AL-Raida

Lebanese American University

Al-Raida Volume XVI, No. 85 Spring 1999 *The Pioneer* الرائدة

1999: International Year for Older Persons

Special Issue on Elderly Women

ABOUT IWSAW

The Institute for Women's Studies in the Arab World (IWSAW) was established in 1973 at the Lebanese American University (formerly Beirut University College). Initial funding for the Institute was provided by the Ford Foundation.

OBJECTIVES: The Institute strives to serve as a data bank and resource center to advance a better understanding of issues pertaining to Arab women and children; to promote communication among individuals, groups and institutions throughout the world concerned with Arab women; to improve the quality of life of Arab women and children through educational and development projects; and to enhance the educational and outreach efforts of the Lebanese American University.

PROJECTS: IWSAW activities include academic research on women, local, regional and international conferences; seminars, lectures, and educational projects which improve the lives of women and children from all sectors of Lebanese society. The Institute houses the Women's Documentation Center in the Stoltzfus Library at LAU. The Center holds books and periodicals. The Institute also publishes a variety of books and monographs on the status, development and conditions of Arab women, in addition to *Al-Raida*. Twelve children's books with illustrations, and two guides, one of which specifies how to set up children's libraries, and the other which contains information about producing children's books, have also been published by IWSAW. In addition, the Institute has also created income generating projects which provide employment training and assistance to women from war-stricken families in Lebanon. The Institute has also devised a "Basic Living Skills Project" which provides a non-formal, integrated educational program for illetrate and semi-literate women involved in development projects. Additional IWSAW projects include: The Rehabilitation Program for Children's Mental Health; Teaching for Peace; and the Portable Library Project. The latter project was awarded the Asahi Reading Promotion Award in 1994. For more information about these or any other projects, write to the Institute at the address provided below.

ABOUT AL-RAIDA

Al-Raida is published quarterly by the Institute for Women's Studies in the Arab World (IWSAW) of the Lebanese American University (LAU), formerly Beirut University College, P.O. Box 13-5053/59, Beirut, Lebanon; Telephone: (01) 867-618, ext. 288; Fax: (01) 791-645. The American address of LAU is 475 Riverside Drive, Room 1846, New York, NY 10115, U.S.A.; Telephone: (212) 870-2592; Fax: (212) 870-2762. e-mail: al-raida@beirut.lau.edu.lb

PURPOSE AND CONTENT: *Al-Raida's* mission is to enhance networking between Arab women and women all over the world; to promote objective research on the conditions of women in the Arab world, especially conditions related to social change and development; and to report on the activities of the IWSAW and the Lebanese American University. Each issue of *Al-Raida* features a File which focuses on a particular theme, in addition to articles, conference reports, interviews, book reviews and art news.

SUBMISSION OF ARTICLES: We seek contributions from those engaged in research, analysis and study of women in the Arab world. Contributions should not exceed ten double-spaced typed pages. Please send a hard copy and a diskette. We reserve the right to edit in accordance with our space limitations and editorial guidelines. Submissions will not be published if they have been previously published elsewhere.

SUBSCRIPTION

THE ANNUAL SUBSCRIPTION FEE FOR *AL-RAIDA* IS US $ 30. SUBSCRIPTIONS BEGIN IN JANUARY AND END IN DECEMBER.

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A Country for all Ages

"That is no country for old men" [and women]

"An aged man [and woman] is but a paltry thing,
A tattered coat upon a stick..." From William Butler Yeats's "Sailing to Byzantium".

Before the war, Lebanon was friendly and accommodating towards the old. As far as I remember there was charm and a peaceful contentment on the faces of old men and women in many families including my own. They were accorded a central and unique place within their households that bustled with life and energy. Continuity and group solidarity and cohesion were the main attributes of a family. There was ample space and a great deal of respect, affection, love and protection for the senior members. It was the natural thing to do, and our grandparents felt strong and secure amongst their children and grandchildren. In addition to residing with their children, the elderly women, in particular, maintained strong relations with community members and friends and continued to enjoy close and enriching emotional attachments within their families. They acted as caretakers to their grandchildren and continued to manage the household and maintain a sense of achievement, independence, as well as a constructive attitude to the world around them.

Our culture ensures respect for the elderly and values highly the natural bonds of affection between all members of the family. In our society, the eldest members are a source of spiritual blessing as well as models of piety, religious faith, wisdom and love. Accordingly, the family as a group and as a close-knit entity assumes responsibility for their welfare and survival by helping them with daily chores, and giving them financial assistance and emotional support. In his book entitled *The Arab World: Society, Culture and State,* Halim Barakat asserts that in Arab societies, "children change from being

Picture Credit: Delphine Garde

'iyal (dependent) to *sanad* (supporters) once their parents reach old age. This explains why parents in some parts of the Arab world may refer to a child as *sanadi* (my support)."[1] In fact, the majority of old people in Lebanon (213,284 aged 65 and above in 1996)[2] remain with their families and only a minority live in homes and organizations, showing that the familial situation and the closely knit household structure linger.[3]

While such customs and traditions persist today predominantly in rural areas, it is proving impossible for many people and groups to preserve their culture in the face of inimical forces over which they have no control. One important factor is migration that has contributed to the break up of the extended family network. After the outbreak of the civil war in 1975, and the sectarian violence that ensued making it impossible to lead a normal and safe existence in Lebanon, particularly in Beirut, many individuals and groups were left with no option but to pack up and leave. The pressing problem of sheer survival and the difficulty of securing and maintaining jobs made them all the more determined to look for a new life outside the country. Since then, rooted kindred traits have been undergoing modification, and the old revered values are disappearing. The old ties are being severed and relations are crumbling causing a serious rift in the cohesive family unit.

The migration process had both individual and social consequences for the elderly, the majority of whom were women because of their longer life expectancy and the general tendency for men to marry women several years their junior. Many women were left behind to fend for themselves and bear the consequences of the physical separation from child and kin. One main reason for the exclusion of elderlywomen can be attributed to the selective nature of migration that privileges the young and active and excludes the old and disadvantaged. Under the pressure of a precarious existence manifested in bombardment, abduction and kidnapping, many families had no option but to rush into unpremeditated and hasty decisions. In the heat and flare of war and the terror and desperation felt at all levels, they opted to leave immediately and on the spur of the moment. In such a situation, the grandmother was seen as a nuisance or rather as a burden since the range and frequency of her activity and mobility was restricted.

On their part, many old women, or at least those still in good heath, were unwilling to leave and preferred to stay behind to look after their own as well as their children's homes. Having lived all their lives in one particular place, they found it difficult and perhaps too late to uproot themselves and start a new life on foreign soil. The fear of change taking hold of them, they could not leave the place that preserved their memories and their past. For many women, the fact that they remained behind to maintain their independent household must have afforded them a sense of contentment, independence and continuity. Their preoccupation with the various house chores must have reduced their sense of loneliness and yearning. Despite the anarchy and confusion that prevailed, these elderly women felt relatively safe in a society that - having internalized respect and veneration for its elderly citizens - could not possibly envisage its senior members as direct targets of aggression or violence.

It is important to note here that the elderly, meaning those who have reached the age of 65 (retirement age) and over, are not a homogeneous group and can be divided into three major categories: the young old (65-74), the aged (75-84) and the older old (85 and over)[4], and these different groups do not necessarily have the same problems, and, therefore, their economic, emotional and physical needs tend to differ. If the elderly woman is still mobile, it means that the family can still provide support, financial and otherwise, at least from a distance. Such assistance is badly needed particularly for the mother who had spent her life as a housewife and thus was unlikely to benefit from a pension or any other source of income. Accordingly, children hope that financial assistance can substitute in some way for physical presence and help; however, if monetary remittances are useful when the mother is still active and healthy, they ceases to be of any value as age and dependency increase. Furthermore, the number of children per couple is decreasing and the burden of supporting aged parents, therefore, falls on fewer shoulders making assistance to the elderly more problematic. The shift to smaller households as well as the increasing demands of life and the tight economic situation, cannote reduced opportunities for parents to depend upon their children and declining support for the elderly.

Another problem is that many more wives and daughters today are going to work and since the care received by the elderly comes from the daughter rather than the son, the situation is further complicated. Even though women's paid work outside the home creates opportunities for them and supplements family resources, it generates additional problems that demand new adaptations in the relationships among family members. If older men can rely on their wives for care more than the

opposite, a woman who survives her husband and has no female members in the family to look after her, may be left with little support in old age particularly that she may have limited access to pensions and property rights or accumulated wealth from the marriage.

Another factor is the transition of our culture from a rural to an urban way of life that has prevented children from assisting their parents and providing them with the living arrangements and medical care which they need. Consequently, the extended family and kinship relations have been weakened. While not necessarily coinciding with the Western model, the rise in the relative magnitude of the nuclear household is clear predominantly in Beirut.

If women who are still physically active and mobile can still involve themselves in a variety of social activities, there are others who are prisoners of their bleak and empty apartments living on meager incomes. Having lost all feelings of self-importance and hardly able to cope by themselves, they succumb to diseases and become resigned to their fate with little or no health services, being unable to afford a doctor or hospital. In addition to their deteriorating health, loss of family, and the sense of being a burden with no sources of emotional support, they live alone awaiting death that they see as a relief and alleviation from pain. One elderly woman I know had resided with her daughter who passed away three years ago. For years she had not left the house even though she is still mobile and active. Fearful of the outside world, she managed to restrict her activities inside her home and went as far as to cut herself off from needed assistance. Over the years, she has developed paranoiac fears of the outside world, fears that she must have contracted during the war period when shells fell indiscriminately everywhere and car bombs terrorized people whenever they left their homes. Such fears must have intensified after her daughter's death. With limited income and fear of the worst to come, she has cut down on all expenses including food, not to mention that her refrigerator, her gas, and washing machine do not operate any longer. In addition to the fact that she cannot afford to fix them, she will not allow any stranger into her apartment.

Despite the general feeling among most people in Lebanon that sending an elderly parent to a nursing home violates our sense of sacred duty towards them, many individuals and groups are faced with situations where they have no other alternative. It is clear that the majority of elderly in homes are there owing to circumstances where the children cannot possibly look after them. Among such groups are those whose families are abroad, unmarried women, old people whose children cannot support them financially, and those who suffer from diseases where professional care is needed. There are few cases where the elderly are healthy and need only minimum attention; nevertheless, they are there for social, and emotional support which they no longer receive from their children who are generally swamped with their own problems and daily work and simply have no time for them.

Keeping in mind a growing population of older people, the need arises for more serious government action not only to provide assistance to ill and handicapped elderly members, but to ensure that the potent elderly population remains productive rather than estranged and marginalized, and eventually a burden on society. In short, to make late life a potential period of enrichment and fecundity even as it is also a time of impairment and decline. The Ministry of Social Affairs can help in many ways such as to train current physicians in the field of geriatrics (Lebanon has only a handful of geriatricians since medical schools do not offer this specialty), to integrate awareness campaigns regarding the elderly by changing misconceptions about them, and to build nursing homes. A national policy for the elderly is needed to prepare them both physically and financially for old age: to create jobs for those who want to continue to work, to secure assistance to those who need to look after an elderly parent, and encourage research on health and demographic and social problems of the elderly.

While giving assistance to the sick and disabled, such measures will help those who are still fit to maintain an active and productive life away from the emotional deprivation, loneliness and depression that many feel in nursing homes. In this manner, we can, at least, begin to entertain the hope that we are on the right track heading "Towards a Society for all Ages."[5]

Samira Aghacy
Professor of English
Lebanese American University

ENDNOTES

1. (Berkeley: University of California Press, 1993), p. 98.
2. See "Elderly Lebanese Women in an Aging World" by Abla Mehio Sibai and May Baydoun.
3. Ibid., p.11.
4. See G. H. Maguire, ed. *Care of the Elderly: A Health Team Approach.* (Little Brown and Co., 1985); K. Kinsella and C.M. Taeuber, An Aging World (New York: Economics and Statistics Administration, Bureau Of the Census, 1992).
5. The United Nations slogan for the year 1999 which is designated as the International Year for Older Persons.

Forgive me Hajji ...

By Abir Hamdar
LAU Graduate

I met you on one of my reporting assignments, an old frail woman with eyes that reached out to me, beseeching, imploring, questioning. Why I do not know ... or maybe I know, but I can do nothing ... what you ask is out of my reach .... Forgive me Hajji.

There you are, lying on a large bed with piles of pillow behind you, other women your age right beside you. Everything is white: the walls, the bedclothes, your nightgowns, even your face. The room reminds me of a guess game my sister once performed on me. She asked me what I thought of white rooms, and I said they were the symbol of life. She said it meant death, and I laughed at her. I look around ... perhaps my sister was right.

Nothing breaks the harmony of whiteness except your eyes ... yes it is the eyes ... eyes that have not had the taste of sleep for a long time. They say our eyes shrink with age. Yours have grown bigger. They encompass the whole area of your face, and the balls tinged with a spot of deep red ... almost like they're bleeding ... I know you're bleeding ... somewhere inside ... struggling to forget the truth. You want me to reassure you ... I do ... I tell you lies ... loads of lies. Sometimes a lie has to be the truth: you tell me he is your only child. You brought him up all by yourself after his father died ... he was such a tiny baby ... many a time you would wake up in the middle of the night ... to listen to his heartbeat ... always terrified that he wouldn't make it ... "He was such a tiny baby," you repeat. The other elders do not listen. Perhaps they have heard the tale a thousand times ... each is busy with her own memories ... only once in a while do your memories intertwine with theirs, and a tear finds its way down your cheek. You are unable to tell me what food he liked best. Hajji Oum Saed says he liked chocolate, but you disagree. You tell her it is her son who loved chocolate. Yours wouldn't eat a thing except maybe sweet potatoes. You describe the whole process: mashing the potatoes, making sure they weren't too hot or too cold ... children are very fragile you say ... just like you Hajji ... yes just like you.
You ask me if it's the season for sweet potatoes and do not wait for an answer. You ask the nurse to get you sweet potatoes ... just in case he comes for a visit ... wouldn't it be a wonderful surprise? I nod my head silently and you start to moan and curse the hospital: "They wouldn't let me go to visit my son," you say, between dry hiccups. You spot the question in my eyes: he is bedridden...he cannot come... you repeat the words ... no, not to convince me...to convince yourself.

My son has diabetes, he cannot come and visit me. You repeat ... he is divorced ... he has four children ... he is looking after them. You massage your heart and ask me to take permission from the hospital: "Maybe they'd let me visit him." You groan ... you massage your heart again ... I ask if something is wrong. You tell me your heart isn't working the same since you've come. You say no more, only your dry hiccups ... and the hand that continues to massage your heart ... say all.

I leave silently and I promise to secure permission. I promise to come and visit. I even promise to bring your son along ... I lie ... I know I cannot do so. How can I force a son to visit his mother?

I learn the truth from hospital administrators. The manager shakes his head: "We've gone to him a thousand times," he says, "he doesn't have diabetes," he refuses to come." Let her rot," your son told them. The manager says you have no place to go, no one even visits. You spend the time massaging your heart ... all day and all night. "She has been abandoned" he announces, like someone who has seen it happen before. I am shocked ... like you I find excuses ... he must be suffering ... he loves her ... he will come. And I will come, I'll visit you every week. I care, I won't forget, but once again I lie, and like your son, I leave and never come back. Forgive me Hajji ...

Recent Publications

Dee Ahern, Kathleen. *The Older Woman: The Able Self.* New York: Garland, 1996.
Dodge, Hiroko H. *Poverty Transitions Among Elderly Widows.* New York: Garland, 1996.
Kerner Furman, Frida. *Facing the Mirror: Older Women and Beauty Shop Culture.* New York: Routledge, 1997.
Morganroth Gullette, Marilyn. *Declining to Decline: Cultural Combat and the Politics of the Midlife.* Charlottesville: University Press of Virginia, 1997.
Quill, Timothy E. *Death and Dignity: Making Choices and Taking Charge.* New York: W. W. Norton and Company, 1993.
Rippier Wheeler, Helen. *Women and Aging: A Guide to the Literature.* Boulder, Co: Lynne Rienner, 1997.

Filmakers Library

"Old Like Me" is produced by the Canadian Broadcasting Corporation. To find out how society treats older people, a young reporter, Pat Moore, disguised herself as a helpless 85-year-old woman. Venturing out on the streets in over a hundred cities, she experienced the terror that society can inflict on the weak and the old. She was rendered helpless by the speed and noise of the environment of our youth-oriented society. Once she was attacked by a gang of thirteen-year-olds. She found that even the most simple products can frustrate the elderly and make their lives miserable. Arthritic hands cannot easily open jars or hold pens. Labels are hard to read. She had to survive in a world designed for the young and fit. Here is a provocative film to help people understand the feelings and problems of being old.

Seniors Esteem Issues is produced by Knowledge Network and Forefront Productions. In our society, the natural process of aging is often threatening to a person's feelings of self worth. Because we often judge ourselves by what we can do instead of who we are, self-esteem diminishes as energy and physical prowess decline. Retirement is often a watershed since there is no longer a monetary value for one's abilities. But as psychologist H. Stephen Glenn points out, one can approach aging as another challenge from which to learn and grow. The seniors pictured in this program come from a variety of circumstances. All find themselves happier and more fulfilled when they become involved in the community.

"Our Honor and his Glory" is produced by Sigrun Slapgard for NRK. In some areas of North Africa, the Middle East and Asia, honor is deemed of such importance that a father, a brother or a cousin is entitled by tribal custom to kill a woman, often a young girl, who is suspected of having sullied the family moral standard. This film documents two cases in Palestinian villages. A nineteen-year-old girl attempted to return to her family which had cast her out in disgrace. Her death was announced publicly. One young, pregnant single girl was kept in prison to protect her from her family. After giving birth, she fled to the West Bank where she was given a new identity. While the traditional tacit acceptance of "honor killings" is now challenged by human rights and women's rights groups, in instances like the ones depicted in the film, they have not intervened.

Call for Papers

Feminist Theory is a new international interdisciplinary journal published by Sage publications in April 2000. The journal is being launched to provide a forum for critical analysis and constructive debate within feminist theory.
Feminist Theory will be genuinely interdisciplinary and will reflect the diversity of feminism, incorporating perspectives from across the broad spectrum of the humanities and social sciences and the full range of feminist political and theoretical stances.
The journal will promote:
- Debate among theorists from diverse perspectives
- Critical engagements with shifting disciplinary hierarchies within feminist theory
- Challenges to existing theoretical orthodoxies and conventional definitions of theory
- Empirically grounded theorizing as well as more conceptual work
- Writing which is politically engaged and which explores links between theory and practice
- Innovative theorizing which crosses theoretical and disciplinary boundaries

The journal will be published three times a year starting April 2000. If you are interested in submitting a manuscript contact:

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E-mail: sfj@york.ac.uk

For more information email: jane.makoff@sagepub.co.uk

Teaching Men's Studies

In the Fall semester (1998-1999) the Center for Gender Studies at the University of Karlstad offered a series of literature seminars on Men's Studies. The aim was to present and discuss different perspectives on men and masculinities within the social sciences and humanities. Likewise the Department for Feminist Studies at Goteborg University is offering a similar series during its Spring semester. For more information e-mail Arne.Nilsson@wmst.gu.se Tel. 00 46 31 773 52 24.
(NIKK, the Nordic Institute for Women's Studies and Gender Research, Denmark)

Quote, Unquote

"It is fitting for the last year of the millenium to be the International Year for Older Persons, with the theme 'towards a society for all ages' - a society that does not caricature older persons as pensioners, but sees them as both agents and beneficiaries of development."

(UN Secretary-General Kofi Annan, 1 October 1998)

"Is it true that we had all lived more or less ordinary lives in the way that women do, or thought we had, anyway. But here we were, six women from varying backgrounds, all having made it through wars, financial ups and downs, jobs, marriages, births, deaths, divorces, disillusionments, successes, and all the public and private events of more than 60 years running, and we were claiming to have nothing of interest to say! Women in general, and old women in particular, have had our voices silenced or distorted in so many ways that it is sometimes difficult to think of words that express what is important to us. When we finally start to say them aloud, we release ourselves from the restrictions that have been put on us by others. We are affirming that our lives are important."

(The Hen Co-op, Growing Old Disgracefully, 1994, p. 5)

"It is common knowledge that the condition of old people today is scandalous. Before examining it in detail, we must try to understand how it comes about that society puts up with it so easily. As a general rule society shuts its eyes to all abuses, scandals and tragedies, so long as these do not upset its balance; and it worries no more about the fate of the children in state orphanages, or of juvenile delinquents, or of the handicapped, than it does about that of the aged. In the last case, however, this indifference does on the face of it seem more astonishing, since every single member of the community must know that his future is in question; and almost all of them have close personal relationships with some old people."

(Simone De Beauvoir, The Coming of Age, p. 321)

"In 1990, the world's elderly population (herein defined as those persons 60 years and older) was estimated at 488.8 million, nearly equivalent to the combined 1950 populations of Latin America, North America and the USSR. One out of eleven global inhabitants is at least 60 years of age. Out of nearly half a billion elderly, 44 per cent are male, underscoring the higher levels of mortality among the males as compared to their female counterparts."

(UN document)

"Certainly I take obvious risks living by myself at this age [eighty-three]. I could fall and break my hip without anybody knowing. I could get mugged coming home from a meeting or from shopping. Those risks are quite clear to me, but even clearer are the gains I reap from solo living. The biggest gain is that I get to keep my own ways. Nobody tells me how to be. My friends come visit often, so I have ample fun. But I don't have to rearrange my life for anybody. I don't have to accommodate anyone else's ups and downs. That is just how I want things until death do me part.

(Simone De Beauvoir, Never Married Women, p. 155)

Why do people age? What causes the changes that take place in the body? How might these changes be delayed? These questions have posed a fascinating puzzle for scientists. Much research has been done in this area, and many theories have been advanced to try to explain the enigma of aging. It has been estimated that there are over 20 theories of biological aging. Nathan Shock classifies these theories into three principal categories. The first group, genetic theories, explains aging in terms of defects that occur in the transmission of information from the DNA molecules to the cells. The second group, nongenetic theories, focuses on changes that take place in the cells that interfere with their performance. The third group, physiological theories, explains aging on the basis of the malfunction of a single organ system or some impairment to the regulatory and control mechanism of the body."

(Diana K. Harris and William E. Cole, Sociology of Aging, 1980, p. 123)

"The ideal of independence also contains a tremendous amount of selfishness. In talking to today's young mothers, I have asked them what kind of grandmothers they are going to be. I have heard devoted, loving mothers say that when they are through raising their children, they have no intention of becoming grandmothers. They are astonished to hear that in most of the world, throughout most of its history, families have three- or four-generation families living under the same roof. We have emphasized the small family unit — father, mother, small children. We think it is wonderful if Grandma and Grandpa, if he's still alive, can live alone."

(A New Style of Aging, p. 44)

"Old age! Few words so spontaneously evoke so many different and contradictory concepts: old age/respect, old age/experience, old age/wisdom, old age/in full bloom, - or old age/devastation, old age/dependence, old age/at the margin; few notions are at the same time intimate (one's own old age) and universal because old age is everyone's fate."

(Jeannine Jacquemin, Elderly Women: Living at the Margin or in Full Bloom, p. 7)

"The difficulties in readjustment after the loss of a spouse, the loss of a job, or the loss of health, are accentuated when our friends become fewer as we grow older. Our own increasing rigidity and insistence on regularity often limit our social contacts. Physical difficulties make the maintenance of friendships difficult. When we lose our jobs, we lose many social contacts. We or our friends are likely to move away and there are fewer and fewer old people around. If we have lost our homes, it is more difficult to entertain and more difficult to meet new friends to replace those who have gone."

