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Women's Perceptions of Health and Illness in the Context of National Struggle in the Old City of Nablus, Palestine

Rita Giacaman and Muna Odeh

Reproductive Health Working Group
The Population Council Regional Office for West Asia and North Africa

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PREFACE

Monographs in Reproductive Health

Monographs in Reproductive Health aim at sharing research and analysis undertaken by members of the Reproductive Health Working Group with the wider research community. The Reproductive Health Working Group was established in 1988 as part of a Special Program on the health of women and children within the context of the family and community. The program was initiated by the Population Council's Regional Office for West Asia and North Africa (WANA). The Working Group includes professionals with specializations in anthropology, biostatistics, demography, medicine, public health and sociology, residing in various countries of the region.

The Working Group delineated three key issues which were considered central to women's reproductive health in the WANA region: first, women's physical health in terms of morbidity conditions related to the reproductive function; second, women's perceptions of their health and their dignity in relation to reproduction; and third, on the health service side, the quality of reproductive health services directed to women. The Working Group has been undertaking studies addressing these issues in countries of the region since 1989. Further research interests are currently emerging concerned with developing an intervention framework to improve reproductive health within primary care settings, and with investigating physicians' perceptions of women's health.

Monographs in Reproductive Health and the Policy Series in Reproductive Health are two complementary publications issued by the Reproductive Health Working Group. Papers in the Policy series in Reproductive Health reach out with frameworks, methodologies and evidence of research to policy makers, program managers and health advocates. They aim to contribute to the development of more holistic policy approaches to women's health. Monographs in Reproductive Health address researchers and students primarily, and aim to cross disciplinary lines. They represent original research, reviews of literature and theoretical discussions on subjects of interest to one discipline, either medical or social sciences, bringing concepts and results into the realm of understanding and interest of other fields. In this way the Monographs in Reproductive Health aim to contribute to the advancement of interdisciplinary approaches in research on women's reproductive health.

ABSTRACT

This essay discusses the perceptions on health and illness of women in the Old City of Nablus, Palestine, during the first Palestinian Intifada (Uprising), which began in 1988 and ended in the early 1990's. The study was carried out between 1991-1992, a period when the Intifada dominated the lives and everyday routines of the Palestinian population. The basic demographic and socio-economic data and women's narratives presented here were conceptualized and expressed in terms of women's life stages or life cycles that have been shaped by exceptional political circumstances, circumstances that have had dramatic effects on the economic and cultural aspects of life in this basically poor urban community.

The narratives of the interviewed women present complex and multifaceted views on health and illness as a continuum, influenced by a mix of external factors - political and environmental - as well as internal influences, such as childbearing, aging, ability to cope. Health is portrayed as a valuable asset that is a combination of the physical, the psychosocial and the political. Health is seen as divinely governed, yet with space for human intervention, and vulnerable to the ill effects of the evil eye, *hassad*. Health and illness are ultimately visualized in terms of the ability to cope and to manage stressful situations and difficult life events.

FOREWORD

The second Palestinian *Intifada* erupted on the 28th of September 2000. Casualties have been high, and at present (March 2002) are rising daily. The second year of the *Intifada* has witnessed a sharp increase in death and causalities suffered by Palestinian civilians, with the deterioration in daily life causing difficulties that have surpassed all expectations in their severity, indeed, getting through the day has become a tortuous ordeal for everyone.

The *Intifada* expresses the frustration of a people who have suffered, fought and resisted occupation for many long years. The political struggles of Palestinian men, women and children have become a near daily feature of our media-constructed memory. These daily reports of politically precipitated violence have eclipsed our social knowledge of Palestine and its people. Despite the urgency of current events there is still a role for research that describes, analyses and appreciates the almost unbearable daily conditions that challenge the determination of all Palestinians, but especially the women. The work of Rita Giacaman, Muna Odeh and colleagues who are living through the same daily tribulations describes a dimension of the difficult lives of women living under occupation during the first *Intifada* (1987-1992) and so contributes to such an appreciation. This work defies the simplistic projection of Palestinians as 'victims' and asserts their active engagement with hope, daily life, and a future. It gives the reader a glimpse of the resilience of the entire community.

Because of the dire conditions and the struggle for continuity and 'normalcy' it is essential to look back ten years and give currency to research that did not investigate violence but rather its impact on 'ordinary' life. This publication describes how women managed the first time round and asserts that even victims, to whose suffering the onlooker may have become immunized, have lives that have been tragically affected by these events.

Giacaman and Odeh contribute not just to our knowledge of the health of Palestinian women but also to another initiative concerning health perceptions and identity in the Arab World. This is work that has been pursued by members of the Reproductive Health Working Group, housed in the Population Council, who have been looking at health and its perceptions as aspects of social and cultural change and not just as physical or material phenomena.

This work is presented in celebration of insightful and sound research on the social meaning of health and to the future well-being of the people of Palestine. It is a work that not only honors the victims but also recalls and honors the People Who Lived!

Hania Sholkamy
Cairo, March 2002

AUTHORS' FOREWORD AND ACKNOWLEGMENTS

This monograph forms part of a larger study focusing on the life events of women in the West Bank City of Nablus during the first Palestinian Uprising (*Intifada*) of 1987-1992. It is being published a good ten years later, at a time when Palestine is engulfed by the second year of the second *Intifada*. With conditions in the country, and particularly in Nablus, reaching unprecedented severity, we find ourselves, once again, marveling at the resilience of women, the wives, mothers, and sisters of over 1000 martyrs to date, and thousands of permanently disabled, mostly young men, as a result of Israeli army violence and the excessive use of force. We also find ourselves marveling at the resilience of the entire community, especially children, who are subjected to regular attacks by a phenomenally well equipped army, yet manage to get to school daily under the threat of being shot, beaten or tear gassed, even after their homes are shelled by F16 Jetfighters and Apache Helicopters the night before!

Attacks on civilian targets, shelling, bombing, shooting, periodic partial re-occupation of selected Palestinian Authority areas have all contributed to the escalation of violence in daily life in unprecedented ways. The severe state of siege, the division of the West Bank into at least 64 parts, with Israeli army checkpoints dotting the landscape and inhibiting movement from one village to another, and even from one part of the city to another, have reduced not only the infrastructure and the economy to rubble, but have also made life seemingly impossible to live. Yet, despite these tragic circumstances, women continue to cope with daily life, to 'absorb' the jolts of excessive destruction, injury and death, and manage their family affairs in these trying times. The sense of community is at its peak, and the population's resolve to continue living a normal life is simply phenomenal: people walk across checkpoints, at the risk of being shot, tear gassed, beaten, regularly humiliated and detained, in order to reach work, school, university and home. Shelling and bombing take place in the afternoons and at night, so schools re-adjust schedules to complete the day early. Communal support is provided in every way, with families housing other families whose homes have been destroyed by the shelling and for extended periods of time; resources, although very scarce, are shared in unprecedented ways.

In spite of very difficult conditions, this work is being completed through the support of so many people. The authors would first like to thank Women's Affairs, Nablus, and its director, Sahar Khalifeh and its field workers for having made possible the study of women's lives and health in Nablus, in the late 1980's and early 1990's. Without their help, it would have been neither possible to enter Nablus' Old City nor to complete the work. But above all, we would like to thank Women's Affairs for continuing to operate in Nablus all these years, and to work incessantly today towards the fulfillment of the needs of women and in assisting them in absorbing impossible jolts brought about by the current political conditions in the country.

At Birzeit University, Hala Salem Atieh and Maisoon Filfil contributed to the laborious process of coding and collating the material. Happily, they are still with us today, focusing on unfolding the various aspects of women's lives through research and advocacy for women's rights. We

would like to thank them for withstanding and not only for working. Thanks are also due to Hania Sholkamy who kindly read and commented on the manuscript; to Jan Amin, who went through various stages with us, separated by years at a time, for editorial assistance, and to the staff of the Reproductive Health Working Group, especially Noha Gaballah, for not only having had the patience to assist in every way in the production of this manuscript, but also for having constantly reached out to us with emotional and moral support at a time when support was much needed.

Rita Giacaman and Muna Odeh
Ramallah, March 2002

Introduction

During the early period of Israeli military rule of the West Bank and Gaza Strip, mainstream national forces in the Occupied Territories argued that women's health could not be visualized separately from the health conditions of men. Identifying the political problem as a prime determinant of health conditions in the area, they tended to focus on the impact of occupation and army violence on health in general, omitting to take into consideration the disparities in health status among the population. These disparities are related to internally generated conflicts, and gender specific differentials in health status between men and women, and boys versus girls in particular.

Without belittling the importance of the political conditions and their negative impact on the health of both men and women, a growing body of data generated from field research during the 1980's and early 1990's began to indicate that gender relations have an important influence on health as well. The observed disparity between the sexes, especially among children, began to arouse the interest of the women's movement. This interest coincided with a growing consciousness of the social aspects related to the status of women, and the special burdens imposed on women by virtue of a particular division of labor between the sexes, and a specific social position within the overall power structure. This consciousness developed in the context of a growing social action movement precipitated by the conditions of occupation in general and the specific conditions of the first *Intifada* years in particular[1]. Within this framework, women's health began to assume importance as one of the main issues on the agenda of the women's movement.

The debate taking place within the women's movement, and between women and the health care sector, has gone a step further. With the gradual acceptance of the medical and political establishments, women's health has become a health policy and planning priority. This consent was granted not only because of the influence of the women's or the social action movement, but perhaps as importantly, because of the increasing focus of international donor agencies on the subject of women's health, with many pinpointing this area as a matter of funding priority, and focusing primarily on the provision of family planning services, instead of the broader range of services needed to adequately deal with women's physical and mental health.

