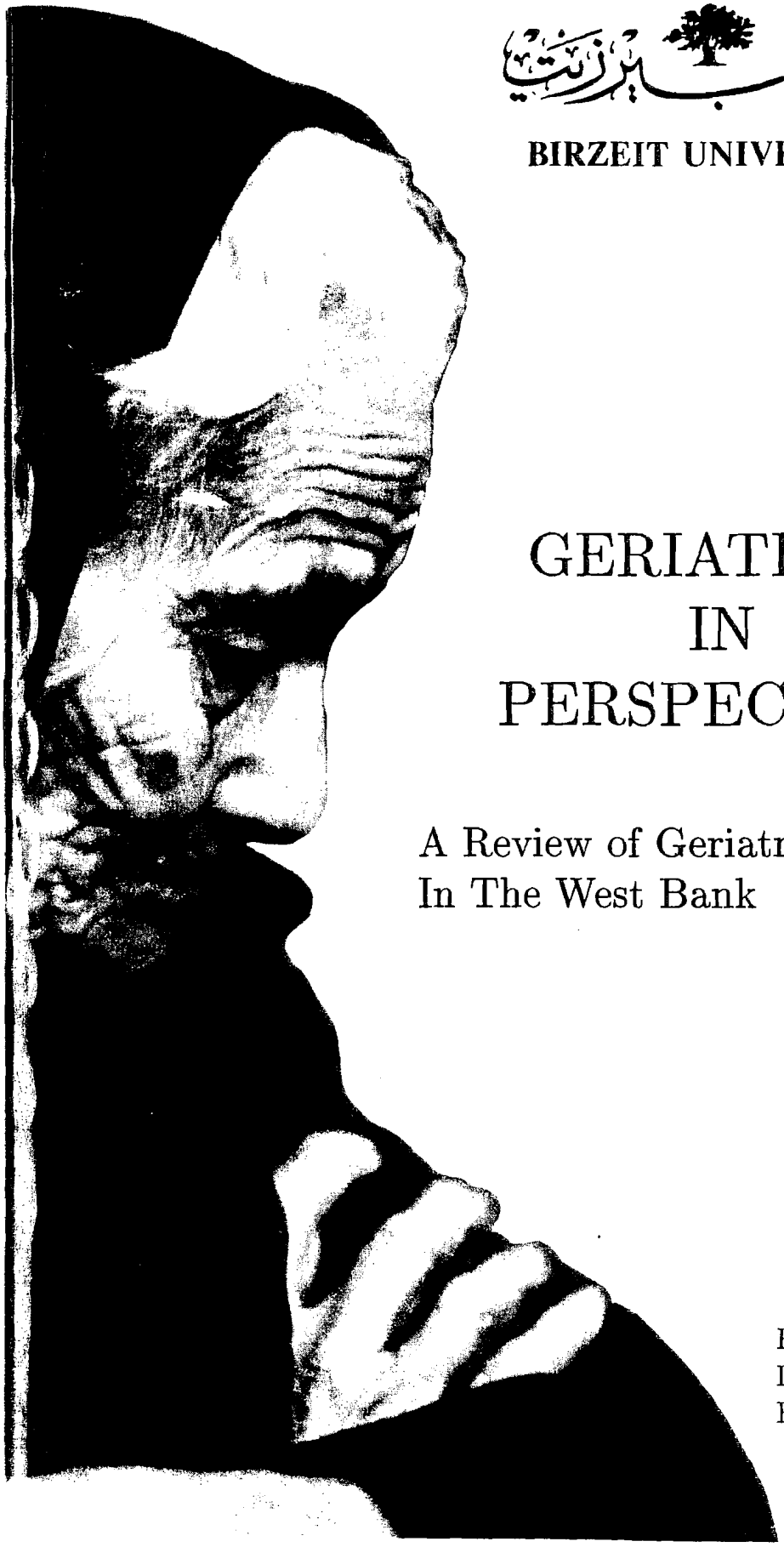

جامعة بيرزيت

BIRZEIT UNIVERSITY

GERIATRICS IN PERSPECTIVE

A Review of Geriatric Services In The West Bank

RITA GIACAMAN
KATE LOCK
HALA SALEM

Geriatrics in Perspective:
A Review of Geriatric Services in The West Bank and Gaza Strip