(Clark Tibbitts (ed.), Living through the Older Years, 1949, pp. 92-93)

NewsBriefs

From Madrid
Consecrated Virgins

"She will never know the love of a man and will remain a virgin her entire life." Some Spanish women have already taken vows to become "Consecrated Virgins". These women differ from nuns in that even though they are devout Catholics they are not willing to become nuns and submit to the rigorous rules of convents. Priests carry out a ceremony where these women are consecrated as brides of Christ and they wear wedding rings to symbolize their union. Apart from that these women lead ordinary lives. Age, economic independence, and maturity are among the requirements qualifying one to become a consecrated virgin. "In order to be consecrated as a virgin by the Church, a woman must be at lest 30 years old, have a job to support herself and have a certain intellectual maturity" according to church representatives. Besides "there is usually no medical exam to check that the women are technically virgins. The Church may accept to consecrate a woman who had early boyfriends, as long as those relationships were not public, the sources said, adding that the women were usually technically virgins." *(Daily Star,* Monday, January 18, 1999)

From Iran
Legalizing Gender Discrimination

A bill was passed by the Iranian mullah's Majlis "prohibiting the publication of any material in the media that would give rise to conflict between the genders on the basis of a defense of women's rights contradictory to religious values." This bill blatantly advocates misogyny and favors anti-human discrimination against women. It enables the mullah's to "condemn advocates of women's equality to imprisonment and lashing according to article 698 of the law on Islamic punishments." According to the head of the Judiciary, Mohammed Yazdi, "women cannot preside in the courtroom and are only consulted in judicial matters." Around 1,800 young men and women were arrested recently on charges of "malveiling and lewd conduct" in an attempt by the clerical regime to uphold virtue and condemn immorality. *(Women Envision,* September-October 1998, No. 61-62 p. 9)

From France
Circumcision is Punishable by Law

Hawa Griyo, a Malian living in Paris, was sentenced to eight years imprisonment after being indicted for performing operations of genital mutilation on forty eight girls. The parents of the circumcised girls were also arrested and jailed on the grounds of promoting violent practices against women that lead to permanent scarring. It is the first trial of its kind to take place in France. (*An-Nahar,* Thursday 18 February 1999)

Women Raise Your Hand for Peace!

From May 11 to 15, 1999, thousands of people will gather at The Hague Appeal for Peace to create an agenda for peace and justice for the 21st Century. Women's groups representing women from every world region are organizing panels, exhibits and demonstrations to make it clear to the governments of the world that we feel sorry about peace and justice and want to be part of any decisions coming out of The Hague Appeal for Peace. However, most of us cannot be in The Hague in May. So we are inviting you to send us a short message, in your own language, that we can place on a cut-out of a hand and stand in a pot filled with sand that will be part of an exhibit in a prominent part of the conference building. In this way, we hope to show that women everywhere care about peace and want their voices heard.

Fax or mail it to:
International Tribune Center
777 United Nations Plaza
New York, NY 10017
USA
Fax: 001 212 661 2704
If you have email, send your message to: iwtc@igc.apc.org
Under subject, put Hague Peace Message.

From Egypt
University Professor Under Attack

Samia Mehrez, a tenured professor and a highly respected scholar of Modern Arabic Literature at the American University of Cairo (AUC) is being charged with "sexual harassment for assigning 'pornographic' material to minors and forcing them to discuss it." The matter gained precedence when some students at AUC complained to their parents about the "pornographic" nature of a novel, Muhammad Choukri's fictional autobiography *Al-Khubz Al-Hafi* (For Bread Alone), they were assigned to read at university. Word spread to the president of the university who called upon professor Mehrez and asked her to "withdraw" the book and apologize to the class for assigning it. She refused but proposed to exclude the novel in question from the examination.

This event brought about public condemnation where a group of Egyptian newspapers waged a campaign to "discredit professor Mehrez and to embarrass the American University." As a result of this campaign two books, deemed by "self-appointed custodians of public morality" to be injurious to good taste namely *The Smell of It* by Sonallah Ibrahim and *Distant Views of a Minaret* by Alifa Rifaat were removed from the shelves of the AUC bookstore. Besides in order to shy away from adverse publicity the core curriculum committee at AUC is seriously considering excluding Tayeb Saleh's novel *Season of Migration to the North* from its reading list for this coming semester.

Such censorship is unacceptable. If it is allowed to go unchecked, this eager censorship will ultimately consign imaginative literature to the role of beautifying and consecrating the ugly reality of violence, oppression, and injustice that prevail, alas, in much of the contemporary Arab world.

All those concerned, please e-mail President Gerhart at:
jgerhart@aucegypt.edu and cc. to Prof Mehrez at samehrez@hotmail.com
(A Document received by IWSAW to be posted and forwarded).

IWSAW Celebrates its 25th Anniversay

The Empowerement of Arab Women was the title of the two day conference organized by the Institute for Women's Studies in the Arab World at the Lebanese American University on December 3 and 4, 1998. The pannels came under the following headings: "Women in the Arab world: A Personal Perspective"; "Women's Centers and the New Millennium"; "The role of International Organizations in the Empowerment of Women".

From left to right: Dr. Franca Pizzini, Dr. Soumaya Ramadan, Mrs. Toujan Al-Faisal, Mrs. Aida Gindy, Mrs. Mona Khalaf, Dr. Balghis Badri, Dr. Yakin Erturk, Ms. Salwa Sarhi, Ms. Sophie Claudet, and Dr. Fadia Faqir

From left to right:Mrs. Mona Khalaf, Dr. Nabeel Haidar, Dr. Riyad Nassar, and Mrs. Bahia Hariri

IWSAW Celebrates International Women's Day

On the occassion of the International Women's Day, the Institute for Women's Studies in the Arab World held on March 10, 1999, a debate entitled "Behind Every Successful Woman is a Great Man!!" Married couples, faculty members and students openly expressed their views on issues such as supporting ones partner on decisions concerning his/her professional life. Conflicts faced by women related to: family life and productive life, husbands bearing consequences of increased involvement in family life, and the feeling of being threatned by their partner's success.

From left to right: Mr. Nabeel Alameddine, Dr. Said Makkawi, Mrs. Safa Makkawi, Dr. Nadia Cheikh, Dr. Kamal Shehadi, Mrs. Natalie Shehadi, Dr. Mounir Khoury, Mrs. Huda Hammoud, and Dr. Hassan Hammoud

Elderly Women

Introduction

"Age only matters when one is ageing. Now that I have arrived at a great age, I might just as well be twenty." Pablo Picasso

Given that the year 1999 has been designated by the United Nations as the International Year for Older Persons with the theme 'Towards a Society for all Ages,' the File for this issue of *Al-Raida* is devoted to elderly women. Since the problem of aging in Lebanon is not as drastic as it is in Western and developed countries, we are fortunate to have the time to prepare ourselves, plan ahead and determine whether the measures taken by these countries to alleviate the problems of their aged citizens are also relevant to our culture and society.

Another source of knowledge and inspiration that we can learn from is the United Nations whose Principles for Older Persons assert the need to take action to alleviate problems that the elderly face worldwide in order to ensure a dignified existence for the old and a society that caters for the needs of all its citizens. Among such principles are ensuring independence to older persons including access to food, shelter, clothing, and health as well as the opportunity for work or other income generating opportunities, and the right to reside at home for as long as possible and continue to participate actively in society. In addition, old persons should also be entitled to benefit from family and community care and protection and to have access to health care and legal services. They should also be able to pursue opportunities that would give them self-fulfillment, and finally live in dignity free of exploitation and physical and mental abuse.

Picture Credit: Pierre Couteau

For the United Nations, the society for all ages is one that "adjusts its structures and functioning, as well as its policies and plans, to the needs and capabilities of all, thereby releasing the potential of all, for the benefit of all." It is a society, according to the UN Secretary General, Kofi Annan, that "does not caricature older persons as pensioners, but sees them as both agents and beneficiaries of development."

It is true that when we talk of elderly, we do not always mean the sick, the disabled and unproductive who should be given all the care that is their due. By old we also mean, the majority of people above 65 who are still healthy and active. To be old does not mean to relinquish all social functions and live on the margins of society feeling estranged and cast off. It is a period where the elderly, particularly women who constitute the bulk of the older population, can feel free from many shackles that had chained them in the past. Now is the time for them to challenge stereotypes of women as weak and dependent and embrace a new image of themselves as individuals who no longer have to fit into particular moulds. They can be themselves without the need to subscribe and bow to the stereotypes of wife, mother and lover and to "drink life to the lees," perhaps for the first time in their lives. Accordingly, late life can truly become a potential period of enrichment, independence and self-realization.

The articles in the file cover various aspects of aging, with special emphasis on women. We will essentially attempt to shed light on the elderly population in several countries, their demographic, social, economic as well as physical and mental health problems. Moreover, the file will include an analysis of old age pension schemes in Arab countries, testimonies of women in nursing homes, as well as an interview with a female geriatrician.

Elderly Lebanese Women in an Aging World

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I. Introduction

The turning point at which aging begins is ill defined, and the question arises as to whether there can be an age for aging (Tout, 1989). Old age is culturally determined and varies with time, person and place. Philosophers, long time ago, defined old age as the time when the individual reaches his highest point of development. According to Hippocrates, this is reached at 56, to Aristotle at 35 for the body and 50 for the soul and to Dante at 45 (De Beauvoir, 1972). In some cultures, aged is equaled with menopause in females, and in others men are not regarded as old until they are retired. Old age is perceived differently in Bangladesh where life expectancy at birth is 49 years than in Sweden or Japan where life expectancy at birth exceeds 77 years.

In Arabic, there are more than one word for old man. Though often used interchangeably, each has a different connotation. For example, '*Sheikh*' is a word commonly used to signify respect. '*Ajouz*' is derived from '*ajaz*' meaning 'disability', and hence it undertones an inability to perform a certain task. '*Musenn*' is another word derived from '*senn*' meaning 'age', and indicates that a person has lived for many years.

The chronological onset of old age differs depending on the country considered and on the objective of the research. Although the cutoff point used to describe the elderly population is somewhat arbitrary, it is in line with the criteria used in many countries to define eligibility for retirement and social benefits (WHO, 1995). The World Health Organization has traditionally used the age of 65 and above to designate the elderly. In contrast, the United Nations, in the context of the International Plan of Action on Ageing, defined it as 60 years and over and in developing countries a cut-off point of 60 or 55 is often being cited. However, as the elderly constitute a heterogeneous group, it is more appropriate to define different strata for the aged: the young old (60-69), the middle old (70-79) and the old-old (80 and over). For this article, the cut-off point for the aged was set at 60 years. The age group 60-64 years represents an important transitory stage in the life of the individual whereby he/she is at risk of exposure to a multitude of life events most markedly retirement.

Aging is relatively a recent phenomenon, and the elderly population has been one of the most rapidly growing population segments since the turn of the century. The demographic transition –a concept that was coined 50 years ago– has lead to a rapid decline in fertility and an increase in life expectancy. This transition is marked by three successive stages. The population is in equilibrium at first with simultaneous elevation in both birth and death rates, slow population growth and a young age structure. However, in the second stage (population explosion), mortality is reduced while birth rate remains high leading to a rapid growth in the population. Finally, during the third stage of the demographic transition, the population returns to equilibrium with decline in both mortality and fertility rates. During this stage, a marked increase in the proportion of elderly people is inevitable leading to population aging.

This article begins with a brief account of the particular features of demographic aging in Lebanon comparing women to men. The socio-cultural and health characteristics are presented next for women only. The last section draws upon the results obtained in this study as well as from other studies to suggest a framework for action.

II. Proportion of Elderly in Lebanon: A Secular Trend

The Lebanese population has witnessed a clear demographic transition in the past few decades. The decline in fertility rates has led to a lower proportion in the younger age groups and consequently to a narrowing down of the population pyramid base. While Lebanon has still a large proportion of its population in the 0-14 years age groups, data from several sources show a growth in the proportion of its elderly population. The Central Directorate of Statistics of the Ministry of Planning in Lebanon (1972) had estimated the proportion of population who were 60 years and older as 7.8% in 1970 and the United Nations estimated it at around 8.3% in 1986 (UN, 1987). More recently, and, according to the findings of the Population and Housing Survey that was carried out by the Ministry of Social Affairs in 1996, 10.3 % of the total Lebanese population consisted of elderly people (10.2 % among males and 10.4 % among females; Table 1 & Figure 1). Given the continuous decline in fertility rates and increase in life expectancy, because of imported medical interventions and technologies, this demographic transition is expected to continue in the coming decades.

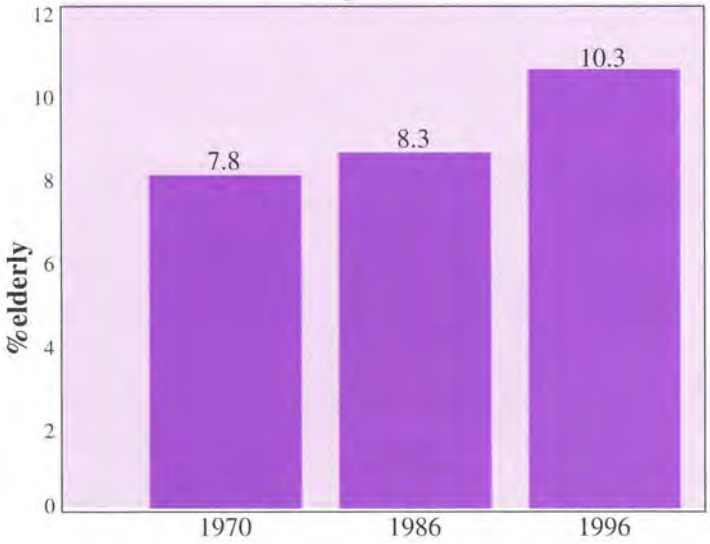
III. Distribution of the Elderly by Age, Sex and Geographical Area

In 1996, and according to the Population and Housing Survey (PHS), the total elderly population (above 60 years) was estimated at 319,142 (156,920 males and 162,222 females), and the number of centenarians i.e. persons aged 100 years and

Table 1. Proportion Elderly Above 60 and 65 Years Among the Lebanese Population, 1970 - 1996.

Study	Males		Females		Total	
	N	%	N	%	N	%
Lebanon, 1970						
60 years and above	83,115	7.3	80,565	8.2	163,680	7.8
65 years and above	52,770	4.9	52,575	5.0	105,345	4.9
Lebanon, 1996						
60 years and above	156,920	10.2	162,222	10.4	319,142	10.3
65 years and above	104,818	6.8	108,466	6.9	213,284	6.8

Figure 1. Trend in Percent Elderly Above 60 Years Old in the Total Lebanese Population, 1970-1996.



older were estimated at 271 for males and 431 for females.

Table 2 presents the distribution of the elderly population by age and sex as well as the sex ratio in each age category. Sex ratios were found to be close to unity in the younger olds (60-74 years). In contrast, the proportion of females among the elderly population exceeded that of males in the older generations. The M/F sex ratio was equal to 0.85 in the age group 80 years and above, whereby females accounted for a higher proportion (12.1%) than the males (10.6%). Such a pronounced gender imbalance has been described as the 'feminization of aging' and is the current experience of many developed countries.

Table 3 shows the geographic distribution of elderly population by place of residence as reported at the time of the survey in 1996. The elderly populations in Lebanon are not equally distributed across Governorates. In fact, the largest number of elderly people (38.6%) resides in Mount Lebanon and the smallest in the Governorates of the South (7.3%) and Nabatieh (7.1%). In addition, most of the elderly group (82.3%) resides in urban areas rather than rural ones. These figures, in fact, represent proportionate percentages and hence reflect the concentration of the elderly individuals across the Lebanese Governorates. Their significance lies, not in terms of degree of aging, as much as in guiding policymakers when planning service provisions to the elderly in Lebanon.

Percentage elderly in the total population — which reflects the degree of aging in a certain region — was highest in Beirut (13.6%). In contrast, the percent elderly was found to be small in Mount Lebanon (10.8%) and in the Bekaa and North regions (8.9% and 8.8% respectively) and to a lesser extent in the South Governorate (8.3%). As expected, rural areas showed slightly larger estimates than urban ones. The relatively high figure in Nabatieh (11%) reflects emigration of the young population to safer areas within or outside Lebanon seeking better employment opportunities, and leaving behind a larger proportion of elderly people.

IV. Life Expectancy: Comparison with Other Countries

Life expectancy is one of the desirable summary indices commonly used as an indicator of aging. It is shaped by a

There is a greater differential in life expectancy of women compared to men in developed countries

Table 2. Distribution of Elderly Population (60 Years and Above) by Age and Sex, PHS, 1996.

Age (years)	Males		Females		Total		Sex ratio (M/F)
	N	%	N	%	N	%	
60-64	52,102	33.2	53,756	33.1	105,858	33.2	0.97
65-69	42,771	27.3	42,651	26.3	85,422	26.8	1.00
70-74	31,293	19.8	31,078	19.0	62,371	19.4	1.01
75-79	14,094	9.0	15,126	9.3	29,220	9.2	0.93
80+	16,660	10.6	19,611	12.1	36,271	11.4	0.85
Total	156,920	100.0	162,222	100.0	319,142	100.0	0.97

Table 3. Geographic Distribution of Total and Elderly Population by Place of Residence, PHS, 1996.

Place of Residence	Total Population	Elderly Population	Proportionate %	% Elderly in Total Population
Governorates				
Beirut[1]	407,403	55,466	17.4	13.6
Mount Lebanon[2]	1,145,458	123,082	38.6	10.8
Bekaa[5]	399,891	35,542	11.1	8.9
North[3]	670,609	58,937	18.5	8.8
South[4]	283,057	23,438	7.3	8.3
Nabatieh[6]	205,411	22,675	7.1	11.0
Area				
Urban	2,513,461	262,800	82.3	10.5
Rural	598,367	56,343	17.7	9.4
Total	3,111,828	319,143	100.0	10.3

1. Administrative Beirut
2. Includes: Baabda, El-Metn, El-Shuf, Alay, Kesrwan and Jbeil
3. Includes: Tripoli, El-Kura, Zghorta, El-Batrun, Akkar and Bsharre
4. Includes: Saida, Sour and Jezzin
5. Includes: Zahle, West Bekaa, Baalbek, El-Hermel, and Rashayya
6. Includes: Nabatiyye, Bent Jbayl, Marj'ayun and Hasbayya

multitude of factors including social, economic, cultural and health characteristics and is often determined by the level of development in the country. Because of the lack of baseline data, demographic estimates for life expectancies in Lebanon vary in international statistical books. Nevertheless, data from different sources are consistent with the greater life expectancy at birth for women in comparison to men.

For comparative purposes, table 4 shows life expectancy at birth for selected countries as presented by the Human Development Report for the year 1996 (UNDP, 1996). Few countries were selected from each of the developed, developing and the Arab World. In the developed world, life expectancy is relatively elevated for both genders (above 75 years for the United States and close to 80 years for Japan). The Arab countries show wide variations in their life expectancy ranging from as high as 75 years in Kuwait to 63.9 years in Egypt and as low as 50.4 years in Yemen.

In contrast, people in some developing countries are not expected to live on average for more than 50 years. According to the Human Development Report estimates, Lebanon's figures, for both sexes, are closer to the developed than the developing world.

The gender gap in life expectancy appears markedly different between developed and developing countries. There is a greater differential in life expectancy of women compared to men in developed countries. In these countries, women live on average about six years longer than men. While less pronounced, the difference in life expectancy between men and women in Lebanon is nonetheless evident (around 4 years). The wider the gender gap the more elderly women are expected to suffer from the consequences of widowhood, loneliness, major restructuring of family relationships and social roles, loss in socio-economic resources and decline in social support.

Table 4. Life Expectancy at Birth for Selected Countries, Human Development Report, 1996.

Life Expectancy at Birth (Years)	Males	Females	Total
Lebanon	66,8	70,7	68,7
Developed Countries			
Japan	76,5	82,6	79,6
United States	72,6	79,4	76,1
Arab Countries			
Kuwait	73,4	77,3	75,0
Saudi Arabia	68,6	71,6	69,9
Tunisia	67,1	68,9	68,0
Iraq	64,6	67,6	66,1
Egypt	62,7	65,1	63,9
Yemen	50,1	50,6	50,4
Developing Countries			
Kenya	54,1	57,1	55,5
Nigeria	49,0	52,2	50,6
Angola	45,2	48,4	46,8
World	61,4	64,6	63,0

V. Socio-Economic, Social and Health Characteristics of Elderly Women

The social status as well as the health profile of aging women is readily seen to stem from their economic, cultural, social and biological characteristics. The first two sections below focus on major socio-economic and social resources of elderly women in Lebanon using data from the PHS survey. The third synthesizes data from other sources and studies to describe their health profile.

A. Socio-Economic Resources

Financial security in old age is determined by the interaction of many factors. The most important of these are education, occupation and income. Educational attainment distinguishes groups differently situated in their initial encounters with the labor market.

Picture Credit: Ali Hassan, "An-Nahar"

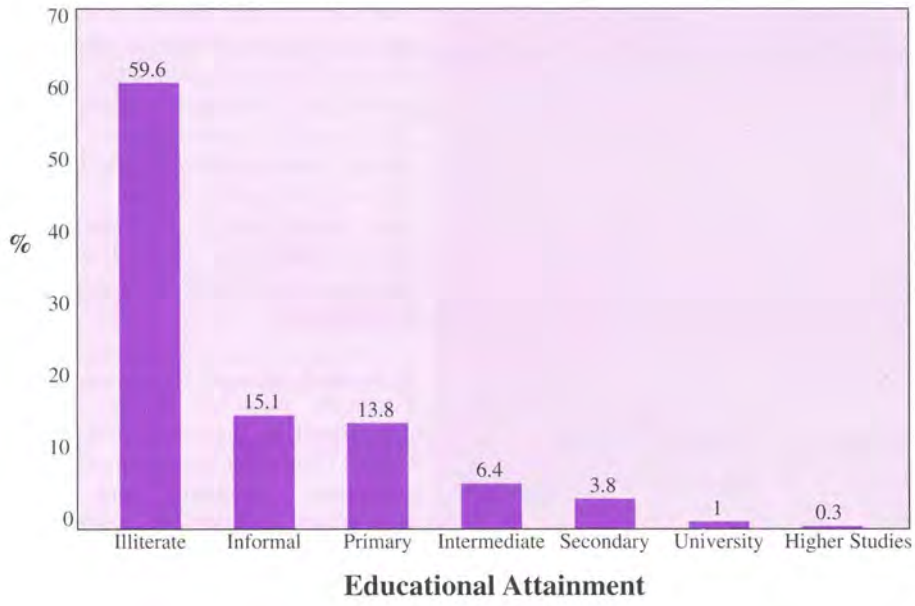
During working years, the level of education of individuals in a community may affect their income in a direct manner. However, with the advent of old age, other indirect routes affect an educated person's income and financial security (Crystal et al., 1992). While this may be marked for elderly males in general, it is less distinct for females. Because of this, the following analysis aims at assessing the socio-economic resources of the elderly female population from a broad angle, including resources at both the individual and the household levels.

1. Educational Attainment

Levels of literacy and education among our current cohorts of aging women are relatively low (Figure 2). The majority of elderly women were illiterate (59.6%) at the time of of the Population and Housing Survey in 1996. Broadly, around one fourth had reached primary level of education (25.3%), with much lower proportions reaching secondary and university levels (5% and 1.3% respectively). The educational attainment of our future elderly population in the coming 20 years will, however, present a different pattern. For example, the proportion of illiterate women, currently in their mid 40s, did not exceed 18.3% and those having reached secondary level or more was estimated at around 24.4%. The radical changes that are occurring over time in the social norms and values, particularly for women, will create a larger group of aging women with improved education and concurrently a larger pool in the work force.

This trend will eventually reduce current illiteracy rates and promote better health outcomes among our future elderly. The close relationship between education and different health outcomes is well established in the literature. People with higher education levels show consistently lower proportions of morbidity and disability and better chances of recovery after illness and improved survival.

Figure 2. Percent Distribution of Elderly Women Aged 60 and Above by Educational Attainment.



2. Labour Force Participation and Pension Plans

Economic activity is bound to decline with aging and to be most affected by age at retirement in a given country. For this reason, age was grouped into three categories (60-64, 65-74 and 75 and above). Table 5 shows the distribution of labor force participation across the different age groups. Among the elderly female population, labor force participation was low (6.7%) even before reaching retirement age (64 years). This proportion decreased with increasing age to reach 0.9% among the older generation (75 years or more). On the other hand, home-based workers accounted for a

Table 5. Distribution of Elderly Women by Working Status and Age, PHS, 1996.