However, as was the case with the primary health care debate of the early and middle 1980's[2], and with notable exceptions located in the women's and non-governmental organization movements, the Palestinian medical and political establishment absorbed the terminology of women's health, but not the substance. Their concept of women's health, although modified, linked into the orbit of the national ideology: struggle against Israel through the demographic factor, by having as many children as possible. Thus women's health and women's needs fell in the midst of two opposing ideologies: a pro-natalist ideology espoused by the nationalists, and an anti-natalist one driving the funding of international aid agencies[3].

These events generated yet another internal debate over what constitutes women's health, focusing on an attempt to influence future health policies and plans. Indeed, with peace negotiations taking place, and the structures of the Palestinian Authority taking shape, this task became urgent. While taking into consideration the importance of biological reproduction in women's lives, health and well-being, this trend is currently pushing towards a more extended view of women's health, one that is shaped not only by the fact of biological reproduction, but also by their role in society, in the economy and in politics, and by their increasing ability to participate actively in all aspects of Palestinian life[4]. In this sense, seeing women's health as more than just childbearing, understanding women's experiences of health and illness as a continuum, with episodes of ill health early in life affecting their childbearing ability and their social and health status later in life, and adequately providing services that can fulfill their needs in their totality, is likely also to have the effect of improving child survival and health as well[5].

This essay is based on a study conducted in the early 1990's by Women's Affairs [6] and the Institute of Community and Public Health, Birzeit University, in the Old City of Nablus. Our primary aim was to shed some light on health issues of importance to women who live in a poor urban area that was particularly affected by Israeli army violence. Our choice of working with this category of women naturally excluded the possibility of making generalizations, since our sample women live in particularly difficult conditions. Our task was not generalizeability of data. Rather, it was to begin unfolding key elements pertaining to women's health as they themselves perceived it, by focusing on a particular group: women who were not only poor but also burdened by military violence, instability, insecurity and generally stressful life events. The study was designed in such a way that the women's narratives would help us understand the ways in which they construct health and illness and how they view themselves and their roles in relation to such stress, as well as for the purpose of addressing, at a later date, health policy issues related to their views and needs.

A Framework for Analysis

The lives of women in the old City of Nablus are structured and constrained by a triple burden: the ongoing conflict and violence of military rule, poverty and financial insecurity, and gender relations. Although conflict, war and poverty have an impact on all of the civilian population, men and women are affected differently, by virtue of their domestic, economic, social and political roles; women in particular are affected by their limited power and ability to influence decision making and response to crises [7].

For our purposes in this essay, we define health and illness as Morsy did, in terms of structures of power, where gender is seen as the dependent variable, and where male-female power differentials emerge as outcomes of specific relations of production and associated super-structural apparatuses which promote their replication[8]. Social structures are in turn associated with women's gender roles and attitudes, which influence health related behavior and which in turn determine perceived and experienced health status. That is, health behaviors and attitudinal variables can be seen as the mediators between socio-economic class and health[9]. However, this political economy/structural approach, although

useful, does not allow for the needed space to explore the sometimes considerable variations in the power that women wield in similar structural circumstances, and during different periods in their lives. Utilizing the life cycle approach to understand women's health perceptions and needs, Lane[10] perceives of women's health and perceptions in the context of women's life cycles and daily life and work experience. Central to this theme is the notion of role expectations and responsibilities; and these affect health, health perceptions and access to health resources. Also central to her argument is the notion of women's changing responsibilities as they age, and consequently their ability to make decisions, access resources, and modify their definitions of health change as well.

Clearly, definitions of health are not constant over time, but are changed and modified in line with changing life events and experiences. When life experiences are stressful, as in the case of conflict, war and poverty, they can impart profound effects on health, especially the health of the most politically and economically vulnerable sectors of the population, particularly women and children under five years of age [11]. Stressful life events also influence health perceptions, where distress can lead to more negative health perceptions[12]. That is, we can identify for our purposes a war/health relationship identified elsewhere, with interactions between women's definitions of health, and war, their world views and social position.[13]

Furthermore, perceptions of health are culturally specific. A cultural approach to understanding health and health perceptions entails, at least in part, addressing experiences of illness within their broader socio-economic dynamic, where knowledge of the body, health and illness are seen as a cultural product undergoing constant negotiation[14]. Bourqia integrates this concept further by drawing on Foucault. In contrast to Morsy, who identifies power in terms of the state, class or other such structures of power, power here is not seen to be found in one central locus, but rather everywhere, notably in culture, in people's perceptions and their cultural practices[15], eventually affecting health and health perceptions, where women's images of health can be seen as a reflection of expectations on the women in society[16] . Although Bourqia and others are correct in pointing out that power is a relative matter and that certain elements of power could make a difference in women's perceptions and ability to cope, nevertheless the effects on consciousness and perceptions of generalized structures of power, such as the state, or, in the Palestinian context, military rule, cannot be ignored.

Guided by the responses obtained from women in this study, our approach lies between structure and action, both being conceived as important in understanding women's views of health and daily realities. It is a mixture of the two, taking into consideration the changing nature of dominant structures, social position and culture in ways that can allow or disallow women to act, to cope and to manage crises, and as a result, influencing her perceptions of health and well-being. While our approach acknowledges the influence of politics and class on health and health perceptions, it nevertheless accepts the notion of relative power, and the way in which this relative power, within the neighborhood, within the family, over the children and daughters-in-law, can have an impact. Women were interviewed at a point in their lives when experience of life imparts an important influence on health and perceptions of health. Further, our approach takes into consideration another element, attitude/internal

strength/ ability to cope, a psychological dimension to health and health perceptions, which is perhaps the result of the different influences and constraints on women's lives, but which appears to be one of the defining features of a healthy state. The case of *imm al-mutarad* - the mother of the fugitive- is a case in point, where her role, status and power within and outside the family, is defined by political considerations in relation to her role as **the mother** of the fugitive, and where **he** is her primary concern. Yet it is also defined by her attitude, internal strength and ability to cope with a particularly tense life situation; her perception of her health, as well as health in general, is integrally affected by this.

Thus the concept of health that we espouse here is based on the notion of an interplay between a biological predisposition, and social, cultural, political, economic and psychological factors; the outcome of a particular predisposition is determined by this interplay. Analysis of the women's narratives provides a picture in which health is defined by a multiplicity of factors and represents a continuum of experiences, the pushes and pulls of life. In the context of women's health, biological reproduction is seen as a key element with influence on health status especially of women of childbearing age, but not the sole one. Age, not only as a biological category, but also as a social construction defining status, role expectations, responsibilities, perceptions, expectations and ability to utilize existing resources, is also important. Cultural factors are also influential, as they so often determine health perceptions and the position at which ill health is acknowledged, demarcating the point of entry into the process of seeking health resources. A psychological dimension - ability to cope, internal strength, attitude - is very much part of this definition, since this can be an important element in the determination of the rate of development and eventual outcome of illness, but also a feature that can explain differences between people who otherwise live in similar conditions.

Methodology

The research began with months of anthropological investigation and profile building, working closely with 10 field workers living in the Old City themselves. The fact that over half of the field workers were from the Old City itself helped in more than one way. Indeed, the field workers were key to our ability to enter the Old City. In addition to the normal problems associated with entering communities, we were faced with the particular problems of *Intifada* dynamics in the Old City. The site is like a citadel, with two forces at war: the *shabab* (the young men) and the Israeli army . Foreign-looking people like us could not have entered the area without the local field workers.[17]

Drawing on the insights gained in the initial investigation phase, three types of questionnaire were developed. They were relevant to three categories of women representing three types of life experiences, and broadly, three categories of questions, reflecting three types of focal issues and concerns regarding health. Together these questionnaires aimed to elicit the main features of a woman's life cycle at the time of the study: unmarried women, ever-married women of childbearing age, and older women. It should be noted that despite the different views that these categories of women hold pertaining to their health and the health of others, certain concepts and lines of demarcation

unite women from each of the age categories. So we included questions related to all in each of the questionnaires to allow us to make comparisons.

After having gone through trying times attempting to define the borders of the Old City, we finally came up with a geographic region of 12 *haras* (neighborhoods), occupied by about 1,500 households. Of those, we found 213 abandoned houses, leaving about 1,200 houses occupied by about 10,000 persons. We then took a third/stratified (every third house, stratified by hara), random sample of women living in each of the *haras* proportionately to the total population of each *hara*. This sample was subdivided into a ratio of 4:2:1 married, unmarried, and older women. Thus the number of women studied was 207 unmarried, 416 ever-married of child bearing age and 102 older women, a total of 725, constituting approximately one third of the population of women over the age of 15 years in the Old City. In addition to the questionnaires, we succeeded in completing about 50 in-depth interviews with selected categories of women, as well as traditional healers, the field workers themselves who live in the Old City and selected informants.

Our analysis included the following steps:

1. We began with an analysis of the discourse of women pertaining to health and health perceptions that we obtained from the profiles we constructed utilizing interview materials.
2. We then completed a content analysis of the questionnaires, before coding; that is, we examined each and every questionnaire before coding and collated responses to specific questions so that we could build up profiles for the women, in addition to obtaining statistical aggregates for the defined groups of women.
3. Having understood the patterns of responses in light of the profiles and the individuals' responses to questions, themes were identified. We then coded the statistical information in line with this understanding in order to shed further light on the issue of health perceptions. Because the range of responses was so wide, we had to code responses utilizing simple and biomedical categories - such as acute versus chronic illnesses - in order to yield meaningful statistical data, but by doing this obfuscating the richness of these women's responses. We hope to have partially made up for this by including quotations from the women, whenever possible.