RITA GIACAMAN
Birzeit University Community Health Unit

KATE LOCK
Community Nurse - Jerusalem

HALA SALEM
Birzeit University Community Health Unit

1991

Contents

1 Introduction

Throughout the world, the number of the elderly is increasing. Today, they comprise 15–20% of the population in industrialized countries. Their average age is also steadily rising, increasing their general and health care needs. In contrast, only 3–5% of the population of the developing world is over the age of 65 years, a reflection of the depressed socio-economic conditions in such countries. Yet although the proportion of the elderly relative to the rest of the population is likely to remain small, their absolute number is expected to rise steadily (Landsberger, 1985, Siegal and Hoover 1982, WHO, 1989). Their need for long term care will therefore also increase.

This study is the first in a series of steps geared towards examining the needs of the elderly in Palestine for the purpose of policy formulation and future planning. It was induced by an observed rise in the absolute number of old people in the country. It was also prompted by changes in the socio-economic conditions affecting and changing lifestyle. The increasing incorporation of women—the primary caretakers of old people at home—into the labour market and the increasing nuclearization of the family is making the care of old people at home increasingly difficult. These changes necessitate a fresh look at the question of the care of the elderly and the fulfillment of their physical, psychological and social needs.

2 The Survey Method

Our method consisted of designing an open-ended general survey questionnaire that was administered to accountable people in old people's homes of the West Bank and Gaza Strip. The questions pertained generally to the type of services available and the number of people served. A study of the quality of service was undertaken, although not in detail. Thus the preliminary comments that will be made below regarding quality are based on observations made during the field visits, indices of quality included in the questionnaire—such as the presence or absence of special rails and toilets in the premises inspected—and extended interviews conducted with selected local professionals and experts who have been delivering services to the elderly. A review of the international literature on geriatric care was made to assist in the identification of the

issues of major concern.

3 Issues of General Concern

A. Loneliness Versus Poverty

One of the main problems that the elderly face in the industrial world is loneliness. In Britain, for instance, it was shown that of the total number of people over 75, 30% never had children and 33% had no living offspring. Women were expected to care for their elderly relatives, although this is becoming more difficult because of the breakdown of traditional patterns of life and the increasing economic activity of women outside the home (Landsberger, 1982).

Most writers agree that in the developing world the situation is rather different. They identify the major problems of the elderly in these countries as rooted in poverty—as opposed to loneliness—since they are financially dependent, being among the poorest of the poor. Increasing city migration leaves the elderly to care for themselves, sometimes supported by migrant labour remittances (Hampon 1985, Mpolo, 1984 and Tout, 1988). The speed of change in society makes matters worse in that the poor level of education of the elderly prevents them from adapting to these changes, thus compounding their already disadvantaged status.

B. The Problems of Long Term Care

It is generally taken for granted that community care of the elderly is preferable to institutional care. But even in the industrial countries it is acknowledged that care services to the home are still not adequately provided. The problem is rooted in the nature of long term care in the home and the way in which it crosses the boundaries between home, state and private institutions. The complexity of this service provision can leave the client ill-served (Rothman, 1986).

The reduction in the number of available carers, the financial, emotional and physical burden of caring for the elderly is also a problem. Dementia and incontinence are reported to be the most stressful problems (Mathiesen, 1989). In all, while community care is the preferred and more 'humane' way of caring for the elderly, institutional care remains indis-

pensable.

Information pertaining to long-term care networks in the developing world is not abundant. However, overall, it is emphasized that institutional care is not appropriate for these communities and that financial and professional support for the families of those caring for an elderly relative is the way forward for long term care. This may be in the form of tax relief, allowances or subsidies for these families (Apt, 1990). In contrast, in China as part of a highly organized long term care system, lone elderly receive care at home from two or three volunteers (with or without compensation). The volunteers take turns visiting and supporting the elderly. Obviously, the operation of such a system involves extensive organization and follow up as well as good coordination among the various sectors providing care to the elderly, for example, social work, medical and psychological services (Liand and Shengzu, 1990).