Working Status	60-64 N	60-64 %	65-74 N	65-74 %	75+ N	75+ %	Total N	Total %
Housewife	48,373	90.0	68,087	92.3	31,452	90.5	147,912	91.2
Working	3,603	6.7	2,036	2.8	327	0.9	5,966	3.7
Home Based Worker	512	1.0	558	0.8	77	0.2	1,147	0.7
Retired	298	0.6	591	0.8	311	0.9	1,200	0.7
Others *	970	1.7	2,458	3.3	2,570	7.5	5,998	3.7
Total	53,756	100.0	73,730	100.0	34,737	100.0	162,223	100.0

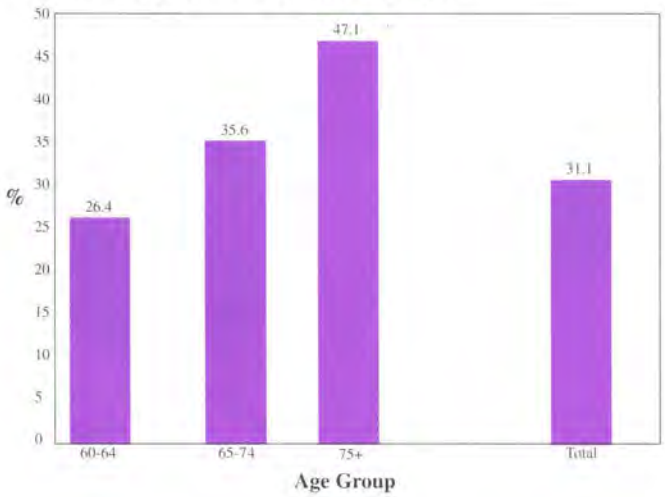
* Others include unemployed and self-sufficient

small proportion (0.7%). Despite their small number, they represent major supporters in the household with the most disadvantageous social security benefits. The majority of working elderly females were employees (68.9%) rather than self-employed (31.1%). However, self-employment increased significantly with age (Figure 3).

In fact, no matter how old the woman was, her principal occupation remained that of a housewife (around 91%). This finding is similar to that noted in the United States and most other countries, whereby elderly women in general encounter low rates of work force participation and seek their primary activity as housekeeping to the extent that less than 1% of elderly women perceived themselves as 'retired'. Though not assessed in the data at hand, the role of caregiving played by the majority of elderly females need not be overlooked. Aging women are more likely to care for their older husbands. They act, as well, as caregivers for their much older frail parents and quite often for their younger grandchildren.

The principal occupations in which the economically active elderly women were engaged in are presented in figure 4. For self-employed women, the most dominant types were vending (38%), agriculture and skilled work (24%), and handicraft and technical work (25%). In the case of women who were

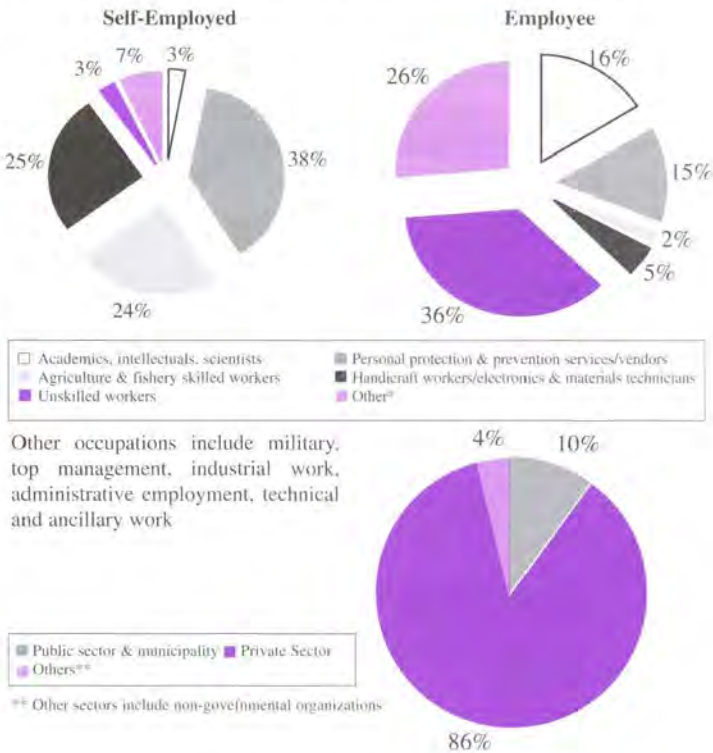
Figure 3. Percentage of Self-Employment Among Economically Active Elderly Women by Age, PHS, 1996.



employees at the time of the survey — whether in the public or private sector– the most dominating type of work was that of unskilled labor (36%). Figure 4 also displays the percent distribution of economically active elderly women by sector of principal occupation. Engagement in the private sector (86%) dominated significantly that of the public (10%).

In Lebanon, there is no clear-cut government policy regarding the welfare of the elderly. Hence, the sector of economic activity interacts with the type of occupation to determine old age security for both elderly men and women. For example, while employment imposes an age at retirement, self-employed

Figure 4. Percent Distribution of Economically Active Elderly Women by Type of Occupation and Sector of Activity, PHS, 1996.



Other occupations include military, top management, industrial work, administrative employment, technical and ancillary work

** Other sectors include non-governmental organizations

elderly are not given any sort of health insurance or indemnity. In addition, among employees there is a great variation in health coverage and other old-age pension plans. Civil servants and government employees enjoy a wider range of privileges than those covered by the National Social Security Fund (NSSF). Upon retirement, the elderly, who was once covered by the NSSF during his/her productive years, is deprived of any health insurance coverage just at the time when health and

social needs start to escalate. Shortcomings of the NSSF are reflected adversely on the retired elderly, full-time housewives and old widows.

3. Household Characteristics: Assets and Resources

Household members share common characteristics that shape their overall well being. Most important of these are 'housing conditions' and 'material possessions'. Such characteristics shed some light on the conditions under which the elderly lives and, hence, may provide a proxy measure for the social and economic standards of his/her living conditions.

Results of the secondary analysis of the PHS data showed that most elderly women resided within apartments in buildings (around 77%), although a significant proportion (23%), mostly in the rural areas, lived in independent housing units (table 6). The residence was entirely owned by the household members among a large proportion of elderly women (66.7%).

Personal space for elderly people is very crucial for their general well-being, and this is conceptualized at the micro level in terms of crowding index (household density or the number of persons per room). Crowding has many social, psychological and health implications among the elderly. The crowding index was calculated at the household level by dividing the number of household members over the number of rooms in the house, excluding bathrooms and kitchen. Despite the advatageous setting of living in an independent residence and owning entirely the housing unit, the crowding index exceeded 1 person per room in around 40% of our elderly population (table 6). In addition, the mean crowding index increased slightly with age from a value of 1.16 among those aged 60 to 74 years to 1.20 among those who were 75 years old or more. The dynamics of change in household structure could not be assessed from the PHS data, and space allocation for the elderly within the house remains a more important measure for the status and autonomy of the elderly than the direct objective measure of household density or crowding. A significant proportion (45%) of the elderly women lived in households where members reported possession of one type or another of real estate. However, only a small proportion (less than 10%) relied on it as a primary source of income (Table 7).

Table 7. Distribution of Elderly Women by Possession of Real Estate, PHS, 1996.

	Age (Years) 60-74		75+		Total	
Real Estate	N	%	N	%	N	%
Provides Primary Income	9,582	7.5	2,590	7.5	12,172	7.5
Provides Secondary Income	13,464	10.6	3,939	11.3	17,403	10.7
Does not Generate any Income	33,732	26.4	9,100	26.2	42,832	26.4
No Real Estate	70,709	55.5	19,109	55.0	89,818	55.4
Total	127,487	100.0	34,738	100.0	162,225	100.0

Table 6. Distribution of Elderly Women by Type and Ownership of Residence and Crowding Index, PHS, 1996.

	Age (Years) 60-74		75+		Total	
Type of Residence	N	%	N	%	N	%
Independent Residence	27,024	21.2	9,617	27.6	36,641	22.6
Apartment in a Building	100,193	78.6	25,059	72.3	125,252	77.2
Shacks/Other	359	0.2	61	0.2	330	0.2
Ownership of Residence						
Entirely Owned	84,427	66.2	23,780	68.5	108,207	66.7
Partially Owned	3,272	2.6	1,220	3.5	4,492	2.8
Rented	31,692	24.9	7,017	20.2	38,709	23.9
Other	8,095	6.3	2,720	7.8	10,815	6.7
Crowding Index						
<1Person/Room	53,070	44.2	15,336	45.5	68,406	43.2
1 Person/Room	21,199	17.9	6,198	18.1	27,397	16.9
>1 Person/Room	52,947	37.9	13,142	36.4	66,089	40.8
Mean (SD)	1,16	(0.84)	1,20	(0.96)	1,18	(0.90)
Total*	127,424	100.0	34,737	100.0	162,223	100.0

* Totals for the separate variables do not necessarily add to the presented total due to missing values in the corresponding variable, in particular, for the number of rooms.

B. Social and Living Arrangements

The probability of an elderly person being poor is a function of his/her living arrangement as well as gender. Older women are found to be twice as likely to be poor as are aged men. For instance, in the year 1990, the proportion of elderly women in the United States (aged 65 year or more) who were living below the poverty line was 15.4% in comparison to 7.6% for aged men (Choudhury and Leonesio, 1997). Those living with their own families are much less vulnerable than those living in non-family households and women are usually at a disadvantage in this respect. In the developed world, a significant

proportion of people over 60 years of age lives on their own. However, in developing countries, and based on studies conducted in the Western Pacific Region, a high proportion of the elderly remains an integral part of the family structure and more than half of them live with their children and in households that consist of five people or more (Andrews, 1986).

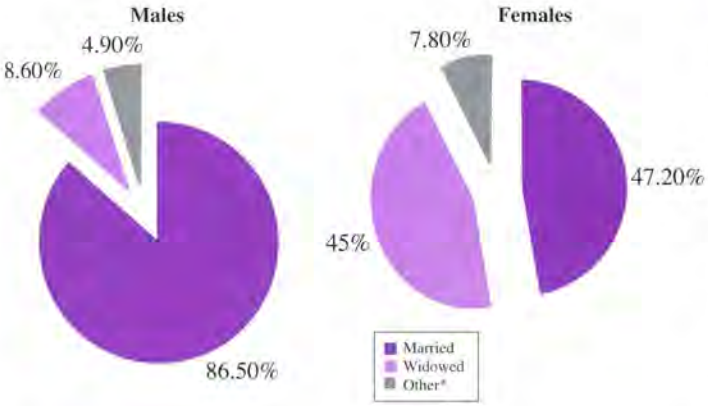
Social support to the elderly person can be informal and formal. The informal type of support stems from personal assistance and care given by family members and this form continues to be the most dominant in most countries. Formal support services are provided by public or private institutions and organizations. The data at hand provide proxy information on informal support only. For this, three measures were utilized: marital status, household size and family structure. The distributions of these characteristics are presented in table 8 with age being grouped into 5-year age categories.

1. Marital Status

Marital status has often been associated with a variety of health outcomes among elderly people and studies on this subject date back to the 1800s. The presence of a spouse is one of the most important sources of social and economic support that determines the well being of an elderly person. Marriage has a protective effect and it tends to increase longevity, improve health status, and enhance preventive health care utilization (Goldman et al., 1995).

At the time of the survey, almost half of the elderly women (around 47%) were married, while a significant proportion (45%) were widowed. The most striking finding was the trend in widowhood with age (table 8). The proportion of widowed women increased significantly with increasing age to reach a level as high as 77.0% in the older age category (80 years or more). These percentages are better appreciated when compared with the marital status of elderly men (Figure 5).

Figure 5. Distribution of Elderly Men and Women by Marital Status, PHS, 1996.



*Other include never married, divorced and separated

The proportion of elderly men who were married in 1996 (86.5%) was around twice as that of elderly women (47.2%). Elderly men tend to marry and remarry more often than women do in case of widowhood and divorce. In general, widowed individuals are considerably more likely to be poor than married couples and unmarried older women experience higher poverty rates than do unmarried older men (Choudhury & Leonesio, 1997).

2. Household Size

Although elderly women are usually themselves the primary caregivers within the household, their potential care giving capacities are significantly reduced with aging. Traditionally, families in Lebanon are the primary source of care for the elderly. Cultural and social values still protect the majority of elderly males and females. Nevertheless, provision of care to the frail elderly by other family members, especially daughters, is faced by other competing role responsibilities as more women are joining the work force. Thus, the number of people residing in the household is not sufficient to indicate the quality of care provided to the dependent elderly woman (Kelman et al, 1994). Nevertheless, living alone is without doubt the most disadvantaged living arrangement with the least social support avenues. As shown in Table 8, 12.7% of elderly women were living alone at the time of the PHS survey in 1996. The probability of living alone increased at a fast rate with aging to reach a level of 22.4% in the very old age category (i.e. 80 years or more). Isolated females were more likely to be concentrated in the Nabatieh Governorate, to be working in the private sector and less likely to rely on real estate for income than other females (data not shown).

The relatively high poverty rates for elderly women living on their own have been recently explored in the literature. It is noted that shared living arrangements provide an important source of economic support, particularly for aged widows (Waehrer & Crystal, 1995). However, the data at hand do not give a clear idea of the potential resources available to these elderly Lebanese women living alone, their living conditions or health status. Future in-depth studies should focus on this sub-group in Lebanon.

3. Family Structure

With aging, families tend to change in structure from nuclear to extended ones. This movement was pronounced among the elderly female population. In fact, while only 18.1% of women aged 60 to 64 years lived in extended households, 39.8% of the older women (80 years and over) lived within this family structure. Polynuclear families that consisted of more than one nuclear family, with parents being mostly siblings, accounted for less than 6% of the population and this proportion was relatively stable across the different age groups. Household types that were gouped as 'others' were mostly of the 'single' nature or female-headed households where the elderly woman was either living on her own or with non-relative others. The propotion living in such a structure increased significantly with aging from 9.9% among the young olds (60-64 years) to around 27% among the very old (80 years and over).

Table 8. Distribution of Elderly Women by Marital Status, Household Size and Family Structure Stratified by Age, PHS, 1996.

	Age (Years)					
	60-64	65-69	70-74	75-79	80+	Total
Marital Status	%	%	%	%	%	%
Single	7.1	7.5	6.3	6.3	5.7	6.8
Married	63.2	51.6	40.5	30.7	16.8	47.2
Widowed	28.4	39.6	52.3	62.4	77.0	45.0
Other*	1.3	1.3	1.0	0.6	0.5	1.1
Household Size						
One (Living Alone)	6.6	11.0	16.6	18.7	22.4	12.7
Two	19.4	23.2	24.5	25.0	21.1	22.1
Three to Four	35.7	33.3	27.2	24.9	20.3	30.6
Five or More	38.4	32.9	32.4	32.2	36.9	35.1
Family Structure						
Nuclear	66.1	56.3	47.2	40.2	27.0	52.8
Extended	18.1	23.3	28.3	31.6	39.8	25.3
Polynuclear	6.0	5.6	5.7	5.8	6.3	5.8
Other**	9.9	14.8	18.9	22.4	26.9	16.1
Total N	53,756	42,652	31,079	15,126	19,611	162,223
Total %	100.0	100.0	100.0	100.0	100.0	100.0

* Includes the divorced and separeted elderly women
** Includes those living alone or with non-relatives

C. Health Status and Needs

The 'demographic' transition described earlier is accompanied by changes in the pattern of diseases, the 'epidemiological' transition. The former refers to the declining trends in mortality and fertility rates accompanied with an increase in the proportion of elderly population while the latter refers to the secular changes in patterns of health and disease from infectious to chronic degenerative diseases in relation to social, economic and demographic factors.

It is well established that the complex interplay between demographic changes, risk factors and therapeutic interventions is the one that influences morbidity and mortality patterns in a given population (Feachem, 1992). As nations modernise, a decline in fertility immediately translates into a reduction of childhood diseases and deaths as well as a sharp increase in the proportion of elderly. This demographic factor is also responsible for inflating the effects of aging and producing a shift towards non-communicable diseases. Risk factors play an important role in the health and epidemiological transitions. Changes in the prevalence of exposure to risk factors such as cigarette smoking and diet alter significantly age-specific morbidity and mortality rates. Finally, access to and effectiveness of therapeutic measures influence both the prevalence and case-fatality rates associated with certain communicable illnesses. This will inevitably inflate the burden of chronic degenerative diseases of old age. The two sections below describe causes of morbidity and disability that the elderly females suffer from.

1. Morbidity: 1983-84 and 1992-93

The elderly suffer from a multitude of co-morbid conditions, both infectious and chronic. Because of the deterioration in the inflammatory and immune response with aging, infections in the elderly are a common cause of morbidity and mortality. Nevertheless, the leading causes of morbidity remain chronic in nature, mainly heart diseases, hypertension, diabetes, arthritis, hearing and visual impairments. Even though morbidity is often non-fatal, it is usually associated with disabilities and it detracts greatly from comfort and jeopardizes the quality of life among the elderly.

Table 9. Prevalence (per cent) of Selected Chronic Conditions Among Women Aged 60 Years and Over, Beirut 1983-84 and 1992-93.

	Year			
	1983-84*		1992-93**	
Age (Years)	60-69	70+	60-69	70+
Condition (%)				
Hypertension	31.0	35.1	29.5	29.9
Heart Diseases	14.2	25.8	16.4	24.4
Arthritis	16.5	14.4	19.7	20.8
Diabetes	15.8	15.5	17.8	14.2
Back Pain	12.3	8.9	18.0	16.2
Hypercholesterolemia	12.0	7.0	15.3	11.7
Cataract	3.5	10.7	4.9	9.6
Glaucoma	0.9	1.5	1.6	4.6
Ulcer	4.1	3.7	4.6	3.0
Kidney Problems	6.3	1.8	6.0	4.6
Asthma	2.2	2.2	3.3	3.0
Anemia	3.2	1.5	4.7	7.6
Mental Problems	1.3	0.0	1.1	1.5
Cancer	0.0	1.1	0.0	0.5

Sources: *Khlat, M. & Armenian, H., 1984
** Nuwayhid, I., Sibai, A., Adib, S. & Shaar, K.H., 1997


Picture Credit:
Sunshine Cards

In Lebanon, no cause-specific morbidity data are available on a large scale. However, the two surveys that were conducted in Beirut by the Faculty of Health Sciences (FHS), American University of Beirut, during the years 1983-84 and 1992-93 shed some light on the health status and needs of its aging population (Khlat & Armenian, 1984; Nuwayhid et al, 1997). The findings of these two surveys are compiled for the older age groups in table 9. Hypertension and heart diseases remain the leading causes of morbidity among elderly women in both the 1983-84 and 1992-93 surveys. Arthritis accounted also for a significant burden of morbidity in 1984 and its prevalence was more pronounced in 1992-93 among this subgroup. Other diseases of importance included diabetes, back pain and hypercholesterolemia followed by cataract, glaucoma, ulcer and kidney problems. It is worth noting that the two studies were not directed specifically towards the elderly population, and are limited by the small sample size of old age groups as well as reporting biases. A study directed specifically towards the elderly which includes clinical assessment and measurements is needed for a better appraisal of the health status and needs of our elderly population.

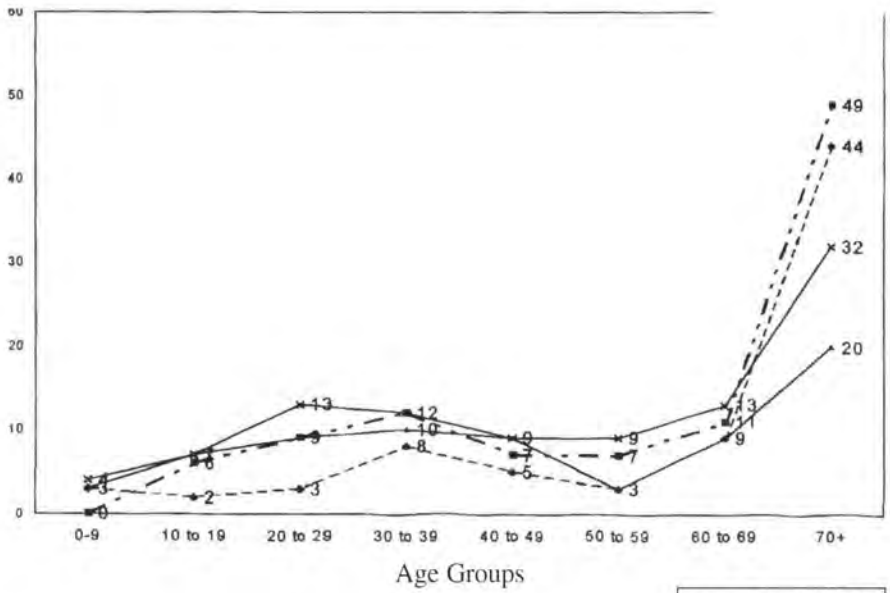
2. Disability: 1983-84, 1992-93 and 1996

The objective of health and social policies in old age is not simply to extend the life span but also its quality and the goal remains not to add years to life as much as to add life to years. Thus, an understanding of the determinants of living free of disability (or healthy life expectancy as it is generally termed) is essential.

In assessing the burden of disease, disability should be included in addition to mortality and morbidity. Disability among the elderly is best measured by activities of daily living (ADL) and Instrumental ADL. Studies that use these measures are currently lacking in Lebanon. Nevertheless, the following analysis utilises the PHS data and the FHS Beirut surveys on disabilities as a proxy measure for ADLs. There is a general belief, however, that all data sources suffer major under reporting biases on disability statistics (Sibai, 1999).

The results of the secondary analysis of the PHS data are shown in figures 6 and 7, and comparisons are made with the other two FHS surveys conducted in Beirut in 1983 and 1993. In Lebanon, as a whole, and according to the PHS data (1996), 3,136 elderly females suffered from one type or another of disability (19 per 1,000). Across all studies, disability rates increased markedly with increasing age, in particular, from 60-69 years to 70 years and above (Figure 6).

Figure 6. Trends in Prevalence of Disability (per 1,000) Among Total Lebanese Women by Age and Over Two Decades: 1983-84 [1], 1992-93 [2], and 1996. [3]

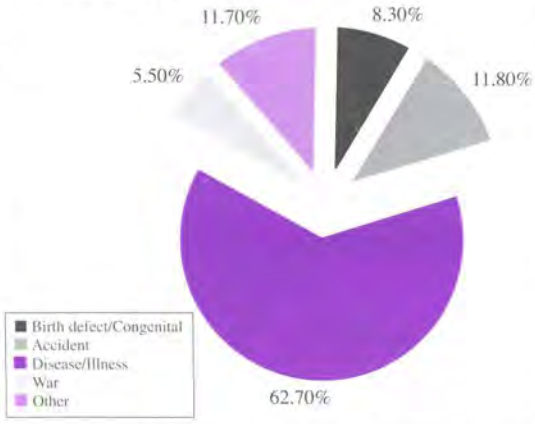


Sourses:
1. Khlat, M. &Armenian, H., 1984
2. Nouayhid, I., Sibai, A., Adib, S., & Shaar, K.H., 1997
3. PHS, 1996

Figure 7 presents the data obtained from the PHS survey regarding the distribution of causes of disability among elderly women. The leading cause of disability was diseases (62.7%), mostly cerebrovascular, seeing and hearing impairments. Such a finding points to the importance of the burden of diseases among this age group and is in accordance with published literature in other parts of the world (Murray & Lopez, 1997a). As pointed out earlier, cardiovascular diseases and their associated co-morbid conditions are the most prevalent diseases among elderly women in Lebanon, and these in turn contribute to disability.

World-wide, it is estimated that these conditions account on average between 9 and 22% of life-years lost due to disability (Murray & Lopez , 1997b). Despite the great scope for prevention, intervention activities in Lebanon lag behind.

Figure 7. Proportionate Distribution (%) of Causes of Disabilities Among Elderly Women, PHS, 1996.



VI. A Framework for Action

Although the present article focused on elderly women, much of the features of aging in Lebanon relate to elderly men as well, and in the long run what benefits women will also benefit men. Moreover, even though the factors and characteristics associated with aging women were presented individually, they are inter-related and rarely occur in isolation. Lebanon faces certain issues that render the aging of its population rather a complex challenge: inadequacy of data regarding the health and social needs of its growing elderly, lack of aging policies and deficiency of resources. Without an adequate information base, planning and policy recommendations remain spotty and intuitive.