A Flavor of the Setting and the People

The Old City of Nablus takes up most of the valley between the two mountains on which Nablus is built. The gates of the City lead to relatively narrow alleyways lined with shops and houses. The entrances to the houses are easily missed, especially during the bustling commercial hours when the City is crowded with shoppers and merchants, mainly from the region's villages and refugee camps. The Old City is divided broadly into two quarters: the Eastern Quarter *(al-Mantaqa al-Sharqiya)*, which is occupied mostly by villagers and urban migrants, coming in primarily from villages and refugee camps near Nablus, but also from the different parts of the West Bank; and the Western Quarter, (*al-Mantaqa al-Gharbiya*) including al-Yasmineh, financially and politically the biggest and most influential *hara* in the Old City.

Although it is impossible to define the borders of the Old City exactly, it is estimated that it is occupied by some 10,000 people living in 12 *haras*. There are no clear demarcations between the different *haras* within the same quarter: somehow one naturally leads to the other. A *hara* is really a social entity: everyone knows whether someone comes from this *hara* or that, as the *hara* is very much part of individual local identity. Other than the *hara*, the next identifying feature is being from the Old City, where anywhere beyond that appears to be simply 'the world out there' for most of the inhabitants. Within this context, anything that happens in a *hara* is known immediately by everyone. There is a strong grapevine information exchange process taking place as a matter of routine, and as a matter of security against army invasions.

Each *hara* is made up of several *hoshs* as well as of houses overlooking the street directly. A *hosh* is a compound with one entrance leading from the *hara*, joining several buildings and homes into one courtyard and animal shelters - *bawayek*. The *hosh* is the extension of the *hara*, physically and socially as well: this is where the children play and where the families socialize. The *hosh* is signaled by a *qaus* (arch or vault) and a dark entry point.

Once in the *hosh*, you enter into the *saha* (courtyard). This is a confined area specifically for the use of the families living in the *hosh*. The children play in the *saha*, an area that has gradually become the only safe place for children to play in; the outside street came to be seen as dangerous and exposed to military violence. With the long curfews imposed by the Israeli military, sometimes extending for several weeks, and the subsequent inability of the children to go to school, the physical space available to them and their families would literally become confined to the *sahas*.

The *saha* leads to the different homes. Usually, there are several families living in the area of one *hosh*, each with a separate entrance. The *hosh* space or the *saha* is used for social activity, especially by women. After work is finished in the home or outside, women tend to meet at their entrances, which are close together, to talk and gossip. The feeling is that of close community spirit and is expressed by the inhabitants in a proverb referring to *ghalaq wahad or bab wahad* (one community one door). The community spirit is so strong there, that families are often found sharing food and lending food or money to each other. As women say: *Al wahdeh bi-tifrij la al-tanieh* (one relieves the difficulties and the pressures of the other). Since the beginning of the *Intifada* such sharing, especially of food, has increasingly become a necessity with curfews and strikes becoming so much part of daily life and resistance. Indeed, the Old City of Nablus has become famous for its invincibility to *Intifada* conditions partially due to this community spirit that characterizes its inhabitants.

Houses usually have at least one window that overlooks the *hara*. This is how most women monitor the comings and goings of people and their family members during the day. This is also how they communicate the coming of the army to raid the *hosh* looking for the *shabab*, a task that the women seemed to have taken over with intensity during the *Intifada*. Generally the homes are quite humid, mainly because of inadequate sunshine, and because they were built many years ago, 100 years ago or maybe much more than that. With time, families have added new rooms to existing structures here and there, only adding to the

problem of bad ventilation, where the new structures have blocked the sun's rays from penetrating the old ones, sometimes even creating rather odd living arrangements. In one particular case, we had to go through the sitting room of one family in order to reach the home of another: that was the only way in!

Once you are on the roof and you look at the Old City you virtually see one roof: all the houses are linked to each other at the top. This makes privacy virtually impossible; sounds, discussions, arguments and fights can all be heard by the neighbors. As a result a special moral code has developed in the Old City where neighbors cover up each other's problems. Yet closeness is a double-edged sword, for this physical closeness is on the one hand intrusive, and on the other has led to an amazing degree of social closeness, community cohesion and sharing, especially during trying times.

Unfortunately, the army has caught on to the advantage of linked roofing, creating a constant state of anxiety for the inhabitants: they use the roofs to follow the *shabab* from one place to the other quickly, and often jump into the living rooms and bedrooms of people in the middle of the night. This kind of atmosphere creates the perfect setting for constant anxiety, as anyone and everyone is subject to this treatment by the army in pursuit of the *shabab*. As you walk around the Old City you can clearly identify army posts[18] everywhere, not only in the street, but also on the roofs where the visibility is better. So you are neither spared this surveillance when you are walking in the street, nor are you spared when you are in your home, trying to relax, or even when sleeping. The women's narratives in this study often referred to the threatening and unpredictable violations of privacy by the army, using the rooftops at all hours, as a source of anxiety and stress that directly affected their state of well-being and health.

The Old City is a political moving force in the area. It is famous for its resistance activity, and the great courage and sacrifice of its inhabitants. The army is everywhere, and so are the *shabab*. It is a situation of ongoing tensions between the population and the occupier. This state of generalized political emergency expressed itself in many ways, affecting economic and social activities, and even protocol and semantics: after being offered coffee to drink, people now say: *Bi hadat albal*, (here's to tranquility of the spirit*)* instead of the pre-*Intifada dayman* (may your condition/prosperity prevail*).*

Throughout the *Intifada* years high road blocks and barricades were erected by the army at the main entrances of the Old City, as well as inside it, in order to seal off access from one *hara* to another. They were designed to prevent the *shabab* from escaping into the alleyways during a confrontation with the army. But they also reduced the traffic and limited accessibility to homes: it was especially striking to have many reports from women complaining that these blockades made it impossible for ambulances to reach close enough to homes to pick up critically ill or injured people.

As part of the collective punishment measures imposed by the Israeli army, the road blocks and barricades totaled 14 at the time of the study. There existed a variety of types and shapes, sizes and heights of such barricades, from boulder blockades, habitually 3-4 meters high, to cement walls, to barrels filled with cement up to 4 meters high, blocking a whole

entrance in and out of the City and finally, prison-like iron barred gates and in some cases, a combination of one or more of such blockades.

Women's roles outside the household were positively enhanced especially at the beginning of the *Intifada*. Their social and political role became more pronounced as they increased their activities, becoming the core of the neighborhood committee community support system, in protecting the *shabab* with their lives, in throwing stones at the army, in distributing leaflets and in straightforward and nerve-racking confrontations with the army. This activism, in the case of married women with children, became more pronounced regarding the protection of their own, as well as other children - they all became 'my' children, in the popular language of resistance - children's imprisonment, martyrdom, and, perhaps worst of all, fugitiveness. Here, youths can run as fugitives for years, living in different places in the Old City and moving regularly, perhaps daily, so as not to be arrested by the army[19].

Quite clearly, the political setting has had a dramatic impact on the consciousness of women. It certainly appeared to give them unbelievable strength, reinforced by the support mothers get from the *shabab*, their sons' friends. They come to visit the mother, not the father. The relation between them is quite strong and loving: in essence they treat her like their mother. Yet women's roles and involvement in the national struggle also witnessed modifications early in the *Intifada*, reaching beyond the domestic or private sphere and gradually extending to the public sphere, the women in this case becoming a more visible and vocalized force.

Women's Perception of Health

Unmarried Women

The 207 unmarried women's ages ranged from 15 to 49 years. Of those, 65% were in the 15-19 age group, 15% between 20 and 24 and 20% 25 years or over, a rate of spinsterhood that strikes one as high. The average age was 20.5 years. On the whole, these women were reasonably well educated, given the generally low socio-economic status of their families. Their mean educational level was 8.7 years for those over 18 years of age, and 8.9 years for all the women, including those still in school. Only 3% had not had any education at all, 17% had had 1-6 years of schooling, 71% 7-12 years and 9% 13 or over.

What seemed to define the status and ability of these unmarried women to cope with life, even to answer our questions openly and exhibit self-confidence, was a mixture of age and educational status. In general terms, girls of school age who were still in school, tended to be open and answer questions more daringly. Although open, they tended to feel pressurized by family, especially fathers and brothers, and restriction to the home, since they knew and understood the value of the world out there. The engaged girl, even if in school, was even more frank than the others, as the *katb al-kitab* (engagement) allows her a new social status and gives her relatively more freedom, and what seems to be a social sanction, to speak up. The third category of 'girl' is the older - over 25 - for, even if she is in her forties she is still called a girl to denote virgin status. She tends to be caught within the

confines of the domestic sphere, often being used to serve family members, with parents planning for her to serve them as they grow older.

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Perceptions of Health

We found an unexpectedly high rate of reported conditions and symptoms for this age group and social status category which is not expected to be predisposed to disease or to have many health complaints. These complaints, however, appeared to be mostly mild in nature. What is especially curious is the higher than expected rate of reporting burning sensations at urination (26% reporting having these symptoms frequently or sometimes) and the vagina (23% with frequent or sometimes reports). Reports on period pains were also high, with 54% of the women denoting frequent strong period pains and 30% only sometimes. These reports may be partially explained in terms of an excessive pre-occupation of younger unmarried women with the regularity of their periods and the nuisance of their symptoms. They may also be seen as a measure of future social achievement through marriage and improved options in life that the field workers noted (complaints as evidence of future reproductive possibilities). On the other hand, given the physical and financial constraints imposed on younger unmarried women against seeking medical advice, and the fact that women in this category can become ill and require attention, but are not allowed to do so by the taboo associated with seeking reproductive health care in the unmarried state, these reports could indicate an unfulfilled medical and health care need.