C. Residential Homes for the Elderly

In industrialized countries, three problems relating to the care of the elderly in residential homes are identified as of major importance:

1. The mental health of residents

It is estimated that approximately 50% of the residents of old people's homes have some mental health problem, including dementia and psychosis (Hepple et all, 1989, Richter, 1989) and that about the same percentage are on psychotropic drugs—supposedly with calming effects on the patients (Fatis, 1989). Initiatives to improve the lives of older demented patients concentrate on improving their ability to care for themselves which leads to increased self esteem and better staff-patient relations (Neimoller, 1990).

2. Untrained and underpaid management and staff

One of the major problems encountered with people cared for in homes for long periods is their gradual institutionalization. Apathy and deterioration in personal habits have been found to be linked to the excessive control homes place over clients, geared to residents' safety and the smooth running of the home rather than to individual choice (Booth,

1985, Cooke, 1987). The lack of trained staff, poor pay and rigid routines of management are thought to be the cause of this poor attitude and its consequences on the elderly (Kane and Kane, 1986, Booth, 1985).

3. Quality assurance

Reports of poor care abound in the literature. Much has been written to suggest that the standards of care are very low, in some cases abysmally poor. This came to light in England for instance when the Nye Bevan Lodge home for the elderly was closed following reports of what amounted to routine abuse of the elderly. The inquiry following the scandal recommended improved training for nursing aides and a better system of inspecting homes. However, because of the rapid increase in the number of homes, local authorities do not have the resources to perform this duty (Gibs et al, 1987). In Germany (Diessenbacker, 1989) and America (Kane and Kane, 1986), similar problems exist, and reforms in their 'confused systems of inspectors' have been suggested. There is no doubt that while some homes effectively carry out care, those that do not are rarely forced to raise standards in the present system in industrialized countries.

In general, residential accommodation of the elderly in the developing world is relatively unimportant, for the majority of care takes place at the level of the home and the community. Whenever present, residential homes are seen as shelters for the destitute or havens for the very rich. In Egypt, for instance, Rugh (1985) found that elderly homes were either cheap and of very poor quality, catering to the needs of the elderly and the destitute, or were expensive and well run for the rich. Only a tiny percentage (0.004%) of the elderly in Egypt live in these homes in contrast to 3–4% of older people living in residential homes in industrialized countries (Factor, 1989, Horrock, 1984). Similar patterns were observed for Zimbabwe (Hampton, 1985), as well as Palestine as we shall see below.

4 The Elderly in Occupied Palestine

Studies that have examined the situation of the elderly in Occupied Palestine suggest conditions resembling those of the developing world. As a proportion of the population, the elderly are estimated to repre-

sent 3–6% or 45000–90000 people (Powell, 1987, Giacaman, 1988 and Benvenisti, 1989). Since fertility rates do not seem to be falling, the proportion of the elderly is not likely to rise significantly in the near future although their absolute number will.

Weihl et. al. (1986) found that in Arab villages in Israel 97% of the sample of elderly interviewed had children, and 60% were living in multigenerational households, in which almost half lived with both children and grandchildren. Thus despite migration, a family support system seems to still be in place. The authors also found a much higher level of disability among Israeli Arabs compared to Jews, probably the consequence of inadequate socio-economic conditions of this sector of the population and the deficient provision of health care services provided to Arabs in comparison to Jews.

Although the study of the conditions of the elderly among the population in the West Bank and Gaza Strip has not been attempted to date, an examination of community health studies might be of help. In a health status assessment study of three rural communities in the West Bank for instance, Giacaman (1988) cites a 2:1 ratio of elderly males to females, a pattern opposite to that noted in industrial countries. She also reports that while 44% of these rural men 55 years or over are literate, only 1% of their female counterparts were. Like Hampon (1985) in Zimbabwe, Giacaman reports that many of the younger people had migrated, leaving the middle aged people (the possible carers of the elderly) under-represented in their communities. Most older people relied on their children for financial support. Consequently the elderly seem to represent a segment of the population that is poor and that has little access to resources other than relying on children for their livelihood.