Two types of investigative efforts are needed: firstly, a thorough assessment of present resources including services and activities provided by the government, voluntary organisations and families; and secondly, a thorough assessment of present and projected needs of the elderly in the community and in organisations (Sibai, 1993). Such data will provide valuable information for health and social policy makers to plan interventions.

Picture Credit: Fikrun Wa Fann (68)

Old-age pension plans and health insurance schemes do not have a sufficiently wide coverage to satisfy the needs of our elderly population. Given the relatively low income of older women, strategies must focus on insurance coverage and free access to health care and social services. Social and health security schemes should include self-employed workers, unskilled labourers, full-time housewives, widows as well as the never married elderly women. There is also a need to recognise the role of primary caregivers to elderly frail individuals. Caregiving women need to be supported and given options as part of community-based health care services especially for the disadvantaged and low-income groups.

There is a great diversity among older women, and actions should be tailored to their specific needs. Disadvantaged groups among elderly women include those who are widowed (45%), those who are living alone (12.7%) and those who are disabled (1.9%). Disability and dependency among the elderly may be improved by focusing on the disease itself when present (e.g. prevention, treatment, palliation), the individual (e.g. education, welfare benefits, social support), and the environment (e.g. public transport, shops, entertainment, interior design). Public health medicine, health and social services, local government authorities and other sectors may achieve better health for the ageing populations through concerted rather than fragmented actions (Ebrahim, 1997).

Aging is a continuous process. The patterns of living, exposures and the health of a woman in earlier periods of her life determine her health status and needs in later stages (Bonita, 1996). Health and activity in later ages are therefore a summary of the exposures and actions of an individual during the whole life span.

Picture Credit: Fikrun Wa Fann (68)

Recently, the WHO Expert Committee on Aging in its meeting in Geneva in October 1998 endorsed that a life course perspective for active aging is needed. This looks at the cumulative health benefits, including factors associated with living conditions and social roles, that will accrue to aging individuals through improvement of health at all ages.

The United Nations is marking 1999 as the 'International Year of Older Persons', with the theme 'Towards a Society for all Ages'. The WHO has also chosen as a theme for the World Health Day this year 'Active Aging Makes the Difference'. This recognizes that active aging through a life course perspective should be a key component of all development programmes. Challenges remain and struggles for successful aging should continue.

This article is based, in part, on a report presented to the Ministry of Social Affairs entitled ' The Elderly in Lebanon : Their Demographic, Socio-economic, Social and Health Aspects', (Sibai, 1998).

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United Nations Principles for Older Persons
To add life to the years that have been added to life

The General Assembly ... Encourages Governments to incorporate the following principles into their national progammes whenever possible

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.

2. Older persons should have the opportunities to work or to have access to other income-generating opportunities.

3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.

4. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.

5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.

Participation

6. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.

7. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.

8. Older persons should be able to form movements or associations of older persons.

Care

9. Older persons should benefit from family and community care and protection, in accordance with each society's system of cultural values.

10. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

11. Older persons should have access to social and legal services to enhance their autonomy, protection and care.

12. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.

13. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfillment

14. Older persons should be able to pursue opportunities for the full development of their potential.

15. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

16. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

17. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

(Implementation of the International Plan of Action on Aging and related activities, 74th Plenary meeting, 16 December, 1991)

(gopher://gopher.un.org:70/00/ga/recs/46/91)

Prevention is Better than Cure

In Lebanon there are no more than ten doctors specialized in Geriatric medicine. Dr. Thuraya Arayssi is the only Geriatric specialist at the American University Medical Center (AUB - MC). She is also a specialist in Internal Medicine and Rheumatology . This interview took place in her office at AUB - MC.

Myriam Sfeir: Where did you complete your specialties and why did you choose Geriatrics?
Dr. Thuraya Arayssi: I did my Geriatrics specialty at the University of Rochester, Rochester, New York, and I pursued work in Rheumatology at the National Institutes of Health in Washington DC. The field of geriatrics is underserved and very few people know about it. At this point research in this area is still in its infantile stages. I think one can contribute a great deal to one's patients and to the community by conducting studies and research along these lines. As we grow older, the way diseases present themselves change, so we need to study that to be able to give better care to our patients. I believe that every physician needs to develop expertise in geriatrics, for whatever specialty one chooses one is bound to have older people among his/her patients.

MS: How does geriatric medicine differ from other specialties and what are its objectives?
TA: The most important thing to know is that unlike other specialties, geriatrics is not organ oriented. Let me explain that further. When you specialize in cardiology you are a specialist in diseases of the heart. Moreover, if you opt for gastroenterology you are a specialist in the diseases of the gastro intestinal system. In geriatrics there isn't a single organ system that you are involved in, it is more of a holistic approach to a human being and to a patient. Geriatric medicine does not only seek to cure diseases, but to prevent them by striving to educate (instruct) people on how to age successfully. The concept of successful aging is something very important nowadays. Geriatric medicine basically attempts to answer questions related to how we age, how our aging interfaces with the environment and with the community and what we, as physicians can do to promote the health of the aging population.

MS: What are the ailments mostly encountered by geriatric physicians?
TA: I believe that it is very important for us to start differentiating between diseases and natural aging. As we age many of the disorders that we suffer from, although they accompany the aging process, are in fact minimally due to old age and more related to environmental exposure and to how well we have managed to care of ourselves. For example we start losing muscle power because we didn't exercise well, we start having lung problems because we smoked.

Many people assume that the health problems they are suffering from are the result of aging. For example, some elderly take it for granted that forgetting things and losing one's memory is not a problem since it is part of the aging process. This is a misconception, for even though losing one's memory or dementia is one of the common problems the older adult may suffer from, not all dementias are irreversible. Therefore, we cannot always presume that if somebody is 70 years old and has started to forget things is part of normal aging.

Other conditions that we deal with are recurrent falling, urinary incontinence , depression and so on. As far as the latter condition goes, it is well known that prevalence of depression is much more common in older adults than in younger ones.

All these ailments are dealt with in collaboration with other medical specialties. For instance cases of dementia are treated in collaboration with the neurologist and the psychiatrist, urinary incontinence in collaboration with the gynecologist and the urologist, depression with the psychiatrist. So this again tells you that this is a holistic approach to the patient where we do not presume that we are specialists in one particular organ.

MS: Do people know about geriatric medicine? Are the patients you treat mostly men or women?
TA: Unfortunately, most people are unaware of the existence of this specialty. Yet, this is not surprising because this is

relatively a new specialty and only recently did it start to gain recognition even in developed countries where a large proportion of the population is over the age of 65. I think people are now starting to seek the help of physicians specialized in diseases of the elderly, who can assist them in directing the care of their elderly parents.

The majority of my patients are female rather than male by virtue of my specialty, since arthritis affects more women than men and since there's a predominance of women in the older population. If I had been a cardiologist I would have had more male than female patients. The majority of my elderly patients come for consultation along with their children and the majority, I believe, are dependent on them.

MS: Are your patients fearful of death and do you broach upon issues related to dying ?
TA: My experience in Lebanon is limited since I've only been here for a year or so. Yet from my limited experience I can say that we Lebanese are very reluctant and uncomfortable talking about death and dying issues. It is a taboo subject that is not even discussed among children and their parents, and I think it is not healthy. Children in Lebanon end up doing what they feel, in their better judgment, to be best for their parents which may or may not turn out to be the wishes of their parents.

Unlike Lebanon, in the US it is very normal for patients to talk to their physician about measures to be taken in cases of terminal disease when they are physically or mentally unable to decide for themselves. In fact part of my training dealt with how to address death and the issue of dying with patients and their families. Patients usually fill in a health care proxy which will describe what their wishes are if such and such (x or y) were to happen to them.

When I first came back to Lebanon I tried to apply what I had been taught, but I noticed a lot of disapproval and resistance on the part of my patients and their families. I am sure a lot of people think about death yet they rarely talk about it. Very few of my patients discuss their fear of death and I personally, due to the prevalent values, don't feel very comfortable discussing this subject with the patient though I may do that with the family members.

MS: Are your patients health conscious and do they come for regular checkups?
TA: Not at all. Health awareness in this country is practically non existent. This has to do with our ignorance in health matters. We tend to be oblivious when it comes to health education about preventive medicine. I often try to explain to most of my patients who come to me with minor problems about the importance of preventive medicine. I advise them to have regular checkups for breast cancer, colon cancer, osteoporosis, but most of them look at me in astonishment and with questioning eyes: "Well I feel fine why should I worry about all these things." Even if I try to remind my patients about their flu vaccines they are surprised: "I am well, why are you calling me?"
People will sooner or later realize the importance of preventive medicine given the fact that treating an already existing disease is much more difficult than taking measures to prevent it.

MS: Did your parents object to your becoming a physician given that you are a woman?
TA: Not at all, my parents were very supportive. My parents have helped me, ever since I was a child, to make decisions on my own, and they always supported me in everything I chose to do. They actually taught me to be a free person and made me feel that I have the potential to do anything I want. They helped me a lot in this sense, and they allowed me to grow into a mature person who can take the right decisions and is willing to bear the responsibilities and consequences of those decisions. So the manner I was brought up helped to shape my personality.

HEALTH CARE PROXY

I, _____ hereby appoint the following person as my HEALTH CARE AGENT, to make any and all health care decisions for me except for any restrictions I have noted below. This Proxy shall take effect when and if I become unable to make my own health care decisions.

_____ _____
HEALTH CARE AGENT NAME PHONE

_____
ADDRESS

_____ _____
ALTERNATE HEALTH CARE AGENT NAME PHONE

_____
ADDRESS

Optional instructions or limitations on the Health Care Agent's authority, if any:

_____
_____
_____
_____

Unless I revoke it, this Proxy shall remain in effect indefinitely. (Or until the date or condition stated below, if any.)

_____
_____

Source: Sample health care proxy taken from Quill, Timothy E. Death and Dignity: Making Choices and Taking Charge

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

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This article is part of a research project financed by the European Commission to assess disability and its psycho-social, economic, and epidemiological impact on families among adults in the West Bank (Occupied Territories) and in Lebanon. The research is co-ordinated by the Department of Community Medicine, University of Cambridge, UK. Partners in this project also include the Institut National d'Etudes Demographique in Paris, France, the Department of Health Sciences, American University of Beirut, Lebanon, and Aid to the Aged (ATTA) in East Jerusalem, Occupied Territories.

Introduction

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

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

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

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

Picture Credit: George Hadjimenikou

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

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

Methodology

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

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

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

Picture Credit: Delphine Garde

Results

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

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

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

Women spend more on their health than men

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hence it can be comfortably concluded that refugee camp

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Picture Credit: Anita Nassar

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

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

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

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

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

Picture Credit: Pierre Couteau

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

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Caring Institutions in Lebanon

I hope to retain my independence for as long as possible. This may mean that I have to pay for help, but I do not expect it from you or your partners ... If I reach a point when I cannot live independently I do not expect any of you to provide me with a home. I hope and plan to make arrangements with some of my friends to live together in some sort of sheltered accommodation but, failing that, I will have to find the most acceptable place I can and if it uses all my savings - well, they are my savings! If, by then, I am unable to make decisions for myself, you may have to jointly find the best place for me but none of you should feel guilty about not taking the burden. I do not want you to do so - whatever I might be saying at the time. (Growing Old Disgracefully, p. 179)

Testimonies: Elderly living in Caring Institutions

Ramza (Umm Yousef)
I am 80 years old. I came to Hamlin Hospital four months ago. After a visit to my daughter I got very sick and needed constant medical attention. Unable to take care of me, my children decided to put me in a home. All my children visit me especially those who live close by. I am very happy here, and they all treat me with kindness and care.

Adiba Saba Rahbani
I don't know how old I am, maybe 82 or 92, I can't remember. I've been here for a long time but I don't know exactly how long. I am not happy here. I want to go back home. I have a house next to the church in our village and I want to go back and live there. My brother decided to put me in this home because I couldn't take care of my self. My brother comes to visit me from time to time. He is a school teacher and is busy.

Laurice Saafer
I can't remember how old I am, maybe 85. My sons brought me here because I am too sick. My sons are unable to take care of me and since I need constant attention, they decided to put me in a home. At Hamlin they take good care of me; they are very kind and I am happy here. I feel at home and the people here are like my family. My sons visit me every two weeks. They are too busy. I sleep most of the time since I am unable to do anything else. I am too weak and sick.

Eugenie Abou Rjaili
I am 80 years old, no 85 or maybe more, I really can't remember. My son brought me here because I am very sick. I can't move, stand or walk. I just got admitted. I am very happy here, they are very helpful, warm and compassionate. They are very kind to the elderly. My son is very busy with his work; besides, he lives in Mansourieh so he can't visit me everyday.

Saydeh Mashalani
I am 60 or 70 years old, I really don't know. I've been here for a long time (the nurse tells me that she has been in Hamlin for the past 10 years and that she is handicapped.) My sister and nephew brought me here. They visit me once every seven months. My sister had an operation and she is not very healthy so this is why she doesn't visit me very often. It's been a long time since she last visited.

Hamlin, an elderly home in Hammana
Picture Credit:Bassem Maamari

Mounira Houri
I can't remember how long I've been here nor do I remember my age. Yet, I know that I've been here for a long time (10 years according to the nurse). I have 4 children and all of them come to visit me (the nurse says only one comes). I chose to come to Dar Al-Karamat, no one brought me here. I am very healthy (the lady suffers from Alzheimer's disease).

Al-Hajji Raifa Zaydan
I've been here for around 3 years. I am a widow with no children. Thanks to my husband's pension that I can afford to stay in this place. My brothers come to visit me whenever they can. I am very happy here. My health is deteriorating. I can't see well, my leg is broken and I have a constant cough. Besides, my heart and lungs are weak. I am not scared of death, my child, I've been to the Hajj 11 times. If I die it is God's will. My arms will be open wide to welcome death.

Jihan
I can't remember how long I've been here. I never got married. I have two sisters and they decided to bring me here. They always visit me and get me everything I need. My sisters were unable to take care of me for they have their own families so after I broke my leg and couldn't move or walk they put me here. I am not scared of death. On the contrary Ahlan wa Sahlan bil Maut (I will welcome death when it arrives). I am very happy here and I feel as if I am within my own family. I consider them to be my family.

Caring Institutions

1. Ma'wa Al-Ajazi Al-Faransi

Founded: 1904 by a French organization - Notre Dame de la Douleur - the first elderly home in Lebanon.
Number of beds available: 70
Number of elderly residents: 65
Admission fee per month: free or minimal contribution depending on one's economic situation.
Criteria for Admission: the elderly should be healthy, able to walk and eat on their own, and they should have a guardian.
Funds: the Ministry of Social Affairs, contributions and donations, fund raising activities such as lunches, dinners, parties.
Number of doctors available: two, doctors on call.
Facilities: food, laundry, hot water, medication, clothes.
Recreational Activities: picnics, trips, birthday parties, visits by schools and other charity organizations.

2. Myrrh Bearing Society (Jam'iyat Hamilat al-Tib)

Founded: 1936
Number of beds available: 18 beds.
Number of elderly residents: 16
Admission fee per month: 250,000 LL ($ 160).
Criteria for Admission: none.
Funds: a per-dium of 4,000 LL for each elderly paid by the Ministry of Social Affairs, contributions and donations, fund raising activities such as lunches, dinners, parties.
Number of doctors available: one, doctors on call.
Facilities: food, laundry, hot water, medication when available, clothes.
Recreational Activities: no fitness program for all the elderly are too frail to excercise, no library for most of them are illiterate, watch T.V. and listen to the radio.

3. Dar Al-Rahmat

Founded: Beirut 1949
Number of beds available: 700
Number of elderly residents: 500
Admission fee per month: 1st class: $ 700, 2nd class: $ 500 with balconny, $ 400 without balcony, 3rd class: $ 300.
Criteria for Admission: healthy individuals.
Funds: the Ministry of Social Affairs as well as municipalities.
Number of doctors available: two, doctors on call.

Picture Credit: Bassem Maamari

Facilities: food, laundry, hot water, medication when available, clothes (charity).
Recreational Activities:T.V, radio, cards.

4. Jam'iyat Al-Khadamat Al-Ijtima'iet

Founded: 1951
Number of beds available: 150
Number of elderly residents: around 120
Admission fee per month: free.
Criteria for Admission: none (elderly, sick, disabled).
Funds: Ministry of Social Affairs, funds, income generating activities, donations.
Number of doctors available: 3 (general practitioner, rheumatologist, neurologist) and 15 on call.
Facilities: food, laundry, hot water, medication, clothes.
Recreational Activities: parties, trips, visits by schools and other charity organizations.

5. Dar Al-Ajaza Al-Islamieh

Founded: 1954
Number of beds available: 800
Number of elderly residents: 800
Admission fee per month: free (minimal contribution depending on one's economic situation).
Criteria for Admission: the elderly should be in need attention.
Funds: Ministry of Health, Ministry of Social Affairs, UNRWA, medical brigade in the Lebanese army, private patients charity, donations and contributions.
Number of doctors available: 25
Facilities: food, laundry, hot water, clothes, medication, specialized medical treatment, dentistry attention, laboratory examinations, x-ray, etc.
Recreational Activities: T.V., radio, video, walks, trips, sports, painting, excursions.

6. Ma'wa Al-Ajazi - Tal Cheha

Founded: 1957
Number of beds available: 40
Number of elderly residents: 30
Admission fee per month: free or minimal contribution depending on one's economic situation.
Criteria for Admission: healthy individuals.
Funds: Ministry of Social Affairs, contributions and donations.
Number of doctors available: one (general practitioner), doctors on call.
Facilities: food, hot water, laundry, medication.
Recreational Activities: picnics, trips, parties, outings to restaurant, prayers.

7. Hamlin

Founded: 1971
Number of beds available: 90 to 100
Number of elderly residents: 26

Source: Brochure of Dar Al-Ajaza Al-Islamia

Admission fee per month: 1st class $ 665 (room for one person, toilet, hot water), 2nd class $ 400 (room for two peole, toilet, hot water), 3rd class $ 300 (room for two people).
Criteria for Admission: none.
Funds: Ministry of Social Affairs, contributions and the Evangelical Presbyterian Church covers the deficit.
Number of doctors available: one, doctor on call (hospital ten blocks away, all elderly are treated free of charge).
Facilities: food, laundry, hot water, medication, clothes.
Recreational Activities: parties, picnics, visits by schools and other charity organizations, prayer services,

8. Deir Mar Youssef Jrabta

Founded: 1973
Number of beds available: 50
Number of elderly residents: around 45
Admission fee per month: free or minimal contribution depending on one's economic situation. Some pay $ 200 others pay $ 400 and those in first class pay $ 500.
Criteria for Admission: none.
Funds: Ministry of Social Affairs, contributions and donations.
Number of doctors available: one.
Facilities: food, hot water, laundry, medicine, clothes if donated.
Recreational Activities: T.V., radio, picnics.

9. Dar Al-Karama

Founded: in 1983
Number of beds available: 50
Number of elderly residents: 30
Admission fee per month: class a - fit and healthy $ 440, class b - unhealthy elderly who need more care $470, class c - are invalids $ 500.
Criteria for Admission:none.
Funds: Fees exempted, donations, contributions.
Number of doctors available: one, doctors on call.
Facilities: food, laundry, hot water, clothes if donated.
Recreational Activities: T.V. cards, parties on Mother's day.

10. Jam'iat Al-Bir Al-Masihi Al-Orthodoxi - Tripoli

Founded: 1984
Number of beds available: 45
Number of elderly residents: 45
Admission fee per month: free or minimal contribution depending on one's economic situation.
Criteria for Admission: accept all elderly even sick ones.
Funds: the Ministry of Social Affairs, contributions and donations, fund raising activities such as lunches, dinners, parties, selling hand crafts, etc.
Number of doctors available: two - general practitioner and gynecologist.
Facilities: food, laundry, hot water, medication if needed, clothing.
Recreational Activities: games, T.V., picnics, visits by schools and other charity organizations.

11. Ain Wa Zin

Founded: in 1989
Number of beds available: 74
Number of elderly residents: 73
Admission fee per month: $ 300 (no classes).
Criteria for Admission: none.
Funds: the Ministry of Social Affairs, Ministry of Health, contributions and donations, fund raising activities.
Number of doctors available: two doctors, one available everyday and the other every week.
Facilities: food, laundry, hot water, medication when available, clothes if donated.
Recreational Activities: trips, picnics, handicrafts.

12. Mustashfa Dar Al-Sahil lil Naqaha

Founded: 1990
Number of beds available: 32
Number of elderly residents: 10
Admission fee per month: 1st class $ 800, 2nd class $ 500, 3rd class $ 300.
Criteria for Admission: none (elderly, sick, disabled).
Funds: Ministry of Social Affairs, contributions and donations, the founder and owner Ms. Khayriet Alama often covers the deficit.
Number of doctors available: three (geriatricians, cardiologists, general practitioners).
Facilities: food, hot water, laundry, clothes, share in paying for medication with the parents.
Recreational Activities: T.V, radio, card games, walks.

Picture Credit: Bassem Maamari

13. Al-'Omr Al-Madid

Founded: 1992
Number of beds available: 60
Number of elderly residents: 23
Admission fee per month: suite $ 775 (2 beds, salon, toilet, balcony) $ 400 (1 bed, salon, toilet, balcony), $ 100.
Criteria for Admission: absolutely healthy individual because Al-'Omr Al-Madid is more of a residence for the young old.
Funds: private donations from individuals.
Number of doctors available: one.
Facilities: hot water, food, laundry.
Recreational Activities: trips, conferences, picnics, gym, members of the club elderly run by Al-'Omr Al-Madid.

Psychosocial, Health,and Economic Aspects of an Elderly Armenian Population in Lebanon

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Introduction

To study how older people are treated within a society and how the elderly attest with the unavoidable problems of aging, particularly those involving health and income is of immense importance today. Health problems include normal losses in hearing, eyesight, and memory, and the increased likelihood of chronic diseases. Economic problems include loss of employment and therefore significant decreases in income and reliance on pensions, and social security. Social problems include greater difficulty to maintain social relationships because of health limitations, death of family members and friends, loss of work mates and lack of transportation.

The present generation is probably the first in history to be raised with the expectation of old age, with about 20% of all humans who have passed the age of 65, now alive (US Bureau of the Census, 1993).

The principal objectives of the study are:
- to appraise the demographic, social and economic characteristics of the elderly population among the Armenian community in Lebanon.
- to assess physical and mental health in the elderly population in consideration with other factors such as social, and economic and
- to examine how these processes vary among elderly living in the nursing home and those living in the community.

Methodology

Selection of Study Area: It was necessary to commence with the one nursing home that belonged to the Armenian community, which was located in the Bourj-Hammoud district. This area is a suburb of Beirut City, actually located East of Beirut. Most of the housing resembles squatter settlements, though these apartment buildings also exist. One particular area had been set up several decades ago, immediately after World War I, to house the poverty-stricken Armenians who had fled from the massacres perpetrated by the Turks, to Lebanon. This area was essentially a camp bequeathed by the Lebanese Government, where the Armenians could lodge and find some sort of shelter. These shacks are still in use today, by those who have not climbed the paths of societal orders. The apartments referred to above, generally were equipped with electricity, water supplies, toilet and bathing facilities. However, there were quite a few without heating facilities. The second district from which samples were selected was Achrafieh, also a suburb of Beirut city, located East of Beirut city but West of Bourj-Hammoud. Achrafieh is relatively a large district with several different grades of socioeconomic backgrounds. In general, however, it is far better off socioeconomically, than Bourj-Hammoud, with generally, better housing conditions.

Sampling Procedure: The sample for this study included two groups of elderly people: nursing home residents and community dwellers over the age of 65. A total of 94 nursing home (all residents >65 years of age) residents were interviewed. In order to compare the characteristics of the nursing home population with elderly living in the community, a sample size of 142 was determined. The procedure for selecting this sample from the community follows the nested case control rules since a strict neighborhood case control was not feasible. The questionnaire used was that developed by the Older Americans Resources Program at Duke University (Duke OARS), Multidimensional Functional Assessment Questionnaire (OMFAQ). Some questions were modified to suit the environment of the study population. In addition to the OMFAQ, general questions were added to fulfill the objectives of the study.