Examining burning symptoms by age we found that 23% of those 15-19 years old reported such symptoms, compared to 31% among those 20 or over; and although the relationship of these reports to the reports pertaining to overall health were not found to be statistically significant, the pattern does indicate that those who rate their health as good suffer fewer such symptoms than those who defined health as moderate or bad. These results suggest that these problems may be physical/biological and not only a manifestation of psychological stress, and may in fact require medical attention.

We also found a relatively high rate of reported pain symptoms with a range of 25% reporting frequent and moderately frequent episodes of stomach pain, and a high of 75% for headaches, 50% for back pain, and 43% for muscle pains. Interestingly, when we examined reports of pain in relation to whether these girls had been subjected to beating (by male family members or by the occupying army), girls who reported being beaten also reported a higher percentage of symptoms of pain, with, for instance, 63% of those who reported themselves as experiencing beating reporting also episodes of back pain, compared to 37% among those who did not report any beating; similarly 53% of those reporting beating also reported episodes of muscle pains compared to 33% among those who did report that they had been beaten. Likewise, women who reported higher levels of pain and other symptoms, such as burning on urinating or in the vagina, and who assessed their health more poorly tended to come from poorer backgrounds, with worker or unemployed fathers or househeads, compared to lower levels among those whose fathers were professionals or white collar workers.

We found no relationship between reports of pain and reports of psychological distress, such as anxiety, lack of sleep and inability to concentrate. However, in their narratives, these young women associated body pain with fear, anxiety and a generally unstable lifestyle:

> *'... I feel like an old woman physically, with pains all over, and always tired because of pressures, political mostly, but also psychological.'*

In some cases, regular direct exposure to military violence was used as an explanation of health problems. Of the total number of women 30% reported no anxiety problems and 70% related their anxious states to fear of the army and war conditions; 50% reported an inability to concentrate, with all explaining this problem in terms of either military violence or fear about the future; 30% reported no psychological problems, and another 30% reported serious ones, again pertaining to military violence and fear about the future. A combination of school closures, general strikes, a high level of violence in the street, and a lack of ability to visualize the future seemed to grip the consciousness of these women. In the particular case of a 15 year-old girl, the fact of having a fugitive brother resulted in frequent night raids by the army and the beating up of family members, including herself. Explaining the reason for her irregular menses she said:

> *'Because I fear the army and each time they beat me, my period comes earlier and accompanied by a strong flow.'*

Thus these women would talk about pains in different parts of their bodies in terms of a consequence of the fear which surrounds them, insecurity, the army, curfews, tear gas, beating, clubbing, imprisonment of relatives, demolition and sealing of houses and generalized street violence and the experience of the death of loved ones.

The lives and destiny of these young, unmarried women was directly affected by the stressful life conditions of the family experienced during the *Intifada*. In the following example, the young woman's two brothers were in prison, sentenced for life, and the burden of family support was on her shoulders since her father was dead. She had been stripped of her youth, was taken out of school to take care of the house while her mother was working and following up lawyers to get her children released from jail. She concluded by saying:

> *'I hate life, I wish to die because I live a life that is meaningless and full of pain and sorrow. Before the Intifada, I was the Mudallala (the spoilt one). They* (her family) *wanted me to have an education because they had none. But unfortunately the school is gone and the hope is gone. So. this is my health, because I have emotional and mental pain.'*

On the whole, the unmarried women tended to have a holistic view of their own health, explaining physical symptoms in terms of psychological, political and social causes. When we asked them who had good health, a high of 18% reported than no one had good health 'these days' (a reflection of the difficult life events of people living in the Old City), 9%

specifically said it was those who lived away from the army and confrontations who had good health, 25% said it was those that had no worries and had achieved happiness, 20% focused on the physical environment, such as good housing, sewerage, water etc, and 18% explained health in physical promotive terms such as those who ate healthy food and exercised regularly; the rest explained health in a combination of all the above mentioned factors.

Thus, these women tended to negate the presence of disease by virtue of age, since age represented a denial of the sick role defined for them by society and culture. Yet the influence of the biomedical model is evident, since women often maintained that there was nothing organically wrong with them and that their symptoms must be psychological in origin. What is interesting here is what appears to be a transitional phase in their consciousness, mixing indigenous holistic views of health with modern medicine. The responses of those explaining health in biomedical terms also tended to have a recipe-like nature: almost a recital of health tips commonly encountered in popular magazines and the media in general. This perhaps reflected their lack of first-hand experience with illness, whether as carers or as patients and was in contrast to other women who were married or who were older in age. This period, or stage of transition, is possibly reflected in these young women's attempts to reconcile prevailing traditional health explanatory models on the one hand, and on the other, views that are available to the general reader in the media and even in school textbooks, seen as modern and perhaps also more in resonance with the interviewers' supposed opinions and views.

The following examples demonstrate the multifaceted character of the definitions given to a healthy state and the recipe-like components common to many. This 11th grade student considered that being healthy means:

> *'That every morning to drink a glass of milk and to stay away from having tea first thing in the morning, because tea and coffee are bad for the health of humans, and in addition to practice sports.'*

Perhaps the best example of this type of definition that sought to incorporate 'idealized' notions of health was the one provided by this 24 year-old who was a college student:

> *'First cleanliness, second decreasing agitation, third choosing foods that contain vitamins, fourth sports, fifth to go to the outside world through making visits and sixth a good sleep.'*

A shocking 99% reported having been exposed to tear gas sometimes or a lot, one of the many effects of army violence and its policy of collective punishment. Of those, 87% reported that exposure to tear gas had had an impact on their health, describing symptoms in line with what is typically described by the population at large - respiratory, digestive, skin and eye problems.

With the tear gas question, we also had a chance to approach the usually sensitive question of physical abuse and beating, specifically domestic violence mixed with army violence. Of

the total a high of 54% reported having been beaten sometimes or a lot. Of those reporting being beaten, 62% said they had been beaten by the army and 32% by family members. A higher proportion of the women who reported being beaten were under the age of 20 years. They tended to be the daughters of workers or unemployed men, as opposed to householdheads with white collar or professional jobs. They were found to have higher levels of reported anxiety, with 59% of those beaten reporting anxious feeling, compared to 41% among those who were not beaten; they tended also to report higher levels of pain in their bodies, although reports related to their health status in general were similar.

Taking these facts into consideration, it is perhaps not surprising that many of the respondents would assert that "no one has good health", meaning that, given the then current political and socio-economic realities, a 'complete' healthy state is beyond the Old City population's reach. Such words were usually the opening statements of responses, with additional definitions later provided by the same respondent:

> '*No one is healthy, healthy people are psychologically in a good state and are free of worries. Freedom gives good health.*'

Other more complex health perceptions would use an inverse relation and conclude that the occupier, the one seen as causing ill health to the population, was the only one to enjoy good health:

> *'Shamir* has good health because he is like a monkey; when we see him on TV, we see that his health is good and that the way he walks shows that his health is good.' (**The prime minister of Israel at the time the study was conducted.)

An analogous understanding was also found among married women as in the following:

> *'In this situation, no one is healthy except for the occupiers, perhaps they are the only ones who are tranquil –hadi al-bal- and in good health.'*

and to conclude this understanding of health, we offer the words of a young woman:

> '*Good health is not being a Palestinian. To be a Palestinian is bad health*'.

Health was also seen by these women as the ability to manage and overcome stressful life conditions, pointing out that the individual could indeed play an active role facing and withstanding a harsh life:

> *'Our neighbor has good health, although her sons are in prison, yet she is living a normal and happy life.'*

This statement also invokes a specific attitude in defining an overall state of health. Despite physical and other difficulties, internal as opposed to external factors are seen as ultimately determining overall health status.

Health and illness were also defined in terms of the ability to be involved in social activities, for example, the ability to socialize inside as well as outside the home. This reflects the inter-relation between a transformed every-day life as a result of all the violence, and the frustrations that it brings about on the one hand, and the resulting impact on health, mainly on the psychological level.

To sum up:

* Pain seems to dominate the consciousness of these women, expressing overall tense, difficult, unstable and deprived life conditions, and manifesting these life conditions in concrete physical symptoms. Their explanation of their physical experience of pain moreover is also related to their general life conditions within the family, as women deprived of the right to make the most elementary decisions regarding their life, as well as outside the family, in the context of intensified political conflict.
* These women tended to define their health in terms of their generalized psychological state, precipitated by the political conditions, and combining this aspect with other physical elements, such as recent sickness (within the past two weeks), urinary tract infections and other reproductive organ problems, in addition to period irregularity. Because of their age, biology, and social status as young and unmarried women, they are generally not sanctioned by society to fall into the sick role in biological/ physical terms. However, age and inexperience allow for discussions of psychological problems, enabling these women to express themselves extensively in mental health terms. Anxiety, irregular sleep and concentration difficulties were among the indicators showing a high level of instability. According to the explanations of these women, an inability to cope and a feeling of hopelessness, in addition to material poverty, translated into disease. Thus they saw their health in a holistic framework in terms of their overall life conditions.
* Given this general viewpoint, differences in perceptions among these women were noted, influenced by financial status, and a mixture of education and age denoting present social status and future hopes in life. The poorer the women, the more self-reported illnesses, the more pain and the worse the view of their health. Those pulled out of school also tended to report more health problems and to view their health as worse than those who had graduated or those who were still in school. The latter appeared to suffer least, whether physical or psychological symptoms, since they were still in the process of building their future and had not begun to be hit by real life's lack of options and desperation. Those who had been pulled out of school reported the worst life conditions, and reported the worst health conditions, including incidents of beating by both family members and the army. In a nutshell, personal as well as generalized views of health do appear to be linked to the specific socio-economic and family context of the individual woman, despite the generalized neighborhood/national context, the fear, and the hopelessness that the Old City people live in, and that justify the relatively high reports of both physical and psychosocial symptoms.

