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The Housing Environment and Women's Health:

The Case Study of Ramallah al-Tahta

By

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List of Abbreviations

CHF	The Corporation of Housing Foundation
MOH	Ministry of Housing
NGO	Non-Governmental Organisation
PNA	Palestinian National Authority
UNDP	United National Development Programme
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WHO	World Health Organisation



Preface

This study was conducted over the span of 2 years with the field work portion taking place during the latter of 1995. Over the course of the past four years, political, social, and economic changes have taken place throughout Ramallah which affect the lives of the women included in this study. Therefore, some of the descriptions of Ramallah al-Tahta and the results of the focus group discussions and interviews represent the conditions of 1995 and not necessarily those of present day.

Note must also be made that the names of the women, their families and members of the community have been changed to protect their privacy.



Introduction

This study examines the perceived relationship between women's health, well-being, and the housing environment through the voices of women in a poor urban area of Ramallah. This work was taken on in the hopes of making a contribution to research on Palestinian women's health, with a focus on its relationship to the housing environment. Results presented here may be used by women's organisations, health planners, and the housing and urban planning sectors to rethink housing policies in a gender-sensitive manner, thus providing a healthy housing environment for Palestinian families.

Within the academic field of housing, researchers have neglected the relationship between the housing environment and health in the Palestinian context. Instead, they focus almost solely on the documentation of the Israeli military practice of demolishing or sealing homes of Palestinians accused of anti-Israel activities. We assume the demolishing of homes has a serious impact on the health of the residents. Yet, housing demolition is only one of many issues that needs to be studied in relation to health and housing environment. Limited attention has been paid to the housing problems of the population who were not directly affected by demolishing policies. This study is a step towards filling this research lacuna.

At the time of this study, during the year 1995-1996, the only source of information on housing conditions was from Israeli government statistics, showing significant improvement in the housing conditions of Palestinians living in the West Bank and the Gaza Strip after 1967. For instance, the majority of Palestinian housing units had running water and toilets by the mid-1980s. Additionally, there was an increase in the average area of a

living unit and a decline in the average number of persons per habitable room. Houses in urban areas show more improvements than houses in rural areas or refugee camps in respect to water, sanitation facilities, and crowding ratio (Statistical Abstract of Israel, 1987). Intra-urban differences in Palestine are not dissimilar from the statistical data on urban living conditions in other developing countries (cf. Harpham et al., 1988).

Although very little research has been conducted in poor urban neighbourhoods in Palestine, two studies have taken note of the special needs of these communities in Nablus and Jerusalem. The studies focused on the perception of residents rather than objective analysis of the physical environment. Giacaman et al. (unpublished) and Habash (1995) found that poverty, inadequate housing, and crowding are perceived as causes of poor health particularly among women, children, and the elderly.

The internationally available literature on housing and health suggests that inadequate housing conditions have a negative effect on physical, social, and mental well-being. Crowding, for example, increases the spread of air-borne diseases (Cassel, 1979), and people living in a home defined as crowded are more likely to suffer from psychological stress related to housing conditions (Gabe and Williams, 1987). Facilities within a home also impact health. The lack or inadequacy of a water supply and sanitation facilities are connected with the spread of water-borne (e.g. giardiasis) and water-washed (e.g. trachoma) diseases (Cairncross and Feachem, 1983). Noise and air pollution in the residential environment influence the physical, psychological, and mental health of residents as well (Satterthwaite, 1993).

There are two different approaches to researching the relationship between housing and health. The first deals with household members as one homogeneous group and assumes that housing conditions have the same influence on children, men, women, and the elderly (cf. Kasl, 1979; Beard, 1979). Often, such research relies on large samples or census data. The second approach views household members as belonging to different social groups which have different needs and roles within the housing environment (cf. Gabe and Williams, 1987; Munro and Smith, 1989). In turn, the housing environment has varying effects on their health and well-being (Chombart

De-Lauwe, 1961). For example, women who are housewives and mothers express a greater need for water and sanitation facilities than do men. The lack of water facilities in the home increases women's work load, adding to fatigue and psychological stresses (Jordan and Wagner, 1993).

This study uses the second approach to look at the effect of housing environment on women, as they represent a distinct social group in households. However, all women cannot be viewed as being part of the same social group. At different stages of their life cycle-childhood, adolescence, reproductive age, and old age-women play different roles and have different needs. Lane and Meleis (1991) and Giacaman et al. (unpublished) utilised the life cycle approach to research women's perceptions of health. This approach relies on the fact that the perception of health depends, in part, upon the different roles and daily experiences of women in different age groups. Researchers' analyses confirm this theory, showing different patterns in women's perception of health across age. For example, marital status and the reproductive roles of women were found to influence women's perceptions of health during the childbearing age.

The life cycle approach is used in this study to look at how women at different stages of their life perceive the effect of housing conditions in the inner city of Ramallah on their health. This study is divided into three sections. Chapter 1 introduces the general relationship between housing environment and health and how it influences the lives of men, women, and children. This study is based on the review of the available literature. Each of the studies, whether or not conducted in Palestine, help to ground the particular examination of the effects of housing on health in the Palestinian context. Chapter 2 discusses the general relationships and expands on this framework to account for the relationship between the housing environment and the health of women. The latter part of this discussion considers the different roles of women in the home environment and at varying stages of the life cycle. Section 2, Chapter 3 moves from the broader conceptual framework provided in the previous two chapters to a specific focus on these issues as they are manifested in the Palestinian context. Chapter 4 presents a general view of housing and health in

Palestine, encompassing women's role in this relationship. The third section of this paper is the case study of women in Ramallah al-Tahta. Chapter 5 outlines the methodology and background for this case study. Chapter 6 presents the results of the focus groups and interviews with women and examines their perceptions of the effect of housing on health at different stages of the life cycle, excluding childhood.

In the planning stages of the research, I had intended to concentrate on the perceived effect of poor housing on the physical and mental health of women of different age groups, both married and unmarried. What I obtained was evidence that most, if not all, women's lives are connected to their homes and surrounding neighbourhood environments. Women view health as a product of their overall socio-cultural, economic, and political conditions, and see their state of health as a reflection of their lives and their subordination as women. I found the home environment had a profound influence on the lives of women in Ramallah al-Tahta, highlighting the need to give attention to housing, the home environment, and health as a whole.

Section One

Chapter One

Housing and Health: General Issues

Introduction

Moser (1987b) describes housing as the constructed physical fabric of the house and the land on which it is built. Yet, housing is only part of the larger residential environment. Specific components of the residential environment are seen as parts of the individual and community identity that impact on health and well-being. These components include: the living unit and the division of space within the unit, hidden space within the building, indoor and outdoor recreational areas, sanitary facilities, water supply, weather protection, heat and noise insulation, neighbourhood circulation patterns, and proximity to sources of noise and fumes (Kasl, 1979; Burden, 1979). These definitions and notions of residential environment are the ones used throughout this paper.

The relationship between housing and health has long been researched, tracing back to the 19th century when the ill-health of working class families, particularly their susceptibility to tuberculosis, was attributed to poor housing conditions (Mirta, 1989). However, other researchers have not substantiated the relationship between health and housing and do not believe there to be a significant association between physical housing environment and the spread of diseases. Kennedy (1979) and Beard (1979) discuss the methodological problems of isolating the impact of poor housing conditions from other factors such as poverty, education level, working conditions, and social relations. Beard writes:

New concepts of the relationship between housing and health are based on the occurrence of non-specific responses, in which a given cause may give rise to various health patterns, and a given syndrome of physical or emotional maladjustment may arise from

various combinations of several causes. Poverty, malnutrition, social handicaps, and poor housing usually interact, and the separate identification of one or another as the casual agent for illness is impossible. Nevertheless the relative importance of each in any situation may be estimated through the use of multifactorial analysis. (Beard, 1979: 307)

The World Health Organisation (WHO) disagrees with Beard, stating, “by deductive reasoning, a strong relationship between housing and health can be established” (WHO, 1961: 18).

Attempts to isolate the impact of housing on health should include the impact of two aspects of the man-made environment on health (Cassel, 1979; Gabe and Williams, 1987; Munro and Madigan, 1993; and Fuller, 1993). One is the physical objective environment: the living space, availability of water and sanitation, persons per room, etc. The second is the subjective, perceived environment: inhabitants’ satisfaction or dissatisfaction with housing environment and associated services which they see as causes of morbidity and/or stress. Fuller et al. (1993), through use of multivariate analysis, found that objective aspects of housing, such as crowding, influence health and can be the cause of fatalities. They also found that the subjective, perceived environment, as expressed by the inhabitants’ views of housing facilities, also affect health.

In developing countries where housing is an increasing problem, particularly for the urban poor, the provision of minimum basic housing needs is considered the core issue of urban planning. Hardoy et al. (1990) estimate that at least 600 million urban residents of the Third World live in what might be termed as “life-threatening” homes and neighbourhoods. The debate on the housing problem in Third World countries and the ensuing fundamental change in housing policy stems from the fact that in the last three decades conventional governmental housing programmes have failed to satisfy low-income housing demands. The direct consequence of this failure has been the proliferation of squatter settlements and shantytowns. Viewed in the 1950s and 1960s as a temporary phenomenon, these human settlements had been assumed to be transitional accommodations for rural migrants first arriving in the cities.

In an attempt to contain the housing problems of the urban poor, governments and NGOs started low-income housing projects for inhabitants of squatter settlements. However, low-income housing has failed to cover housing needs, documented by Moser (1987a), Wratten (1995), and Hardoy et al. (1990). The required costs for living in low-income projects have been beyond the affordability of many urban poor households.

It was found the housing and living conditions of the urban poor might be better improved through slum upgrading and improvement rather than displacement (Mirta, 1989; Harpham and Stephens, 1992). Slum upgrading focuses upon legalising land tenure so inhabitants feel safe to participate and invest in housing and infrastructure upgrading.¹ Additionally, governments and policy makers facilitate the provision of basic services such as health care, water, sanitation, educational facilities, and transportation networks (cf. Denaldi, 1994; Moser, 1991). But even the augmentation of housing for the urban poor in developing countries tends to neglect particular groups in society, such as the elderly, female-headed households, and street children.

Housing and Health: Contributing Factors

For the purposes of this research, an integrated approach was used for establishing the relation between housing environment and health. This approach accounts not only for the physical, man-made environment of the housing unit and the neighbourhood, but also for the facilities that impact health, and the needs of different groups in the community. The relationship between housing and health can be discussed within the following framework of contributing factors.

Direct Factors

Site of Residential Area

The site of a residential area affects health through factors such as the area's

1. Squatters, without legal tenure to the land, are vulnerable to displacement by government policies capitalistic landowners.

proximity to industrial pollution or any naturally occurring disasters. Indoor pollution is influenced by outdoor pollution; people who live in the vicinity of industrial areas are at a great risk of air pollution. It was found that blood levels in the children of workers living close to industrial areas were higher than the blood levels of children of managers living in “good neighbourhoods” (Kasl, 1979). Kasl (1979) and Satterthwaite (1993) argue that the people who live in poor environments are those who cannot afford to live in healthy environments. For example, a factory worker who lives in relatively inexpensive accommodations close to an industrial zone chooses to do so because he cannot afford to live in other areas farther away from industrial pollution. Even if the cost of accommodation were the same in the two areas, there would be other costs to consider. Thus, workers tend to choose to live in a polluted area.

Urban settlements develop in order to group capitalistic enterprises in a cost effective spatial configuration. Many people are attracted to cities mainly by the opportunities for work . . . Cheap housing areas and heavy industry both tend to be located on lower cost land in cities.
(Wratten, 1995: 22)

Naturally occurring disasters can also negatively affect housing environment. For example, residential areas located on lands at risk of earthquakes are mostly inhabited by squatters who have no choice to live elsewhere (Satterthwaite, 1993; Malwanda, 1993).

Building Materials

Historically, people built houses to protect themselves against weather changes and natural environmental danger. Nevertheless, the use of hazardous building materials has created a new set of dangers.

One example is the use of asbestos, a carcinogenic material, widely used in the construction of walls and ceilings often unbeknownst to residents in many developing countries. Lead paint, which can lead to lead poisoning (especially among children), is a hazardous building material commonly used in Palestine. Higher rates of lead poisoning occur in dilapidated houses

than in more affluent homes where layers of lead paint are protected from reach (Beard, 1979). Building materials may fail to provide adequate insulation and protection from weather changes. In Bariloche, Argentina, insufficient protection against excessive cold resulted in a series of illnesses such as colds, pharyngitis, and neuralgia (Abaleron, 1995).

Natural Lighting and Ventilation

Poor housing structure lessens natural lighting in rooms, preventing exposure to the sun rays which provide the necessary ultraviolet rays for the body to utilise vitamin D (WHO, 1989). Lack of such exposure can give rise to tooth decay, rickets in children, and osteomalacia in adults. Additionally, the sun rays can help in killing viruses and germs.

Poor ventilation causes dampness, which predisposes both adults and children to tuberculosis, allergies, nausea, stomach-aches, and vomiting (Byrne et al., 1986; Platt et al., 1989). In some cases, psychological distress has been attributed to dark, damp housing (Cassel, 1979).

Crowding

One of the more widely held and cherished notions in medicine is that the spread of infectious diseases is facilitated by crowding. This assumption underlies many research endeavours seeking to establish a relationship between housing and health. (Cassel, 1979:31)

Measles (Samsi et al., 1992), diphtheria, whooping cough, and other airborne diseases are more prevalent among children who live in crowded, inadequate housing in developing countries (WHO, 1992). The spread of trachoma is also facilitated by crowded sleeping arrangements. Additionally, tuberculosis, which accounts for the death of three million adults worldwide per year, is concentrated in crowded housing areas (WHO, 1992; Cassel, 1979).

