy burden not altogether without any support from the rest of the family or from an external source. Sons rarely offered physical help in the home although some did pay for all the expenses of looking after an elderly relative. Thus it is the wives, daughters and daughters in law who cared most for a sick elderly member of the household. The situation is much easier when both wife and daughter assist each other caring for an elderly father/husband. Wives were the least to complain and considered it their sacred duty to care for their husbands. It was rare to see the reverse. In one of the visits an 86 year old but comparatively healthy woman was the only carer of her totally disabled 64 year old son. Some of the disabled who had no close relatives nearby, were looked after by a neighbour who would visit every few days to do some cleaning, washing and cooking. Although some had well to do children either living in the country or abroad but who rarely called or sent money, the majority had caring and kind relatives. In all of the households visited during these second interviews, none received help and support from official or private sources in the form of assistance in the home or nursing care, and none of the disabled elderly or their carers received rehabilitation services whether at home or outside. Hence the larger than necessary financial, physical, and emotional burden that the family has to endure when caring for a seriously ill and disabled relative.

The majority of disabled elderly Palestinians are also looked after by their families including spouses, daughters, and daughters-in-law

The situation was different in East Jerusalem where second visits of 10 of the more disabled of the respondents also took place. As in the other parts of the West Bank all were seriously ill with mostly cardiovascular or cerebrovascular conditions often accompanied by hypertension, diabetes, arthritis and osteoporosis. Unlike the rest of the West Bank, however, they were all covered with Israeli health insurance schemes through the National Sick Fund "Kopat Holim". Two of them (20%) had already died by the time the second visits occurred. But of the remainder, aside from the health services and medication, six (over 62%) received social services, domestic and nursing care services in their own homes, whereby three were assisted through the official social service programmes attached to the Jerusalem Municipality, and two through private companies. Three people did not receive assistance of any kind.

The Jerusalem disabled elderly were generally older than their West Bank counterparts. The ages of the remaining three men and five women ranged from 98 to 62 years with a mean age of almost 86 years and, despite the outside care and attention, most were unhappy and had deteriorated during the year. More than half complained of the services they received, claiming they were irregular and insufficient with not enough time allocated to them. But, perhaps, what contributes to the general feeling of dissatisfaction is deteriorating health and increasing dependence, the isolation, and the moderate to poor living conditions. The majority were in the old city living in mostly damp, poorly ventilated and, in at least one case, dilapidated conditions.

In common with the rest of the West Bank, the majority of these elderly lived with other members of the family who lent support and assistance in activities of daily living. Financial support was less pronounced than elsewhere, however, because of the external assistance and benefits. Outside the family, social life was almost non-existent and few ventured out of their homes.

A serious observation among all the disabled or semi-disabled people who were revisited, whether in Jerusalem or elsewhere in the West Bank, is the fact that there is a marked absence of organised leisure activities in which these elderly can engage in. Of course, the fact that the greater majority are disabled cannot be ignored, but there still remains the need for those simple pleasures which other people may take for granted. Many of the people interviewed have not stepped outside their homes for more than two years and they would welcome an opportunity to be assisted to do so and, perhaps reach a shop or stop by the local coffee shop for a chat with old acquaintances. Such simple activities are mostly not carried out and even with the presence of carers in the family, none of them seems to realise the importance of a simple drive to town or in the country, or the opportunity to meet other people, especially when the disabled elderly is feeling better and in need of a change of scene. Hence the

almost universal and acute sense of boredom and even depression expressed and observed during those interviews. Such negative feelings inevitably aggravate the already poor quality of life observed.

This doesn't mean to say that all of the elderly interviewed expressed these understandably negative attitudes. There were a minority who were quite content, especially those who had most of their family with or around them. Some others were also not aware of the need for these little extras as long as they find a relative who would keep them company and assist them in their very basic daily needs. Yet others were more or less resigned to their fate but only too aware of their poor and deteriorating situation. But in any such group, and especially in this one, there are too many, even among the very ill and frail, who refuse to resign themselves, and who feel entitled to a better life, keep on fighting for a better life, and who are not ready to give up - not yet.

Conclusion

Older Palestinian adults and the elderly show trends in health similar to those observed in other developing societies with a particularly noticeable prevalence of chronic disabling conditions, especially hypertension, diabetes, arthritis and related disorders. The Palestinian elderly also have a relatively poor perception of their own physical and emotional health and well being. Yet prevalence of disability as assessed by levels of dependence on activities of daily living is not high. It is certainly higher among women and the older age groups with more dependence on instrumental or secondary activities of daily living than primary.

Older Palestinian women show more disabling chronic conditions than do older men in the same age categories. Incidence of depression and cognitive dysfunction is relatively high and associated closely with a poorer self assessed physical health and these are also higher in women than in men.

Among both men and women, advancing age, lack of schooling and education, negligible or haphazard income, widowhood, divorce and separation, and living with relatives in their home all have detrimental effects on both physical and mental health. The fact that such adverse life circumstances appears more common among women than men cannot be ignored.

Women and the very old are more frequent users of official health services and charitable services. Up to two thirds of the sampled population possess some kind of a health insurance policy with slightly more health insured people found among women, the older age groups and, paradoxically, among the less educated and economically more disadvantaged as they rely on welfare to pay for the insurance fees which are not obligatory. Nevertheless, the health insurance policies are not being used to full capacity with too many of the health insured having to pay for specific treatments not available through the insurance. The financial burdens of health care of the older adult and elderly Palestinian remains very much a family affair with the majority of the elderly still being looked after by their children.

The majority of disabled elderly Palestinians are also looked after by their families including spouses, daughters and daughters in-law. The quality of this care varies as does the level of support both from within and outside the family. Apart from medical care there is little else that the older person can benefit from. In the West Bank most of this care is to be found in fairly accessible clinics and hospitals and, except in East Jerusalem, there is very little organised and systematic community or home based care. Social services are negligible and haphazard and there is very little awareness for the need for organised social, cultural and leisure activities in the community. This also applies to East Jerusalem as well where social life and circumstances do not differ much from the West Bank and where the elderly do not appear to be more content than their counterparts in the rest of the West Bank despite the more integrated and comprehensive health services.

Risk factors are many and include in addition to age, poverty, illiteracy and lack of proper schooling, widowhood and adverse marital and family circumstances, and lack of vocation. There are indications that such risk factors and adverse life circumstances in earlier stages of adulthood have strong detrimental effects on health in later stages of adult development. When asked as to why older women in the study came out as particularly disadvantaged one elderly gentleman remarked:"I remember in the old days just after the Nakbah (catastrophe) of '48 when the refugees were still living in tents, the young mothers, still school age, would walk barefoot 2 or 3 kilometres in the hot sun to the nearest well to fill their water jugs. They would come back balancing these jugs on their heads trying hard to hold on to their children not to mention those they were carrying, while not too far away their men folk would be seated outside their tents chatting earnestly over a cup of coffee... What would you expect these women to become fifty years later?"

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