Table 1. Distribution of Elderly Population by Age and Sex (%)

	Sex				
Age	**Males**	**Total**	**Females**	**Total**	**Sex Ratio (M/F)**
65-74	40.4	(16.1)	35.8	(24.2)	66.52
75-84	28.6	(9.3)	33.3	(22.5)	41.33
85-89	16.9	(5.5)	18.9	(12.7)	43.31
90-94	5.2	(1.7)	9.4	(6.4)	0.3
95-100	-	-	2.5	(1.7)	-
Mean Age	[75.7]		[78.2]		
N	77 (32.63)	(236)	159 (67.37)	(236)	48.43

Results and Discussion

Age and Sex: Table 1 reveals the age and sex distribution of the elderly study population in the Armenian community. The mean (± SD) age of the study elderly population was 77.4 (±8.7) years. The average ages for males and females were quite close - 75.7 years and 78.2 years respectively.

While the ages of the 206 elderly were accurate (i.e. based upon date of birth recorded in a passport or ID), there were 30 persons whose age was estimated by the caregivers. The ages of those who did not know their dates of birth ranged from an estimated low of 67 to an estimated high of 100 years.

Table 2. Distribution of Elderly Population by Place of Residence Age, and Sex (%)

	Place of Residence					
	Home			Institution		
Age	Males	Females	Total	Males	Females	Total
65-74	57.1	50	(52.8)	28.6	19.1	(21.1)
75-84	30.4	33.7	(32.4)	23.8	32.9	(30.9)
85+	12.5	16.3	(14.8)	47.6	48.0	(47.9)
N	56 (39.43)	86 60.56	142 (60.2)	21 (22.34)	73 (77.66)	94 (39.8)

Males: X2 = 11.287, P = 0.0034, (P<0.05)
Females: X2 = 23.319, P = 0.0001, (P< 0.05)

Place of Residence: Table 2 shows the distribution of the study population by place of residence, age group and sex.

Ninety four subjects were institutionalized elderly and 142 lived at home. Of the 94 nursing home residents 21 were males and 73 were females (with a sex ratio of 28.76%), while there were 56 males and 86 females (with a sex ratio of 65.11%) out of 142 elderly living at home. The lower sex ratio in the nursing home is in fact envisaged by Cavanaugh (1993) where the "typical nursing home resident" revealed to be a single, very old female. However, controlling for sex, the percentage of the age group 65-74 living at home was the highest (52.8%), the percentage of the same age group was lowest among institutionalized elderly (21.3%). This indicates that higher proportions of young olds (65-74) are living in the community, whereas higher proportions of oldest olds are living in the institution. This was true for males as for females.

Marital Status: Marital status is plausibly one of the most important determinants of socio-demographic characteristics of any given population. The percentages of female singles and female widows (25.8% and 62.9% respectively) were quite high compared to their male counterparts (20.8% and 23.4% respectively). More than half the males were married (50.6%) compared to only 11.3% of the females. The percentage of widowed was far greater for females than for males (62.9% and 23.4% respectively), most women having married men much older than themselves. Spending their old age without their spouses places elderly women at a disadvantage. However, to understand some of the other social characteristics, we must look at the marital status of these elderly, according to their place of residence (Table 3).

Analogous to the literature, the typical nursing home residents are single, and in our case, also widowed females (39.7% and 56.2% respectively). While institutionalized males also fell in these two categories, there were more single males than widowers (57.1% and 28.6% respectively). Only 14.0% of females and 7.1% of males who lived at home were single. The percentage of married males, living at home (67.9%) compared to 17.4% for females could be explained by the male lower life expectancy and the fact that most of these men have married women by far younger than themselves.

Economic Characteristics

Employment Status: Old age brings with it major life transitions, including retirement. The study population revealed the following situations concerning employment (see tables 4 and 5):

- The non-working population is much larger than the working one. This is due to two main factors: (1) the decline in the physical and mental health of the elderly; (2) the official age of retirement in Lebanon (64 years). Working status was also naturally affected by the place of residence. Elderly males living at home were more involved in economic activities (56.4%) than those living in the institution (7.7%). The same

Table 3. Distribution of Material Status by Place of Residence and Sex (%)

	Place of Residence					
	Home			Institution		
Sex	Males	Females	Total	Males	Female	Total
Marital Status						
Single	7.1	14.0	(11.3)	57.1	39.7	(43.6)
Married	67.9	17.4	(37.3)	4.8	4.1	(4.3)
Widowed	21.4	68.6	(50.0)	28.6	56.2	(50.0)
Divorced/ Separated	3.6	-	(1.4)	9.5	-	(2.1)
N	56	86	142	21	73	94

Table 4. Distribution of The Employment Status of the Elderly by Place of Residence and Age Group (%)

	Employment Status				
	Working		Not Working		
Age	Home	Institution	Home	Institution	N
65-74	29.1	4.3	50.0	16.1	93
75-84	7.1	_	56.3	36.7	71
85+	1.8	3.7	37.2	57.3	54
Total	(9.2)		(90.8)		218

Table 5. Distribution of The Employment Status of the Elderly by Place of Residence and Sex (%)

	Employment Status				
	Working		Not Working		
Sex	Home	Institution	Home	Institution	Total
Males	56.4	7.7	18.4	9.5	(34.4)
Females	28.2	7.7	41.3	30.7	(65.6)
N	39 (17.89)		179 (82.11)		218

holds true for females (28.2% and 5.5% respectively). This could be explained by the fact that the majority of nursing home residents were among the oldest old, as opposed to the majority of community dwellers.

- The figures for males and females were identical for institutionalized elderly. This could be due to the very large number of institutionalized women who are single, and therefore had had to work during their younger years and continue to work in the institution.

- The highest figures of employment lie in the youngest age group - where 33.4% of the elderly between 65-74 are working; 7.1% for the 75-84 age group and 5.5% for the >85 age group. Of course, percentages for those living at home are higher than those of the institutionalized - except for the >85 age group. Institutionalized elderly are assigned light duties such as working as telephone operators, distributing lunch to a few other elderly, feeding the ones who could not feed themselves and shaving the older men (a man in his 70's, who had been a barber prior to retirement had undertaken this duty), integrating work with the nursing home environment and feeling rather useful. Nonetheless, of the 39 elderly who were working, the greater number were involved in service type work and the rest had their own small businesses to run.

- By and large, elderly living at home were in the higher occupational statuses prior to retirement than elderly living in the institution. While males at home had more or less "skilled - foreman" as well as "manager - proprietor" types of jobs (25.4% and 20.0% respectively), institutionalized males were mostly classified at the "semiskilled - operative" and "service - worker" levels. Females showed a slightly different picture. While 33.3% of those who lived at home were of the "skilled" type, 30.7% lay in the "service worker" sector. The figures for institutionalized women were different. Here, the majority were "semiskilled - operative" type, followed by "service - workers" (38.2% and 32.3% respectively).

Educational Levels: Altogether, the large percentages seen in the lower ranking jobs may be attributable to different educational levels, (see table 6). With a large group (68.7%) having only primary education we see a large number of institutionalized elderly working in jobs not requiring any particular level of education. Therefore, the high figures seen in low level occupations can, to some extent, be attributed to the high percentages of low-level education. This aspect, however, proved to be problematic for institutionalized elderly where most inmates do not provide intellectually stimulating conversations, or even any frivolously pleasant chit-chat to the few who are well-educated.

Table 6 shows that elderly living at home presented a higher percentage of primary level education in females, while all other educational levels weighed toward males. The exact opposite is seen in the institutionalized coterie - number of males with only primary education (89.5%) proved to be higher than the corresponding figure for females (66.7%); whereas in the rest of the categories, females outnumbered males. One reason for the difference may be that this generation, in general, had not had much of an education to start with. Also, females who were unmarried were also the more educated - this was in fact an illustration of the fact that the majority of males with higher education had not particularly married an equally educated wife. Females on the other hand, with a relatively high level of education had waited for equally

Table 6. Educational Level of the Elderly by Place of Residence and Sex (%)

	Place of Residence					
	Home			Institution		
Sex	Males	Females	Total	Males	Females	Total
Educational Level						
Primary	52.8	75.6	(66.7)	89.5	66.7	(72.4)
Secondary	30.9	22.1	(25.5)	5.25	22.8	(18.4)
College	7.2	1.15	(3.5)	5.25	8.8	(7.9)
Post Graduate	9.1	1.15	(4.3)	_	1.7	(1.3)
N	55	86	141	19	57	76

Table 7. Self Rated Income Adequacy Level of the Elderly by Age/Sex (%)

	Income			
Age*	Ample to Adequate	Somewhat Inadequate	Totally Inadequate	N
65-74	12.8	_	87.2	86
75-84	7.1	_	92.9	70
85+	11.1	_	88.9	45
Total	(10.4)	_	(89.6)	201
Sex**		_		
Males	17.6	_	82.4	68
Females	6.8	_	93.2	133
Total	(10.4)	_	(89.6)	201

* No Significance.
** X2 = 5.693, P = 0.01703 (P<0.05.)

Table 8. Informant Rated Income Adequacy by Age/Sex (%)

	Income			
Age*	Ample to Adequate	Somewhat Inadequate	Totally Inadequate	N
65-74	54.5	36.4	9.1	66
75-84	57.9	36.8	5.3	57
85+	51.7	43.3	5.0	60
Total	(54.6)	(38.8)	(6.6)	183
Sex**				
Males	50.0	44.2	5.8	52
Females	56.5	36.6	6.9	131
Total	(54.6)	(38.8)	(6.6)	183

* No Significance.
** No Significance.

Picture Credit: Choghik Boulghourjian

I could never imagine myself in this situation, alone, in a nursing home

or more educated husbands, such as Miss. A. who admitted, "if I hadn't been so picky about the standard of education my future husband should have, I probably wouldn't be here now".

Income Levels and Reserves: The major outcome of retirement is manifested by steep declines in income levels. Self rated and informant rated income levels are given in tables 7 and 8, respectively.

While income levels drop or disappear altogether, elderly who have reserves (which may include liquid money, or assets such as bank accounts, houses, lands, etc.) feel, at least, more secure in their old age. Table 9 shows the income adequacies by place of residence, and table 10 shows the presence and absence of reserves by place of residence.
Greater percentages of institutionalized elderly had no reserves. Elderly living at home were more likely to have reserves as opposed to institutionalized elderly. There is a significant

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Table 9. Income Adequacy Level of the Elderly by Place of Residence (%)

	Income			
Age*	Ample to Adequate	Somewhat Inadequate	Totally Inadequate	N
Home	59.6	27.0	13.5	89
Institution	50.0	50.0	_	94
Total	(54.6)	(38.8)	(6.6)	138

X2= 19.688 P= 0.00005 (P<0.05).

Table 10. Presence/Absence of Reserves of the Elderly by Place of Residence and Sex (%)

	Place of Residence					
	Home			Institution		
Reserves*	Males	Females	Total	Males	Females	Total
No Reserves	32.1	33.7	(33.1)	85.7	83.6	(84.0)
Reserves Present	67.9	66.3	(66.9)	14.3	16.4	(16.0)
N	56	86	142	21	21	94

* Males: X2= 17.607 P= 0.00003 (P<0.05)
* Females X2= 39.929 P= 0.00000 (P<0.05)

decline in the number of elderly with reserves with age; 54.5% of the youngest age group have some reserves, while 30.0% of the 75-84 year olds and only 15.5% of the >85 group had reserves.

Housing conditions: Table 11 shows the state of housing conditions. The old felt safe from theft and intruders, but their major complaints were factors such as humidity which was a major problem. It was repeatedly mentioned that during winter, rain water would infiltrate through the walls, leaving the house damp, humid, and unhealthy.

However, looking at these housing conditions with regard to place of residence may reveal some important reasons and justifications for moving. Safety, availability of drinking water, cooking and toilet facilities did not differ significantly between institutionalized and non-institutionalized elderly. Therefore these factors might not have been "push factors" for institutionalization. However, very significant differences are observed between home and nursing home residents when bathing and heating facilities are considered (only 80.8% and 19.2% of institutionalized elderly actually had these facilities respectively). In the nursing home most of the elderly complained of "feeling cold", since most of the workers did not need the heaters to be turned on (they always felt warm), even during some of the coldest days in the winter when the nursing home was cold.

Table 11. Housing Conditions of the Elderly Living at Home and Institution (%)

Condition:	Per Cent	N
Feeling Safe	67.5	197
Feeling Fairly Safe	28.9	197
Have Drinking Water	91.2	193
Have Cooking Facilities	95.3	192
Have Toilet Facilities	99.0	192
Have Bathing Facilities	90.1	192
Have Heating Facilities	67.2	192

Physical Health Status: A highly significant relationship was found between age and amount of medical treatment. By amount of medical treatment is meant the number of medications an elderly person is prescribed. 37.9% of the >85 age group received extensive medical treatment. The percentage dropped to only 9.5 and 9.3 for the age groups 65-74 and 75-84, respectively. Concurrently 70.5% of the 65-74 year olds received routine medical treatment as well as 69.3% of the 75-84 year olds and 51.5% of the >85 group.

There were no significant differences between males and females in the amount of medical treatment received, although slightly more females had extensive treatment and this is because of the slightly higher average age of females. Another possible reason for the differences in medical intake between the sexes could be the physiologic factors which affect women more than men in old age - including osteoporosis and heart disease (risk of heart disease increases with age more so for females than males, because of decreasing estrogen levels after menopause). Institutionalized elderly receive significantly more medication than do the non-institutionalized elderly (33.0% and 7.0% respectively).

Table 12. Self Rated Physical Health of the Elderly by Age/Sex (%)

	Self Rated Physical Health			
	Poor	Fair	Excellent-Good	N
Age*				
65-74	78.3	15.2	6.5	92
75-84	73.1	26.9	-	67
85+	79.5	15.9	4.5	44
Total	(76.8)	(19.2)	(3.9)	203
Sex*				
Males	70.0	22.9	7.1	70
Females	80.5	17.3	2.3	133
Total	(76.8)	(19.2)	(3.9)	203

* No Significant Relationship.

Although very few admitted to actually having excellent-good health (almost 4% of the total study population), about 20% rated themselves as fairly well. The other 76% considered themselves as having poor health. A reason for the high percentage of perceived poor health could be due to personality factors where different life exposures could have resulted in a depressive, socially isolated group of people. Many of these elderly have been exposed to extremely tragic situations - some have lost siblings and offspring to the war, some have become handicapped themselves, and others simply lost their life's savings. Their memories trace back to these extreme events, disheartening their already vulnerable conditions. De facto, looking at perceived health, there were no significant differences observed between the sexes. However, more males (7.1%) as opposed to females (2.3%) had excellent to good health. No significance was observed while taking age into account. The >85 age group stated having poor health the most (79.5%), and when an overall physical health rating was computed, the discrepancy stood out clearly.

Table 13. Physical Health Rating of the Elderly by Age and Sex (%)

	Physical Health Rating Total*		
	Mild-Moderate Impairment	Severe-Total Impairment	N
Age**			
65-74	77.9	22.1	95
75-84	74.7	25.3	75
85+	59.1	40.9	66
Total	(71.6)	(28.4)	236
Sex***			
Males	77.9	22.1	77
Females	68.6	31.4	156
Total	(71.6)	(28.4)	236

* There are only two categories of health rating because no one was rated as having excellent-good health
** X2= 7.278, P= 0.02627 (P<0.05)
*** No significant Relationship

Table 13 indicates that there is no significant relationship observed between the sexes. Males and females showed similar patterns; however, more females were afflicted (31.4%, as opposed to males, 22.1%). There were however, significant differences observed, with older olds being sicker. Besides the above observations, differences in self-rated physical health were not significant between institutionalized and non-institutionalized elderly. In fact, they were almost the same.
Activities of Daily Living (ADLs) are important considering the overall health of the elderly individuals because if an elderly is unable to perform routine tasks, such as preparing meals, or getting dressed, there usually is an underlying cause,

Picture Credit: Choghik Boulghourjian

morbid in nature. The majority of 65-74 year olds had excellent-good ADLs (36.0 %), while a large majority of the >85 group (61.5 %) were "totally impaired". Although significant differences were not found between males and females, again, female elderly were more likely to be impaired, essentially being older, and exhibiting more morbidity than males. The underlying reason for the discrepancy between males and females may be attributed to the fact that the males who survived to old age were probably stronger and healthier physiologically than other males who died before them. Therefore, in general, they had healthier profiles than other males allowing them to survive longer than other males, as well as females.

Table 14. Major Helpers of the Elderly by Sex (%)

Major Helper			
	For Males	For Females	Total
Spouse	48.9	3.3	(18.5)
Sibling	2.2	3.3	(3.0)
Offspring	22.2	47.8	(39.3)
Grandchild	2.2	1.1	(1.5)
Other Kin	4.4	5.6	(5.2)
Friend	6.7	12.2	(10.4)
Other	13.3	26.7	(22.2)
N	(13.3)	(26.7)	135

Table 14 is reasonably one of the most interesting. Almost 50% of the male elderly had their spouse taking care of them. The corresponding figure for females was a mere 3.3%. This may not be too surprising after all. Female life expectancy being higher than male life expectancy, husbands probably die before they get a chance to see their wives age and therefore in need of their care. Female elderly were looked after by their children (47.8%).

Mental Health : Physical illnesses and mental decadence are quite closely correlated. While one may be undergoing a negative change, it may also be catalyzing the others' deterioration (Zimbardo, 1988); mental health, therefore, is as important as physical health. Table 15 shows the intellectual capacity of the elderly Armenian population.

Table 16. Enjoyment of Life of the Elderly by Sex (Self Rated vs. Informant Rated) (%)

	Enjoyment of Life (Self Reported)		
Sex	**Life not Exciting**	**Life Exciting**	**N**
Males	66.2	33.8	77
Females	88.7	11.3	159
Total	(81.4)	(18.6)	236
	Enjoyment of Life (Informant Reported)		
Males	42.0	58.0	50
Females	49.2	50.8	132
Total	(47.3)	(52.7)	182

* X2= 17.231, P= 0.00003 (P<0.05)
** X2= 0.763, P= 0.382 (P<0.05)

Table 15. Intellectual Capacity of the Elderly by Age/Sex (%)

	Intellectual Capacity				
	Severe Impact	**Moderate Impact**	**Mild Impairment**	**Intact**	**N**
Age*					
65-74	8.6	14.0	20.4	57.0	93
75-84	34.8	20.3	17.4	27.5	69
85+	58.0	14.0	8.0	20.0	50
Total	(28.8)	(16.0)	(16.5)	(38.7)	212
Sex**					
Males	22.1	9.3	17.3	50.7	75
Females	32.1	19.7	16.1	32.1	137
Total	(28.8)	(16.0)	(16.5)	(38.7)	212

* X2= 47.891 P= 0.00000 (P<0.05)
** X2= 9.117 P= 0.028 (P<0.05)

Interestingly, while there were significant differences by sex, there were significant differences by age also. While males and females equally contributed to the "severe impact" category, 50.7 % males and 32.1 % females were intact. To understand these differences one could say that the the educational level can predict performance in old age since the higher the education, the better the performance scores on intellectual capacity. More males had higher educational levels than females. Putting this in perspective with age, 58% of the >85 age group lay in the "severe impact" category as opposed to 34.8% in the 75-84 age group and 8.6% in the 65-74 age group. The significant difference in the decline of intellectual capacity is clear; however, this decline may not necessarily be due to the aging process per se, but to the fact that the younger age groups had more access to education than did the older olds. Physiological factors also contribute indirectly, such as eyesight and hearing - when these senses have lost their acuity, they bring about lower levels of intellectual capacities.

Self "rated" psychiatric symptoms were measured by another set of questions. As opposed to intellectual capacity, psychiatric symptoms revealed the opposite relationship, i.e. a significant inverse relationship with age. As age increased, psychiatric symptoms decreased. A large percentage of the 65-74 age group (31.6%) lay in the severe impact category, while 22.7% of the 75-84 year olds and 21.2% of the >85 age group lay in this same category. This unexpected finding can only be explained in one possible way which is that people in good mental health may not adjust well to changing social and employment roles, as well as nursing homes (Wacker, 1988). This may indubitably lead to feelings of hopelessness, uselessness, unrest, and depressed moods, resulting in the development of negative psychiatric symptoms. This finding complements a study by Saxena and Kumar (1997) who found that mortality rates increased significantly during the few years immediately following retirement.

Enjoyment of life is another important component of overall mental health, which, if negatively inclined, has several repercussions including depression and deterioration of physical health (Butt and Beiser, 1994). No significant relationship was observed between age group and enjoyment of life as reported by the elderly or informant; although there was a slight positive inclination where increasing age was associated with decreasing percentages of enjoyment of life. Some positive congruence was observed between informant rated and self rated "enjoyment of life", although to a very small extent (r=0.354, p=0.000). The main reason can be summarized as follows: if enjoyment of life, as mentioned above, is more affiliated to lifelong achievements, it is also related to satisfying intimate relationships (Zimbardo, 1988). The latter could have been lacking for many elderly in this study group because several had either married very early,

Table 17. Mental Health Ratings of the Elderly by Age/Sex (Self vs. Informant Rated)(%)

a	Mental Health Rating (Self Rated)			
	Excellent-Good	Mild-Moderate Impairment	Severe-Total Impairment	N
Age*				
65-74	19.4	41.9	38.7	93
75-84	4.3	46.4	49.3	69
85+	4.0	30.0	66.0	50
Total	(10.8)	(40.6)	(48.6)	212
Sex**				
Males	18.7	41.3	40.0	75
Females	6.6	40.1	53.3	137
Total	(10.8)	(40.6)	(48.6)	212
b	Mental Health Rating (Informant Rated)			
	Excellent-Good	Mild-Moderate Impairment	Severe-Total Impairment	N
Age***				
65-74	6.1	71.2	22.7	66
75-84	2.0	50.0	48.0	50
85+	6.8	34.1	59.1	44
Total	(5.0)	(54.4)	(40.6)	160
Sex***				
Males	7.8	52.9	39.2	51
Females	3.7	55.0	41.3	109
Total	(5.0)	(54.4)	(40.6)	160

* X2= 13.570 P= 0.00880 (P<0.05)
** X2= 8.315 P= 0.01565 (P<0.05)
*** No Significant Relationships

perhaps slightly forcefully too, or had chosen to remain single. Therefore, very few actually had satisfactory intimate relationships. Lifelong achievements had also been hindered by several external factors such as the wars, and consequent poverty. Table 16 shows the enjoyment of life among the elderly by sex, self and informant rated.

Among the self-reported, a significant difference between the sexes and perceived availability of help was seen. Males enjoyed life and found it more exciting than females. However, this was not particularly true when asked of the informant. Although the pattern was the same, there was no significant difference. The reason why females enjoyed life less could mainly be due to them having led dependent lives and not having achieved their lifetime goals. Also, this line of thinking may have led to a cycle of self pity which with increasing age and increasing morbidity levels, worsened. (Schaefer and Lamm, 1992).

Part (a) shows the self rated age and sex relationships where we find highly significant evidence that, in general, mental health declines with increasing age. The differences between males and females were also significant, with more males on the excellent-good end and more females on the severe-total impairment end. The elemental reasons for this difference can be related to the differences in life exposures and experiences positively inclined toward the males of this particular generation along with those cited previously for intellectual capacity, psychiatric symptoms, and enjoyment of life .

Last, but not least, the physiological declinations occurring with age, hit women harder than men, and since physiological health and mental health may catalyze one another, the fact that women were mentally less apt than men can be rationalized. Part (b) of table 21 shows the informants' ratings of mental health, where no significant relationships were observed between the variable and age/sex.

Case Study

Mrs. Mary never lived by herself. She grew up in an orphanage with other girls like her. Later, she married Mr. S. and lived with him until his death, seven years ago. They never had children, but loved and respected one another incredibly. She could not imagine life without him - it was not only devastating but also not manageable either. Her grief and despondency culminated in a stroke, which crystallized her by enfeebling and crippling her legs, rendering them useless. She decided to move to the nursing home; she gave them her "momoired" jewelry and her savings in return for shelter, food, and some medical care.

"You know, I was an orphan, when I got married. My husband was very good. We used to go to the movies together all the time, so everyone nicknamed us "Romeo and Juliet". Later, I used to go to his shop and help him in the afternoons - everything was so fine, so wonderful - [she starts crying in despair, like every other day of her life in the nursing home] I could never imagine myself in this situation, alone, in a nursing home".