While community care remains one of the most important methods of caring for the elderly in Palestine, it has not been studied specifically. Statistical health reports concentrate on the young and indicate that health conditions of Palestinians resemble those in developing countries (Vermund, 1985). Other reports list health services available to the general population but none mention the problems of the elderly and the way in which their health care and other needs are met. It thus appears that the elderly have not yet become a priority in the eyes of either Palestinian organizations or the international aid agencies operating in the area.

The only study of residential accommodation for the elderly in Palestine

was conducted by Sabella (1988), who reviewed the homes of the elderly in the Jerusalem/Ramallah districts. He estimates that 1.2% of the elderly of the West Bank live in residential homes—in contrast to 3–4% in the industrialized countries and less than 1% in the developing world. He compares elderly services in the area to those available to Jewish Jerusalem residents and concludes that there are insufficient residential homes in this area. No attempt is made to discover whether the homes quoted are over—or under—used by the community or whether or not they have waiting lists for their beds.

In conclusion, in contrast to the industrialized world where loneliness is a major problem facing old people, the Palestinian elderly are in general surrounded by family. However, two other types of issues appear to be of importance: the lack of support for care in the home and the poor quality of care in old people's homes. This survey concentrates on reviewing the type of institutional services available to the elderly and their quality, seeking to assess the level of demand for these services in society. We have deliberately left the issue of quality of care in the home to be approached in detail in a study on its own because of its complexity.

5 The Survey Report

Although 23 old people's homes and institutions caring for the elderly are currently in operation in the West Bank and three in the Gaza Strip, we succeeded in obtaining information from only 21. Of the total, only three provided home services to the elderly, primarily hot meals. None provided day care. The rest were old people's homes. Following is a summary of the major results:

A. Date of Establishment

12 or about half of the institutions were established in the 1970's and 1980's, that is, after the 1967 occupation. The existence of geriatric homes in the country in the pre-1967 era indicates need/demand from society for such homes/services that dates as far back as the 1940's (the time when the first home was established). However, the gradual increase in the number of homes established over the years (8 in the 1980's, 4 in the 1970's, 4 in the 1960's, 3 in the 1950's and 2 before that

period) might be indicative of changes in social structure and consequently lifestyle in the family especially during the last decade leading to increased demand for old people's homes.

B. Location

Seven of the institutions are located in the Bethlehem area, 4 in Jerusalem, 2 in Ramallah, 2 in Jericho, 2 in Nablus, one in Hebron, one in Jenin and 2 in the Gaza Strip. As expected then, the concentration of geriatric services is in the centre of the country, where more than half of the institutions are located and where not more than one quarter of the population lives. This leaves the northern and southern areas of the country where the majority of people live, less well served and more in need of these services, although perhaps with less demand overtly expressed by people.

C. The Number of Residents

The total number of residents in these institutions was found to be 698 persons at the time when the survey took place, or about 1% of the total population of old people in the country. Evidently then, the very large majority of old people in this country are cared for in their own homes.

D. The Sex of Residents

The residents of these homes were found to be almost equally divided among the sexes with 340 males and 358 females. Sixteen of those institutions provided services to both sexes and the rest to women alone. Thus none provided services to men only, although men are disproportionately more represented among the residents of these old people's homes relative to women. This is consistent with the observation that women in general are more able to care for themselves especially in old age and are therefore less likely to seek the services of old people's homes. At the same time, in the West Bank and Gaza Strip as a whole—in contrast to rural areas—women over 65 constitute a larger proportion of the geriatric population than men of the same age (Sabella in Taraki, 1990), explaining perhaps the preponderance of institutions catering to the needs of women only.

E. Major Health Problems of Residents

Of the total number of residents (698) 9.1% or 64 were reported as having urinary incontinence, 6% or 42 fecal incontinence. We also found that 562 or 81% suffer from dementia ranging from mild to severe, in contrast to 40–70% estimated for industrialized countries. 498 or 71% of the total required daily physical help such as feeding bathing and going to the toilet. The generally high level of dementia and dependence of the residents in these homes may be linked to the over-prescription of psychotropic medications. It could also be due to depression confused as dementia, and may arise from the lack of stimulation observed in these homes.