The effect of crowding is not limited to the spread of physiological illnesses. Psychological stress due to crowding occurs when an individual's demand for space is not met and therefore desired levels of privacy and private

space are not achieved (Munro and Madigan, 1993). Crowding has been suggested to worsen intra-family relationships because of the competition among family members to achieve their desired level of privacy (Booth and Edwards, 1976; Satterthwaite, 1993). The objective crowding ratio is expressed in number of persons per habitable room, or number of square meters per person. Subjective crowding differs among household members according to their roles at home, influencing health outcomes, particularly mental health (Gabe and Williams, 1987; Fuller et al., 1993). Within this context, Fuller et al. (1993) and Gabe and Williams (1987) consider the individual as the unit of analysis, but acknowledge that individuals are first and foremost members of particular social groups which differ in their use of and control over the available household or neighbourhood resources. Thus, one must assume that the effect of crowding on health is not the same for all household members; differences exist between women, men, the elderly, the disabled and children. Psychological and mental stresses are more often attributed to subjective rather than to objective crowding (Munro and Madigan, 1989; Fuller, 1993).

Availability and Access to Water and Sanitation

The association of enteric diseases with unsanitary waste disposal and with inadequate or impure water supplies is well established, and it is also known that these relationships can occur readily in the context of the residential environment, i.e., in a neighbourhood or a dwelling unit. (Beard, 1979: 313)

Waterborne diseases, including diarrhoeal diseases, hepatitis, and intestinal parasitic infections, are closely related to the lack or inadequacy of potable water supplies (Cairncross and Feachem, 1983). Additionally, water-washed diseases, such as some types of skin and eye infections, are caused by the lack of sufficient amounts of water for personal hygiene. In 1991, WHO reported the following:

While there was considerable progress during the 1980s (designated by the United Nations as the International Drinking Water Supply and Sanitation Decade) in increasing water supply and sanitation coverage, WHO

estimates about one-third of [the] urban population in developing countries did not have access to safe water supply. This figure understates the number of people inadequately served. There are several reasons for this; firstly, the criteria used to define an 'adequate' water supply are open to question. For instance, the availability of a water tap within 100 meters of the house is often considered 'adequate' water, yet this is not necessarily adequate for maximising health. Classifying coverage as adequate is often based on the assumption that settlement dwellers who are supplied by communal water taps are adequately served. (WHO, 1991: 189-190)

The insufficient treatment of water supplies, as occurs in many developing countries, results in environmental health hazards even when water supply is available (Cairncross and Feachem, 1983; WHO, 1992).

Sanitation services meet even fewer people's needs: almost 50% of the urban population in developing countries do not have adequate sanitation facilities (WHO, 1991). Additionally, sewage systems cover only a few sections of cities and towns, resulting in the discharge of untreated waste water from the remaining, uncovered areas into streams, rivers, and lakes. In some cases, wastewater penetrates into the soil resulting in the pollution of surface and ground water.

Squatter settlements and urban slums are viewed as illegal by governments and are not part of urban planning, excluding them from essential services such as water and sanitation. In other cases, particularly with economic structural adjustment programmes and governmental cuts in public expenditures, governments are unable to afford the costs of service provision (Wratten, 1995; Satterthwaite, 1993; Hardoy et. al., 1990). The people living in squatter settlements, whose conditions are already poor, are slighted even further.

Indirect Factors

The previous five factors, as supported by the cited research, are part of the constructed living unit and its environment which directly affect health.

Other factors indirectly related to the immediate housing environment that also have an influential affect on health include the availability and accessibility of public services, such as health care, education, transportation, as well as employment.

Proximity to Health Care

For urban dwellers who live in poor housing conditions, often struggling economically, access to health care is particularly important to mitigate the effects of the poor housing environment.

Easy access to efficient vaccination programmes may reduce the spread of measles, whooping cough, diphtheria, and other vaccine preventable diseases which are easily spread in a poor housing environment. In the case of health promotion education, hygiene education can reduce water- and sanitation-related infections. Curative services are important for patients who may not be able to reach the city hospitals and health centres despite living in an urban area.

Neglect of the urban poor by the primary health care system is a result of planning in the 1970s and early 1980s, which had a rural focus. Planners thought that the urban poor in slums would have access to urban health care facilities, however, this is not a reality for many poor families.

Access to Education, Transportation, and Place of Employment

The lack of educational facilities and schools in, or close to, the neighbourhood, may deprive children of an education. Long-term affects of poor education on children are the lack of skills which enable them to function in society as adults and the loss of employment opportunities.

For adults who are employed, accessible transportation may be a trade-off for reduced costs of living in a distant residential neighbourhood. However, the cost of transportation (in terms of money and time) may decrease the incentive to work far from home. The result may be opting for less pay for a job closer to home, or choosing unemployment.

Tenure

The state of insecurity caused by the lack of tenure rights affects residents' physical and mental health as they must cope with the threat of clearance and eviction. This insecurity prevents long-term planning and investment. For example, residents may refuse to pay for collective expenses like water supply if they are not sure whether they are going to be allowed to continue living in the residential area.

Harpham and Stephens (1992) argue that tenure is one of the key measures to improving urban health, providing residents with an incentive to invest in upgrading their environment. Legalising tenure rights and recognising settlements also encourages and enables planners to provide public services to these areas.

One solution for the landless poor is low-income housing projects. This move of the urban poor from slums or squatter settlements to other urban areas integrated into the cities is not always an improvement in living conditions. Residence in housing projects requires higher housing payments to cover housing loans and can increase the time spent travelling to and from work. In many cases, children of new residents have been unable to find places in schools. Relocation also led to a decrease in food purchases and to social and psychological stresses resulting from living in a new environment. Had planners considered the relationship between the housing environment and health extended beyond merely the living unit, many of these problems could have been avoided (cf. Hardoy et al., 1990).

Authors researching this topic note that legalising tenure rights for squatter settlements is important for policy planners who consider slums and squatter settlements as areas of development. With tenure, planners can give attention to the provision of the services of health care, education, transport, and upgrading housing. When slums and squatter settlements are considered illegal and areas of eviction, no service provision takes place, depriving residents of services and security.

The Subjective Housing Environment

The way that people perceive housing is related to the roles they perform at home and their desires and aspirations with regards to space, facilities, and communication with other persons or family members with whom they share the living space. Thus, satisfaction with and positive perceptions of the house, achieved through the reduction of housing stresses, are important for assuring a good state of health (Burden, 1979).

Analysis of the impact of social and perceived housing environment on health revealed that stress, anxiety, and other physical symptoms, such as elevated blood pressure, are higher among those who have a negative perception of their residential environment (Kasl, 1979). Gabe and Williams (1987), found that women with children experience crowding more than men, since they spend more time at home and are therefore at higher risk of a variety of symptoms of stress.

Researchers here have shown that to reach a comprehensive understanding of the effects of the man-made environment on health and well-being, it is essential to acknowledge a variety of factors and their effects. More specifically, these are the effects of the objective physical environment, the objective social environment (such as tangible access to friends and relatives), and the subjective environment as perceived by the various social groups in the society.

Chapter Two

Women's Health and Housing: A General Conceptual Framework

Introduction

...Men and women play different roles in society with gender differences shaped by ideological, historical, religious, ethnic, cultural and economic determinants. These roles show both similarities and differences across and between classes as well as societies. An understanding of the social construction of gender relations also recognises that because men and women play different roles in society, they can often have different needs. Planning at the level of the household or family does not necessarily accommodate these needs. (Moser, 1987b: 5)

Focusing on the effect of the housing environment on the health of women does not necessarily mean that women have more health problems related to housing quality and location than men. However, due to their different roles in the home, women may experience different symptoms of ill-health than men. Analysing the symptoms requires an analysis of the gender-based division of labour and power and how these divisions interact with women's perceptions of the housing environment and shape their health and lives. This chapter will explore these issues within a broad framework, reviewing the available literature on housing and women's health in a variety of contexts.

The Gender Role's Effect on Women's Health in Relation to the Housing Environment

To understand the relationship between women's health and housing environment, one has to consider not only the physical aspects of the housing

environment, but also women's positions and roles in the house. Additionally, it is worth discussing how housing policies address women's social housing needs, as these influence their health and well-being.

Women shape their lives to fit around family needs and the domestic domain (Oakley, 1994); their concerns about "home" are greater than men's concerns. Their housework duties and the caring for children and adults in the household strongly binds women to the home. However, these socially determined roles of women may put women under stress and contribute to causing illnesses (Doyal, 1991; Walters, 1993). Additionally, the social subordination of women impinges upon women's health and well-being. While women are responsible for the house, men have the ultimate control over the housing environment and household resources, deciding on issues such as house ownership and changes of residence. Thus, women have to adapt their lives according to men's decisions (Roberts, 1991). For women of the lower class, coping with the effects of unequal distribution of power may be even greater because they have to manage with fewer resources (Doyal, 1991).

Power Relations in the Home

Recent discussions on the feminisation of poverty argue that women are more likely than men to be poor. This is not only because they predominate in the households which are poor (both as single parents and as elderly), but also because they are likely to have an unequal share in the power over household finances. Thus, women may be kept "poor" even within relatively affluent households (Glendinning and Miller, 1987).

...We might say that...while few wives (if any) are all together excluded from decisions about the use and disposal of household resources, their financial power is not necessarily in direct proportion to the amount of time they spend on resource management work. To have demonstrated that women make crucial contributions to this aspect of household maintenance, therefore there is no way to negate the body of research which indicates that women's financial power is not the same as their husbands. (Sharma, 1986: 86-87)

Women's limited financial power is reflected in the decision-making process concerning housing, allocating money for housing payments (rent, mortgage or purchase), and improvement of housing conditions. These decisions regarding housing depend on the man's income and age (Krishnan and Krotki, 1989) and on the time men spend at home. For example, men tend to decide to spend more money on upgrading housing conditions when they spend considerable time at home. However, men who have two jobs or spend their time socialising with other males outside the home are unlikely to appreciate the importance of improving housing conditions (cf. Chant, 1987; Wikan, 1976). This means that women and their children can be left in poor and inadequate housing, as they often are not able to make decisions about allocation of money. There are, however, some changes on the horizon. Women's participation in paid labour has put them in a stronger position, in which shared decision-making is possible (Chant, 1987; Munro and Smith, 1989).

Physical Aspects of the Housing Environment and Women's Health

Women and children spend much of their time at home where they are exposed to a wide array of problems, with the home itself a potential source of problems (Surjadi, 1993). The residential environment imposes a higher rate of exposure to air pollution, road accidents, rodents, and insects on women and children due to the extensive amount of time they spend at the home. Additionally, women are exposed to occupational hazards resulting from heat and chemical burns, and chemical poisoning.

The Housewife and Housework

It is a myth women are relatively safe from danger as compared to men because they are at home. Doyal (1991) and Oakley (1994) argue that the idea that women are safe and protected by the home environment is not accurate. Housework has occupational health hazards, both physical and mental. Rosenberg (1984) argues that the stresses of housework resemble those faced by workers who deal with high levels of occupational stress, such as teachers, policemen, and health workers. She also goes on to say the working conditions of housewives are worse than those for professionals as there are no days off from housework and no way to change the workplace.

Water and Sanitation

Because women are the primary caretakers of the household and are responsible for childcare, they have a great need for safe water and sanitation to ensure their health and that of the other members of the household. Where there is no access to water within the home, women have to fetch water—a task which increases women’s working hours and raises the incidence of fatigue-related illnesses (Okojie, 1994).

E **Environmental and Health Hazards of Housework**

Accidents in the Home

Poor and inadequate housing increases the risk of home accidents, particularly when the house is dilapidated (cf. Hardoy et al., 1990; Doyal, 1994). Although children are at a higher risk of accidents in the home, women are at risk of a variety of accidents, including burns, electrical shock, falling from unsafe stairs, and injuries from broken glass, etc.

Home Cleaning Products

Home cleaning products contain chemicals which when inhaled, cause throat irritation, nausea, and vomiting. Other products cause skin and eye burns when coming into contact with the user (Rosenberg, 1984). In some developing countries, precautions are not written on the containers. High illiteracy rates among women limit the effectiveness of the precautions when they are provided. Worse yet are imported products with precautions written in foreign languages.

H **ousework: A Stressful, Demanding Job**

The hallmark of a housemaker’s relationship to her house and her husband and children is her availability. The identification of her own need[s] separate from theirs become[s] blurred. Some tasks may be shared, some delegated to others, but the responsibility typically remains with the housewife who indeed feels married to

the house. With this responsibility goes an affective or emotional servicing. Meeting needs, avoiding conflict, creating routines which please everyone, frequently mean subordinating herself. Women are very likely to experience their own privacy as a form of selfishness. (Munro and Madigan, 1993)

The caretaker role is stressful, both physically and psychologically. Some women care not only for their children and husband but also for in-laws or other elderly relatives who might be living in the same home. Fuller et al. (1993) and Gabe and Williams (1987) argue that women's perception of crowding in the house is higher than men's perception, and their desired privacy is rarely achieved. The needs of the female caretaker are set-aside by herself and often ignored by those she cares for. This is why psychological stress symptoms are more apparent in women than in men.

I feel like I could crawl out of my skin and scream. I need 20 minutes for myself and if I could go for a walk, or anything, a cooling down period. But I just do it and at the end of the night I am so tired, I just toss and turn, and I can't shut my mind. (Walters, 1993: 397)

A Home may not be a "Safe Haven" for Women

Domestic violence is a direct threat to women's health, although usually viewed as a crime rather than a health hazard (Doyal, 1991). Even so, legal measures designed to deal with the crime have proven woefully inadequate in a variety of contexts. Furthermore, the legal protections that are on record do not always protect women in reality, due to inadequate and inconsistent enforcement. Domestic violence prevents the home from being a secure place for women. Instead, they are trapped inside the home with somebody who is a threat to their physical and mental well-being.

The Effect of the Housing Environment on Women throughout the Life Cycle

Most of the literature on women and the housing environment focuses on women of childbearing age and their role in the house as mothers and

housewives. The effect of housing and home environments on the health of women at other stages of the life cycle has not been researched to the same degree. This section illustrates the effects of housing on women in the stages of their life neglected by most studies, with a focus on the situation in developing countries.

Childhood

Cultural differences between male and females are defined early in life. The fact female infant and child mortality rates in developing countries exceeds that for male infants and children indicates that females are provided with less care and attention in the first years of life (Okojie, 1994).