Apparently, Mary used to be relatively overweight, however, at the age of 87, she is a combination of skin and bones. Someone cut her hair in the nursing home (since it is easier for the workers to clean and maintain elderly with short hair rather than elderly with long hair), and the "look" she now has is very unrefined. She has bits and pieces of rags around her bed, so, if there is a visitor, she hastily ties one of the shreds around her head.

Her day begins by merely waking up in anticipation of breakfast to arrive. This wait is ordinarily a lengthy duration because one of her "roommates" constantly has a direly melancholic look on her face complaining of unbearable pain

Picture Credit: Choghik Boulghourjian

all over her body. Six years ago Mrs. Mary used to sympathize with her roommate, now, it has become a predictable episode; when she complains, Mary only looks back with a blank face, somewhat sympathetic eyes and turns away. After breakfast, she waits for lunch except on Thursdays of course, when the nurse and other workers put her on a wheelchair and off she goes to become a cleaner, nicer-smelling person. At Easter, the nurse comes into their room with a pair of tweezers; "I'm going to make all of you very pretty today, you might have visitors at Easter" and starts pulling out the craggy, whitish hairs around the chins, of these old women. This act by the nurse pleased them. Righteously, they all wanted to look beautiful.

She has a couple of teeth left in her mouth, using them with some difficulty during eating hours. Her incontinence was very troubling at the beginning, but now, she has become accustomed to the special "undergarments" they make her wear. She knows she will never be able to walk again, and that her heydays are completely over. Pictures of Christ and the Holy Mother are stuck on the headpiece of her bed, but she does not have prayer books like all the others. In fact, she did not know how to read and write or even speak the Armenian language; at the orphanage, she had only been taught French and Arabic; she only learned how to speak Armenian in the nursing home. Now, there was a challenge! Learning her native language at 81 years of age. How did she learn to speak? Initially, it was not a completely new language, everyone around her communicated in Armenian. Although she had not spoken Armenian, she did understand it. Here, in the nursing home, she was obliged to use it to make herself understood. This was a great achievement for her, an environment that taught her something. With a wave of the hand and a wearied look in her disparate and asymmetrical eyes, she signifies that she is too tired to continue the interview. One or two more questions are answered, but promptly stopped by crying and feelings of intense and abstruse self-pity. Her intellectual capacity settled in the severe impact category, along with psychiatric symptoms and overall mental health. She was completely helpless at this point in her life, like many of the other old women. She was destitute, although when her husband was alive, they had been well to do. To eat alone was the only ADL she could perform. When asked if she can take care of her own appearance, like combing her hair, she quickly dallies her hands on her head demonstrating that she certainly can! Like most other women from her cohort, she had been completely dependent on the male figure in her life. In "those days", there was nothing wrong with that, on the contrary, what she had done (become dependent on her husband) was the plausible and "right thing" to do.

Conclusions and Recommendations

Discrimination against age is a particularly important issue, since regardless of sex, race, religion and health conditions, everyone is subject to it in due time. The aged are not only discriminated against, but due to their vulnerability, they can do little to change their situation alone. The deterioration of their physical and mental health, and the dissolution of their socioeconomic resources, leave them helpless. In fact, many of them, in anticipation of death, lose hope and interest in their own well being (Schulz and Heckhausen, 1996).

Among the recommendations to improve the condition of the elderly population, one could propose:

1. Asking medical practitioners to provide improvement in function rather than "cure" for disability, which is often the most appropriate goal of geriatric assessment - aimed at addressing a broad spectrum of problems including medical, cognitive, social, economic, etc.
2. Eliminating, through education, the stereotypic perception of the senior years as being accompanied by loss of physical attractiveness, vitality, and health - because such negative images have hampered the development of several activities for elder individuals. This would also help to strengthen family bonds and create values on attitudes towards the aged.
3. Stimulating further research in the field, in the region, for providing better environmental conditions with the elderly in mind.
4. Revising the income tax provisions to support the aged and create a system of old age pension in Lebanon.
5. Training of domestic health care providers specifically for the elderly in order to minimize the movement from home to nursing home.
6. Developing plans to introduce ways of enabling the elderly among professionals, experts, technicians, and others, to remain

productive and active in society, keeping in mind that the employment of the elderly is mainly pertinent to the "aged poor", rather than the "aged efficient".

7. Having different retirement ages for different categories of workers.

8. A key solution to the problems of aging is economic security. Those elderly who do not have families to look after them should be provided for by social services programs, governmental and public pension systems collaborating mutually. For those of whom family is present, this collaboration will include family support.

9. With the ever-increasing number of elderly persons, health care will have to be directed toward emphasis on geriatric medicine.

10. Developing volunteer and non-governmental organizations, to visit the elderly in nursing homes on a weekly basis, celebrating special holidays together.

11. Encouraging research concerning the differentials of the higher levels of morbidity among female elderly and the higher levels of mortality among male elderly.

12. The inevitable growth of the elderly population will surely necessitate the construction of more nursing homes in the country. Therefore, clear guidelines should be drawn with respect to the environmental conditions of these new nursing homes where not only the necessary physical conditions (such as the heating and bathing facilities) are well met, but also the intellectual ones, such as rooming elderly with similar socioeconomic and educational backgrounds together or in close proximity. The latter could reduce conflict among the elderly and be a better aid for socialization and hence more satisfaction.

Picture Credit: Choghik Boulghourjian

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Elderly Women in the Netherlands

This picture was taken during a fashion-show for the elderly women.

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In politics, the media and the public eye, the "older woman" is under regular discussion. That older women can be an active group could be seen in a recent edition of the magazine **Rails** (a consumer publication from the Dutch Railway) entitled "Old is in" with an eighty year old model on the cover. The eighty year old model illustrated with her sophisticated outfit the kind of classic tops, body stockings and singlets that will soon be available in the shops.

The aim of this article is to describe the position of elderly women in the Netherlands. This will be sketched along the following lines: What is the attitude of the public and the media to the older woman in the Netherlands? How are they received in the employment market? How do older women see themselves, and how do they shape their lives?

Public Images

The population of the Netherlands is becoming increasingly older, and the majority are women. In recent years, the government devoted much attention to the position of the older woman. In its policy towards the elderly, the government considers older women to be a separate interest-group. Older women are still a disadvantaged and undervalued group in society in respect of income, education, employment and participation in political decision making. In daily life older women are constantly confronted with the many prejudices related to them. In the negative image, elderly women appear as unattractive, unhappy, dependent, asexual and socially isolated. At the same time, they are more liable to be judged on their appearance than their male counterparts. A 56-year-old television program-maker asserts: "What I find most difficult is when people give me the idea that I am finished, that they consider me to be no longer 'in my bloom', that I have become sexually unattractive."[1] This negative attitude is mainly focused on the mental and physical weakening of the older woman. Such view does no justice to the independence, competence, and capabilities of a large number of older women.

These negative images give the impression that there is nothing positive to be said about them; however, contrary to the traditional view have arisen positive images in which the older woman is seen as vigorous, active, enterprising, and adventurous. These views fit into a new vision of the elderly, which includes the new opportunities and possibilities open to them as they enter a new phase in later life. Recent investigations into attitudes towards the elderly members of the Dutch population give a more positive view of older women than of older men. Women are seen as more sociable and hospitable. They have a rich social life with (grand) children, brothers/sisters, neighbors and friends and generally feel less lonely than men of their age. Older women take care of their appearance and their health and are better able to look after themselves and structure their lives than men.
Images of the elderly are diverse and differ among different age groups, the older Elderly and the younger Elderly. Since today

women of 50 or 55 are viewed as elderly, the number of elderly people has not only increased, but has added a good number of active people within its ranks.

Older Women in the Media

The portrayal of older women in the media is twofold. One view is that they are associated with sickness and death, and are opposed to everything that is young and dynamic. Aging is seen as pure misery for women; men no longer want you, because the word "woman" automatically means "younger woman". On the other hand, there are other attempts in the media to break the association between age and negativity and to introduce a more positive view of older women, women who are still functional and attractive despite their age, and who are still lively and active in employment and social life.

Older Women and Employment

The consequences of negative images and representation can clearly be seen in age discrimination against older women in the job-market. In Dutch society, where youth and productivity are important factors, finding employment for older women is difficult since the general view is that a career must be established before one's fortieth year. Since the capacities of the older woman are undervalued, she is placed within the category of an unproductive group, unable to keep up with new developments, and feeling threatened by the younger generation. There are many kinds of employees among women: breadwinners, second-starters, part-timers and others. This diversity requires more jobs tailored for women particularly that there is a group that makes the conscious decision to engage in work after forty (second-starters). It is untrue that older women are unproductive, and companies with second-starters are enthusiastic about hiring them since these women have a high sense of responsibility and a low sickness rate. Granted that it is hard to change jobs as you grow older, women who undertake to work in later life are faced with barriers that have nothing to do with their knowledge, experience or ambition, and everything to do with their age. Just like older men, older women are the victims of age discrimination. This explains why a vast number of older women in the Netherlands are engaged in volunteer work rather than regular paid jobs.

A woman of 59 asserts: "I wanted a job. I applied but it was no use. I'm too old and too expensive."[2] In certain areas, such as politics and care, there is a rising percentage of older women, and it is expected that there will be an increase in the number of older female doctors in view of the number of women who have chosen this profession.

How Older Women See Themselves

Aging is regularly touched upon in all kinds of women's magazines. Subjects such as: "Grandmas with filled agendas", "Is getting old really such a disaster?" and "Fun-loving at fifty" are included. How does the Dutch woman see herself? Investigation seems to show that the self-image of the older woman is more likely to be positive than negative. Health is the chief criterion by which people measure aging. A woman evaluates herself through her physical condition. Good health leads to a positive self-image. Older women who still have a partner and live independently have a more positive attitude than those who have lost their partner and are no longer independent. Loneliness, dependency and bad health, lead to a negative self-image. These are indirect consequences of aging, especially since Dutch women live on average seven years longer than men.

In the Netherlands the elderly continue to live independently for as long as possible. When this is no longer viable they move to special apartments, retirement-homes or nursing homes. This vision of a life of dependency is, for many women, so frightening that younger elderly women tend to paint a negative picture of the organized world of the elderly with its retirement-homes and nursing-care: "They sit there (in the retirement-home) and have no more interest in the outside [world]. Those people are dead. Old-people's homes give me the shivers" [3] (A woman of 69). In reality the percentage of elderly people in care is around 8%, and as many older women as possible remain independently housed.

Among the positive aspects of aging are more experience, wisdom, the ability to relate, increased freedom, peacefulness and new chances to develop: "I'm finally free to do as I please. I am no longer concerned with what is expected of me. I make my own decisions, and that is a form of liberation"[4] (A woman of 66, divorced and working for a women's organization).
"I find this a nice age to be. You are more confident and better able to know what you want. Men treat you differently, more as a person, than as a woman. I like that. I am judged on my qualities, not on my sex"[5] (A 54-year-old woman, director of a chemical concern).

Movement of Women from the House to the Public Arena

Over the years gender has been an important criterion that has contributed to the generally accepted attitudes to women. The roles of men and women were clear. The man assumed the duty of financial provider for the family, and the woman was responsible for raising the children and running the home. Most women stopped working after marriage, and these assumptions over the division of labor between men and women caused division in various areas of life until the sixties. Women drew their identity from parenthood, family life, social life and only marginally from paid employment. The choice of paid work was limited and women generally were hired as domestics, nurses, seamstresses or teachers; however, the changes of the sixties and the rise of the Women's Movement brought about a revolution in assumptions about gender. Married women with children began taking paid work and generated extra income, but also extended their activities into other areas of life creating a greater involvement in society.

Older Women as Conscious Designers of their Own Existence.

Older women are much less influenced by gender than before when it comes to organizing their lives. These days individuality is the most important source of identity and it is to be expected that this tendency towards individualization will increase in the coming years. Greater self-awareness has led many women to abandon the assumptions which previously governed the form of their lives and the realization of their own limited wishes. In the Netherlands, the traditional bonds of society whereby children take care of their parents, and grandmothers care for the children have disintegrated.

Increased individualization has led to freedom from the traditional class and family ties, so that individuals are gradually relying more and more on themselves. Since women live longer than men, they need to seek new challenges in life in order to avoid loneliness. Today women make less sacrifices in the care of a partner and (grand)children and make demands that would earlier have been unthinkable. Grandmothers do not want responsibility for raising their grandchildren. Research indicates that the meaning of aging is different among men and women. As their domestic responsibilities recede, older women seek activities in the public arena. Men, on the other hand, on retiring from a life at work, feel better in a domestic environment and direct their activities more towards the wife and grandchildren.

Picture Credit: Maria Poppe

A Diversity of Styles.

At this moment there are many diverse ways in which older women can shape their lives. The personal experience, historical situation, health, and financial situation of the woman are critical in her forming of her own life.
Research (T.Nederland 1998) shows that there are five different life-styles among older women:

- Independence/Autonomy: Financial and emotional independence are essential to these women. In dividing their time, priority goes to time spent in paid work.

- Self-Development: These women are above all interested in their personal development. This takes the form of study, social or political activity, volunteer-work or creative activity though the relationship with their own children remains an important part of their program.

- Seize the Day/Enjoyment: These women are concerned with the joys and pleasures of life. They emphasize "not having to", and insist on their freedom. The activities of these women are leisure, dining out, cinema, museums, shopping and travel. They join clubs where they share company with other women and avoid social isolation. Among their activities are swimming, playing bridge, golf, etc. Contact with their families basically depends on whether it gives these women happiness and does not restrain their freedom.

A woman of 63 asserts: "I'm used to the rhythm of my new life, into town to shop, play bridge, or stroll with friends, occasional travel, alone or with my husband. I don't want to give these things up. Not that I don't like my grandchildren, on the contrary I'm crazy about them, but I have so many wonderful things to do that I don't want commitment. I expect the care of the grandchildren to be properly organized. I prefer being a "free-grandma" not one who baby-sits, and I certainly don't want to be a part of bringing them up."[6]

- Service/Altruism: They get their satisfaction from caring. Caring for others takes up most of their time. These women mainly do volunteer work but they are the ones to determine their availability and the extent of work, they will indulge in.

- Complementation: This is the group that looks backwards on important events and past experiences that have influenced their lives. These women often have bad health and have

Picture Credit: Maria Poppe

I am finally free to do what I please I make my own decisions and this is a form of liberation

resigned themselves to their fate, and their social network is mainly restricted to friends and family without any involvement in social activities.

Aging demonstrates that the role of gender as a source of identity is changing. Many women have abandoned gender-determined assumptions and have moved on to a personalized, self-awareness attitude. The notions about division of labor by gender have disappeared. Older women have expanded their horizons beyond the care of husband and children into the public arena of paid work, education, and volunteer-work. Men, on the other hand, go in the opposite direction and withdraw from society. For a long time children were the core of women's existence, but, women today have other interests. They have their own life and prefer to seek new fulfillment in life once the children have left home.

Out-of Date Image - Changed Policy.

Although older women have been underrepresented in many areas of society, they are now a major group within the government policy for the elderly. The main aims of this policy are to remove the barriers that prevent the elderly from participating in society, and to find employment in various areas. Special attention is focused on women's problems and making training sessions available to help them to adapt and assert themselves and be in the forefront.

In 1999, the UN year of the elderly, special attention is being paid to opinions of older women. One example is the international film festival "Images of Aging" which will be held during the UN year in the Netherlands. The media, in particular, must be motivated to portray the elderly in accordance with their contribution to European society, to avoid stereotyping, and to strive for a more sophisticated reporting of the elderly in their publications.

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3. Ingeborg van Teeseling. op cit., p.20.
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5. Lilian Schuit. "Oma nieuwe stijl heeft een volle agenda" (Grandmas with filled agendas), Opzij, 1998, p.26.
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(Endnotes and references originally in Dutch. Translated for Al-Raida).

Highlights on Pension Schemes in Nine Arab Countries

By Dr. Hyam Mallat
Lawyer, professor at Saint Joseph University, and Chairman of the Board of National Security Fund in Lebanon (1993-1999)

[Abridged from a study entitled "Social Security and Social Insurance Law: A survey of Nine Arab States" by Dr. Hyam Mallat that originally appeared in Yearbook of Islamic and Middle Eastern Law, Volume 4 1997-1998 (eds. Eugene Cotran and Chibli Mallat) published by KLUWER Law International]

With the exception of Qatar and the United Arab Emirates, all the Arab countries of the Asian Middle East have implemented pension and lump sum payments schemes based on employer and employee participation. Lebanon is the only state to continue to apply terminal lump sums in the private sector.

Lebanon

The Pension Scheme in Lebanon

In Lebanon, a distinction needs to be made from public sector and private sector employees.

The Public Sector

Civil servants have the right to choose, from the age of 64 for public employees and 68 for judges, between a retirement pension or an indemnity of retirement. For members of the armed forces, a mixed system of pension and lump sum indemnity is implemented.

If they choose a service termination payment, a lump sum is paid to retirees in the amount of one months salary for each year of service for the first ten years, two months from ten to thirty years' service and three months for more than thirty years' service. After that, the retiree has no further financial relationship with the state, but continues to enjoy medical benefits provided by the Civil Service Mutual Fund.

If they choose the retirement pension, this is calculated on the basis of 2.5 per cent of the salary for each year of service. Thus for forty years' service, the retiree receives 100 per cent of the salary, for thirty years, 75 per cent of salary and for twenty years, 50 per cent. Where the retiree's service is greater than forty years, he receives a pension in respect of the forty years and an additional lump sum of three months for each year of service over forty years.
In addition, where the retiree has been in service for less than twenty years, he is not entitled to a retirement pension and is eligible only for a termination payment.

The Private Sector

Although article 49 of the Social Security Code 1963 laid down the transitional nature of the system of terminal payments, and despite studies carried out in cooperation with ILO to introduce a retirement pension scheme in the private sector, only the termination payment scheme is currently in operation in Lebanon.

The right to an end-of-service termination payment has been compulsory for all employees entering service after 1 May 1965, when the scheme came into effect, and any compulsory or voluntary contributor who satisfies the following conditions is eligible:
- completion of a total of at least twenty years' employment, adding the period of contribution to the fund to years spent in the employer's service prior to the date when this scheme came into effect;
- disability of at least 50 per cent making him unable to keep his employment or carry out similar work appropriate to his qualifications and training;
- in the case of a female employee, marriage or leaving employment within the twelve months following the date of her marriage
- having reached the age of 64.

In the event of an employee's death, the following heirs are entitled to his end-of-service indemnity:
- the employee's father and mother, if aged over 60 or who, as a result of physical or mental disability, are not able to earn a living;
- the wife of the insured, or where more than one wife, the first wife;
- the husband of the insured, if aged over 60 or who, as a result of physical or mental disability, is not able to earn a living;
- the legitimate or adopted children of the insured up to the age of 16. The age limit may be extended up to a maximum of 25 for children who are unable to support themselves, either because they are in full time education, or as a result of physical or mental disability, provided that the disability is permanent or arose before the age of 16. Disabled children are supported by public welfare after the age of 25;
- minor brothers and sisters of the insured who, at the date of his death, were his dependents.

Picture Credit: Bassem Maamari

Calculation of End-of-Service Indemnity

Article 51 of the Social Security Code determines the amount and method of calculation of the end-of-service indemnity. It is equal to one month preceding the date when he became eligible for the indemnity. In addition, if the salary is calculated wholly or partly on commission, it will be equal, for each year of service, to one-twelfth of the amounts actually paid to the person concerned of the twelve months preceding the date of crystallization of the indemnity.

In addition, for each year subsequent to the first twenty years, an insured who has reached the age of 60 (or 55 for a woman) is entitled to an additional indemnity equal to half a month due only in respect of the contributory period.

Finally, the employee is entitled only to a reduced indemnity in the following cases:
a. if he voluntarily leaves the enterprise where he served his apprenticeship before the expiry of two years;
b. if, as a voluntary member of the scheme, he voluntarily leaves his employment before the expiry of twelve months following the date of his admission to the end-of-service indemnity scheme;
c. if he declares that he has permanently ceased his employment, the indemnity is equal to:

- 50 per cent if he has contributed to the Fund for five years;
- 65 per cent if he has contributed to the Fund for five to ten years;
- 75 per cent if he has contributed to the Fund for ten to fifteen years;
- 85 per cent if he has contributed to the Fund for fifteen years but less than twenty years.

Disability Pension

The disability pension, for which there is provision in the Social Security Code and its amendments, is not yet in effect in Lebanon

Funeral Grant

Under Article 45 of the Social Security Code a grant for funeral expenses is currently set at one and a half times the minimum salary, i.e. $ 300.

Saudi Arabia

Conditions for award of an old age pension
To receive an old age pension, the insured who ceases contributory employment must:
- have reached the age of 60;
- have paid a minimum of 180 months' contributions, or:
- 120 months of contributions, 36 of which were during the five years immediately preceding the date of retirement;
- 60 consecutive months of contributions immediately preceding the date of retirement.

However, an insured person who retires after the age of 60 during the five years following the date when his cover under the social insurance scheme started and who has not fulfilled the minimum period of 120 months of contributions is credited with the necessary amount on the basis of previous employment periods.

Bahrain

Conditions for award of the old age pension
To receive an old age pension, the insured who has ceased pensionable employment must:
- have reached the age of 60 for men and 55 for women;
- have paid a minimum of 180 months' contributions; or
- 240 months of contributions prior to the age of 60; or
- 120 months of contributions after the age of 60, with at least thirty-five consecutive months of contributions during the five years preceding retirement. Reduced pensions in the case of early retirement are provided to persons who have already paid 240 months' contributions (for men) and 180 months for women.

It is not necessary to leave work to receive a pension.

The old age pension is calculated as follows:
- 2 per cent of the average salary for the last two years multiplied

by the number of contribution years, with an additional credit of five years for those who retire aged sixty or before 30 September 1997. The minimum amount of pension is calculated as the lower of the insured's average salary for the last two years, or 155 dinars (about US$ 305).

Iraq

Old Age Pension

The conditions for the award of an old age pension are as follows:
- men must have reached the age of 60 and women 55 and have paid contributions for twenty years; or
- any age with thirty years of contributions for men and twenty years for women;
- retirement from a regular employment;
- the pension may be paid abroad in certain cases;
- the pension is calculated on the basis of 2.5 per cent of the average salary for the last three years multiplied by the number of contribution months and divided by twelve. The minimum pension is set at 54 dinars a month and the maximum 140 dianrs. In the case of ineligibility for a pension, a lump sum equal to one month's salary for each year of contribution is paid to the insured.

Jordan

Old Age Pension

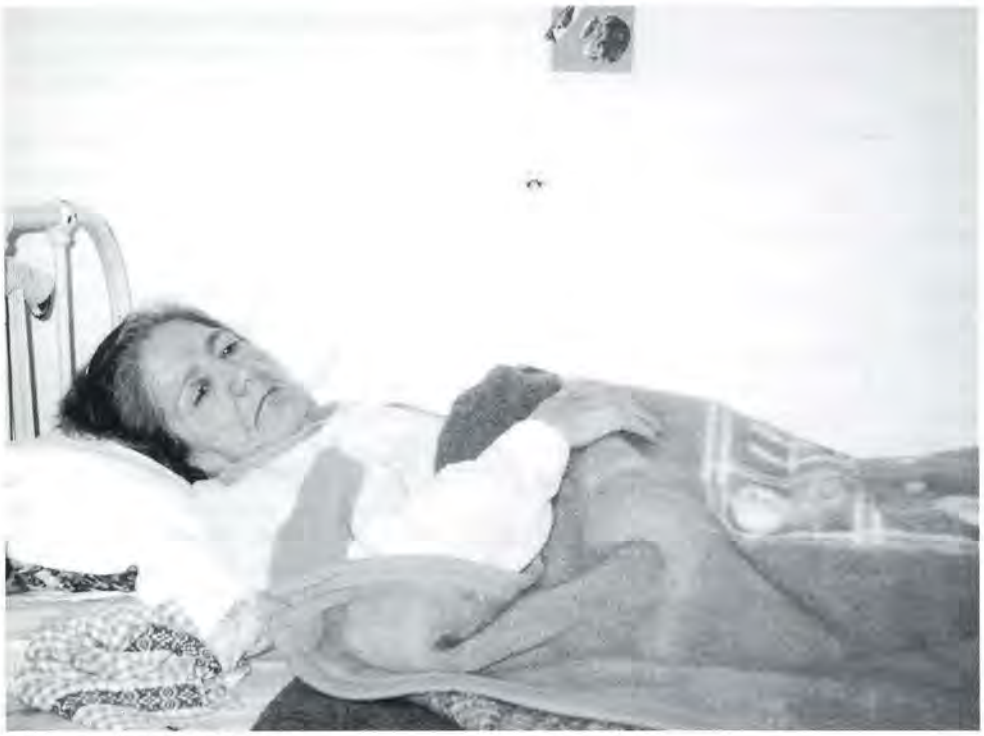
The award of this pension requires the employee to:
- have reached the age of 60 for men and 55 for women;
- have contributed for 120 months (thirty-six consecutive months during the last five years), or total cover of fifteen years.