F. Criteria for Admission

Of the total number of institutions 18 reported inability to care for oneself, the lack of family support and absence of family members as the main criteria for admission. In other words, the criteria are basically an inability to care for oneself. This suggests that the decision to enter an old people's home in this country is taken only when all other methods of support have been exhausted, probably because of the social stigma associated with placing elders in homes. This may also be due to financial considerations (the costs incurred in placing old people in homes in contrast to keeping them among the family) as has been argued by Kane and Kane (1986) in noting differences between need and demand for old people's homes generally. Because of this apparently strong reluctance to utilize the services of old people's homes, the burden of care in institutions is probably higher here than in industrialized countries where the decision to enter a home is made earlier and with the persons in question less disabled.

G. Payment Schedules

Nine of the homes visited provided services free of charge to residents, combining geriatric care with the care of the poor. The rest operated sliding scales with residents paying according to availability of resources. This probably is one reason for the 'charitable' atmosphere of the homes, and the approach of 'caring for the aged' instead of 'helping them to care for themselves' as we will elaborate later.

H. Sources of Funding

12 of the 21 institution representatives reported that main sources of funding for the home they operate are Christian churches. One reported a mosque as the principal funder. Seven indicated that charitable societies took care of the bill. The local social work departments and local contributions were also sources. Thus churches and charitable societies appear to be the main supporters of old people's homes. Whether these results are an indication of a fundamental difference in lifestyle between the Christians and Muslims of this country or are merely a reflection of the particular interests of Christian institutions is a matter that requires further study.

I. Resident Turnover

We found that the total number of residents in these institutions in 1989 was 684, in contrast to 698 for 1990, indicating a 2% rise in 1990. Because we were unable to obtain accurate estimates of the number of residents for the years before, it becomes difficult to discern a clear cut time pattern. However, discussions with administrators at these institutions does suggest an absolute rise in the numbers of institutionalized old people.

J. Demand for the Services of Old People's Homes

It is interesting to note the discrepancy between need and demand for old people's homes services observed in this study. On the one hand we note a rise in the need for such services precipitated by the rise in the absolute number of old people coupled with changing lifestyles, especially the incorporation of women into the labour market. On the other hand the demand for the services of old people's homes appears to remain minimal: only three of the institutions indicated that they have waiting lists of more than a few people. This finding, coupled with the fact that all of the old people's homes together house hardly 700 persons or about 1% of the total geriatric population indicate that the large majority of our old people are being cared for in the homes and that the demand for these services is not high, despite objective increasing need for elderly care. These findings point to the need to look further into the possibility of establishing home care services for the elderly.

K. Patient Employee Ratio

A total of 163 workers care for the 698 elderly people in these homes, with an average of 4.3 residents per worker.These are mostly full time workers, with the exception of the professional staff who are attached to these centres on a part time basis. Of the total workers 8 or 5% are physicians—all working on a part time basis—20 or 12% are nurses, 54 or 33% are cleaners, 6 or 4% are accountants, 45 or 28% are nuns, performing whatever is needed, from cleaning to supervision, 15 or 9% are social workers, and 7 or 4% are guards. The almost total absence of night duty leaves the residents with no service during the night.

L. Employee Salary Scale

59 of those workers or 36% of the total had salaries below 120 JD monthly. All the nuns (45) are non salaried, leaving only 62 employees or 48% earning more than 120 JD's, with a maximum salary of 180 JD's. Quite clearly, then, the rather low salary scale is an important point to consider when reviewing the quality of services in these institutions.

M. The Educational Level of Employees

The educational level of the employees of these institutions appears to be inadequate. Of the 130 employees with known educational backgrounds (the information for 33 was unavailable) 39, or 30%, were completely illiterate, 21, or 16%, had primary school education, 4, or 3%, preparatory, 16, or 12%, secondary school education, 20, or 15%, had some post-graduate training course, 15, or 11%, completed community college and 15, or 11%, went to university. Almost all had educational backgrounds not precisely relevant to geriatric care, and there was an almost total lack of in-service training. This educational picture of staff in these institutions is probably related to an attitude pervasive in these institutions and society at large that geriatric service does not require much except the physical 'maid type' service, rather than specialized and professional training. These observations are corroborated by the fact that we found that none of the institutions indicated that any of their staff had any training in geriatric care in any extended or thorough way. In addition, only one has a psychologist on board, 8 receive the help

of a psychologist from other institutions, mostly providing medication services with no other service support.