More female than male children are obliged to drop out of school, particularly among poor households where women's work is of more value (Okojie, 1994). These young girls are expected to perform housework duties, including fetching water and firewood (Agrawal and Adnan, 1982). They may also participate in cleaning and caring for both younger children and the elderly. Within this context, it can be deduced that these girls are overburdened with physical labour disproportionate to their actual physical strength and as a result, might be more vulnerable to fatigue and illness.

Participating in housework duties has both negative and positive effects on the psychological development of girls. On the one hand, they can be deprived from access to education and skills learned at school, as well as play-time with peers due to housework obligations. This negatively influences their feelings of satisfaction in the home environment and leads to psychological distress. A potentially positive effect of girls carrying a heavier housework burden is that they may value their role, gaining psychological benefit from feeling important.²

Yet, in effect, boy and girl children are exposed to different dangers. Spending more time out of the home, boys are more likely to be exposed to violence and abuse at school and on the streets than girls who spend more time in the home. Nonetheless, both boys and girls are exposed to the risk of home accidents such as burns, poisoning by chemicals, falls, and electrical shocks, although girls who do housework tasks are at a higher risk.

2. I did not have access to literature on the psychological effect of the housework load on children. this analysis is based on consultation with Dr. Sylvie Mansour, a clinical psychologist.

Adolescence

Adolescent women play a greater role in housework duties than do adolescent men. Housework duties increase as the age of the girl increases, with the hazards and stresses of housework increasing proportionately as well.

The perception of housing and home environments at this stage of a girl's development differs between adolescent girls who are still in school and those out of school. In a study on the perception of health in the old city of Nablus, school girls had a lighter housework load compared to those out of school. Yet, crowded, noisy homes are not suitable for study, nor offer the privacy wished for when peers visited (Giacaman et al., unpublished).

When an adolescent girl marries and is not prepared for the tasks of a housewife, she may develop psychosomatic disorders or mental illnesses due to her inability to cope with her new roles. For example, in a psychiatric hospital in the West Bank, a newly married fifteen year old woman was diagnosed with schizophrenia after being brought to hospital by her father and husband. While it is impossible to isolate her age at marriage as the causal factor, we should note that this woman was married when she was fourteen years old and had her first child when she was fifteen (referenced in UNDP, 1995:52).

Old Age

The number of elderly in developing countries is growing with more women reaching old age than men. Elderly women are mostly widowed and forced to take on the burden of household leadership and financial responsibilities (Les Sennott-Miller, 1993)

Economic Impacts on Elderly Women's Housing

The majority of elderly women are former full-time housewives and mothers who had fewer educational and work opportunities than their daughters and granddaughters. When these women reach old age, they lack access to economic resources because of the limited opportunities presented to them in the past. If their housing is not guaranteed, they may be forced to choose the cheapest housing possible. Lack of resources also limits women who have secured housing to improve or renovate their surroundings. Even if

they were living in decent housing before, they are not be able to improve and renovate the house. In turn, this results in the gradual deterioration of housing quality (Rosenberg, 1984; Krishnan and Krotki, 1993).

Impact of Housing on the Health of the Elderly

Generally, the elderly are prone to suffering from a variety of diseases, with elderly women having higher morbidity rates than elderly men (Neysmith, 1990). And, as women's mobility decreases they may suffer from other disabilities, such as musculoskeletal problems. Osteoporosis, characterised by the excessive loss of bone tissue, predisposes women to fractures of the spine, hip, and long bones of the arms and legs with an often deadly outcome. Globally, 50% of women over 65 die from falls and their consequences compared to 17% of men (Lopez, 1990). With poor housing and the possible lack of caretakers for the elderly, the possibility of falls increases and thus long-term suffering or death.

Social Housing Environment and the Elderly

The strain of coping with stresses facing women (e.g., sexual subordination, multiple roles, double or triple work days, responsibility without authority, and continuous care giving for a lifetime) places women at a high risk of psychological problems in later life (Smith, 1990b). Exacerbating these psychological stresses are family structural changes and the neglect faced by older women, leading to loneliness as well as poverty (cf. Giacaman et al., unpublished).

As women reach old age, their position and role changes within the household. In developing countries where the extended family structure still exists, older women are often cared for by younger women in the household. For old women who live alone, health outcomes may be negatively affected. In an ageing population in India, for example, the breakdown of the joint family system was related to lower calorie intake among the elderly (Natarajan et al., 1993). In Kerala, India, more sickness was reported among women who live alone than men, and the capacity for self-care among females was lower than among males (Kumar et al., 1994). Older Palestinian women in Nablus perceived loneliness as a major reason of their suffering (Giacaman et al., unpublished).

“[W]e are so lonely...[we need] some assistance, especially for buying medications.”

The Implications of Housing Policies on Women and Their Health

Policy Attitudes towards Women’s Housing Needs

Housing policies in developed (cf. Gilroy and Woods, 1994; Roberts, 1991) and developing countries (Moser 1987a, Moser 1987b) underestimate women’s needs, perceptions, and aspirations for housing. Housing policies are based on the assumption that a household is constituted of a nuclear family: a male breadwinner, a housewife, and children. This assumption neglects the fact approximately one third of the world’s households are headed by women, with the ratio reaching as high as 50% in some developing countries (Moser, 1993). The results of biased housing policies favouring a nuclear family structure is deprivation of female-headed households to equitable access to housing.

- Low-income housing projects are mostly beyond the affordability of the poorest 10%, the majority of these very poor households are headed by women. Thus, these households may not have the opportunity to participate in low-income housing or to improve their housing conditions (Keare and Parris, 1982). Because the households that are headed by women form the majority of the poorest households, this group is more likely to stay in squatter settlements under the threat of eviction (Pronchokchai, 1992).
- Due to their high rates of illiteracy, women’s access to information is limited. When women submit low-income housing applications, they are most likely to be rejected because the forms are not properly filled out (Nimpuno-Parnet, 1987).
- Applicants have to report fixed income. Most of the urban poor women work in the informal sector or are self-employed, they have no fixed income to report, so they are not accepted as applicants (Nimpuno-Parente, 1987).

Female-headed households are more likely to move more often than male-headed households. This may be due to the greater likelihood of female-headed households renting rather than owning their dwelling or land. Female-headed households are also less likely to upgrade their dwellings and are more likely to share toilets, to not have electricity, and to use the cheapest fuels (McLeod, 1990).

Housing policies often do not take into consideration the provision and access to essential services for those living in the residential units. In a residential area poorly serviced by public transportation, women who work outside the home face long waits, increasing the time outside of the home. These additional hours out of the home increase fatigue and stress, reducing women's time and energy to fulfil their reproductive roles and duties. In turn, women often decide to leave or change places of employment. This decision often means a reduction in pay, decreasing monetary resources for household expenditures on such basic items as food and heating (Roberts, 1991; Peake, 1987).

In developing countries, poor urban women rely on the informal sector for income and are often self-employed, working from home. Yet women living in government housing are rarely consulted about their needs with regard to housing design. When women work from home and use part of the living space as storage for merchandise or preparation, and if housing designs do not accommodate this fact, the multi-purpose use of living space leads to crowding, stress, and a hazardous housing environment (Moser, 1993).

Many women's health movements recognise women's lives start at home, and organise around women's needs in both the physical and social aspects of the housing and residential area environments (Doyal, 1994). Thus, research and policy planning for women's health should acknowledge women's physical and social needs in housing environment as an important aspect of women's health promotion programmes.

Addressing Women's Housing Needs

International literature suggests the following recommendations to address women's needs in relation to housing and to create national gender-sensitive housing policies.

- Due to their position and gender role, women spend more time at home, and their health is greatly influenced by housing conditions. Housing policies have to consult women regarding their needs for housing design and facilities.
- Women's needs for services such as water and sanitation exceeds men's needs. Women have to be consulted about the design and type of service, as their satisfaction is important to ensure proper use.
- Housework is a health hazard. The hazards related to housework have to be recognised in housing and furniture design. More information about possible health hazards of home cleaning products should be provided to women in a comprehensible manner.
- The social aspects of women's health are of crucial importance. Women's organisations and primary health care must deal with the psychological stresses of housework and provide refuge and assistance for victims of domestic violence.
- Housing policies are not fair to female-headed households. These households should be given access to low-income housing projects, and special consideration should be made by those who design and provide such housing options.
- The other roles of women (their participation in the formal and informal sectors) should not be underestimated by housing planners.
- Women are able to take community management roles. Experience proves that women are able to address their housing needs and thus positively influence their health as well as their community's (Moser, 1987b; Moser, 1993). These initiatives should be encouraged and subsidised by aid organisations.

Section Two: The Palestinian Context

Chapter Three

Housing and Health: The Palestinian Context

Land and City Planning in the West Bank under Israeli Occupation³

During the 27 years of Israeli Occupation of the West Bank and the Gaza Strip, from 1967 to 1994, there was no housing policy in and of itself, only that related to city planning and land confiscation. Construction relied on individual initiatives to invest in housing. In 1994, the Palestinian National Authority (PNA) took over health and housing responsibilities in the Gaza Strip, and partial responsibilities in the West Bank. This includes a Palestinian housing policy now in the process of being formulated.

To better understand the force behind the current housing construction and human settlement in the West Bank urban areas, we need to look at land and city planning the areas under Israeli Occupation. Before 1967, there were two main plans for the West Bank: the first was drawn in the 1920s and early 1930s during the British Mandate, and the second was drawn by the Jordanian government in the 1960s. These two plans defined and allotted locations for building and construction purposes, road planning, and boundaries of villages and municipalities (Coon, 1995).

Israeli authorities have used these city plans to impose control on land and resources. These measures can be seen from the following:

1. Israelis referred to the plans of the British Mandate to identify municipality boundaries. The population has tripled since the British Mandate and there is a need to expand these boundaries. This resulted in the limitation of land available for building which increased the price of residential land and made residential areas more crowded.
2. Under Jordanian planning law, the state could acquire 30% of the land

3. This section discusses city planning in the West Bank and excludes the Gaza Strip as the area of study is in Ramallah, an urban centre in the West Bank.

from its original owners to be used for public good purposes. The Israelis used this law to seize land. However, to no one's surprise, they did not use it for the purposes of the public good.

3. Israelis also acquired the land and buildings possessed by Palestinians who left Palestine before 1967 or upon the 1967 Israeli Occupation of the West Bank and the Gaza Strip. Palestinians did not register these holdings in the 1968 census and Israeli authorities declared the land and buildings as state property.
4. Rigid restrictions were imposed on building licenses in villages, except in building areas defined during the British Mandate. Most land in the villages is considered as agricultural and/or public. It is nearly impossible to get a license to build on such land.
5. In addition, under military law Palestinian land is subject to confiscation. People need only be told orally that their land is being confiscated, and the presence of an Israeli bulldozer is "enough" to let landowners know that their land is being confiscated.
6. Any building that was established without a building license was liable to be demolished. Approximately 1500 houses were bulldozed between 1986 and 1989 for this reason (Welchman, 1993).

During the Israeli occupation, 60% of the Palestinian land in the West Bank was confiscated and put under Israeli control, a practice that has not stopped after the Oslo Accord. In addition to land, Israel took control over more than 80% of the West Bank's water resources. Restrictions have been imposed on water use for farming, destroying the development of Palestinian agriculture. Israeli Occupation also did not allow for the development of Palestinian industry. Israeli policy made an overall attempt to hinder the development of Palestine's economy and to create dependence on the Israeli economy.

Israeli control over land and other resources has hindered the development of new urban areas where jobs and residential areas could be developed. Thus, urbanisation in the West Bank has been confined mostly to the main cities of Nablus and Hebron (Coon, 1995). Urbanisation in other towns like Ramallah and al-Bireh increased in the early 1990s when the political situation ostensibly began to settle.

Within this context, pressure arising from land confiscation and restrictions on building left rural Palestinians with no choice but to leave their villages and migrate to the cities, urbanising the West Bank. Highly educated rural Palestinians tend to live in towns and cities where they may find jobs and other patterns of investment. For less educated rural Palestinians who migrate to towns and cities, it is hard to find employment in the formal sector, so most join the informal sector (Hammoudeh, 1991).

Traffic congestion and crowded neighbourhoods are increasingly becoming features of Palestinian cities in the West Bank. Services such as water and sanitation are inadequate. Although most houses and buildings are connected with piped water, in the summer there are shortages and many parts of the city suffer from cuts in water for weeks.⁴

Housing and Construction in the Urban West Bank⁵

Palestinians place a high priority upon home ownership. As Arabs, owning a home is seen as essential when establishing oneself, usually occurring right after marriage. In light of the occupation in Palestine, home ownership takes on more importance. The action of building a home asserts the Palestinian right to the land on which the home was built. Due to uncertainty and unwillingness to invest in the business sector during occupation, residential construction provided an alternative source of investment (Bahiri, 1991). The income earned by Palestinians working in Israel, or from relatives in other countries, contributed to the interest and investment in the residential building sector (c.f. Giacaman, 1988).

Ownership of Dwelling

According to Israeli statistics, home ownership in 1974 was estimated at 59% in villages and 49% in towns and cities (Statistical Abstract of Israel, 1976). In 1985, home ownership was estimated at 91% in villages and 68% in cities and towns (Statistical Abstract of Israel, 1987). However, these estimates do not consider household composition and thus give a

4. This is my own analysis based on my personal experience and information I gathered from people living in different cities of the West Bank.

5. This section focuses on urban areas of the West Bank.

misleading impression that each nuclear family owns a home. Many households consist of more than one nuclear family, as it is common for more than one brother and their respective families to share the same dwelling.

Housing Conditions

Research on housing conditions in the West Bank cities shows that conditions are much better than in other developing countries. These improvements include better access to water and sanitation facilities, electricity, more living space, and lower crowding ratios (cf. Bahiri, 1991).

Building Materials

The most commonly used materials in Palestinian buildings are locally-made stone and concrete, widely available in the West Bank. The exterior walls of buildings consist of cut stone or poured concrete with a cut stone facing. The interior walls are constructed with stone or concrete blocks, and the roofs are made of poured concrete. Accessories such as doors and windows are made of wood and recently, aluminium. Asbestos is used in home construction of poor residential areas for ceilings as well as for some water and sewage pipelines.