Married Women

The ages of the 396 ever-married women of childbearing age included in this study ranged between 15 and 49 years, with 38% under the age of 29, 35% between 30-39 and 27% between 40-49 years. Of the total, 93% were married at the time of the survey, a low of 2% were divorced, 4% widowed, 1% with husbands in prison (it is usually the sons, not the husbands, that are most active in the *Intifada* and that end up in prison) and 0.3% *hardanat* - estranged and living temporarily in their biological family's house.

As one would expect, the relative educational status of these women was poorer than that of the younger generation, with 18% having had no education at all, (3% among the unmarried), 52% having had 0-6 years of schooling[20], (20% among the unmarried), 43% having had 7-12 years of schooling, (71% among the unmarried), and 5% having had post high school training in contrast to 9% among the unmarried. They generally came from poor backgrounds, with 50% denoting househead as a worker or farmer, 17% as unemployed, in prison, disabled or dead, and 28% as white collar or professional worker, generally from the lower or middle classes.

The large majority of these women did not work outside the home, although many assisted in earning income for the family through small tasks that they performed at or near home, such as sewing, knitting, embroidery and the processing of vegetables for sale in the Old City. Some were domestics or held other types of menial jobs such as cleaning the heads of animals to be eaten by what they visualize as rich people outside the Old City, cracking almonds, cleaning *mloukhieh* (a green leafy vegetable), coriander, parsley and other such food items which they could do at home. Work as domestics would not usually be divulged, since such occupations continue to be unacceptable and seen as reflecting badly on the head of the household, implying an inability to provide for the financial necessities of the family.

Perceptions of Health

As was the case with the unmarried women, the narratives of this category of women also contextualized their own health situation, as well as their more general views on health within the broader political and socio-economic realities that they were experiencing at the time of the study. Also similar to the unmarried women virtually all married women - 99.5% - reported having been exposed to tear gas sometimes or a lot, giving us a consistent gauge of the military violence that is so much a part of their stressful life experience. The harsh life resulting from the collective punishment measures and the generalized intense violence that characterized the Old City was seen by many as an 'injustice' imposed upon the civilian population who had been made to pay the price for actions that they had not committed. The uncommonly bold words of this 40 year-old who had ten children, and one son in prison, illustrate this point:

> *'There is no one that is healthy.(...) The Old City is basically full of wrongs. It has become a centre for the Israelis and for the shabab and the residents are the victims in all cases. This is – thulomm- a wrongdoing, and*

the way it should be is to distribute the activities and not to concentrate them over here for the sake of the children and the mothers. Ours is a life full of tensions.'

Note also how the same respondent summarized the way in which her constant worries and anxiety over the safety of her children had affected otherwise well-grounded, established and undisputed social values,

'A girl is better, especially these days- all my ailments are caused by my fear for my sons, we women have come to hate having sons.'

On the whole, as is the case with women in general in different cultures, their definition of health seemed to be linked to their present life cycle and primary role and responsibilities as child bearers and mothers as the next example demonstrates. This 50 year-old married woman said that she purposefully tried to avoid getting sick:

'because I am responsible for children and there's also my responsibility for my husband.'

As one would expect, married women report more conditions and more episodes of pain, including a higher rate of reported burning on urination, at 55%, and in the vagina, at 54%. They reported a feeling of anxiousness at a higher level of 78%, compared to unmarried women. They generally defined themselves as less healthy than the younger unmarried women, with 37% reporting good health, compared to 63% among the unmarried women, 53% reporting moderate health and 12% reporting bad health. While the question of whether these symptoms were in fact an indication of the presence of disease or not cannot be answered here, it remains true that these results reflect an increased preoccupation and awareness of these problems, perhaps reflecting the known increased incidence of gynecological and urinary tract infections found in general among married women.

There is no question that health is generally seen partially in terms of age: the younger the healthier. Here, their reports on their own general health status were indicative, with 47% of those 15-29 years old reporting good health, compared to 34% among those 30-39 years old and 25% among those 40-49 years old. As the women see it, with age, you accumulate the prerequisites for sickness: childbirth, and hard physical work that wears you down. This is gradually and eventually, as we shall see later, linked to the 'expected': old age brings sickness, and, of course, eventually death. But not only that, health is a cumulative concept, where the accumulation of worries, burdens of life, increasing age, and childbearing altogether end up precipitating disease, as described by this 46 year-old woman:

'Nobody has good health at my age. But I think that despite diabetes and hypertension I have good health since I am still very active - hirkeh.'

Yet, here was this woman in the end defining health in rather functional terms, as the ability to move around and manage daily life, despite diagnosed conditions and concrete

symptoms. However, age is not all there is to the formula. A central theme linking women's definitions of their own health is their reproductive role, pregnancy, childbearing, lactation and childrearing. The ability to have children, and to fulfill social roles and obligations, effectively safeguards the woman's status, as is seen in the case of this 29 year-old, married for fourteen years, with 5 children, who said:

> *'.. I like children and it is my desire to have another one so that I will have three girls and three boys, also so that my husband doesn't get a second wife because he likes el-khilfeh (children) - and also this is what Abu Ammar (the Palestinian President) has said.'*

These women were found to have an average number of children of 4.7, with 8% having no children at the time of the survey. The range, among those who did have children, was between one and twenty (one woman).

The social pressures related to having a larger number of children, specifically males, apparently had an added influence during the *Intifada*. In the already existing and nationally adopted slogan or rhetoric childbearing is seen as a 'weapon', a form of resistance against the Israeli occupation which is popularly regarded as having the aim of 'liquidating' the Palestinian people. Sometimes this has been magnified and in light of the intensity of the army violence during the *Intifada*, this is sometimes expressed in desperate attempts to counter it, again through bearing even more children, as in this extreme case. The respondent was 41 years old and had had 10 children, one martyred during the *Intifada*:

> *'I am sick because I had many children ... Yet my husband wants another son so he can bring back the name of our martyred son Imad.'*

In addition, there were many examples where women directly related ill health, or even the contraction of a disease, to the repercussions of the army violence, which escalated visibly during the *Intifada*. Health and illness in such contexts are not seen as 'fixed' states, rather they are amenable to external factors and stressful or traumatic events. It is thus that we see a direct link between martyrdom and imprisonment and the mother acquiring an illness, in some cases almost immediately, by witnessing or knowing of the event. One respondent, who was 45 years old and had high blood pressure, said that she became ill:

> *'Since the moment that my son was imprisoned and from so much crying and sadness.'*

The view that the *Intifada* had a direct effect on the lives and health situation of the interviewed women is further reinforced in the case of having male children. One of the married women's most prominent worries was expressed this way:

> *'Whoever has male children worries so much about their security they become unhealthy. I wish my fugitive son would get arrested, at least I would know something about him, where he is and how he is doing.'*

On the whole, their definitions of what constitutes health reinforce the notion of the link to generally stressful life conditions. When asked about who was considered healthy in their eyes, 20% reported that no one was healthy 'these days', 39% reported that it was those that faced no worries or fears, 24% said it was those who were free of disease and had a good diet, and 10% said that the healthy were those who were not poor.

We also noted a strong tendency to view a healthy state as vulnerable to envy - *hassad*-, making it difficult for most women to point to a particular person as healthy, and prompting us to raise the question in very general terms, asking what type of person they would think is healthy. It was through this exercise that health was revealed to us not just as a physical state or condition, as our initial questioning assumed, but rather as an asset to be cherished, and one that is delicate and vulnerable to the evil eye. Perhaps due to the fact that health was also defined to us as being divinely bestowed, its discussion and manifestation are also seen along the same lines, that is, divine in nature, yet subject to the effects of the evil eye. In order to cancel out the harmful effects of *hassad*, the women would eventually refer to or name someone as being healthy but first be sure to state - more to God than to us - that their intention was not to bring about *hassad*, or the evil eye.

Health as an asset susceptible to the evil eye is a complex notion and is not only reflected in the physical state of health in terms of the presence or absence of a disease, but also in the possession of highly socially valued attributes, such as fertility. This woman was 31 years old, and had had 10 children, two in prison and one a martyr:

> *'My leg is hurting me because some time ago a visitor came here to the house and said: look at this one who has borne many children. I woke up the following morning and couldn't move my leg. By God, she had given me the evil eye- hassadatni wallah.'*

It is important to note that this belief did not arise as often among the unmarried women. The narratives of the married women also reflected a complex notion of disease and health as being the domain of the divine, within which humans have the space to intervene. In the next example, we see illness as part of life and the steps taken to address it as a personal responsibility, almost the expected response to illness:

> *'Every person has to experience illness, it is thus a natural thing, and the human being is able to discern what is harmful to the health and this way should try to stay away from it.'*

Yet, there is a difference between actual ill health and complaining about bad health, which makes defining health very difficult in her view, and, understandably so. Health and illness were also related to the personal financial situation, in this case wealth as opposed to poverty:

> *'She is healthy because she has money and this makes her smile and feel confident.'*

Or,

'She is healthy because she lives in a good house with water and all outside the walls of the Old City.'