N. The Physical Facilities

16 of the institutions had gardens. With a total of 114 rooms (bedrooms, living rooms etc, excluding toilets) the average is 6.1 residents per room, which is probably crowded. Eight of the institutions have private rooms for those residents who can afford them, or in cases where the resident especially needs to be alone. In general, the buildings tend to be overcrowded and ill prepared to facilitate movement and independence: rails are often absent, toilets difficult to use, beds dented and mattresses in a bad way. Many safety features are lacking, for instance; there are a lack of bannisters on stairs and unmanageable steps.

O. Problems that the Institutions Face

Twenty interviewees listed financial problems as major problems coming in the way of their provision of proper services. Thirteen listed workers complaints of low salaries as major, 4 workers lack of training and 5 that workers treat residents badly. Ten listed family neglect of residents as a problem. As expected then, there was an acute awareness expressed by responsible people of the financial problems facing these institutions. In contrast, the awareness of the problem of the lack of proper training of the staff was minimal.

P. Urgent Needs

Nineteen of these institutions listed the need for a special building as most important, and only one noted the proper training of workers as important. One thought the institution needed the creation of new programs in order to stimulate the elderly. The low level of awareness as to the need for more sophisticated elderly services than the strictly physical is obvious.

6 Summary and Conclusions

In summary, the geriatric services available in Occupied Palestine are mostly institutions for housing the elderly. With notable exceptions, such as food delivery, the different facets of home care are completely unavailable to those elderly living at home, who constitute the large majority—99%— of the total elderly population in the area. This survey has shown that old people's homes today continue to lack the most essential services and therefore the elderly suffer the effects of the low quality of the services that are provided. They also suffer the harmful consequences of the unsuitable physical conditions of these homes.

Staff are generally untrained and unprepared to handle the special and delicate problems of this sector of the population; staff are underpaid and uninterested in their work. It is as if they are there for the lack of better jobs. Discussions conducted with selected old people living in these institutions and observations made by the study team are indeed suggestive of ill treatment and even abuse that is not usually revealed to outsiders. As one of the residents of these homes expressed it:

> ' I fear the woman responsible... she beats me if I am not in my bed at an assigned time and if I do not follow her orders. Please do not tell her I told you because you are leaving and I am staying here.'

The residents of these homes tend to be the most frail among the elderly population of the country: with a very high rate of dementia and incontinence. These people enter geriatric homes mostly when the are completely unable to care for themselves and when caring for them in the home becomes impossible. This places a high burden of work on the staff of these homes, making the comfort of the residents an ordeal indeed.

The services that these homes provide are also minimal. Medical services consist mostly of part time doctors who principally provide medications and transfers to hospital. Psychological services are composed of medication provision which, coupled with the lack of entertainment and general stimulation, might be a contributing factor to the high rate of mental health problems noted among these residents. Physiotherapy and exercise services are almost completely lacking: during field visits, the study team noted many incidents of bed sores and offensive odours,

dirty clothes and old people sitting on floors apparently neglected.

Most important of all, with very few exceptions, the problem is one of a charitable and sometimes inhumane approach to the delivery of services, a type of service provision which does not attempt to encourage self care and work towards improving the quality of life. This unfortunate attitude towards the elderly and their needs is encapsulated in the answer of one of the administrators:

> 'it is difficult to deal with these people because they have a long experience with life. It is impossible to change them, they have no willingness to cooperate or listen to others in addition to them being very talkative and they always want others to listen to them, for they talk like a radio. If they start it becomes hard to stop them.'

This desperate situation is well expressed in the response of one of the residents to one of our questions:

> '...old people's homes are places of death, where one stays during one's last days. I worked hard all my life, I got married, I got educated and I worked, and I had children and gave them an education. And my life went. And now, what do I deserve from my children and my relatives? Even a question about how I am doing does not come. I feel that I have already died since I arrived to this place. I wish myself a fast death indeed. I have not seen any of my relative for months now. If you see any of them, please beg them to come and visit me.'