Water and Sanitation Facilities

In 1962, most dwellings in the West Bank towns and cities lacked basic water and sanitation facilities, as people had built the houses before the essential services of water, sanitation, and electricity were available. Only 12% of households had running water, with most people relying on rain-fed cisterns, a prerequisite for a building license. Thirteen percent of homes had electricity, 7% had bathrooms, 24% had an internal toilet, and 31% had separate kitchens (derived from Bahiri, 1991). By 1985, 79% of dwellings had running water, 93% had a kitchen, 50% had only a sink, 27% had a bathroom with toilet, and 99% had a toilet-of which only 52% flushed (Statistical Abstract of Israel, 1987).

This increase in numbers shows the significant improvement in water and sanitation facilities over the twenty year period, leading to an expected improvement in the health and well-being of the Palestinian population.

Crowding

For many Palestinians, living in an extended family household is the only affordable option, as most poor nuclear families are not able to pay for the rental or construction of a separate housing units (Heiberg 1993). With the increase in household size in mind, and despite the improvement in the crowding ratio, 33% of the West Bank and 38% of the Gaza Strip population lived in dwellings with three or more persons per room (Statistical Abstract of Israel, 1988).

Statistics show that in May 1967 there were 226,000 inhabitable rooms in the West Bank with the population estimated at 845,999 inhabitants, a crowding ratio of 3.3 persons per room is yielded (Bahiri, 1991). The average household size at this time was 5.5 persons (Bahiri, 1991). In 1987, 398,470 rooms were estimated in the West Bank with a population of 848,850. Thus, there was a crowding ratio of 3.06 persons per room, with an average of 6.51 persons and 3.06 rooms per household (Statistical Abstract of Israel, 1988). These figures show that while the crowding ratio decreased, the average household size has increased. This increase is thought to be due to the number of extended families living together rather than an increase in the birth rate (Bethlehem University, 1990).

When extended families reside together, the use of living space is determined by the relationship among the heads of household. In some cases, more than one brother shares the same housing unit, each with an individual family (husband, wife, and children). Each family has their own rooms, limiting access to the other facilities of the dwelling. For example, if there are three brothers sharing the housing unit, cooking is done separately for each family unit. In other cases, the different families share cooking, with the kitchen used by the different members in the housing unit. To maximise space, sometimes the room that is used for sleeping might also be used as a kitchen and for food storage. Such issues are not considered in the figures related to crowding.

Within towns and cities, there are deprived neighbourhoods often located in the older parts of towns, resembling the urban slums of developing

countries. In these neighbourhoods, the houses are dilapidated, damp, overcrowded, with poor sanitation facilities. Shared toilets are common. Many houses have only one or two rooms, without a separate kitchen (cf. Giacaman et al., unpublished). Housing conditions and intra-urban differences are not identified in macro-level statistics and are neglected by both researchers and development agencies.

Housing Construction Finance

After the Israeli Occupation of the West Bank and the Gaza Strip, Israeli authorities imposed rigid restrictions on the foundation of housing societies and co-operatives. This was used as a measure to control the construction process and make life difficult for Palestinians as a means of forcing them out of the area.

By 1974, public building starts had been reduced to 2% of the total building starts in the West Bank. From 1979 to 1995, there were no public building starts. However, between 1979 and 1985 approximately 3,000 families received a cumulative 27 million JD (\$80 million US) from the Joint Palestinian-Jordanian Committee for Housing to build.⁶ This amount involved an average of \$20,000 US per family during this time. Apart from this loan scheme, the burden of residential construction fell on private individuals, something few were willing to take upon themselves (Bahiri, 1991). Political and economic instability during the Intifada heightened the financial risk for individuals to undertake the building of a new home.

Housing and Construction in the 1990s

The start of Israeli-Palestinian peace negotiations has brought a rapid increase in building and construction activities. Real estate corporations have been established, and some of the banks operating in the West Bank have introduced loan schemes for housing purposes. Most of the real estate corporations established aggregated multi-story buildings for sale where a flat can be purchased. Due to the absence of authority and regulations,

6. This committee was established to introduce Palestinian funds from PLO to the West Bank as the Israeli authorities had forbidden the PLO funds to be invested in the West Bank and Gaza Strip for "security reasons".

these buildings do not have all of the needed facilities, such as garage space, garbage disposal, elevators for the handicapped, or playgrounds for children.

Additional funding for home construction has come from housing corporations established by employees in various sectors, such as teachers, physicians, and engineers. Participants pay a down payment for the land purchased, and the rest of the costs are paid in monthly payments.

Utilising money received as a grant from the European Union, the Palestinian Housing Council has started a number of housing projects, in the form of high-rise buildings, in the West Bank and the Gaza Strip, with the aim of housing low-income families. Applicants for Council housing are those who do not possess a house nor land upon which they may construct a housing unit. They also have to guarantee the first payment, which covers about 20-30% of the flat's cost. The remainder of the cost is paid on a monthly basis, with compound interest, for up to ten years. The proposed monthly payments are assumed to be up to 30% of the family's income; this may reach \$400-500 US per month.

Given these stipulations, low-income families are excluded as they are not able to afford the down payment nor the monthly payments. The Housing Council is now facing the difficult task of attempting to keep the balance between guaranteeing revolving capital (requiring high payments) to establish more projects, guaranteeing the housing needs of low-income families and at the same time, prevent subsidised housing (Palestinian Housing Council, 1995). Yet, despite the building-boom, there is little access to land designated for building because of rigid city planning rules and the high cost of land.

Many newly-married, middle-class couples chose to rent apartments in new high-rise buildings. These rents are high compared to the average Palestinian family income, constituting more than 40% of their income.⁷ Low-income couples often opt for cheap rental accommodation in the inner-cities and deprived neighbourhoods, or live with extended family. Therefore, what used to be relatively spacious areas are becoming more crowded.

Future Needs for Housing

Recently, housing has received more attention by the PNA and private sector with several studies looking at the future housing needs of the Palestinians. Under the Oslo Accord, a number of Palestinians who live in the Diaspora will be allowed to return to live in Palestine. Their future housing needs must be addressed as well as the housing needs of Palestinians who have been living in Palestine.

Within the current context, the United Nations Commission on Human Settlements in 1991 estimated the future housing needs of Palestinians for the period 1988-2007 at 341,506 housing units for the existing population and an additional 228,500 units for returnees (UNCHS, 1991). This assumption relies on maintaining the 1987 crowding ratio for each area, which is estimated by Habitat at 1.95 persons per room in East Jerusalem, 2.17 in the West Bank, and 2.27 for the Gaza Strip. Should future housing policies aim to decrease crowding per room, the proposed number of new housing units would need to be adjusted upward.

A housing needs assessment for the West Bank and Gaza conducted by the United States Agency for International Development (USAID) analysed the suitability of existing housing. USAID found that in urban areas of the West Bank, 73,600 units (80%) of the housing stock is at a minimally acceptable standard, 14,300 (15%) should be improved, and 4,100 (5%) should be removed from the housing stock (CHF, 1993). To meet housing needs for the future, the study took into consideration that the Palestinian population in the West Bank is estimated at 1,500,000 people, with an annual growth rate of 3.5%. USAID also considered the fact that 56% of the population are under 18 years old. As the population is quite young, Palestinian society will have rapidly increasing needs regarding housing and other services (CHF, 1993).

To meet projected housing needs outlined in the USAID report, 200,000 housing units for low-income housing projects have to be built between 1995 and 2015, with an average of 34,000 new units per year. Upgrading

7. This is based on my own observation and contact.

of 6,000 units need to take place for the first five years, with the next five years allotted for the construction of 58,000 new units, and 7,000 units upgraded per year. This building timeline takes into consideration that older units might be removed from housing stock over the course of the 20-year period.

The same study also defined an acceptable and affordable choice for low-income housing as a 40m² housing unit with basic services built on a fully serviced 160m² plot. To make this housing available and affordable to low-income households, units would be paid for with long-term loans. The low-income housing recommendations provide plots rather than units in high-rise buildings, taking into account the cultural importance of land in Palestinian society. Traditionally, a Palestinian family prefers a house with a surrounding courtyard. Additionally, the traditional conception of ownership is based on land ownership, a flat in a building would not satisfy that expectation or desire.

Although USAID's plan appears to address needs over the next twenty years, at least four problems arise in this proposal at this time. First, the Ministry of Housing (MOH) does not have a clear plan of how best to establish housing projects. Second, most current housing plans focus on the establishment of new living units, under-emphasising and underestimating the more wide-reaching issue of improvement of upgradable housing units. Third, planning is overly centralised. The difficulty with centralised planning is that it is done on a macro-level (i.e., for the country), so it does not specifically target the needs of the population in each specific locality. This may potentially create problems at the implementation level. And fourth, planning is vertical with no formal coordination among the different ministries, such as health, environment, social affairs, education, and transportation.

With the coming of the PNA, the MOH and the Palestinian Council for Housing took on the burden of planning housing in the West Bank and the Gaza Strip. However, there remains an information gap to meet and assess MOH needs. According to the MOH, the types of information still needed include:

1. The number of low-income families in need of low-income housing;
2. The composition of households;
3. Socio-economic conditions and attitudes toward desired housing; and
4. Accurate statistics to measure income (Palestinian Ministry of Housing, 1995).

Complicating MOH's long-term work is the planning and implementation of housing projects conditioned on the progress of peace negotiations concerning the future of the West Bank and the concomitant arrival of funds from donor countries.

Housing and Health in Palestine

There are three geo-demographic categories in the Palestinian territories: urban, rural, and refugee camp dwellers. Normally, housing and living conditions in refugee camps are the worst of the three. Housing units are very crowded and residential areas are overpopulated with population densities ranging between 50,000 to 100,000 persons per square kilometre (UNDP, 1995: 50). The urban population is perceived as being relatively rich and well serviced compared to their counterparts (UNDP, 1995: 51). Housing conditions in Palestinian urban areas are therefore considered fairly good compared to the poor housing stock in refugee camps. In camps, 60% of the housing stock is estimated as non-upgradable and should be removed from the housing stock and replaced. Nevertheless, in poor urban neighbourhoods, housing conditions and crowding may be as bad as in refugee camps (cf. Giacaman et al., unpublished). In rural areas, housing conditions vary according to the economic status of the community.

Despite inadequate conditions in Palestinian housing, its impact on the health of Palestinians has been underestimated, perhaps due to some of the diseases prevalent in developing countries which are attributed to poor housing (such as malaria, cholera, typhoid, or tuberculosis) are not prevalent in the Palestinian territories. In addition, immunisation coverage in Palestine exceeds 90%, which protects against the spread of airborne diseases such as measles, whooping cough, and diphtheria. Another possible reason for the lack of research on housing and health in Palestine is that it is usually

conducted by urban planning departments and institutes in collaboration with health professionals and academics. In the case of Palestine, both sectors have been manipulated while under the control of Israeli authorities. And, what is published about the health and housing situation from the Israeli Statistics is often criticised by Palestinians (cf. Giacaman, 1983).

Literature on Palestinian housing shows there has been significant improvement in housing conditions, particularly with water, sanitation, and electricity. These changes are expected to have made a positive impact on the health of Palestinians in comparison. Still, the effect of crowding on health has not been adequately researched. Several studies show crowded households tend to be poorer and thus have more morbidity than less crowded ones (cf. Giacaman, 1988). Just as important as physiological impacts are the psychological ones. Feelings, perception, and satisfaction of housing environment have been underestimated by many in the field.

Chapter Four

Women, Housing and Health

Women's Social Status, Health, and Access to Economic Resources

The Status of Women in Palestinian Society

Palestinian women have always actively participated in the national struggle against Israeli Occupation. This participation ranged from acts of solidarity to armed operations. Yet, this participation did not translate into major changes in attitudes toward women and their role in society.

In the Palestinian society, neighbourhood relationships and friendships are of great importance to women due to their restricted mobility (cf. Hammami, 1993). They spend most of their time in the neighbourhood and it is there where social networks are established. In Palestinian urban areas where the role of extended family is still valued, it is not uncommon to find separate but adjacent housing units occupied by the grandfather, his sons, and grandsons (Hammoudeh, 1991). In this context, we assume an important part of women's lives is shaped within the neighbourhood environment, with a direct effect on women's health and well-being.

In regards to housing, women in Palestine generally do not participate in the design or construction of their home. Their role is to manage the home without participating in decisions about its location and design. Because women and men have different roles at home, they view space differently. Women tend to imagine their houses in a manner that decreases their housework load and provides relaxation and privacy for everybody at home. Men tend to focus on a prestigious lounge in which to receive visitors, with the remainder of the home not given the same level of importance (Habash, interview, 1995).

At the household level, women have only limited power in decision making. As revealed in a study conducted in the old city of Nablus (Giacaman et al.,

unpublished), the majority of women reported that they were unable to make decisions regarding their children's education, their daughter's marriage, or even the choice to go outside the home without a man's permission-some women reported this as true even to seek medical treatment. Similar findings are reported by Hammami (1993) who found that the majority of Palestinian women lack freedom of mobility. Thus, women's position has been kept inferior to men's with women still viewed as childbearers and caretakers of the family and household.

Property and Access to Economic Resources

In Palestinian society, where it appears a small percentage of women participate directly in paid labour, it is important to assess their access to other economic resources when attempting to assess women's status in the nation. Since the Intifada there has been a noticeable increase in the number of women working from home in sewing, embroidery, food processing, selling clothes, and child care. Women's participation in the formal sector is estimated at 9% in the West Bank (World Bank, 1993); this participation is concentrated in low-paying, low-status jobs, due in part to unequal educational opportunities. This estimate does not include women's participation in the informal sector, for which there is no estimation.

Historically, inheritance has not been an economic source for Palestinian women. Islamic law (Shari'a) gives a woman the right of one half of a man's share. A wife is entitled to one eighth of her husband's property upon his death. However, traditionally it is seen as shameful for the woman to get her share of inherited property, as her father's property would go to "strange" men (her husband and sons). In certain cases, women are compensated with money in exchange for land and buildings, but in most cases, compensation does not occur.