The respondents also provided modern-day explanations in which good health was seen as absence of disease, eating properly and taking exercise. The focus of the unmarried women was on active promotive health - good eating and exercise - much more than the absence of disease; married women stressed the absence of disease as an explanation of health, and good eating habits as measures of prevention, but with a generally more passive attitude:

'*Being healthy is avoiding eating fatty substances – alduhniat.'*

It was also noted that married women generally employed more elusive and thus more complex terms and notions on what being healthy was, compared to the unmarried women who tended to give straightforward answers, mostly reflecting how one can attain an idealized state of health.

We need to stress here that the majority of women defined a healthy state in more than one way, often mixing answers, including the internal and the external, the physical and the *hamm* (worry). One woman verbalized this, generally very holistic, view of health as follows:

'*Tranquility - hadat albal - social, psychological and financial define good health*'.

As we have mentioned, the statistical analysis of the data also consistently indicated that the older the women, the worse the perceptions of their health, with 47% of those 15-29 reporting good health, as opposed to 21% among those 40-49 years old. Older women reported more concrete symptoms, as one would expect, including anxiety and anxiety-related symptoms, in line with the relationship between age and the perception of their own health. Explanations of good health in terms of mental state, happiness and *hamm* seemed to increase with increasing age, as well as the association of health with poverty. The only exceptions to this pattern were explanations of health in terms of modern-day concepts where the pattern was not as clear and where those under 40 seemed to have absorbed modern concepts more so than those who were over 40. This may be due to the effect of the educational level of the women, at least to some extent, with 22% of the women with 0-6 years of schooling reporting absence of disease and a healthy diet as an explanation of good health, in contrast to 31% among those with 7-17 years of schooling. Overall, the implication is one where age is seen as representing life experience, as opposed to a biological category, defining roles, responsibilities, general life conditions and all that her social context entails.

Although initially strong relationships were noted between reports on self health and health in general on the one hand and the education of women on the other, controlling for age these relationships virtually disappeared, with minimal but very weak and conflicting patterns remaining. These results give one the impression that the facts of marriage, having children and living in the Old City homogenize perceptions among the women so much so

that education becomes almost irrelevant. While schooling history was of major importance in determining perceptions of health among the unmarried women - where education means future options in life and possibilities for improving one's lot - its importance obviously dwindles with marriage and the shift of roles when women's lives become more and more focused on coping with life, leading to consequent changes in their health perceptions. Once married, however, the pre-occupation was less directed towards the future and more inclined to focus on the present. It is as if this suggests that the effect and value of education is curtailed by the ability of married women to utilize their education to cope with life as wife and mother. When education is of no help, women tend to turn to other influences of life, where perception becomes shaped much more by a vivid life experience. Indeed, knowing the school system under Israeli military occupation, one can safely state that the approach to, and content of education, often fails to prepare women for dealing with life and ill health.

On the whole, although there was a discernable pattern indicating that poorer women tended to report less good health, more episodes of illness, more symptoms and generally to identify good health in terms of poverty and lack of worry as opposed to the absence of disease and promotive health, the patterns were rather weak, adding further weight to the argument that age, not the biological age, but as expressed in the sum total of life's present experience, was the primary determinant of perceptions of health and disease among these women.

To sum up:

* With a generally lower level of education than unmarried women, the married women were found consistently to report more episodes of ill health and symptoms, and to define their health in a less positive way. Their perceptions appeared to be more focused and directed towards the health and well-being of their families, especially their children, neglecting themselves and even at times defining their health in terms of the overall well-being of the family, in contrast to the more self-centered view that the unmarried women revealed.

* Married women appeared to encompass a much more diffuse and extended view of health than the unmarried women, less influenced by modern-day explanations, with a less actively promotive orientation and more an 'absence of disease and symptoms' view, perhaps reflecting their health and disease experience, which younger women, by virtue of biology and different roles, responsibilities and obligations at home, had not yet experienced. This view of health takes into consideration immediate family needs and constraints, such as poverty and making ends meet, family security, the political - especially as this relates to male children - and the overall environment in which the family lives.

Older Women

There were 102 older women in the sample, a large proportion, 52%, were widowed, 35% had living husbands, 6% were divorced, 5% had never married, and 2% were second wives. Their ages ranged from 50 to 94 years, with 38% 65 years of age or older, and 9% 80 years

of age or older, suggesting an unexpectedly high rate of longevity, considering their life situation. Of the total 56% had not had any education at all, 86% had had between 0-6 years of schooling and only 14% had reached levels between 7-11 years of schooling. Comparing these rates with those for the younger cohorts we can observe the dramatic increase in educational levels of women over the years. As to living arrangements we found 16% who lived completely alone - this category was living in the most difficult conditions. As many as 34% lived either alone or with just one other person, usually the husband, and 66% lived with the extended family.

It was revealing to find out that only 3% of these women considered life to be without major problems. Of the total, a high of 40% denoted loneliness, and/or the death of loved ones, as a major life problem affecting health, 15% blamed the *Intifada*, 14% denoted illness in the family as a major cause of women's problems and ill health, and finally, 23% denoted financial difficulties as a causative factor in making a good life and health difficult to achieve.

In discussion with the older women, three features appeared to define their life conditions: age, whether they lived alone or with their husband, and whether they had children or not. The first phase in the older woman's life cycle is at the younger age of 50 to around 65 years old (early old age). This type of woman tends to define health in psychological terms such as, *hamm* or *zaal* (worry or sadness), with 38% explaining health in terms of absence of disease and pain and good eating habits, and the rest in a mixture of terms combining age, disease, good eating habits with the mental health state as well as her or her family's financial conditions. Of the total in this age category, 32% blamed the *hamm*/*zaal* formula for their sickness, 38% the physical consequences of old age, and the rest a mixture of these or other terms. The other category of women is those who were 65 years or older. Here, we found an increasing awareness of the old age/physical status as a determinant of health, where, for instance, 49% reported physical weakness and diseases of old age as an explanation of their ill health and only 18% reported *hamm/zaal* as the cause if illness.

Between 50-65 years of age a woman is undergoing a transition. On the one hand she is no longer a childbearer, and has lost a central element of her social identity - biological reproduction. Yet, on the other hand, her children are older, and male children are now generally married, bringing a new woman into the extended household. If they live together, this new woman takes over the heavy burden of household chores. As the mother of a married son, the older woman does not have as much to do as she did previously. Yet, she is still strong, so she continues to participate actively in housework as well as in the rearing of her grandchildren. She becomes a center of power in the family, which she wields by virtue of her experience, knowledge and self-confidence, and undoubtedly, the presence of male children. She generally controls her daughter-in-law, especially during the first years of marriage. If she does not suffer from major chronic diseases, she may even deny sickness when it is there, as this may be seen as a sign of weakening. In fact, many in this age category become more active as health care providers than ever before. Their knowledge and experience allow them an expanded role. In addition to their role in the extended family, they often become traditional healers, semi- specializing in herbs, massage, and midwifery, especially if they are poor and in need of extra sources of income.

But they can only practice as assistants to healers and can never become full-fledged specialists, since specialists are considered people who have been granted this gift of healing from God. This gift is handed down from generation to generation within particular families only.

In contrast, a woman who lives without her children in a nuclear family setting, either with or without an elderly husband, and who has reached later old age when she begins to lose physical strength, suffer the problems of chronic diseases, and require care and attention, lives a very different life. Either having no children or with children living abroad, she is generally poor, lacks company, gets sick and receives no attention from anyone and may in fact live on charity. This group of women was pointed out to us as being particularly vulnerable and helpless during the frequent and prolonged curfews that characterized the *Intifada* years in the Old City. This vulnerability was related not only to access to food but access to medication as well. This was felt acutely, especially by those on daily medication who found themselves unable to get to a pharmacy, nor did they have access to a friend or neighbor to purchase these medications for them. This prototype older woman is physically frail and generally poor. Yet she must take care of herself and her husband in every way, including during sickness. Sometimes, neighbors help out and sometimes her children might send her money, but certainly she feels the lack of attention. This prototype woman was generally very, very lonely, as this woman expressed it:

> *'I have married daughters, but they do not visit me. They are too busy, and their husbands do not tolerate me if I visit. I wish there was a place for older women during the day or some activities for us. We are so lonely. Not an old people's home... but something, and some assistance, especially for buying medication.'*

On the other hand we also heard of cases of women who lived on their own but were supported by the generosity of their neighbors and by the strong social community ties. One aged 75, a widow living alone, had a heart problem and the neighbors gave support as did the generous people- *ahl al- kheir*- a concept highly valued in religion as *al sadaqa (charity)*:

> *'All my neighbors are good, they make me feel at ease. This is the complete happiness that maintains ones strength and 'afiyeh- (well-being), with that one is able to go and come and to socialize- yi'asher- (interact) with people, to talk, to them. Staying at home, not talking, not interacting with anyone does not make sense.'*

Perceptions of Health

The data analysis demonstrates a shift from acute to chronic diseases, relative to the younger women in the sample, as well as a sharp increase in the reports of pain, all consistent with the expected biological picture of old age. We found that 80% of the women reported being sick very often, in contrast to 47% among the married women and 17% among the younger generation. The explanations as to why they got sick were often

revealing, where the older women explained their sickness in terms of God's will in the form of old age, or fate:

'Sickness is what God brings. Nobody has good health at my age.'