Early retirement with a reduced pension is possible for those aged forty-six who have contributed for fifteen years. In addition, those insured who have reached retirement age and who need at least five more years of contributions to meet the conditions for a pension may contribute up to the age of sixty-five to satisfy those conditions.

The pension calculation is based on 2 per cent of the average monthly salary for the last two years multiplied by the number of years of contribution. The maximum pension payable must be equal to 75 per cent of the average monthly salary for the last two years. An increase in pension of 10 per cent is provided for the first dependent and 5 per cent for each of the second and third dependents.

In the case of early retirement, the pension is reduced as follows:
- 10 per cent of early retirement between 46 and 50.
- 5 per cent for retirement between 51 and 54.

In the case of ineligibility for an old age pension, a lump sum is granted to the insured, in the amount of 10 per cent of the average annual salary if the contribution period is less than 60 months, 12 per cent if the contribution period is from 60 to 119 months, and 25 per cent if the contribution is equal to or greater than 120 months.



Picture Credit: Bassem Maamari

Lebanon is the only country that continues to apply terminal lump sums in the private sector

Kuwait

Old Age Pension

The award of this pension requires the employee to:
- have reached the age of 50 and have contributed for fifteen years;
- in the case of early retirement, to have reached a minimum age of 45 for men and 40 for women, having contributed for twenty years;
- it is anticipated that the minimum retirement age will rise progressively until 2020, when it will be 55 for men and 50 for women. In addition, early retirement for women with children is possible provided that they have paid contributions for a minimum of fifteen years.

To be entitled to an old age pension, the insured must take retirement and cease work, except in a few cases where the full pension is paid if the insured is aged 50 or over, and reduced by a quarter if he is under 50 where the salary and pension together exceed 1,250 dinars per month.

The pension calculation is based on 65 per cent of final salary plus 2 per cent of the final salary for each contribution year up to fifteen. The maximum pension payable must not exceed 95 per cent of the final monthly salary. Part of the pension may be paid as a lump sum at the request of an insured who becomes disabled before the age of 65. Finally, transitional arrangements allow insured persons to enjoy a pension with less than fifteen years of contributions.

Oman

Old Age Pension

The award of the old pension is subject to the following conditions:
- reaching the age of 60 for men, with at least 180 months of paid contributions, and fifty-five for women, with at least 120 months contributions.
- in the case of early retirement, 180 months of contribution are required, of which 36 at least during the final five years prior to retirement.

The pension is calculated on 1/60 of the average salary for the final two years of employment multiplied by the number of full years of contribution.

Syria

Old Age Pension

The award of the old age pension is subject to the following conditions:
- reaching the age of 60 for men, with 180 months of contributions, i.e. at least fifteen years of contributions; or
- reaching the age of 55 with twenty years' service and 240 months of contributions.

The pension may be reduced if the insured, on reaching the age of retirement, continues to work and receive a salary higher than his pension.

The method of calculation of the old age pension, under Article 58 of the Social Insurance Law 92/59 as amended by Legislative Decree 35/76, is based on 1/45 of the average final monthly salary for the last two years of contributions or the average monthly salary for the last five consecutive years of the final ten contribution years, provided that the old pension does not exceed 75 per cent of the current monthly salary or 1127.5 Syrian pounds in 1996, with a minimum pension of 419 Syrian pounds.

In the case of ineligibility for a pension, an amount equal to 11 to 15 per cent of the total pensionable salary will be paid to the insured in full settlement.

Yemen

Old Age Pension

Article 51 of law 26/1991 set out legal conditions for eligibility to an employment pension, namely:
- reaching the age of 60 for men and 55 for women, provided that the contribution period is not less than 180 months, i.e. fifteen years' contributions;
- reaching the age of 45 provided that the contributory period is not less than 240 months, i.e. twenty years' contributions, and the employee does not continue in employment, as defined in law 26/1991;
- where the contribution period of a man who has reached the age of 50 is 300 months (twenty-five years) or 240 months (twenty years) for a woman aged 46;
- the insured may continue to work until contributions amount to 180 months, provided that the extension of employment does not exceed five years, or contributions, for the purposes of being eligible for an old age pension. The insured may also make a single lump sum payment to top up his and the employers' missing contributions.

The method of calculation of the old age pension, under Article 56 of Law 26/1991 specified that the amount of the old age pension should be calculated as 1/420 of the insured's average monthly pensionable salary for the final year, for each contribution month, provided that the total amount does not exceed 100 per cent of that amount.

Most Arab countries have implemented pension and lump sum payments schemes based on employer and employee participation

Care with Love Training Program for Home Health Care Providers

By Magda Iskander
Centre For Geriatic Services
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The Egyptian society has experienced socio- economic changes as a result of development and modernization strategies, which resulted in a decline in the family size, education and employment of female family members, as well as migration of adult family members in pursuit of employment opportunities. These changes have affected the structure of urban families.

The improvements in life expectancy as a result of good medical care and health awareness, have culminated in a rise in the proportion of older persons (above 65 years of age). The proportion of the elderly within the Egyptian population has reached about 6.2%. It is estimated that around 600,000 of them reside within the Greater Cairo area. An increasing number of them are either living alone, with elderly spouses, and/or with only one or two family members. The weakness in the traditional extended family support has resulted in a drastic decline in the capacity of families to provide home health care for members convalescing, with disabilities, with chronic diseases and/or needing special health care. The capacity of existing health institutions does not meet the urban family emergent health needs.

The center is in need of training home health care workers to give service to the elderly in their homes

There are limited options that are accessible to fill this service gap in hospitals or at homes. The option of paid home health care is also quite limited regardless of the large number of unemployed new graduates. There are no programs to train Home Health Care Providers, and domestic service suffers from low esteem since it is not addressed as a skilled occupation requiring adequate training.

There is a dire need for a system of Home Health Care Providers who are skilled and confident of what they do and how they do it, and who can provide the quality of home care that is client centered while taking into account circumstances of the family as well as the community in which the client lives. Such needs are manifested in constant requests for such services by the Center for Geriatric Services and Asalam Hospital.

In response to these dire needs the Care With Love program which is a training program for Home Health Care Providers (HHCP) was established. The purpose of the program is to create a sustainable well trained cadre of Home Health Care Providers in Egypt in order to staff units for Home Health Care Services. It was developed at the Center for Geriatric Services (CGS) in partnership with the Coptic Evangelical Organization for Social Services (CEOSS) and Asalam Hospital, Mohandessin (S.H.) The program had the following objectives:

1. To Provide a comprehensive curriculum for training home health care providers.
2. To provide training in order to create a corum of trainers for such programs.
3. To create new job opportunities.
4. To establish HHCPs referral units to provide affordable, accessible, and reliable services.

The name "Care With Love" was chosen because it was felt that this kind of service, to be meaningful, can only be done with love.

Students for this training are recruited from communities where CEOSS have development projects, and where other NGOs and Church groups work in underprivileged areas. Selection of students is a painstaking process to assure the good quality of the candidates. Capable young men and women of good disposition (17-25 years of age) that read and write fluently must be of sound mind and able body to be able to join the training.

The training course is comprehensive offering the following subjects:
- Public Health & Nutrition Awareness
- Body mechanics and moving patients

- Communication skills
- Daycare skills
- Body systems & Healthcare
- First aid & common diseases

The name "Care With Love" was chosen because it was felt that this kind of service, to be meaningful, can only be done with love

Evaluation is an ongoing process, not only for academic achievement and acquiring practical skills, but also for personal growth and adjustment. Throughout the course there is emphasis on the wholeness of the human being with respect to individuality and privacy. Upon completion of the training course as designed and before graduation, the trainees spend a month of internship working as Home Health Care Providers under close supervision and evaluation.

After a period of preparation and fundraising (9 mo) the first training course began on September 8, 1996. The main objective of the project was to train 80-100 trainees within two years from the start of the training program while establishing Referral Units for provision of the HHCPs services to the community. About a 115 trainees joined the program and took different courses from September 8, 1996 to January 31, 1999 with 99 graduates (constituting 90% of the candidates). The training course that started in March 99 is still running.

Following the graduation of the first group, the services of the graduates (HHCPs) were offered to the community through the CWL project to test the reaction of the market to the system of service provision and supervision. The need of the community was overwhelming. Feedback from the clients proved that our graduates were not only well trained, but also reliable, well mannered and compassionate.

The procedures for receiving and processing requests for service were tested ,refined, and re-tested. The fees were estimated according to the type of service and number of hours/days requested. Training personnel for future referral units started in November 1997 at the CWL office. Two referral units were established at CGS and SH respectively in February 1998 under the supervision of the CWL project. There is a fee for service, and the graduates are paid through the referral units. Now these units are integrated into the services of CGS and SH, and the HHCPs are employed by these respective institutions.

Fifty five percent of the graduates are working through the CWL project as HHCPs, 6% are working with CWL as trainers, and 15% of the total trainees are working as HCPs in other institutions.

The CWL program not only addresses community needs but national government goals as well. New job opportunities are created through appropriate education and training without burdening the national budget. A new generation of trainers in the field of Health Care will increase the future number of trainees and reduce the overall cost of training. The tuition fees will be offered to the trainees as a payable loan to be paid over a period of time after graduation. Some stipulated scholarships are available through Health Institutions. Other scholarships are available for support of out of town trainees.

In view of the experience of the CWL project ,the three partners (CEOSS, CGS, and S.H.) have decided to continue the training program beyond the two years that were agreed upon initially, and as an ongoing program. Other health institutions are now expressing their desire to do likewise. A twinning program has already started with a Sudanese group to train Sudanese HHCPs.

The Ministry of Health has agreed (Aug. 98) to extend the services of Asalam Hospital to the community through the Home Health Care Providers which means granting the HHCPs full insurance and employment benefits as hospital employees. Home Health Care will ultimately become an integral component of the national health care system reducing the per capita cost of long term health care services.

The Implementing Agencies

The Coptic Evangelical Organization For Social Services (CEOSS) is a well established Egyptian non-government organization registered under the Ministry of Social Affairs. CEOSS is a development agency that addresses problems of health, education, economics and community interrelationships. In these endeavors CEOSS serves members of all denominations.

Through its Community Health Unit, CEOSS has a long history of training community health workers who are involved with education and consciousness- raising in all aspects of public health. Besides its role in preventive medicine, there is direct intervention through the Primary Care Program, the Nutrition Program, the Family Planning Program as well as the Rehabilitation Program for the physically disabled.

The Center for Geriatric Services (CGS) is a non- profit long-term health care facility for the older persons. It was established and managed by the Women Union of the Evangelical Church (Synod of the Nile). The Center is in need of training home health care workers to achieve its objective of a "reach- out" service to the elderly at their homes.

Asalam Hospital (100 beds) is a private hospital committed to the delivering of quality health care through well trained health workers. It is also interested in delivering post- discharge short-term care to its patients in their homes, thus shortening their hospital stay and reducing the cost of health care.

Quality of Life and Social Resources of Elderly Nursing Home Residents in Beirut

By Hind Beydoun

This article is based on: "Determinants of Mental Health among institutionalized elderly people in Beirut", a research project conducted by Hind Beydoun and Nisrine el Rachidi during the period of 1997-98 at the American University of Beirut (Faculty of Health Sciences) in collaboration with Dar al Ajaza Hospital.

I. Introduction

1. Aging of Societies: A Global Trend

Nowadays, population aging or the gradual increase in the proportion of elderly people is a global phenomenon affecting both developed and developing nations. The overall decline in fertility and mortality and the increase in life expectancy at birth constitute the main cornerstones for this worldwide demographic transition.

Cross-national surveys have revealed larger proportions of aged individuals in developed nations as compared to their developing counterparts. Western Europe, today, is the region of the world with the highest percentage of persons aged 65 years and over, ranging between 13.6% for Luxembourg and 18% for Sweden – the largest share of elderly in the world. The next highest percentages are found in Eastern Europe, North America and Australia, with proportions of elderly ranging between 10% for Poland and 13% for Bulgaria. Finally, countries of Africa and Asia (excluding Japan) have relatively lower percentages of elderly, with a range between 2% and 6% (Kinsella & Taeuber, 1992).

These figures might suggest that population aging is mainly an issue for developed societies. However, such findings mask the relatively large and increasing number of elderly people living in developing countries. In particular, 62% of the world's monthly net gain of aged individuals occurs in developing nations alone (Kinsella & Taeuber, 1992). According to the United Nations projections for the year 2000, the percentage of individuals over 65 years is expected to attain 13.2% and 4.7% in developed and developing nations, respectively. However, absolute numbers of persons aged over 65 years will be 229 million in developing nations as compared to only 167 million in developed nations (Ciba Foundation, 1988).

The situation in Lebanon (both urban and rural) is evolving at a rate similar to that of most developing nations in the world. Almost thirty years ago, the Ministry of Planning in Lebanon estimated the number and proportion of elderly people (65 years or more) to be 105,345 individuals, or 4.9% of the overall Lebanese population (MOP, 1970). According to a recent survey conducted by the Ministry of Social Affairs on a representative sample of households in Lebanon, estimates of the number and proportion of elderly people aged 65 years and above were 213,284 and 6.8 %, respectively (MOSA, Population and Housing Survey, 1996).

The burden of population aging is more pronounced in the urban areas of Lebanon, especially in the area of Beirut and its suburbs. A household survey of the population of Administrative Beirut was conducted in the early 80s at the Faculty of Health Sciences at the American University of Beirut. Household members were first interviewed in 1983-84 and then followed up longitudinally until 1992-93. The results of this longitudinal study have suggested an increasing trend in the proportion of persons aged 65 years and above: 5.3% in 1983-84 and 7.7% in 1992-93 (Deeb, 1997).

2. Dependent Elderly: A Burden on Society?

Although the perception of elderly people as a burden on society is in part socially created, some aspects of aging bring about innumerable losses both at the individual and community levels.

As is the case for young dependents, most elderly people are non-productive members of society and are therefore considered as a burden on the economically active adult population. Furthermore, the prevalence of chronic and infectious diseases as well as functional impairments and disabilities increase with age, placing greater pressure on the social network of the elderly person and on the nation's health care systems.

As a consequence of their gradual physical, mental, and social impairment, many elderly individuals will require additional resources for assistance in activities of daily living, for health maintenance and rehabilitation or for the treatment of common illnesses. Such services may be provided in the community by the individual's social network (e.g. spouse, children, other relatives, and friends) or by specialized institutions (e.g. community nursing services).

Some elderly people suffer from serious health conditions or are too frail or too poor to survive on their own in the community. Others lack suitable caregivers to provide the needed economic and social support. One permanent solution

for such highly disadvantaged people is their placement in long-term care institutions where a multidisciplinary team (e.g. physicians, nurses, social workers, dietitian, physical therapist, speech pathologist, occupational therapist etc.) replaces family members and friends as their primary caregivers (Maguire, 1985).

3. Institutionalization vs. De-Institutionalization

In the past, care for the impaired or frail elderly was a family function. Institutions for the aged were small and custodial in purpose and served as charities for the poor and homeless. With the tremendous increase in the size of the elderly population, increased incidence of non-communicable disease, lowered fertility, increased geographical mobility, and rapidly advancing medical technology, institutionalization has become a major health resource (Borson, 1987; Kinsella & Taeuber, 1992).

As opposed to developed societies, the rates of institutionalization in developing nations (including Lebanon) are usually very low, even negligible (UNDIESA, 1985; Hugo, 1991). The most common living arrangement for the elderly persons in this region of the world is with their children and grandchildren (Kinsella & Taeuber, 1992). However, homes for the aged are becoming more common in countries where the sustained fertility decline has led to a rapid population aging and reduced the number of potential family caregivers (Kinsella & Taeuber, 1992).

However, the rising awareness that institutionalization is likely to have adverse effects on the quality of life of elderly nursing home residents prompted the search for alternative forms of care (Jacelon, 1995). A general trend towards de-institutionalization and the emergence of community care was observed in many developed societies. The "community services" alternative has the advantage of keeping people in their own homes and requiring less governmental expenditures than institutional care (Jorm, 1993; Grolier, 1995). Decision-making with respect to the optimal form of care depends on several outcomes including health status, patient preferences and costs (National League for Nursing, 1988).

II. Aging and Quality of Life:

1. Physical and Cognitive Health

Aging is known to have an adverse effect on physical health and on the individual's overall "quality of life". A thin line separates the perception of aging from that of disease.

a. Chronic Diseases & Infectious Diseases

Several types of chronic illnesses have been shown to increase with advancing age. The risks of cardiovascular diseases, diabetes, arthritis, chronic obstructive lung disease, kidney failure, cancer and some neurological diseases (e.g. Parkinson's and Alzheimer's disease) are known to be age-associated.

b. Cognitive Health

Physical health is not the only area affected in old age. In fact, the incidence of various types of cognitive disorders rises in an exponential fashion as a function of age. The most frequent form of cognitive disorders is dementia – "a significantly deteriorated mental function resulting from organic brain disease" (Ciba Foundation, 1988; Mortimer & Schuman, 1981).

2. Functional Impairments and Disabilities

On the other hand, most elderly men and women suffer from multiple functional problems including immobility, inanition, urinary incontinence and sensory impairment. Contrary to the well-defined chronic and infectious diseases of the general population, these common health problems are usually taken for granted as normal manifestations of the aging process. They are subjected to geriatric treatment, which emphasizes caring (i.e. improving symptoms and function) rather than curing the underlying pathophysiology (Rubenstein & Federman, 1995).

A general assessment of the degree of impairment or disability of older adults and their dependency on other persons or instrumental aids is usually performed to determine the form of treatment required for each geriatric patient.

Several interview schedules were developed for assessing the ability of elderly patients to perform basic "Activities of Daily Living" (ADL). For instance, the physical ADL scale relates to simple bodily functions such as eating, dressing, caring for personal appearance, walking with or without the use of aids, getting in and out of bed, taking a bath or a shower and getting to the toilet on time.

3. Mental Health

The mental health of elderly people is often measured in terms of either a particular mental disorder or an overall state of psychological wellbeing. A more holistic perspective of the concept of "mental health" relates to both its positive and negative aspects. Thus, the focus of our study is on two indicators of mental health – depression and life satisfaction – taken simultaneously.

a. Depression

Clinically speaking, depression is an affective disorder characterized by symptoms of sadness and dejection, decreased motivation and interest in life, negative thoughts and such physical symptoms as sleep disturbances, loss of appetite, and fatigue (Atkinson, 1993). The aged is at a considerably high risk of mild depressive disorders and dysphoric states. Depression is directly associated with advancing age and is more prevalent among females at any particular age (Blazer, 1991; Carpinello, 1989; Katona, 1994).

b. Life Satisfaction

Life satisfaction generally refers to "an overall assessment of one's life, or satisfaction with domains, perhaps a comparison of aspiration and achievement, or in comparison with others" (Bowling, 1993). The measurement of life satisfaction constitutes an alternative approach to the measurement of pathological aspects of mental health (e.g. depression).

Higher life satisfaction scores were observed among men in general, married men, women with a higher socioeconomic status (education & occupation), and those elderly men and women with adequate financial resources. The availability of social networks and the regular performance of social activities were also important determinants of life satisfaction (Iwatsobu, 1996).

III. Aging and Social Resources:

A less visible form of aging relates to the interaction of elderly people with their social environment. Sociological aging, as opposed to biological aging, affects the type and extent of participation of the elderly individual in social networks. Children of elderly parents usually would have left home to establish their own nuclear families; interaction with work associates becomes more difficult after retirement; and the death of old friends further narrows the breadth of friendship associations available to old people. However, the most devastating life event of old age is the loss of a spouse, with its various implications from the psychological and economic viewpoints (Maguire, 1985).

Social isolation is a common situation for many elderly - particularly women in the developed societies. In the United States, the "decline of the family" and the prevailing values of self-fulfillment and egalitarianism have destroyed the bond that used to link generations within families. Consequently, there is much less influence today of the elderly over their own children. By contrast, the cultural values that prevail in a great number of developing nations (including Lebanon) have rendered the elderly an integral part of the family structure (Carpinello, 1989).

Social support of the aged individual – both material and emotional – has been historically obtained from the family, the basic institution around which societies are organized. Spouses and children constitute nearly three-fourth of primary informal caregivers of older, disabled persons. Fortunately, the proportion of older persons with living spouses is likely to increase due to improved mortality at the older ages. In addition, persons who have entered the oldest old cohorts are more likely to have living children due to historic changes in fertility and current trends in mortality (Freedman, 1988). Our culture is known to discriminate against female offspring and to celebrate the birth of a male who will carry the name of the family. Curiously, daughters and wives are more likely, than sons and husbands to provide informal care to their elderly parents or spouses (Ciba Foundation, 1988; Freedman, 1988).

However, potential caregivers face a number of obstacles, primarily of economic nature. The fact that spouses and children are also aging limits their caregiving capacity. Employment outside the home and child rearing responsibilities, particularly among women, compete for time which might otherwise be devoted to caring for an impaired older parent (Silverstein & Bengtson, 1994). Such competing roles and responsibilities from jobs and family may constitute a barrier for non-spouse caregivers, particularly daughters, leading to an increased demand for formal types of support – i.e. community services or long-term care institutions (Kelman, 1994).

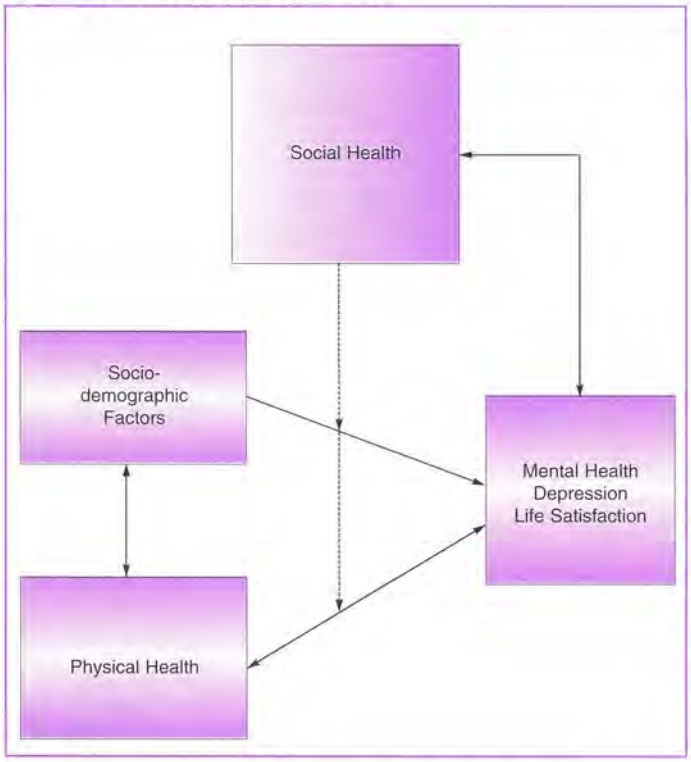
Besides their greater need for caregivers to support them financially and emotionally, some elderly people engage in a variety of social activities, as a means to boost their morale or to avoid social isolation. In fact, the regular performance of physical exercise, of hobbies (e.g. painting or reading) or activities within associations, trade unions, or clubs are common to the more fortunate members of this age category (Iwatsobu, 1996).