Hammami (1993) found that only 8% of women in the West Bank claimed that they owned land which was theirs to sell, about half of these women lived in cities and towns. Only 9% claimed that they had a house to sell. Most of these women lived in rural parts of the West Bank, with older women and widows highly represented in this group. Less than half (48%)

of the surveyed women claimed that they owned jewellery (mostly gold) to sell. Traditionally, jewellery is bought for the woman as a part of her dowry, which by Islamic law belongs to the woman, and is allowed to be spent according to her wishes. Usually women sell their gold when required to by family needs. For example, they may sell gold to upgrade a dwelling, to cover educational and marriage costs for their children, or to support themselves when they have no other access to economic resources.

Unequal Access to Resources and Future Housing Policies

The proposed Palestinian housing policies consider the members of the household as a single unit, not recognising women have special demands of the housing environment. Economic vulnerability and social marginality of women are not addressed in housing planning (cf. Palestinian Ministry of Housing, 1995). Access to proposed low-income housing projects is to be based on the possibility of loan payments that are estimated at \$30,000 US. This sum of money is a barrier for women who generally do not have access to the economic resources necessary to guarantee payments. The majority of women do not own land and their participation in paid labour is limited. Thus, low-income housing is going to be particularly inaccessible to female heads of households in the West Bank (United Nations, 1990).

Section Three Ramallah al-Tahta: A Case Study

Chapter Five

Methodology and Background

Rationale

This research, set in a poor urban residential area of the inner city of Ramallah (Ramallah al-Tahta), is an investigation of women's perceptions of the effect of housing environment on their health and well-being. More specifically, it attempts to look closely at the roles and relationships (not necessarily person-to-person) women in this community have, and their effects on the women:

- The relationship between housing and women's physical health and well-being.
- The relationship between housing and women's mental health and well-being.
- The effect of the residential environment on women's health and well-being.
- The different roles of women in the household and residential environment.
- The sociocultural subordination of women in Palestinian society.

As discussed previously, the relation between the housing environment and health is well established (cf. Gabe and Williams, 1987; Burden, 1979; Fuller et al., 1993; Smith, 1990:a). Poor housing, particularly crowded housing, may lead to stress and the manifestation of physical symptoms of illness, such as stomachaches, headaches, coronary heart disease, hypertension, as well as others. However, the relationship between housing and health cannot be adequately researched without considering the social environment and the subjectively perceived physical and social environment. Together they work to influence the health-housing relationship (cf. Fuller, 1993; Donini et al., 1990).

Some components of the poor residential environment under investigation—such as dilapidated houses, the presence of rodents and insects, and the risk of car accidents—can be life threatening. However, social networks, friendships, and kinship relationships tend to buffer such effects, particularly for women who tend to invest more heavily in these relationships.

Methodology

Justification of Methods

This study set out to investigate women's perceptions of the impact of housing, social relations between those who live together, and residential environment on health in the inner city of Ramallah. This study uses a qualitative approach in order to provide a deeper understanding of perceptions and was used for several reasons.

- At times, research on people's perceptions on different issues has taken a quantitative approach, in turn missing many important details when it comes to interpreting the results (cf. Fuller et al., 1993).
- Some research questionnaires may include open-ended questions, but when data are recorded and tabulated, words have to be changed into numbers. This process of quantification may result in an infinite number of codes. To record these numbers, the researcher may count similar answers together in order to quantify them under one value label. Yet this categorisation of responses depends on the researcher's subjective judgement, which does not necessarily coincide with the intention of the interviewee. The problems posed by quantification of qualitative data can result in misleading interpretations and findings.
- Finally, this researcher feels quantitative data collection and analysis is prejudiced by the order of questions, determined by the researcher, possibly influencing how participants respond.

While some limitations of purely quantitative methodologies for studying perceptions are noted here, I also acknowledge qualitative approaches have their limitations. One major drawback to qualitative research is results

may not be generalised. This is a significant weakness when attempting to relate a situation to a greater population. Thus for ideal research, a combination of quantitative and qualitative approaches is recommended. This allows the researcher to have a general overview of the research topic (through quantitative means) that is then supported by an in-depth understanding of perceptions and attitudes (through qualitative means).

The qualitative approach is appropriate for the aims of this research: how do women perceive their health in the housing environment (physical objective), in the home environment (the institutional, social interaction inside the house), and in the residential environment (physical and social). In this study, using qualitative methods gives more meaning to the people as individuals. When this study was conducted, qualitative research had not been done in great numbers in Palestine, so this study also aims to contribute to the area of qualitative research on the people of Palestine.

Study Design

During the planning stages for the research, I visited the community to determine if a study would be feasible due to social norms in the area. Through observation in Ramallah al-Tahta and in speaking with women from the area, I gained confidence that the study would be accepted. Focus group discussions were chosen as the tool to implement this research. This decision was in part due to:

- It is common for women to gather, sit in groups and chat for some time in the morning. The atmosphere of group discussion would not be strange or intimidating for them.
- Focus group discussions could be used as an idea-generating tool for myself, the researcher, to introduce new ideas previously not considered (Khan et al., 1991). Group participants have the choice to agree, disagree, comment, and revise topics of research.
- By conducting focus groups, a forum was produced for women to speak and be listened to, a rarity in my experience in Palestine. Participants in group discussion can feel relaxed and confident when they value their own thoughts, perceptions, ideas, and if a trustworthy moderator leads the discussions. Providing a forum

for women to crucial that somebody listen to women saying what they want to say (cf. Aubeil, 1986).

- Discussion participants can be organised into purposive groups defined by similar characteristics and backgrounds (Aubeil, 1994).

This study was designed, in part, based on the approach and findings of the Nablus study (Giacaman et al., unpublished) which found a woman's perception of health is a reflection of her age and marital status. From this, three types of women participants were identified. These were: young, unmarried women (15-30 years old); married women of childbearing age (15-45 years old); and older women, married and unmarried (45 years and older).

The number of focus groups for each of the three identified groups of women was difficult to determine before entering the community because of several unknowns. First, it was not easy to predict the time each group needed for discussion. Second, women's interactions in the discussions and their reactions were also difficult to anticipate. Additionally, it was not easy to predict the quality of new information generated from each additional focus group discussion.

The Field Work

I have lived in al-Bireh for more than ten years, but I did not have any contacts to facilitate my entrance into the Ramallah al-Tahta community as a researcher. Before entering the community to do the fieldwork, I had considered women activists in women's committees as a possible link. However, the activists informed me that their relationships with the women of al-Tahta were not good because of friction caused by the top-down approach the activists employed. Apparently, the women's groups had been telling women what they had to do without listening to their real needs. Instead of relying on the women's groups, I decided to use a single woman, a personal contact, as my medium to enter into the community. This respected middle-aged woman from the Ramallah al-Tahta community facilitated entrance, allowing me to be welcomed by the community.

Three key women in the community assisted me in inviting and gathering

women for the focus groups. Each woman was told to invite friends and neighbours from the old quarters (harat in Arabic; singular, hara) to the discussions. There were no specific instructions as to the number or type of women (single, married, divorced, old, young) to invite. It appeared the women were pleased, as well as confused, about the discussions yet they were gratified somebody was going to listen to them and that their own words would constitute the material for this research. They thought that “ordinary”⁷⁷⁷, oppressed, poor women would be unable to provide material of any value. I was faced with the same question during most of the discussion groups: “Did you get the main points you are looking for?” Women were made comfortable when told that their comments were of value insofar as they reflected their actual life, thoughts, and aspirations. I observed the interaction in group discussions as enthusiastic, and ideas were easily generated by women.

After beginning the focus groups, I realised the discussions alone were not going to work for five reasons. First, it was not feasible for women who are busy doing housework and caring for young children to leave their homes for two to three hours at a time, especially in the morning, to participate in a group discussion. Second, some women were socially isolated and were reluctant to go to neighbours’ homes to participate. Still, these women were part of the community and could not rightfully be excluded; their voices had to be heard. Next, although groups were demarcated by age and marital status, some participants had to be considered in a special context (for example, female-headed households, abused women, infertile women). Age and marital status were not enough when considering the composition of the focus groups. Lastly, some women asked to be interviewed individually because they wanted to offer input that they were unwilling to mention in a group discussion (for example, wives whose husbands are drug addicts or young, unmarried women who have had love affairs). Due to these reasons, individual, semi-structured interviews were conducted with some women because sensitive issues they wanted to discuss could not be done in a public forum.

Finally, the focus groups and interviews were supplemented by observation done at the suggestion of women in the community. Women thought that it would enrich the research findings if I spent some time with them at their

homes and participated in other social activities, such as weddings. I cannot call this full participant observation because I did not stay with them all day and night. However, the time I spent with them in their home environments has consolidated certain issues in the findings, discussed later.

Tools

Focus group discussions: Sixty-one women between the ages of 14 and 65 and of different marital status, participated in ten group discussions conducted with five to seven participants each. These groups were arranged as follows:

- Young, unmarried women: two groups
- Married women of childbearing age: six groups
- Older women: one group
- Married women living with extended family: one group

During the first group discussion which included married women of child-bearing age, married women who lived with the extended family were less likely to participate in the discussion when their mothers-in-law were also participants. It seemed that these young women had something in common with each other outside of being married. In light of this situation, and upon their request, a separate focus group discussion was held for them.

Interviews: Twenty-one, semi-structured interviews were conducted with women considered to have special circumstances. Some of these women I sought out when they did not attend the focus groups. Other women interviewed here were contacted upon the encouragement of women in the community:

- Five interviews with women socially isolated from the community
- Four interviews with female heads of household
- Two interviews with educated, working, unmarried women
- Three interviews with abused women
- Two interviews with young, unmarried women who had “a secret to share”
- Three interviews with infertile women
- Two interviews with women who used their home as a workplace

Observation: I stayed in three households for 35 days, with each household composed of a number of women of different age groups. The time spent did not include the late evening and nights. It was not easy to be fully accepted as a female member of the households, since I did not participate as a household member in their daily tasks. However, bridges of confidence were there to allow them to act freely.

Observation illuminated and further clarified the women's comments and ideas. For example, through observation I was able to witness some of the situations the women discussed, such as how privacy is controlled and to what extent social networks buffer housing stresses.

The combination of the three research strategies and techniques made insight more feasible into the variety of women's lives. This work is intended to provide a more holistic understanding of women's perceptions of health in this particular residential environment.

A Flavour for the Setting

Description of the area

It is difficult to define Ramallah al-Tahta by boundaries because this older part of the town, which was originally inhabited by families of Ramallah origin, has grown over time. Older buildings are mixed with new ones, and the area itself has become a mixture of old and modern types of buildings and constructions. The most important new building in the area is the mosque, which was given a building license because most of the area's inhabitants are now Muslims (Henhen, 1995).

Sahl Street is assumed to separate the older and newer parts of the Ramallah. A petrol station and a variety of relatively new modern buildings are located in this area. Shops are located in the first floor of multi-story residential buildings. At the southern end of Sahl Street, passing Baladeyyeh Street, there is a taxi station for cars travelling to and from some Ramallah-area villages. Close to this area are a variety of food shops, which sell meat,



The Setting

fruits, vegetables, chicken, baked goods, and general groceries. In addition, there is a money changer and a few cafes where men usually spend long hours drinking coffee and tea, smoking argeleh, and playing cards. Two of Ramallah's private schools are located within this area: the Friends Girls School and the Roman Catholic School. The Roman Orthodox Church is also located nearby.

During the Intifada, Ramallah al-Tahta was a site of clashes between the Israeli soldiers and the shabab. Consequently, the Israelis sealed off the entrances to the area with barrels of reinforced concrete, making movement difficult for people. In addition, the Israeli army occupied a building near the sealed wall and used it as a permanent checkpoint, subjecting people to harassment.

Close to *Baladeyyeh* street are the harat, which are named after the families of Ramallah origin who lived in the area until early in this century: Dar Ibrahim, Ash-shaquara, and Dar 'Awwad, for example. Each hara includes groups of old houses clustered along narrow alleyways or surrounding a courtyard. The courtyard and its surrounding houses are called the housh. The number of houses in each housh vary; some have five, while others may have nine. However, because they were built in different periods, there is little organised structure in their location, not only around the courtyard but in the area.

The area also contains deserted, dilapidated houses with piles of garbage accumulating inside, which are a source of health hazards. Rodents, snakes, scorpions, and insects use these houses as breeding grounds. In addition, the houses are falling apart and are life threatening to children who might play or explore in and around them. Generally, the living area is crowded, and poverty can be seen everywhere: in the houses, the faces of people, their clothes, and their complaints.

Description of the Houses and Housing Conditions

The houses in al-Tahta are older than most in Ramallah with some of them built as far back as the nineteenth century. The older homes are built with



(The Stone Oven)

A traditional Palestinian bakery

thick walls from cut stone which is famous in the area. The structure of the house attests to the wealth of its original inhabitants; wealthier families procured larger, multi-story houses, whereas poor families lived in one-room houses (Abu Rayya, 1980). No longer retaining the strict definition of wealth and poverty, now the area is a collection of both larger and smaller homes, and the class distinctions are less clear. Multi-story homes, formerly a sign of wealth, are now inhabited by two or three families, so most residents deal with similar crowding concerns.

Most of the houses in the area did not include kitchens or toilets in the original structure, nor do outer walls or fences surround them. However, some of the present inhabitants have introduced improvements to the original structure. They have built surrounding fences around their houses, providing space for small courtyards as well as for additional rooms, toilets, and kitchens. Other houses, however, maintain the original structure with no additional facilities to meet basic housing needs such as toilets, kitchens, or extra outer space. A few families have renovated the whole structure and established modern housing units.

Indoor Environment

The inside walls of al-Tahta houses are built with a thick outer layer of cut stone, which is lined with clay and plastered from inside. Due to ageing, plaster has decayed and the clay is turning into falling sand. Some inhabitants have remedied this problem by painting a new layer of plaster over the clay, while other families still suffer under a barrage of falling sand. The floor of these houses is usually constructed from either cement or stones, although many houses have replaced the floor with tiles. Few houses have an internal toilet and/or kitchen.