We also noted a contrasting notion that old age is not only about vulnerability and exposure to illness, but rather has the advantage of accumulated experience and knowledge both in terms of self-treatment and in terms of prevention, as this woman said to us:

'*An old person is their own healer - al-kbeer tabeeb nafso.'*

Many older women felt illness could neither be avoided nor prevented, being a gift of God. But once a condition occurred, one had the duty to seek ways of resolving or alleviating it. Thus, age, mixed with fatalism, seemed to be a component of the understanding of sickness and health in this age category of women.

Another understanding, mixing spirituality with modern medicine that we found commonly among the older women, pertained to the causes of illness as given or bestowed by God, but with the doctor and medications as the means to deal with it. Another view we encountered was that illness was a part of life. When asked about avoiding illness, this woman answered:

'No I cannot, human beings cannot do away with illness- ma biyestaghni 'an el maradh.'

But the physical is also important; many women in this category explained why they got sick often in terms of the presence of debilitating or chronic conditions, but also in terms of having had many children, as this woman noted:

'I have al-qalb (a heart condition) and I have had many children'

So, as with the married women, many of the responses were mixed, including more than one element in the sickness formula. A large majority included *hamm* and *za'al*(worry and sadness), as part of their explanation of frequent sickness denoting that the psychological component continued to play an important role in determining disease states:

'al-za'al affects health a lot.'

While married women's *hamm* was focused on children, to the point of negating the self, the older women went back to the self-centered stage observed in the younger unmarried women, as this was now once again legitimized by family and society, and was expressed by her generally excessive and multiple utilization of both the indigenous and modern health services around her, whenever she could afford it. When asked about what kind of person would be considered healthy in her view, one woman responded as follows:

'*No one is happy, everyone has his worries. The sound body is in the sound mind*'.

Good health also reflects itself externally, and mirrors an internal tranquility, an internal strength. The healthy person is:

'*The person who looks happy (mna'nesh) and who has a fresh face (illi wijhoh mfateh.*)'

A 63 year-old woman who had married at 15 a husband who was 45 at the time and who died early leaving her alone to raise the children, and who had diabetes and hypertension said:

'I avoid sickness, my spirits are strong, so I conquer sickness and I take care of myself.'

But then she proceeded to say:

'Sickness is what God brings'

mixing an internal strength to cope with spiritual, external and fatalistic elements to define a healthy state.

Interestingly, the active preventive/ promotive concept of health begins to re-appear once again in older women, where health is seen as subject to envy -*hassad*- to a larger extent than in the younger generations; health promotion is linked not only to good eating habits, but also to attempts to turn away the evil eye:

'*I believe in hassad, so I read the Quran in the name of my grandchild.'*

Some responses pinpointed material/financial status as an important determinant of good health. However, in this case, the material was linked to a psychological component, together defining the concept - *al'iz* (esteem and prosperity). Health is also seen as a function of cumulative life experience, whether one had had a hard or a comfortable life:

'My husband who is 85, and 15 years older than I, has never taken any medicine, and makes sure to eat well; also he did not sweat - ti'eb (get tired) in his youth.'

Of interest also is a concept only relevant to older women, the ability to move around, and muster the energy to go out and see people (*mrouweh*). We also noted this emphasis on the ability to move around as part of explanations for health with the women of other age groups, especially with the younger ones who felt most the confinement aspect of life and the inability to socialize freely and safely. *Mrouweh*, on the other hand, is a term used almost exclusive by older women to define the increasing inability to move around and the decreasing energy levels that come with the aging process; it represents an important

element in the health/aging formula. Here, women tended to think that the ability to move around was a sign of health:

' Those who have mrouweh have good health.'

or

'Those who are strong and are able to go out to visit people are healthy.'

Thus, given a certain amount of ill health imposed by age which affects everyone in this category, movement and *mrouweh* were important in defining a healthy state.

The effects of age - a biological and social category - appear to have a homogenizing effect on perceptions in that, in general, differences in responses to questions pertaining to her own health generally became less pronounced within the over–50 group than in the married women category. Being over 50 - by definition - implies bad health for all, despite the residual strength that the younger category of older women have. The effects of this socially-defined role, the old and always sick woman, perhaps in combination with actual daily experience with illness at this age must be so strong as to make differences disappear. With advanced age also comes the feeling that one has lived one's life and that perhaps it is time to move aside and make way for those who are younger:

'Oh, my children are more important than me. For me it is finished, what is left in life is much less than what has already gone.'

To sum up:

* Older women exhibited an acute awareness of illness and health when compared to younger married and unmarried women: a significantly higher number reported themselves as being in moderate or bad health. In addition, their reports of episodes of illness, as well as symptoms, were also higher and consistent with their overall evaluation of their own health. A combination of biological/old age predisposition to disease, and heightened experience of disease in combination with the sick role being now sanctioned in a fully fledged fashion, are probably two key factors determining these responses.
* An increasing element of fatalism - health is what God brings - underlies their understanding of health and disease. However, this notion is mixed with an element of internal strength and health promotive behavior, allowing women to cope with old age, and to some extent determining the outcome of disease.
* The holistic view of health that the unmarried and married women exhibited continues to appear among older women, along with a heavy dose of *za'al*, as crucial components in the formula. Although health is an internal matter which no one can really gauge, a healthy state nevertheless has external manifestations, often expressed as *mrouweh* (the ability to move around) among the older women. This is defined by all sorts of factors, including the spiritual as well as *al-'izz*, a concept combining positive physical, material and psychological factors first encountered in childhood where basic health perceptions originate.
* Finally, the major concern in life that these women expressed revolved around loneliness and the death of loved ones. This was followed by financial problems, the

problems of the *Intifada*, and then health problems. Combined with the other findings pertaining to women over the age of 50 years, this suggests that in old age, illness is seen as part of the norm. It is internalized as part of the mechanism of acceptance and coping. Instead, the most pressing problem in that phase of their lives becomes death and loneliness.

Concluding Remarks

This essay has focused on Palestinian women's perceptions of health in the Old City of Nablus as reported during the first *Intifada* period beginning in 1988 and ending in the early 1990's. The basic demographic and socio-economic data and the women's narratives that were obtained in this study were conceptualized and expressed in terms of life stages, or life cycles that had been shaped and modified by exceptional political conditions, with important influences on the economic and cultural aspects of life in this basically poor urban area. Our interest was to understand how the women formulated and articulated health and illness and how they viewed themselves and their roles within that framework. The narratives of the women presented complex and multifaceted views of health and illness. Both role and status underwent changes during the *Intifada* in a paradoxical way. While the tasks of the women expanded and the centrality of the woman as a figure of national struggle was more pronounced, women bore a heavy burden in several respects. Managing the economy was negatively affected by the arrest, imprisonment, martyrdom or flight of the main breadwinners of the family. Managing the health of family members, especially of the young who were often in dire situations, was more arduous. They also had to withstand the incessant invasions of their homes by the army and had to pay the price of being beaten and humiliated. In a conservative setting, the *Intifada* played the role of compounding women's isolation and of further restricting their movement. Their lives were characterized by increased degrees of unpredictability and uncertainty concerning day-to-day affairs and future prospects.

The results of this study demonstrate that women's perceptions of their health, as well as their definition of health in general, is primarily related to their life experience at that particular moment. They appear to see health in holistic terms, combining the physical with the psychosocial. They also perceive health in terms of a continuum: there is no clear demarcation between health and disease, making the point at which women define themselves as ill, or not healthy, diffuse. Age, social status, financial status, political conditions and to some extent educational status, all form a part of the definition. Thus the concept of health carries with it a perception of health and disease that is not necessarily directly linked to the actual occurrence of disease, but seems to be more of a subjective definition related to the sum total of their current life experience. Although there are common elements, there is no one overall definition of health that the women shared, as life experience was so crucial in constructing this definition.

The transformations of daily life that took place as a result of *Intifada* conditions meant a literal alteration of the place of living; the physical environment in which these women lived. The women's narratives portray the Old City - their living space- as having been turned into a field of war and conflict involving the Israeli army and the *shabab*, constantly

in direct violent confrontations. In some cases, the women reflected the idea that the population was caught in between. There was an awkward sense of being in space, as one woman eloquently said:

> *'We are like a hanging laundry line, neither attaining the sky nor the ground.'*

The *Intifada*, then, altered the world of the Old City's inhabitants, both in concrete physical terms and, as a corollary to that, in psychological terms insofar as the population gradually lost control of their immediate environment and general life conditions. Yet, it was also possible to see the efforts sometimes made by the population to re-negotiate and to re-organize around this imposed reality, resorting primarily to the strong support network within the community. At other times, such efforts would simply be overwhelmed and a sense of frustration and uncertainty would prevail, accentuating the feeling of being singled out and of having borne the heaviest burden of the occupation. Thus women across all three categories being acutely aware of this, would equate a healthy state to life or living outside the Old City. In broad terms, it was possible to couple the women's narratives regarding health perceptions with the political conditions that prevailed during the *Intifada* and subsequently to identify an interplay between two major aspects. In the first place, the specific architectural structure of the Old City made it vulnerable to certain environmental hazards. The crowding of the spaces and the closely built houses, humid and in need of repair, meant that the waged war of house demolition had a particularly pernicious impact. Not only would the structure of the adjoining houses be affected but the impact was prolonged by the un-removed debris turning into rat and pest infested sites. In less tense times, the debris would be removed by the municipality workers and taken outside the Old City. The enclosed physical nature of the Old City was a disadvantage, for the lack of empty spaces meant fewer options for proper garbage disposal. Finally, the economic impoverishment of the population related to the *Intifada* conditions, such as the weakened ability to trade with prime clients coming from outside the Old City as well as being denied exit to workplaces beyond, effectively undermined the possibility of properly tackling their transformed environment and physical setting.