Clearly, much needs to be done in the avenue of service provision to the elderly. This study indicates that the community/home based approach to elder care is probably the most appropriate for local needs in view of the fact that the large majority of the elderly are being cared for at home and that the situation is not expected to change considerably in the near future. This approach is also favoured because it is cheaper than other methods of service delivery, and because it will probably remain to be the more humane. The community based approached entails the provision of health, social, psychological and entertainment services to the elderly in their homes or in day care centres within their communities. It involves enabling the family and the elderly themselves to

make the stay of old people at home as comfortable and as tolerable to the family as possible. This involves a substantial amount of education, follow up and supervision.

Simultaneously, institutions housing the elderly must be upgraded, especially by way of staff training. They must also be monitored and supervised. While the absence of a national government makes these tasks difficult to achieve, they nevertheless are not impossible objectives. One can start by establishing a body of responsible professionals and interested citizens that could embark on planning for and improving the living conditions of old people by keeping in mind the need to sustain them 'in independence, comfort and contentment in their own homes and when independence begins to wane, to support them by all necessary means' (WHO, 1989). Specifically, such a body could embark on:

1. Promoting the holistic and self reliant approach in caring for the elderly and in handling their medical and social needs, which should be considered in relation to the family and the community. This in turn means embarking on the establishment of integrated home care services that are geared towards disease prevention. These might include: physical/material assistance, food provision, medical/physiotherapy & nursing, social, psychological and entertainment services. The services should be available to all the aged who need them, and developed with the close participation of those using the services.

2. Planning for the provision of hospital services for those who are in need of medical or nursing attention or both. This necessarily means close coordination with the medical sector.

3. Establishing a supervisory framework and continuous evaluation mechanism as part of the system of service delivery. This will improve service quality and enable the policy-makers and those providing care to introduce changes in the system whenever necessary.

Specifically, such a body could then begin to:

1. Study the specific needs of old people living in their homes, taking into consideration that they come from different sectors of society

and might therefore have differing needs. This body would then assist in the introduction of home care services to the elderly based on information obtained by these investigations.

2. Assist the existing institutions in improving their services and maintaining quality control of these services.

3. Assist in upgrading the level of the staff of existing institutions and in training new types of staff through the initiation of training workshops and courses and by offering scholarships to study abroad.

4. Assist institutions in introducing new approaches to service delivery, new programmes, indeed, in the introduction of the very concept of programme, and helping them in developing services to suit the needs of the elderly. New programmes could include proper social work and counselling programmes, physical education, gardening and handicraft training.

5. Fund-raise and help institutions in obtaining the funds that are necessary for the upgrading of existing services.

6. Embark on campaigns geared towards the education of the public and soliciting public assistance in dealing with the problems of the aged and to change the stigma associated with the utilization of old people's homes.

7 References

- Apt, N., 'The Role of the Family in the Care of the Elderly' in, Kane, R. et al (eds)., *Improving the Health of Older Persons, A World View*, 1990.

- Benvenisti, M. and Khayat, S., *The West Bank and Gaza Atlas*, West Bank Data Project, Jerusalem, 1988.

- Booth, T., *Home Truths: Old People's Homes and the Outcome of Care*, Gower, London, 1985.

- Cooke, M., 'Part of the Institution,' *Nursing Times*, Vol. 83 No. 23, 1987, pp. 24–27.