Generally speaking, ventilation in the old homes of this community is poor; some houses do not have windows at all. Thus, the doors have to be open all day. In many of the homes, there is a lower part of the house, called the al-rawieh, underneath which there might be a well. People living in houses with an al-rawieh often must close surrounding rooms due to safety issues, particularly children's safety. In turn, closing off part of the house decreases the living space within the house.

Inhabitants

The vast majority of inhabitants in Ramallah al-Tahta are not from Ramallah originally but rather from villages in the Hebron area. This community of people is denoted as a particular group called Qaiseyyeh who originally came to Ramallah to work as home servants (Hammoudeh, 1991). However, most men are now self-employed in the informal sector as peddlers, selling vegetable and fruits on carts, and as unlicensed taxi drivers. Some men are labourers in Ramallah or, in a few cases, working as labourers in Israel. The majority of women are housewives, some of who are self-employed in the informal sector. Other women from this area work as home servants; people looking for domestic help often come to this neighbourhood to find employees.

The vast majority of these families live on rental tenure, paying extremely low rent (between 2-15 JD a month). The original homeowners are of Ramallah origin, who usually have migrated to the United States. Inhabitants in the community are bound by kinship relationships, as most of those in this area are comprised of extended families from the villages who migrated to the city.

Education does not appear to be a priority in this community as it is in other communities in Ramallah. Young men's wages are needed as supplemental income in relatively poor families, so education is often compromised. Some young women are educated, and a few of them work in the formal and informal sector. However, women usually drop out of school to help with the housework and to get married. The women of al-Tahta generally marry when they are between 14 and 18 years old, while most men marry before the age of 25. Marriages of members within the same harat are common.

Most of the inhabitants of Ramallah al-Tahta are Muslims, with a very few Christian families. Generally, Christians enjoy better living conditions because they are supported by Christian charities in the area. Their houses are in better condition and their children go to private schools, which are beyond the affordability of the Muslim families.

8. Usually mothers do not let their children play unsupervised, because they are afraid of car accidents.

Facilities

Within this area there are two public primary and secondary schools, one for girls and the other for boys. There is a Roman Orthodox school, whose fees are relatively inexpensive compared to the other private schools in Ramallah. However, there is not a kindergarten or day care for infants and toddlers in this community for working women to use.

There is also no health care facility within the community boundaries. Often inhabitants seek medical treatment at the Palestinian Red Crescent Society, a few minutes walk. People in this community also use other charitable society clinics in Ramallah and al-Bireh, such as the Zakah Fund clinic. Other than these few options, they go to private practice facilities which charge more than most families can afford. At the secondary and the tertiary health care levels, the people of Ramallah al-Tahta may use Palestinian hospitals in Ramallah and Jerusalem, the latter only if they can obtain a permit.

Ramallah and al-Bireh's city centre is within walking distance, so people may have access to shopping and transport facilities if they cannot be had within Ramallah al-Tahta.

Rather recently, in May 1995, the area was connected to a municipal piped sewage system. Previously floods of sewage were a common sight in Ramallah al-Tahta's streets. The majority of houses are connected with the municipal piped water supply, with the remaining few households using water from their neighbours.

Chapter Six

Results and Discussion

A Briefing on Daily Life

Early in the morning, everything is quiet and everyone is at home. After men go to work, women start shopping in the neighbourhood. Then they return home to do the housework amid children playing and screaming. When women finish their housework, they gather in the housh courtyard to have breakfast together, drink tea and coffee, embroider, help each other prepare food for cooking, and chat. Their children play supervised nearby.⁸

By noon, women go back to their homes to prepare lunch for the men returning from work and the children returning from school. Women again gather near sunset time, with some men choosing to join. On cold days, women have no way to gather, but on sunny days during winter they usually gather together.

When I entered this community to do the fieldwork, it was summer time, the height of the wedding season. Wedding parties now are allowed, but during the Intifada it was not acceptable to have big parties while people were being killed, injured, or detained. The wedding is located in the housh and is celebrated by all people in the community, especially the women. The women come wearing their best clothes with heavy layers of makeup. They look happy, smile, and sing. For them, it is an evening out, and potentially a long one as the party may last until after midnight.

W Women's Understanding and Perception of Health

“Health is related to everything in our lives”

Women participants in group discussions were asked how they understood the concept of health. They started the discussion with an attempt to come to an agreement concerning the conception of health. In this regard, women

of all groups shared the opinion that ‘good health’ is not only the absence of disease, but includes living without stress and living with “peace of mind” (hadat-el-bal). They felt good health included loving, being loved, cooperating with others, living in happiness and satisfaction, having access to work and money, and ending Israeli Occupation. As one woman said, “health is related to everything in our lives.” The women in the group discussions appear to have made a link between psychological, social, political, and economic well-being in their understanding of health and their accounting for disease. Examples of this connection from the discussions were:

Millionaires are healthy, the poor are always sick.

When we are sick, we do not have the money for treatment.

The soldiers kill, beat, and injure the shabab. They also attack our homes.

When we are happy at home, we feel good and able to do anything.

Gossip [kalame el-nnas] is what makes us feel ill.

Stress causes disease [Al-hamm bigib el-maradh].

Women of the different age categories, however, expressed different perceptions of health. It appears these perceptual differences are related to the different roles the women play, as well as other factors, such as education or wealth.

Young Unmarried Women

Young, unmarried women linked the idea of health with a “western” lifestyle. This appears to reflect the knowledge gained from formal education, as seen in the focus group.

Good health is related to healthy life practices: washing vegetables before eating, eating good clean nutritious food, brushing your teeth, reading about health.

A young woman who dropped out of school sees health from a different perspective than the above women. This woman’s perception seems to relate to her appearance and lifestyle.

I am 17 years old, and I was out of school to help my mother with housework. I am not allowed to go out of the home, no movement, no exercise, and I eat so much that I am fat. Fatness is my disease.

Some women, particularly those who are still in school, blamed uneducated mothers for unhealthy practices that make the children sick. These women in school also see the link between education and health-promoting practices. At the same time, young unmarried women see care-taking for household members as a woman's responsibility, particularly the mother's.

Health, education, and awareness are very important to promote health.

When the woman is not educated, she does not know what to feed her children. She doesn't care to wash their hands before eating.

Young women in this group tend not to report physical illnesses or pains, and overall they feel that they do not suffer from disabling diseases. They may catch common colds in wintertime and may suffer menstrual pains, but these diseases are not perceived as disabling as this group of women can continue to manage their daily lives regardless of their symptoms.

Our health is good; we have no diseases. We are also strong. We recover quickly from colds.

These women did not feel there to be a long-lasting impact of illness during childhood on later stages in life, not even illnesses brought on by poor nutrition.

Despite their apparent confidence, they do not feel happy and report their psychological state to be poor. One day a young woman may feel happy and fine, but the next she feels depressed without understanding why. This emotional unpredictability may be due to boredom and weariness. The women in the focus groups noted that women at their age want to go outside the house and have fun, but there are few interesting things happening in their

lives. They wish they could go to a club, play sports, have a meal in a restaurant, and meet friends when and where they wish. They would like to be able to enjoy something as simple as going for a walk, a luxury their brothers who have freedom can enjoy. For these young unmarried women, a mother or brother must accompany the young woman on any excursion outside the home. For the women who are in school, there are no activities or programmed summer activities to enjoy during the summer vacation. Thus, they stay at home most of the day. Because young unmarried women are deprived of these freedoms, anxiety levels are at a high:

We feel that we may have a nervous breakdown. We are at home all day; nowhere to go. Even at home we cannot do as we like.

Married Women

Interestingly, the married women participating in the focus groups also saw themselves as young and energetic. This may be because their demanding role requires they be strong. Married women in this sample do not note or complain of particular diseases that force them to lay in bed or that render them unable to play their roles in housework and child care. These women, nonetheless, reported having minor illnesses with which they are able to cope, such as neck pains, back pains, and general fatigue. While it does not prevent them from carrying-out their responsibilities, it does make it harder on the women. Many of these women also complain of toothaches and dental problems. The seemingly high prevalence of dental problems is probably due to the high cost of dental treatment, preventing women from seeking treatment until the pain is unbearable and the tooth must be removed.

*We all complain of tooth problems.
If I went to the dentist, he would ask 'why were you so late to treat your teeth?' I know the problem, but the dentist would not know that I could not pay.*

Although these married women did not note suffering from any debilitating diseases, and feel themselves relatively young and strong, they recognised how difficult it is to be healthy, strong, and calm when burdened by the heavy responsibilities of child rearing.

*With children, there is no rest.
When you have children, all of the time you have to think
about their food, their schools, and everything.
It is a headache.*

These women think that they scream at and beat their children because they are so heavily stressed. Yet, although they think their behaviour is caused by difficult living conditions, something they are not in control of in most cases, they feel guilty and angry at themselves.

*We scream, shout, beat the children unintentionally. We
really love them most, but life is very stressful.
As you open your eyes children start their daily fights.
You become nervous and start your daily battle:
shouting, beating and hugging.
Children make us tired and sick.*

The relationship between husband and wife is an important part of a married women's perception of health and well-being. When the husband is loving and caring, a woman feels good and finds herself relaxed and happy. When the husband neglects his wife and the needs of the household, the woman feels deprived, unsatisfied, and stressed. Women frequently report quarrels with husbands negatively influenced their well-being.

*The woman who has a good husband has good health.
[Illi jouzha mnieh sehetha mniehah].
I have a nice husband; he cares for the needs of the
household. He spends good time with us at home. I do
not wish for more.
My husband is a drug addict. He smokes hashish. I am
afraid of him. When he comes home, I feel my whole
body ache.*

Women who live with their extended family suffer more from stress caused by childcare, as they must keep their children quiet for the convenience of the other members of the household.

I can't even raise my voice loudly to scream at my children. If I do so, my mother-in-law would make it a real problem. She will tell me that I am not a good mother and may tell my husband.

Infertile women, whether childless or the mother of only one, feel as though they are disabled; for them, infertility is a disease. The women in this group feel anxious as they do not know if, or when, they or their husbands might be cured of their infertility. They are also insecure and worried that their husbands might divorce them or get married to a second wife because of the situation. The few infertile women interviewed feel their lives are empty, and to some extent, they feel guilty.

Because I don't have children, I feel lazy all day. The housework is done in less than one hour and all day I watch television and embroider.

My husband's dad threatened me that his son is going to marry another wife to have children. My life is miserable.

He is good. He likes me, but because I don't have children, I feel that I don't deserve his love.

When the husband is infertile, then women who wish to have their own babies have to be patient and sympathetic to their husbands.

Elderly Women

Older women perceive themselves as stronger and more adaptable than the younger generations. They reported that they were healthier and tire less easily when they were young. Nevertheless, they agree life today is more difficult and stressful than before.

At their age [the children], we had to carry water and use firewood for cooking. We had neither electricity nor refrigerators. We had to cook everyday. But we felt strong and able to do all this work.

Children before were not demanding. We had to feed



Dilapidated houses



Housing improvement and renovation

*and clean them, and they used to play friendly with the neighbours. These days, children watch television and learn how to become violent.
Life is complicated now, and everything is expensive.
That's why people become tired and die of strokes and cancer.*

Older women were much more likely to mention the large impact disease has made on their lives. Most diseases were those chronic in nature, such as diabetes, coronary heart disease, and hypertension. They also identify stress or a traumatic or tragic event as one of the cause of their disease.

*If you ask all women in this hara everyone of them is a person of disease, because the heart has a limited capacity to bear stresses.
I became a diabetic since my sons were taken to prison.
When my daughter was divorced, I became sick. I have disease in the heart.
I was healthy and strong like a horse until my daughter died.*

The Political Environment under Occupation and the Health of Married Women

Historically, the effects of the Israeli Occupation were very hard on Palestinian women. When there was a problem with the Israelis, it was the mother who followed up. If a son was beaten, the mother took him for medical care. When a son was missing, the mother went to the tents in the Ramallah prison courtyard, where newly arrested young men were placed until transferred to prisons, calling the names of their sons to try to learn whether they were incarcerated. These same duties applied to married young women. For mothers and young wives, this was a fearful, stressful event.

Many mothers perceive this stress as a cause of their fatigue and general pains. This anxiety often translates into sleeping disturbances, making women tired all day. Particularly during the Intifada, women were constantly

worried about their sons and husbands because they were exposed to beatings, arrests, and shootings by Israeli soldiers. Yet, despite the worries, women are proud because they can serve as protective shields for men.

Women's Perceptions of the Impact of the Housing Environment on Health

None of the women in the discussion groups nor any of the women in the interviews mentioned a connection between poor health and the physical housing environment. Nevertheless, women came up with other issues related to housing, classified here as building materials, house improvement, water and sanitation, lighting and ventilation, and crowding and privacy.

Building Materials

The vast majority of women included in both the focus groups and the interviews agreed that old houses have the advantage of thick walls that keep the house warm in winter and cool in summer.

These old houses are good, because we do not need much heating in winter.

In the hottest days in the summer, we do not feel the heat, because the walls are very thick.

Nevertheless, this old construction is an advantage only so far as when the condition of the interior walls is good. When the walls and ceilings are not plastered, they crumble or fall. Women did say this situation is dangerous.

It happens that a piece of dry clay falls on our heads. You won't be able to drink your tea, because the cup will be filled with sand and dust.

It is an old house; it was built in 1884, and it is falling apart. We might die one day if it collapses.

In the minds of the women included in this study, wall and ceiling decay is not connected to a specific disease, but it causes fears that the house might collapse entirely. This fear appears to lead to anxiety and sleeplessness.



Kitchen



Toilet

*Those who are hungry and afraid do not sleep well.
We may not be hungry, but we are really afraid to be
buried under the ceiling one day.*

Structural Improvements

Most women in this study recognise that they are unable to afford rent for a better house. In return, they sometimes invest in improving housing conditions and eliminating safety hazards. Some of the households have their interior walls plastered and leaks in the ceiling sealed. Others families cannot afford or choose not to do so.

*Who cares! My husband is out all day, and in the evening
he goes out with his friends. No money is left, he says, to
plaster the walls or do anything to improve the house.*

Often times, when there is a change in the household economics, such as more working members or fewer expenses, the relative household income is likely to grow, making improvements to the house feasible.