At another level, the enclosed architectural nature of the Old City made it vulnerable to tight physical control by the Israeli army; it easily became a "big prison", as often described by the interviewed women. With the erection of the famous 14 barriers and blockades, the sense of imprisonment was particularly enhanced. In addition, the surveillance posts coupled with the twice-daily foot patrols further compounded a generalized feeling of policing and terror. Indeed, the fieldwork teams were particularly cautious of displaying any research activity: once on the street questionnaires would be securely tucked away and surveillance posts would be deliberately avoided. Eventually, the "big prison" would close in on the population, reducing both the private and the public physical space available to them. Meanwhile, the population responded by engaging in the manipulation and negotiation of their transformed physical environment and political reality, albeit to a limited extent. This is the case of the mud or cement covered bells, the broken light bulbs at the *hosh* entrances and the iron gates replacing older more vulnerable ones as well as the breaking up of parts of the boulder blockades to allow access.

Similarly, the imposed confinement policy brought about behavioral changes and the adaptation of customs and habits. We frequently heard the interviewed women likening health and illness to the inability to come and go, to visit friends and family or simply to socialize. It was clear that the conservative norms that dominate the lives of Palestinian women in general were further accentuated by the prevailing sense of imminent danger and emergency. Yet the relationship between the political conditions and the increased restrictions imposed on the lives of the women is not simply one of cause and effect. The complexity of the interplay between the social and the political can only be detected when one views the broader picture, as opposed to examining the cases individually as is manifest in the following examples. Reflecting the proliferation of arrested, martyred and fugitive youths during the *Intifada*, the women would frequently say that every family had either a son, a relative, a neighbor or a friend in one or another of these categories. This state had turned into a 'shared identity' among the population and had visible repercussions on the lives of the women in particular. The mother of an imprisoned son found herself almost solely responsible for following up with lawyers and making visits to the prison. Meanwhile, the family's eldest teenage daughter would be withdrawn from school in order to help in the household chores and to take on the care of her siblings during the mother's frequent absences. With time the schools that had been closed for months by the army or had simply become inaccessible during the prolonged curfews, began to appear meaningless in view of the incessant interruptions. Thus, these young women who had been withdrawn from school by the family and whose lives had become virtually confined to household chores and to tending to their younger siblings (who also would not be able to get to school during the curfews and the closures), expressed most anxiety and uncertainty concerning their future life expectations. Their perceptions of health were couched in terms exactly opposite to their own current states, i.e. an ability to come and go, to have more time for leisure and to socialize. While male students shared similar interruptions to their schooling, they were unlikely to have encountered similar degrees of confinement or, if confined, to have been limited to household chores and responsibilities.

It is difficult for us to determine in what sense the transformation in the physical environment and in life conditions in general specifically affected or shaped the women's perceptions of health and illness. Nevertheless, it is possible to trace a direct line between the two, both at the collective and the individual levels. What can be seen is an incorporation of the dire political reality into the traditional beliefs and values concerning health and illness. Many respondents, when asked to define a healthy state, did so in relation to the *Intifada*, …invariably starting with, "nowadays", "in other times" or "no one is healthy these days".

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Endnotes

[1] See, for instance, Nasar, J. and Heacock, R., **Intifada, Palestine at the Crossroads**, Praeger Press, New York 1990.

[2] With primary health care, the impact of the alternative health movement's lobbying in conjunction with aid agency 'pressure' led the establishment to declare that primary health care was a policy/planning priority issue. However, the substance of health care provision remained until very recently the same: curative medicine but in the countryside. As one of the main representatives of the classical health establishment noted as he was talking about primary health care as a priority issue for his establishment : ' we will place an x-ray machine in every village clinic'.

[3] Giacaman, R., **Population and Fertility, Palestinian Women, A Status Report**, No. 2, Women's Studies Program, Birzeit University, 1997.

[4] For an account of how changes in the roles women play and the patterns of domestic production affect women's reproductive behavior and the consequences of these changes for the health of women and other members of the family see Browner, C.H., Women, Household and Health in Latin America, **Social Science and Medicine**, Vol. 28 No.5, 1989, pp.461-473. On the impact of the primary roles women play as workers, wives and mothers on their health see, for instance, Thomas, S.P., Distressing Aspects of Women's Roles, Vicarious Stress, and Health Consequences**, Issues in Mental Health Nursing**, Vol.18, No.6, pp. 539-57, 1997, and Kabira, W.M., et al, The Effect of Women's Role on Health: the Paradox, **International Journal of Gynaecology and Obstetrics**, Volume 58, No. 1, pp. 23-34, 1997.

[5] For an interesting discussion of women's health in relation to child health and service provision see Winikoff, B., Women's Health: An Alternative Perspective for Choosing Interventions, **Studies in Family Planning**, Vol 19, No.4, July/August, 1988, pp.197-213. See also McCloskey, L. et al, A Community-Wide Infant Mortality Review: Findings and Implications, **Public Health Reports**, Volume 114, No. 2, pp.165-77, 1999.

[6] A Palestinian women's non-governmental organization operating in the north of the West Bank and focusing on highlighting the gender perspective in research, training and advocacy work.

[7] For an interesting criticism of the limited attention paid to gender when providing for resources and services to populations living in political conflict see Palmer, C.A. and Zwi, A.B., Women, Health and Humanitarian Aid in Conflict**, Disasters**, Volume 22, No. 3, pp.236-49, 1998.

[8] Morsy, S.A., **Gender, Power, and Illness in an Egyptian Village**, Doctoral Dissertation, Michigan State University, Ann Arbor, Michigan, University Microfilms, 1978.

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[10] Lane, S.D., Roles, Work, Health Perceptions and Health Resources of Women: A Study of an Egyptian Delta Hammlet, **Social Science and Medicine**, 33(10), 1991, pp.1197-1208

[11] See, for instance, Garfield, R., The Impact of Economic Embargoes on the Health of Women and Children, **Journal of the American medical women's Association**, Volume 52, No. 4, pp.181-4,1997.

[12] Farmer, M.M., and Ferraro, K.F., Distress and Perceived Health: Mechanisms of Health Decline, **Journal of Health and Social Behavior**, Volume 38, No. 3, 298-311, 1997.

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[13] Schwalm, D.U., The Influence of War on Health Concepts of Muslim Shia Mothers Living in the Southern Suburbs of Beirut**, Curare**, Volume 20, No. 2, pp.323-330, 1997.

[14] Lock, M. and Scheper-Hugues, N. **A Critical Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent**, pp. 47-72, in Johnson, T.M., and Sargent, C.F., **Medical Anthropology, Contemporary Theory and Method**, Praeguer Press, New York, 1990, quoted in a research proposal on health and healing practices in rural Morocco, and submitted to the Population Council by Rahma Bourqia in 1993.

[15] Bourqia, R., op.cit. pp.3-4.

[16] Winkvist, A., and Khtar, H.Z., Images of Health and Health Care Options Among Low Income Women in Punjab, Pakistan, **Social Science and Medicine**, Volume 45, No. 10, 1483-91, 1997.

[17] On our first visit, as we entered through one of the areas, we saw the *shabab* looking at us strangely, then rushing towards a woman passer by, whispering something in her ear. She then headed towards us. The field worker immediately went to her, they both whispered. She went back to the group of *shabab*, again delivered the message - presumably in our defence- and they then all left us to our task.

[18] Some observation posts occupied strategically located houses in the Old City whose owners were forced out and the building taken over with free use of the amenities- electricity and water- and with bills left to be paid by the owner.

[19] On one occasion, we barely started interviewing a woman when we suddenly heard noises coming from outside, followed by a notable stillness and upon looking through the window we saw that the street below was completely deserted. The woman, almost instinctively, stood up and went to another room without saying a word to us. Nuha, a field worker and resident of the city, explained that fugitive masked *shabab* had blocked the streets, not allowing anyone to pass, while keeping surveillance to protect the son's visit to his mother and family in the very home where we were sitting. Within minutes, an unmasked youth, the fugitive son of the woman, entered the house and meanwhile his mother quickly appeared back, he stood there looking at us while his mother was whispering to him explaining our presence. He didn't speak to us, and at one point, we thought that we should get up and leave so as not to disturb his visit, especially that he was unmasked. When we told Nuha that, she quickly held us back to stop us from moving, and said that we were to stay put; our departure would raise suspicion that we were informants to the Israeli army. So we sat there and saw the mother meet and kiss her son, offer him a banana, peel it for him and watch him eating it. It was a highly touching scene. She then hurried to get a previously packed bundle of clean clothes and underwear for him. He left as quickly as he came, as it all happened in the space of no more than ten minutes. The interview went on, the woman all smiling and triumphant, telling of stories of the frequent early dawn raids of the army, sometimes breaking the door and forcing their entry and others making a theatre show asking to be let in, pretending to be friends of the fugitive son. The mother knowing all too well these tricks, would shout out for help from the neighbors, saying that thieves were at her door, invariably succeeding to chase the impostors away.

[20] Note that those with no schooling at all were lumped with those who have up to 6 years of schooling. This is because various researchers and activists in the area of adult education have noted that up to 6 years of schooling merely generates functionally illiterate people.

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