- Dissenbacker, H, Neglect, 'Abuse and the Taking of Life in Old People's Homes,' *Aging and Society*, Vol. 1., Pt. 1, 1989, pp. 61–71.
- Factor, H., Guffman, M. and Shmueli, A., *Mapping of the Long Term Care System for the Aged in Israel*, Executive Summary, Brookdale Institute for Gerontology and Human Development, Jerusalem, 1984.
- Fatis, M. et al, 'Behavioral Psychological Intervention,' *Journal of Gerontological Nursing*, Vol. 15, No. 1, January, 1989.
- Giacaman, R., *Life and Health in Three Palestinian Villages*, Ithaca, London, 1988.
- Gibs, J. et al, *Report of the Enquiry into Nye Bevan Lodge*, London, July, 1987.
- Hampon, J., 'Elderly People and Social Welfare in Zimbabwe,' *Aging and Society*, Vol. 5(1) 39–67, 1985.
- Hepple, J. et al, 'A Survey of Private Nursing Home Residents in Western Super Mare,' *Age and Aging*, Vol. 18, 61–63, 1989.
- Horrocks, P., 'Long Stay Care: A Consistently Depressing Picture,' *Geriatric Medicine*, April, 52–60, 1989.
- Igou, J. et al, 'Nurse-Managed Approach to Care,' *Geriatric Nursing*, Jan/Feb 32–34, 1989.
- Kane, R. and Kane, R., *Long Term Care: A Review of the Evidence*, Division of Health Services Research Policy, School of Public Health, University of Minnesota, 1986.
- Kovach, C., 'Promise and Problems in Reminiscence Research,' *Journal of Gerontological Nursing*, Vol. 16, 1990.
- Landsberger, B., *Long-Term Care for the Elderly. A Comparative View of Layers of Care*, Croom Helm, London, 1985.
- Liang, J. and Shengzu, G., 'Long Term Care for the Elderly in China,' in Kane et. al (eds), *Improving the Health of Older Persons, A World Review*, 1990.

- Mace, N. and Robbins, D., *The 36 Hour Day*, Hodder and Soughton, London, 1985.
- Matthiesen, V., 'Guilt and Grief When Daughters Place Mothers in Nursing Homes,' *Journal of Gerontological Nursing*, Vol. 15, No. 7, 1989.
- Mpolo, M., *Older Persons and Their Families in a Changing Village Society. A Perspective from Zaire*, International Federation on Aging and the World Council of Churches, Geneva, 1984.
- Moneyham, M and Rider, M., 'Nursing's Role in Promoting Health for Elders in the Community,' *Geriatric Nursing*, Sept./Oct. 282-3, 1988.
- Niemoller, J., 'A Change of Pace for Alzheimer's Patients,' *Geriatric Nursing*, Vol. 11 March/April 1986 pp. 86–87.
- O'Mally, K., and Brooks., S, 'Caring the On Lok Way,' *Geriatric Nursing*, March/ April 64–66, 1990.
- Powell, A., *Food Resources and Food Systems in Two West Bank Villages*, Arab Thought Forum, Jerusalem, 1987.
- Richter, J., 'Providing Nursing Home Care for the Chronically Mentally Ill,' *Journal of Gerontological Nursing*, Vol. 15 No. 6, June 1989.
- Rothman, M., *Comprehensive Long Term Care Study*, South East Florida Center on Aging, Florida International University, October 1986.
- Rugh, A., *Family in Contemporary Egypt*, American University of Cairo Press, Cairo, 1988.
- Sabella, B., *The Elderly in Jerusalem and the West Bank and the Need for and Old-Age Home*, Unpublished report submitted to the Evangelical Lutheran Church in Ramallah, March, 1988.
- Sabella, B., 'West Bank and Gaza Strip: People and Land,' in Taraki, L., ed. *Palestinian Society in the West Bank and Gaza Strip*, Dar al-Aswar, Akka, 1990 (in Arabic).

- Siegel, J. and Hoover, S., 'Demographic Aspects of the Health of the Elderly to the Year 2000 and Beyond,' *World Health Statistics Quarterly*, Vol. 35 Nos 3/4, 1982.
- Tout, K, 'Aging: Social Supports and Community Intervention in Developing Countries,' *Danish Medical Bulletin*, Special Supplement Series, No. 6, Oct, 1988, pp. 67–71.
- Vermund, S at al, *Health Status and Services in the West Bank and Gaza Strip - Summary*, Institute for Middle East Peace and Development, New York, 1985.
- Weihl, H et al, *Living Conditions and Family Life of the Rural Elderly in Israel*, Brookdale Institute of Gerontology, Jerusalem, 1986.
- Whitehead, J., The Community Care Maze: What Better Guide than a Carer? *Geriatric Medicine*, January 11–12, 1988.
- WHO *Health of the Elderly*, Technical Report Series WHO, Geneva. 1989.