*When my two sons left school and began to work, we
had a surplus of money to improve the house.*

The incentive to make improvements in the home also arises when the male head of household, the primary decision-maker, spends more time at home. The man is more likely to take note of the poor conditions and make changes.

*We've been living in this house for twenty years now. It
was not good like this two years ago. Before, my husband
was not staying at home; he was out most of the day and
night. Now when he finishes his work he comes back
home, so he wants a good house.
My son decided to plaster the walls because when he
was released from prison; he started to spend much time
at home.*

Female-headed households are the poorest in the community and their houses are reported to be the most deteriorated. With tight finances, there is no extra income to make home improvements.



Poor lighting and ventilation

I am responsible for my six children, and I work as a house servant. All of what I get is hardly sufficient to feed them.

We live in this dilapidated room. That is the best I can do to protect my children under a roof.

In households where the husband or wife is infertile, there are different priorities for spending money. These households were more likely to make expensive infertility treatment a priority rather than to improve housing conditions. Having children is very important for Palestinians, as seen in how these households choose to spend their money; the costs of treatment of infertility take priority in the household expenditures. Infertile men are less likely to pay money for housing improvement because they want to invest in every possible attempt to have a child of their own.

My husband has a good income, but everything he gets is spent on the treatment of infertility. Nothing is left even to plaster the ceiling and walls.

Almost every day I fall on these broken steps. But I have nothing to do with that because infertility treatment is very expensive.

Married women's interest in good housing appears to stem from their interest in providing a safe place for their children, as well as a high quality environment from which the women can manage her family and responsibilities. Unmarried young women's interest in housing is more likely due to her concern for her social relationships in school and in the community. Some of the young women feel their housing situation is temporary, once they marry the situation is expected to end.

We can't invite our schoolmates to such a house. Yes, it is dangerous. But for us, sooner or later, we will get married and move to another house.

Of course, some of these young women realise while they will be married, they are likely to live in a similar house.

*Who is going to marry us? Poor people like ourselves.
We have no choice but living in a house that may fall on
us one day.*

Water and Sanitation

Women laughed when they were asked about the importance of sanitation as they understand many diseases are caused by poor and inadequate sanitation.

The majority of houses are connected with tapped water, supplied by the municipality, inside the dwelling. Very few women participating in the study use their neighbours' water. Only a few houses have an internal toilet, while some of the women's homes have external toilets, possibly shared by more than one family. Some houses do not have toilets at all, and they relieve themselves in different toilets when and where they can. Women responded with interest at the idea of building toilets for each household, but this must be done by individual initiative without outside assistance from health or development organisations. Generally, women included in this study are keen to improve general housing conditions, with sanitation facilities perceived as a priority.

Compared to the situation in many urban slums in developing countries, the water and sanitation in Ramallah al-Tahta is very good. However, in this community among these women even an external toilet is not perceived as adequate, let alone the sharing or complete lack of a toilet. The women replied that everyone in the area has access to a toilet, but the problem is the convenience of access.

*Men may pee or even defecate anywhere, but for the
woman, it is something else. We need more privacy.*

In other cases, a shared toilet can cause friction amongst those using the facility, bringing-up issues of access.

*We used to share the toilet with my two brothers' families.
Once my sister-in-law decided that we should not use
their toilet. What could we do?*

Shared toilets are inconvenient, particularly for women and even more so for a woman with children. Where there is no toilet in the house, a woman will have to use her neighbour's toilet. It is not bad during the day, but:

At night we relieve ourselves in a bucket. Six people in one room, with a bucket full of...

For a woman living in a house with an outside toilet, located in the courtyard:

For me it is a trouble to take my children to the toilet in the evening when it is dark. In winter, it is more problematic to go to the outside toilet; they catch colds and become sick when they leave the hot room to go to the toilet.

Although women might cope with inadequate sanitation, those few days of menstruation are the most stressful.

It is mostly problematic at period time to use a shared toilet; then, we have to wrap the pad and take it back home to put it in the bin. It is embarrassing when men are passing.

If a child defecates in the street or outside the external toilet, mothers responded that they get angry and become afraid of the spread of disease. Nevertheless, they sometimes cannot blame the child nor themselves, taking into consideration extenuating circumstances. The mother may be too busy to take the child to the outside or shared toilet, and the child cannot wait until his or her mother is free.

There is a noticeable difference between women with a toilet inside their home and other women included in the study. Women in households with an internal toilet seem satisfied and find it adequate and healthy.

Last year, they built an inside flush toilet. Our lives have changed.

Before Ramallah al-Tahta's connection to the municipal sewerage network in 1995, households relied on septic tanks requiring evacuation every month or two. Septic tanks would overflow and flood the area, covering the streets with hazardous, untreated wastewater. Women in the focus groups and interviews perceived this as a terrible health hazard, which caused intestinal diseases for both children and adults. It was also a breeding ground for insects causing bites which led to infections.

Overall, women in the focus groups and interviews responded that the overriding problem with sanitation is the perceived inadequacy of facilities. Ideally, toilets should be available for convenient use, particularly for women and their children who spend almost all of their time at home. Women might cope with currently existing conditions, but such coping becomes stressful when there is not a convenient toilet and may lead to less utilisation of the facility. Women said installing an internal toilet is a priority for their own convenience and that of their children, especially their daughters.

Ventilation and Lighting

All women who live in old houses reported their houses are damp in winter and poorly ventilated. Women from each group agreed that dampness and poor ventilation cause respiratory diseases and allergies.

Young, unmarried women see that they do not currently suffer from any disease or symptom related to living in a damp house, although they agree that it is problematic for health.

Dampness is the cause of a variety of diseases.

Young unmarried women also do not perceive having suffered from symptoms related to dampness.

We do not suffer from allergy of breathing problems...maybe when we were young.

Some married women said they had problems with their stomachs, such as nausea and vomiting, because of dampness. Other married women noted dampness to be the cause of arthritis and joint pain.

*I suffer from breathing difficulties. When I went to the doctor, he told me to change the house!
In every house there is at least one person with allergies, especially children, because of dampness.
I have stomach-aches, perhaps because of dampness.
I am not old enough to develop arthritis, but I think it is due to dampness of the house.*

Other married women, however, did not feel that dampness in the home has made them or their family sick.

*My house is damp, but I don't feel any problem from that.
Dampness causes a variety of diseases, but we do not suffer from any symptom related to dampness.
We care for cleaning the house and removing dust to mitigate the effects of dampness. It works.*

Older women see the effects of dampness as having an accumulative effect on health. Signs may not appear at a young age, but when living in a damp house for sixty years, symptoms such as arthritis and joint pain eventually arise.

Now we suffer from leg pains, shoulder pains, neck pains, and arthritis. This is because we have been living in damp houses for all our lives.

As there is a decrease in dampness when old walls are well-plastered, women responded positively to the idea of having their houses plastered and painted, especially to protect their children from the effects of extreme dampness.

Many women of all ages, married or unmarried, who participated in the focus groups and interviews complained that their houses are poorly ventilated. This obliges them to keep doors and windows open in summer and winter, all day long. This solution to inadequate ventilation creates other problems for the women in the home, such as loss of privacy, excess dust in the house from the sandy alleys, and exposure to all sorts of noise

from the hara. Unmarried women specifically said the opening of the windows and doors is embarrassing, increasing the lack privacy and protection at home.

We do not have a window and have to keep the door open all time. Everyone passing in the street may see us. It is very stressful.

The hara is noisy, because there are so many people living here, but when we have to open the door and the window, we hear all of the noise-people shouting, the voice of the neighbour's cassette, the noise of traffic. . . everything. We cannot relax.

Men can sit, sleep everywhere, but for us it is not acceptable; it is a taboo [aib].

Women who wear the veil when they go out often do not wear it at home. But, when the doors are open to compensate for poor ventilation, the women must wear the veil in their homes.

We have to put on the veil, even inside our home.

Married women find opening doors and windows problematic not only for their children, but also because it makes the house dirtier, increasing their work.

My children cannot do their homework because of noise, but they may not survive if we close the door and the window.

When the door is open, children go to the street which is dangerous.

It is always dusty, because we open the door.

Some homes in this area are surrounded by stone or cement walls, offering more privacy. When doors to these homes are opened, privacy of household members is not lost.

We have a wall, a small courtyard and an outside door

to be closed. Even if we open the door of the rooms, we are still hidden and protected from dust, but noise. . . is a problem.

Crowding and Privacy

Women of all ages understand the relationship between living in crowded housing and the spread of infectious diseases, such as colds and influenza. Unmarried, school-educated women link crowding to what they are taught at school.

We studied that more diseases are spread in crowded houses. They taught us that to avoid many diseases, sick persons should be isolated in a separate room.

Married and older women agree that this is what they have noticed from their life experience.

*When all of the family live and sleep in one room, diseases are easily spread.
If there is a person coughing in the room, the next day all the family gets the infection.*

In addition to understanding the quick and easy spread of diseases due to crowded housing, all women also relate crowding to a lack of privacy. In a one or two multipurpose room house, in which a number of people share, privacy is lost. No one is able to do what he or she wishes in what is supposed to be the “private sphere.”

Young, unmarried women feel that they are the most deprived of privacy compared to women of other age and marital status groups. In part due to their youth, they want to dress and to sleep as they wish.

*We have to put on trousers and a shirt all day, because it is not acceptable that our fathers and brothers to see us wearing a night dress or sleeveless shirt. If we have a room of our own, we might be able to do that.
Home is supposed to be a place for rest and relaxation.*

For us it is a place of no rest, and stress. We have no corner of our own. Because there is no space nor money, we do not have a bed of our own. We cannot lay down in the afternoon.

At their age, these young women tend to be moody, becoming depressed and sad easily. When they want to cry, they are unable to do so because they do not have their own private corner in the house.

Sometimes we are angry or sad. We cannot even cry at home because everybody is sitting in the room, and when they see us, they do not leave us alone.

Overall these young women do not feel free because there are so many people watching and commenting on their behaviour. The result of this constricted feeling, they believe, is illness. These young women stated they have continuous headaches and irregular periods because of their stressful lives at home.

When the father and brothers of the young woman go out, she and her sisters try to take advantage of this time as best they can. They may rush to their neighbour's house to invite their female peers, trying to have a time of their own.

When our father and brother go out, we just call Muna and Nadia (the names of peer neighbours) so we can sit, laugh, dance, and talk freely.

Unlike father, mother leaves us alone. She might go to the house to chat with her friends.

There is no sense of individual privacy in these homes. I observed the tensions between young women and male household members while visiting Umm-Mahmoud. Umm-Mahmoud's daughter, Ghada, was exercising when Abu-Mahmoud came in. Tired, he turned the television off and ordered Ghada to stop. Ghada went to a corner and started crying. She then vomited and became very sick, saying she was angry that there is no place for her to be by herself at home.

Due to a lack of limited space in these small, old homes, anger and frustration cannot be exhibited except in front of the family members present. When there is a problem between the parents, they shout and scream in front of the children, the mother might be beaten as well. Young unmarried women who witness this often spoke of fears about what a future marriage might hold.

Mother is always tired, and father is stressed. They always quarrel in the room while we are there. This is the only thing we see about marriage. It is awful.

Young, married women who live with their in-laws or extended families feel deprived of privacy and a place of their own. They live in a room and have to share everything with the rest of the household. They cannot decide what to cook, when to bathe their children, or when and what to watch on television. These women complain that mothers-in-law want them to do all of the housework and keep silent.

They divided the room into two so that we may have a place to live, a private place, but it is not so. We have to share the toilet, the kitchen, and everything.

They interfere in everything in our lives. If we want to go out and buy something, we have to tell them and get their permission.

So many families in the hara live in a one-room house; we live in a room of a house, which is not our own.

We are married to all of the family, not only to our husbands.

We are stressed all time. We beat the children a lot and may injure them to release the pressures exerted upon us.

The stressful conditions for these women who live with their in-laws creates a problematic husband-wife relationship. Women often leave the house and go to their parents' home to exert pressure on their husbands to look for a separate house. Sometimes this gives positive results. Kifeh's house is adjacent to her in-laws with a wall dividing the living space. She says that this is "the wall of happiness".



Garbage and risk of rodents

When I first was married, we lived in this room and my in-laws in the other [an adjoining room], but I had to be part of the whole family. I had no place of my own. Besides, I had to do all of the washing for the family and clean everything. I did not like that and left to my parents house, where I stayed for eight months. I told my father that I wouldn't go back if my husband did not find a separate place for his family to live. It worked, and my husband agreed to build a wall that isolates us from his family. I agreed to sell my gold. You see, we also built a kitchen and a toilet. I, at least, have my own place away from their interference.

Married women living only with their husband and children are not strangers to stress due to cramped living quarters. Women have to cook, wash, and receive guests and visitors in the same room. This lack of living space requires a lot of planning and time management, making women increasingly tired. One solution is waking-up early in the morning, before other household members, to get their work done.

To manage space with housework, we need longer hours.

Mothers with many children have a difficult job of trying to meet family members' needs in limited space. Women must find a place for young children to play and a quiet place for the older ones to study. They have to keep the home clean, which may require cleaning the floor several times a day. When there are many children, these problems become even worse. The women with children agree that if they had planned their family, these stresses might have been less.

We did not know about family planning. Every year we had a new child, which resulted in having six, seven, or even fourteen children living in one room. Younger women are more aware about family planning.

Younger married women are learning from their peers' and mothers' experiences, and are trying to plan their families to cope with limited space and resources.

We are not going to have more children, where are we going to place them.

I have two children, and I do not wish to have more.

Life is difficult and we have no space at home.

My husband wants nine children. We have three now, and I think it is enough. I told him when we have more space, I will have even more than nine.

My neighbour, who has seven children, is too busy to take a deep breath. I am newly married, and I am not going to have more than two.

For women who live in a small homes, further stress stems from sexual advances from their husbands. Women who live in a one-room house find it embarrassing to sleep with children in the same room. Men do not care whether the children are sleeping when they initiate sex. This makes the women feel unsatisfied and stressed.

We sleep in one room, and I have a daughter who is 12 years old. I think she sees everything. . . I mean, when we are doing it.

My son is sixteen years. When my husband comes near me, my son laughs. I feel as if I were a prostitute.

Older women do not feel their homes are crowded now, as their children have married, each living in a separate home. However, they still remember how crowded their one-room houses were when their children were young. The older women remember their children were quieter and more easily controlled than children of the present generation. Yet, they are empathetic with young mothers, whose children are so demanding.

Children now are no longer difficult. They do not stop making problems. God be with their mothers.

Now the house is no more crowded. We still have the younger ones, but the older ones, God be with them, have married and live in their own houses.

We raised our children in one room. Our homes were worse than today. No toilets, no water, no electricity.

The Home as a Workplace

Women's income generation is often a response to shortfalls in the income earned by the men to meet the family's basic household needs. However, tied to the home by small children, women are working out of their homes rather than outside of the home. Examples of this work are running a shop from home, sewing for payment, and food preparation. There are few women in the hara who work away from home. Most women interviewed embroider and are paid approximately 10 JD per month by the Roman Catholic Society. For the women, this is extra income that may be used to buy clothes and school books for their children.

The problem for the women who work out of their house is that there is no space in the living unit that enables them to run their businesses comfortably. This causes stress and is tiring as they have to cope with the available space for family needs and work requirements.

You see all this merchandise? It takes so much space. I have to put it all in bags, and when a client comes she takes everything out of the bags and then I have to rearrange it. It is very tiring.

A woman who processes food does all of the work manually. It is time-consuming and takes a great deal of effort, and to produce greater quantities, she needs very long working hours. As a result, she earns very little income.

I think I need a food processor and a good refrigerator. This would make things easier and increase the production with less effort, but it is very expensive to get them. Men get loans more easily than women.

Because these women work out of their homes, they find it impossible to specify working hours unlike those who leave the home to work. Their clients contact them any time, early in the morning or late in the evening. These working women are not able to leave their homes, lest a client should come. Sometimes their working activity conflicts with childcare.

I couldn't take my child for his vaccination at the

scheduled time because I had many clients that day. When I took him, and it was late, the nurse said that I was careless and screamed at me.

With businesses as small as the ones these women run, it is more cost-effective to work at home. Using the home as a place of work, however, is not convenient for women who have limited space in the house. So, although working from home generates income for women, it also requires long, tiring hours.

Other women assist with the husband's work. For example, if the husband sells corn on a cart, sandwiches, or other kinds of food, women have to prepare everything to be taken and sold in the city centre. Women engaged in this assistance perceive it as an extra workload requiring long hours. However, this workload is seen as a part of her housework and she is unable to refuse.

My husband and son sell sandwiches to school students and to the workers coming from the villages. I have to get up by four in the morning to prepare the falafel and hummos. When they come back, I have to clean everything while they are sleeping or watching television.

Unequal and Unfair Access to Resources

Married and older women agreed that, in general, they are deprived of their inheritance rights. Some women in the sample said that their fathers were rich, they owned land and houses, but only their brothers inherited the property. Women know the law gives them the right to inherit half of what the male gets, but because men traditionally retain the family name, women are often denied their rightful inheritance. Tradition is seen as depriving these women of their rights.

Women see traditions as a tool of discrimination. Because men are allowed to receive higher levels of education they obtain better jobs, resulting in better salaries. Most women in this community are denied entrance into this system that enables a higher quality of life. So, when a woman is

married to a poor man, the woman remains poor while her brothers are much better off. Women also have to burden the responsibility of caring for older parents, adding to problems of debt.

Access to economic and financial resources such as inheritance rights is necessary for women to live in good quality housing. Home improvement or moving to a better house requires money that they normally do not have at their disposal.

Poor Women in Rich Households

Generally speaking, women see their poverty as stemming from their poor husbands or fathers. Nevertheless, these women feel that they get their share of the limited resources to satisfy their basic needs of shelter, food, clothing and sometimes, medical care. The quality of the resources to which they have access to depends on the husband's income. Generally, women do not feel their basic needs are denied, although in the past they have had to neglect their own needs on different occasions in favour of their children's needs. Young, unmarried women see their brothers' needs are favoured and their demands are given more consideration.

Amina is a different case; she sees herself as poor, although her husband is rich. She is a mother of three deaf-and-dumb boys and two "normal" girls. *Amina* is keen to send her boys to the school for the deaf, but the husband does not want to pay the fees. She had to work as a home servant, without the knowledge of her husband and in-laws, to afford her boys' school fees. Her eldest daughter is fifteen years old and has dropped out of school. *Amina* is looking for work for her daughter because she thinks that that is the only way her daughter can leave home.

Amina lives in a three-room flat with a bathroom and kitchen. She has enough space at home, nonetheless, she does not feel secure because her husband is thinking of marrying another woman to have a "normal" son. *Amina* suffers from stomach-aches and continuous vomiting and thinks it could be an ulcer, or even cancer.

I do not feel sick because of poor housing. The flat I live

in is good. The way I am treated in the house and my struggle for my children and myself is what makes me very thin, weak, tired, and even thinking of death.

Women's Perceptions of the Effect of Residential Area Environment on Health

Risk of Road Accidents

Focus groups with married women with young children were the only groups which felt there to be a risk of car accidents from cars and trucks passing by the narrow streets while children play. In three of the six group discussions of married women with young children, two accidents had been reported. One resulted in the death of a child whose mother went insane. The second resulted in a serious injury of a girl.

We all remember that day, when a truck was passing in this street, and the boy was walking. The truck could not avoid the boy, who died under the wheels...

Umm-Khalil's daughter was hit by a car few months ago, and her leg was broken.

All of the time we have to watch children to avoid more accidents.

These mothers feel they have to keep their children at home to avoid such tragedies. The burden of keeping children at home is most stressful for households with no outer wall and who have to keep the outside door open all of the time for ventilation and lighting. These mothers regard there to be no safe place for children to play, making the situation extremely hard. The problem intensifies, during the summer months, becoming almost impossible to keep children inside.

Environmental Hazards

During the Intifada, the Israelis sealed off the entrance of the harat with barrels of reinforced concrete. Now garbage has accumulated in this area, resulting in the spread of rats and rodents. In addition, there are deserted houses nearby, a convenient place for snakes, scorpions, and rodents to

breed. Women complained about these problems, considering them life-threatening. Married women with children find it particularly difficult to live in an area with such risks, worrying about their children's safety.

Last summer, when I was opening the door, there was a snake outside. The snake entered the rooms and stood up; I shouted and let the children out. Our neighbour came and killed it.

Every night I have to check my children several times, because there are scorpions.

We suffer extremely from rats that have grown up and bred near this sealed wall.

These houses are hazardous. They have to be cleaned or removed.

Unmarried women in *al-Tahta* view the local environment as deteriorating, describing their situation in the terminology they learned at school. They blame the municipality for not taking actions to stop this deterioration.

In this place, the environment is deteriorating. Old houses are falling.

The municipality is careless; they do not leave poison for rats and snakes.

The married women in the community decided not settle for such conditions in their neighbourhood. Husbands and sons were of no help, even if they worked for the municipality, so the women gathered and discussed the problem. A number of women went to the municipality several times to ask employees to take action and clean the area. Finally, the municipality responded. During my field visits, the women were celebrating their success. For them, it was one of the most important events in their lives as they realised they could achieve goals when they organise. It also revealed that the women could take action and did not have to wait for the men. We did not believe municipality people when they told us that they would clean the area. However it happened.

Women responsibilities are much more than men in the residential area. Wherever you see a vine tree in the hara, it is cultivated by women and not men.

Summary: The Relationship between the Housing Environment and Women's Health

All women find that there is a strong relationship between the housing environment, health, and well-being. The women in the focus groups and interviews mentioned some diseases and symptoms that can be caused by specific aspects of poor housing conditions: poor ventilation (respiratory infections, asthma, stomach-aches, nausea, and vomiting), poor sanitation (intestinal infections, urine infections, and uterine problems), and crowding (airborne diseases). Not only do physiological problems result from poor housing, but psychological problems arise as well. In the opinion of these women, crowding accompanied by a lack of privacy can lead to psychological distress. However, these women see their poverty as leaving them no choice but to live in this neighbourhood where houses are dilapidated, affecting their children's health.

Yet, the daily life experiences and roles women play in the different stages of their lives influence their understanding of good and poor health. Women of different age groups have different perceptions of the housing environment as related to their roles and positions at home. **Unmarried women** seek a space of their own without the interruption of other members of the household. **Married women** need a space that allows them to do the housework. They also look for space for their children. The women in this group suffer from psychological distress because they spend all day with their children at home, inside for much of the day. **Married women who live with the extended family** do not feel comfortable at home because of the presence and interference of in-laws. **Female heads of households** live in poor housing conditions because they are unable to afford otherwise.

Some women use **the house as a workplace**, increasing the family's income and improving the quality of life. Yet, these women find that their houses are not designed to provide a good working environment. Thus, their job relieves some stresses while causing others. **Older women** feel poor housing did not affect their health when they were younger, but they see that living for many years in damp houses causes some current health problems, such as arthritis. Overall, these women recognise their reproductive role extends

beyond bearing children, but caring for and managing the family and the home and being involved in the neighbourhood.

Women's perceptions of health also reflect their subordination as women. Women agree that the deprivation of inheritance rights, access to work and economic resources causes their poverty. The women feel that if they had received their rights of inheritance they would be able to improve their housing environment.

The social environment is very important for the majority of women in this community, regardless of age. They enjoy close social relationships that buffer the stresses of life. The study shows that women in this poor urban area are able to organise and thus have a role in community management. The success of the initiatives taken by the women of al-Tahta are encouraging, giving women the power to change their housing environment and proving the value of organisation and unity.

Conclusion and Recommendations

This study set out to discover if, and how, women in Ramallah *al-Tahta* perceive the relationship between the housing environment and their health. Achieving the study objective could not be reached, however, without an understanding of how women perceive the greater concept of health.

In this study, as in other work (Giacaman et al., unpublished; Doyal, 1994), women relate well-being and ill-health to aspects of their daily lives. This is probably due to the connection between women, their homes, and their residential environment as the traditional gender-division of labour leaves housework and reproductive responsibilities to women (Moser, 1993).

This study also reveals women in this community understand health in a broad context related to physical, mental, social, and economic well-being. The results of the discussions show both the physical and the social housing environments are of great importance to women's health. For example women, particularly the older women in this study, appear to believe a number of diseases grow more severe as they continue to live in the same housing environment for an extended period of time. In relation to the social housing environment, women noted their role and position in the home continuously affects their physical and mental health.

Women express different health needs and means of meeting these needs, depending upon their current phase in the life cycle. It appears young, unmarried women feel being at ease socially and psychologically is important for good health. Married women of reproductive age relate a good state of health to wealth, psychological stability, and the ability to carry-out their housework and child-rearing responsibilities. Older women see their present health condition, having developed chronic diseases, as a result of the accumulation of their experiences and environments throughout their lives. These women's words reinforce the findings from other studies: when women are asked about their health, reproductive issues are not necessarily given a priority (cf. Giacaman et al, unpublished; Lane and

Meleis, 1991). This challenges the idea that women's health concerns center around their role as a childbearers.

Despite general similarities in perceptions within the different age groups, women in the same stage of the life cycle express different relationships to the housing environment. It appears differences are due to the number of children in the household, as the housework increases with more children, making it more difficult to manage the living space.

The example of women uniting over their concerns about a healthy residential environment and succeeding in their initiative enabled them to realise they could effectively take a role in community management. Such initiatives need to be encouraged by the PNA and NGOs to promote women's participation in their health status, particularly regarding environmental health. If improvements are planned for Ramallah al-Tahta's residential area, women's comments need to be seriously taken into consideration.

Findings in this study show when women use the house as a workplace, their psychological and physical health is negatively affected. Women who are responsible for the housework and do not enjoy the freedom of mobility find the home to be the most convenient workplace. All women who work at home mentioned having difficulties balancing space and time for household members, work, and their clients. Using the home as a workplace entails special requirements of the housing environment for a convenient workplace. In its recommendations on women housing, the United Nations Development Program (UNDP) Commission on the needs of Palestinian women acknowledges women's participation in home-based income-generation projects and that they have special needs (UNDP, 1995: 61).

Funding organisations, Palestinian NGOs, and development planners have to recognise women's employment in the informal sector and support their home-based work. Funding organisations can create opportunities for working women through grants or soft loan schemes. Encouraging women's work from the home has to be integrated with empowering women through training, for example, to increase their awareness of the health hazards in the housing environment related to certain kinds of work.

The participants in this study who are relatively poor see a link among the housing environment, their poverty, and their inability to move or improve

their current housing conditions. Discrimination against women prohibits them from the same educational opportunities, and in turn, economic opportunities as men. Women are also deprived of their rightful inheritance, another financial resource. Were women encouraged and assisted in advocating these rights, these potential resources would allow for an improvement in women's quality of life, beginning at home.

Although this study goes towards showing that women hold certain views on the relationship between health and the housing environment, it does not investigate men's perceptions on this same relationship. Further studies involving men would provide a valuable balance to this work, and increase the understanding of how the housing environment is perceived to influence health.

Throughout the process of this study (its design, field work, and synthesis of information), I have come to the understanding that the relationship between health and housing must take into consideration certain factors, such as poverty, education, and age, which alter health outcomes for different groups of people. This study reaffirms that qualitative research allows us to appreciate the intricacies of these factors, and that the social and cultural dimensions are not easily quantified. Yet, for concrete future development and planning, both quantitative and qualitative methods need to be used for a greater understanding of the community, their situation and their surroundings.

In looking towards the future, Ramallah *al-Tahta* constitutes an important part of the local cultural heritage and needs to be maintained. However, many of the residents are tenants of the homes they live in, leaving them prey to homeowner's decisions. Although all renters are prone to the same laws, the situation of the residents in Ramallah al-Tahta is more tenuous than most as this area's future is undecided, leaving residents vulnerable to displacement for renovation and preservation of the area. Efforts are needed by both the public and the private sector to maintain and renovate the area, although it will not be an easy job if the area is inhabited. Plans to renovate or upgrade the area are important and must include the consultation and participation of the people, the women, living in Ramallah *al-Tahta*.

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