IV. Study Methodology:

1. Study Objectives

The main interest of the current study is to assess differences in the quality of life and social resources of institutionalized and non-institutionalized elderly people in Administrative Beirut. The study also aims at evaluating the effects of demographic, health and social factors on the mental wellbeing (depression and life satisfaction) of elderly people. A theoretical model was constructed that related the outcome variables — depression status and life satisfaction — with the three determining factors, which are, by order of increasing importance: socio-demographic factors, physical health and social health **(c.f. Fig 1)**. This article will tackle only some of the social determinants of psychological health in the elderly population.

Figure 1. Conceptual Framework.



2. Study Design

A cross-sectional sample of elderly subjects residing in an institution was matched on a one-to-one basis to another sample of non-institutionalized domiciled elderly subjects, according to three socio-demographic characteristics, namely, gender, age (+/- 5 years) and area of residence – a proxy measure for socioeconomic background. Similar information was collected on the two comparison groups, using a valid and reliable interview schedule. Questions asked relate to four main study areas: (1) socio-demographic background, (2) mental health, (3) physical health, and (4) social health.

3. Instrument

Two versions of the survey instrument – one for each setting – were developed based on preexisting schedules and scales. Both questionnaires were translated into Arabic, and were pilot tested for duration (30-50 minutes), clarity and ease of administration. The various areas covered by the instrument and the corresponding scales, schedules and items are described in **Box III.**

Box III. Components of the Interview Schedule

Area	Schedules, Scales and items
Cognitive Health	Clifton Assessment Schedule (Pattie & Gilleard, 1976)
Depression	GeriatricDepression Scale (15-item version) (Yesavage , 1983)
Life satisfaction	Life Satisfaction Scale (McDowell & Newell, 1987)
_ Physical health _ Activities of daily living _ Social resources _ Caregiver questions _ Interviewer rating scales	OMFAQ (Fillenbaum, 1988)
Social support	Social Support Scale (Ilfred, 1978)
Sociodemographic characteristics	_ Age _ Sex _ Marital status _ Number of children _ Education _ Occupation _ Income _ Insurance
Lifestyle characteristics	_ Smoking _ Alcohol _ Exercise
Additional questions	_ Time elapsed since loss of the spouse _ Ownership of residence (community) _ Attitude toward the nurse (institution) _ Leisure activities

Box I. PROFILE OF DAR AL AJAZA HOSPITAL

Dar al-Ajaza is a non-profit institution. It is located on an area of 3500 square meters in the Tarik el Jdideh area, in the midst of an environment saturated with camps (i.e. Sabra and Shatila), the disadvantage of which has reflected adversely on the high standards of functioning of the hospital. Today, Dar Al-Ajaza hospital includes two different institutions within its structure:

(1) A neuropsychiatric hospital for the treatment of mental and nervous disorders

(2) A home for the invalids, disabled and old-aged patients

The hospital is currently divided into two main sections: The medical and the administration and services sections. The medical section which is served by 25 doctors of diverse specialization includes 4 sections for neuropsychiatric cases (for men and women separately), 4 sections for elderly and disabled (for men and women separately) and 1 section for children with congenital birth defects or disabilities. The administrative section is composed of other non-medical services such as the Mosque, the General Library, the Central Kitchen, the Laundry, the Maintenance Department, the Computer Room and the Administration as such.

The mission statement of this long-term care institution is to ensure health, medical care, nursing care and social services for mental and nervous disorders, physical disability and problems of old age and senility.

Dar al Ajaza was inaugurated for the first time in May 1954 as a refuge for the elderly. It was converted in 1959 — after the creation of a neuro-psychiatric division — into a second-rate hospital (based on the classification of the MOPH). It started to expand through continuous construction efforts during the period that preceded the civil strife.

During the war, several events resulted in major damages to the hospital. For instance, the Israeli invasion (in1982) caused the demolition of the children's section. In 1985, the camps' war had demolished various sections of the hospital, burning the pharmacy together with the laboratory and depots.

Despite the immense capacity of the hospital, it still has a shortage of place to meet the great demand to which it is exposed. At present there are 800 beds that are permanently occupied by patients. According to the institution's statistics in 1994, a total of 823 patients (of which 142 were elderly) had resided in that hospital throughout the year. Around 30% of these patients resided in Beirut before institutionalization while the remaining 70% came from different regions of Lebanon, mainly the South (155 patients), Mount Lebanon (122 patients), the Bekaa valley (118 patients) and the North (60 patients). In addition, around 90% of Dar al Ajaza patients are covered by the MOPH.

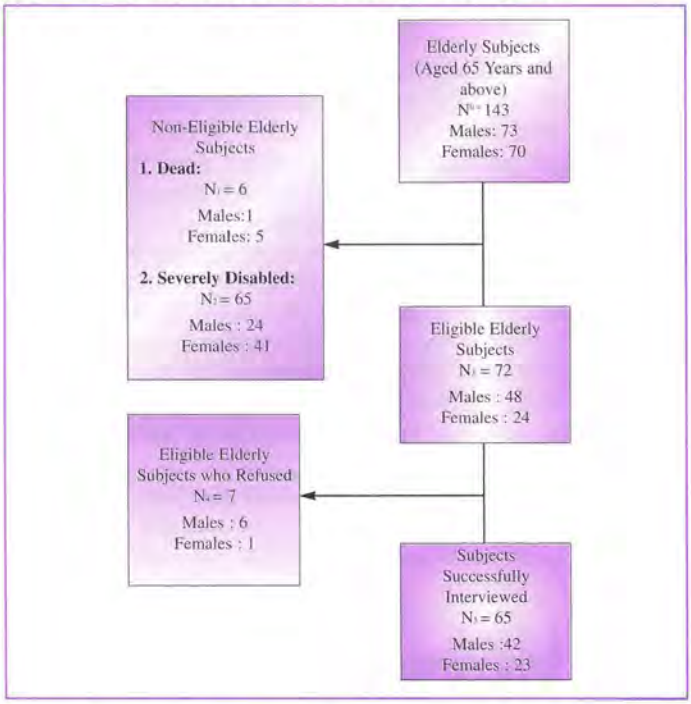
The hospital depends financially for its resources on both stable and unstable sources. The stable sources are formal institutions such as the Ministry of Health, UNRWA, Medical Brigade in the Lebanese Army, in addition to some private patients, all of which cover nearly half of the annual costs. Contributions, financial assistance, charity and donations constitute the unstable sources of funds.

4. Sampling and Data Collection

Institutionalized elderly subjects were accrued from the largest nursing home in Administrative Beirut (Dar al Ajaza Hospital) between December 1997 and March 1998 (c.f. Box I). Eligible cases were all nursing home residents aged 65 years and over, of both sexes. Subjects were excluded if they had any serious physical or mental health condition that would not allow them to participate in the study or to give reliable answers to questions asked in the interview schedule.

The initial number of age-eligible subjects was 143 of which 73 were males and 70 were females. 71 subjects were then eliminated; 6 of them had died before the interview period (1 male and 5 females) while 65 (24 males and 41 females) suffered from a variety of physical and mental ailments that precluded the successful administration of the interview questionnaire. The most prevalent health problems among the excluded cases were senile dementia (53.8 %), chronic schizophrenia (21.5 %), psychosis (7.7 %) and mental retardation (6.2 %). Thus, a total of 72 subjects (48 males and 24 females) were eligible for entry into the study. However, 7 subjects (6 males and 1 female) refused to participate. The remaining 65 (42 males and 23 females) were successfully interviewed **(c.f. Fig 2).**

Fig 2. Sampling Stages in Dar Al Ajaza Hospital



Next, a community-dwelling elderly subject was selected to match each one of the 65 nursing home residents described above. These subjects were judged as eligible if they were 60 years and over and were not mentally or cognitively impaired. As mentioned earlier, the selection of this control group was conditional on three socio-demographic variables that characterized each one of the institutionalized cases. For instance, an 80-year old woman currently residing at Dar al Ajaza Hospital and who used to live in Saida was matched with another home-based woman having these same characteristics **(c.f. Box II).**

Box II. CASE STUDY — OUM KAYED

During our fieldwork, we landed in the marketplace of Ancient Saida. My companions and I went along the dark and narrow alleys of the "Souk", searching for a street named "St Nicolas". We were supposed to locate an eighty-year old woman in that neighborhood. We asked the vendors if they knew anyone that fits these specifications. A little boy told us that his grandmother Oum Kayed was the right person. So, we followed him and climbed irregular stairs to reach the house of the old lady. She received us with a smiling face and was very happy to meet newcomers. I sat right beside her on the sofa. My friend Fatima was next to me and my sister May sat next to Fatima.

While I was gathering sociodemographic information about Oum Kayed, I stumbled upon a question with an obvious answer: "What is your religion?" In fact, the Koran verses were hanging all over the room, and when I asked her this question, her eyes came out of her face. She replied immediately: "Al hamdu lillah". So, I understood on the spot what she meant. At a later stage, I asked her questions that reflect on her mental health status. One of these questions was: " How do you feel about the streamline of your life?" Oum Kayed was very surprised and again she stared at me. So, Fatima had to rephrase the question into "Are you basically satisfied with your life?" Then came the more sensitive questions, like: " Do you think that other people respect you?" Her answer was very prompt. She said: "Why not?" Coming to the question of lifestyle, Oum Kayed admitted that she used to hubble-bubble in her youth in Palestine, and that she started smoking cigarettes only when her husband passed away.

At some point during the interview, I had to list the most common chronic diseases that elderly people usually suffer from. Oum Kayed picked them all (or almost all) by saying: "Ah Wellah " every time I named one. She had in her closet more than a dozen of prescription drugs that were provided by the Wikala (i.e. UNRWA).

Suddenly, Fatima could no longer hold herself and "Oum Kayed" probably thought she was being friendly. Fatima whispered to my sister May: "Look at this closet! Look what's written on it". Indeed, Oum Kayed seemed to have a great sense of humor as she wrote on the drug closet: "Chibli Pharmacy", (Chibli was her last name).

V. Main Study Findings:

The study included several areas for the assessment of the quality of life and social resources of elderly men and women among nursing home residents as compared to their community-dwelling matches. This article will focus on few health indices including mental health (depression and life satisfaction), functional health (Activities of Daily Living) and a number of social resources indices (e.g. social network, caregiver availability, loneliness) **(See Boxes IV and V).**

Box IV. Quality of Life Indices by Gender and Setting.

	Institution			Community		
	Male	Female	Total	Male	Female	Total
Mental health						
Depression score (Mean +/- SD)	7.38 (+/- 3.3)	7.30 (+/- 3.7)	7.35 (+/- 3.4)	5.29 (+/- 3.4)	7.64 (+/- 3.5)	6.09 (+/- 3.6)
Depression status						
% Depressed (GDS > 6)	61.9	65.2	63.1	38.1	68.2	48.4
Life satisfaction score (Mean +/- SD)	8.78 (+/- 3.4)	9.59 (+/- 4.2)	9.06 (+/- 3.7)	11.3 (+/- 4.5)	10.70 (+/- 4.6)	11.06 (+/- 4.5)
Physical & functional health						
# of chronic diseases % Having three or more	23.8	52.2	33.8	38.1	52.2	43.1
Physical ADL score (Mean +/- SD)	8.71 (+/- 4.1)	8.05 (+/- 4.5)	8.48 (+/- 4.2)	13.43 (+/- 2.1)	12.48 (+/- 3.1)	13.09 (+/- 4.2)

Box V. Social Resources Indices by Gender and Setting

	Institution			Community		
	Male	Female	Total	Male	Female	Total
Marital Status (%)						
Never married	54.8	30.4	46.2	4.8	4.3	4.6
Currently married	14.3	4.3	10.8	83.3	21.7	61.5
Previously married	30.9	65.2	43.1	11.9	73.9	33.8
Child Status						
% Having no children	21.1	31.3	25.7	9.5	4.3	7.7
% Having no female children	42.1	50.0	45.7	15.0	--	9.7
Social Network [1]						
% None	45.0	54.5	48.4	5.3	5.6	5.4
% Five or more	10.0	13.6	11.3	71.1	44.4	62.5
Availability of Caregivers [2]						
% Having caregiver	33.3	9.1	24.6	85.0	91.3	87.3
Loneliness						
% Quite often	50.0	56.5	52.5	24.4	30.4	26.6
% Almost never	23.7	21.7	23.0	51.2	47.8	50.0
Presence of Confidant						
% Having a confidant	56.1	65.2	59.4	54.8	87.0	66.2
Social Activities						
% At least one social activity	38.1	23.8	33.3	35.7	17.4	29.2

1. Social network was measured through the number of individuals the elderly subject can visit in their homes.
2. Caregivers were defined as informal providers of care during sickness.

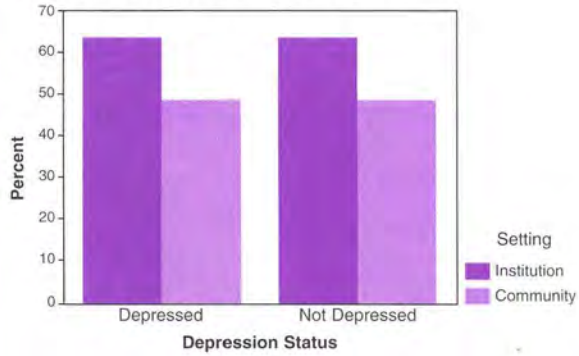
1. Quality of Life by Gender and Setting:

Depression

The depression status of our elderly sample was assessed through the use of a scale specifically designed for this age group – the short version of the Geriatric Depression Scale (Yesavage, 1983).

In the current study, the average depression score differed significantly between the two populations as it was slightly above the cut-off point (Mean 7.35; SD= 3.4) for nursing home residents and slightly below the cut-off point (Mean: 6.09; SD= 3.6) for community-dwelling subjects. By the same token, a relatively high prevalence of depression (63.1%) was observed within the institutional setting, whereas the proportion of depressed community residents was only 48.4% **(c.f. Fig 3).** Depression was also more prevalent among females, irrespective of the survey setting **(See Box IV).**

Fig 3. Distribution of Elderly Subjects by Depression Status and Setting.

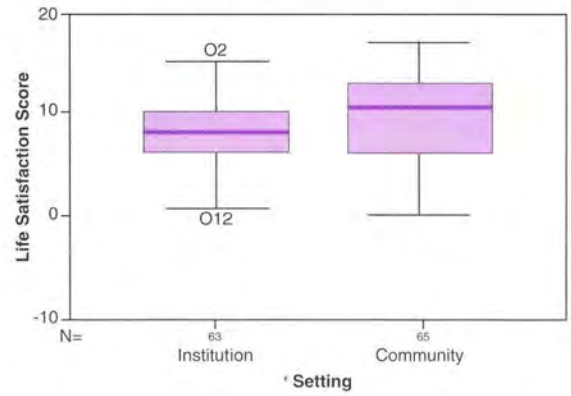


Life Satisfaction

The Life Satisfaction Scale utilized in this particular survey was also a 15-item scale composed of five areas, four of which consisted of binary (Yes/No) questions and the remaining area included Likert-type questions (McDowell & Newell, 1987).

In our study, nursing home residents were less satisfied with their overall life situation as compared to their community-based matches (c.f. Fig 4). In fact, the mean life satisfaction score was significantly higher for the community dwellers as compared to institutionalized elderly (11.06 (SD=4.5) vs. 9.06 (SD=3.7). In addition, female nursing home residents reported a slightly higher

Fig 4. Distribution of Elderly Subjects by Life Satisfaction and Setting



level of life satisfaction when compared to their male counterparts (9.59 (SD=4.2 vs. 8.78 (SD=3.4).

Chronic Illnesses

The burden of disease among elderly nursing home residents and their community-based counterparts was assessed through several mechanisms. The survey instrument included a list of commonly occurring diseases and disorders in the older age categories. Around 43% of community-dwellers were found to have three or more chronic illnesses – a proportion slightly higher than that observed among institutionalized elderly individuals (34%). In both settings, females were more likely to suffer from multiple chronic conditions than were men. The most prevalent diseases were hypertension (29.2% in the institution vs. 32.3% in the community) and Diabetes Mellitus (17.4% in the institution vs. 24.6% in the community). Stroke (32.3%) was also prevalent in the institutionalized group whereas gastrointestinal problems (32.3%), heart trouble (32.3%) and arthritis (24.6%) were more frequently reported by community-dwellers.

Activities of Daily Living

As mentioned earlier, the physical ADL score is an indicator of the degree to which older individuals still maintain their independence while performing activities such as eating, dressing, bathing, walking etc. In our study, non-institutionalized elderly people had a uniformly high physical ADL score – nearly 13 out of 14. As such, they were less physically dependent on caregivers or aids than their nursing home matches with a mean physical ADL score of 8.48.

Among the institutionalized elderly, a decreasing trend in the physical ADL was observed with age. The onset of "dependency" was around the age of 70, whereby we can notice a sharp decline in the physical ADL score. Moreover, no significant gender differential in disability levels was observed among elderly nursing home residents (c.f. Fig 5 & 6).

2. Social Resources by Gender and Setting:

Social resources were either deficient or lacking for the majority of institutionalized elderly as opposed to community dwellers of the same age, sex and socioeconomic background.

Most of the nursing home residents were either single (46.2%) or previously married (43.1%), while only 10.8% were currently married.

Fig 5. Distribution of the Institutionalized Elderly People by ADL Score and Age

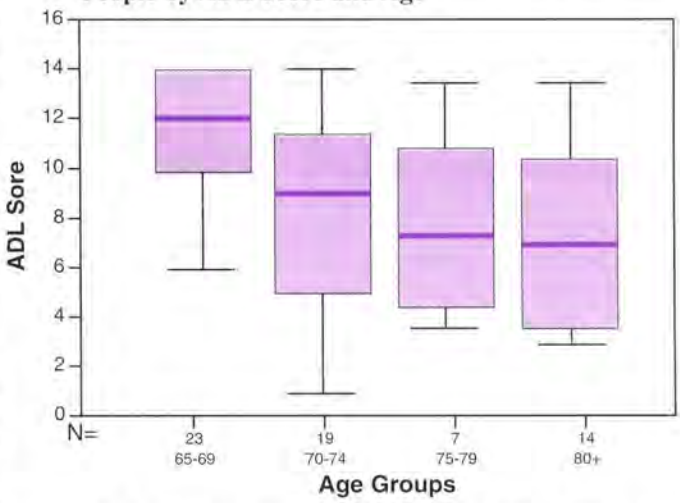
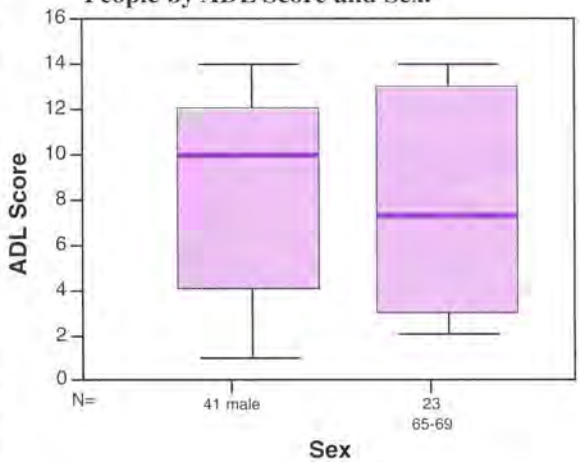


Fig 6. Distribution of the Institutionalized Elderly People by ADL Score and Sex.



By contrast, married elderly people constitute 61.5% of the non-institutionalized sample. As a result of the existing gap in life expectancy between the sexes, elderly women were more likely to be widowed than their male counterparts. Within the institution, 60.9% of females were widowed versus only 21.4% of males.

Over 25% of institutionalized subjects had no children, whereas 92.3% of community dwellers had at least one child. In addition, almost half of institutionalized elderly men and women had no female offspring versus only 9.7% of their community matches. Since children – and more specifically female offspring – constitute a major resource as potential caregivers, childless elderly men and women are at a greater risk for nursing home placement.

Social network was measured through the number of individuals the elderly subject can visit in their homes. Over 60% of community dwellers had a network size of 5 people or more, whereas 48% of institutionalized subjects had no relatives or friends that they consider as part of their social network. On the whole, elderly women were less likely to report a large network size.

The majority of our institutionalized elderly had no informal caregivers from outside Dar al Ajaza Hospital. Over half of them reported feeling lonely "quite often" whereas half of the community dwellers almost never experienced feelings of loneliness.

The proportion of individuals who had a close relationship with another person (i.e. a confidant) was slightly higher in the community when compared to the institution (66.2% vs. 59.4%). In either setting, elderly women were more likely to have a meaningful relationship with another individual than were men.

Similar proportions of elderly people reported engaging in one form or another of the different types of social and leisure activities proposed by the interview schedule. In fact, one third of the institutionalized cases (vs. 29.2% of community controls) were socially active, with males outnumbering females. However, the type and frequency of these activities were shown to be different in the two settings. Healthy community-dwellers had better opportunities for enriching their lives with a variety of social and leisure activities.

3. Social Factors and Mental Health of the Elderly:

One objective in our study was to identify the major determinants of mental health among elderly people in either setting. In our model, social health was given considerable importance since it has both a direct and an indirect effect on mental health (See Fig 1).

Our findings suggested that the determinants of the two major outcomes (i.e. depression and life satisfaction) differed between the two settings. In fact, most of factors that determined depression status at the institution were social in nature, whereas the mood of community dwellers was affected by a myriad of demographic, physical health and social health factors. As for life satisfaction, it was greatly affected by perceived social support in both institutional and community settings.

Thus, social factors seem to play an important role in determining an elderly person's mental health status after controlling for individual variations in sociodemographic background and physical health. For instance, elderly people who reported participating in any kind of leisure or social activities were less likely to be depressed and were more satisfied with their lives. The number of social activities to which elderly people are exposed is a strong predictor of life satisfaction in both study groups. Finally, those who perceived the frequency of contact with their friends and relatives as adequate were at a lower risk of developing depressive symptoms.

IV. Conclusion

Three main conclusions can be drawn from this investigation:
- On the whole, elderly nursing home residents had a poor quality of life and less social resources when compared to their community-dwelling counterparts.
- The health of elderly women and their social support systems were less favorable than those of elderly men, regardless of the setting.
- In old age, social factors – and especially social activities – are strong predictors of mental wellbeing, even after controlling for physical health and sociodemographic background variables.

It is, however, necessary to pinpoint some of the methodological limitations associated with our investigation. One weakness is the cross-sectional nature of the study design, which limits our ability to ascertain the direction of the association between any determinant and the outcome of interest.

Another limitation is the degree of representation of our study sample. Institutionalized elderly people were chosen from a single nursing home that included the largest population of institutionalized elderly people in Administrative Beirut. However, the total number of eligible subjects (n=65) was relatively small due to the high prevalence of psychiatric and cognitive impairment among the residents. This limitation in sample size may have reduced the power of our study. Future research should focus its attention on the health and social needs of the elderly in general and elderly women more specifically, through large-scale cross-sectional and follow-up surveys.

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Dr. Nazek Saba Yared
Renowned Lebanese Writer

By Myriam Sfeir

Dr. Nazek Saba Yared is author of several books and novels. Some of her books have been translated into English, and one went into the second edition which is very rare for an Arabic book. She is a member of the Baalbeck International Festival Executive Committee and the Lebanese Association for Women Researchers (Bahithat). She has assisted in starting the movement for the protection of battered women in Lebanon. In recognition of her "exceptional initiatives and activities in the field of culture and development, she received in December, 1998 the Prince Claus Award. She was given the award for her "commitment to Lebanese culture and society" and her "belief in inter-human and intercultural communication."

Yared was born in Jerusalem of a Lebanese mother and a Palestinian father. According to her she was very fortunate to be brought up in a family where values such as honesty, integrity, independence, and autonomy were highly regarded. She asserts: "My father was a very straightforward, honest and patriotic person, and I inherited these qualities from him. My mother, on the other hand, encouraged us, my sisters and I, to be economically independent. It was she who insisted that we should be professionals and never depend on a man. She was an exceptional woman."

Yared's childhood years were spent in Palestine where she attended a German school for three years. When the war broke down the school was closed, but she continued to take private lessons at home in Arabic and English. Upon finishing her school years she had to leave Jerusalem having received a scholarship to pursue her studies in Cairo, Egypt. She majored in Philosophy and received her "License" from the Fuad the First University. She recounts: "While in Cairo I was cut off from my family who in 1948 were displaced by the Israelis." Her mother moved to Lebanon with her brother and three sisters, after her father died of a heart attack. It was in Cairo that she first met her husband, and since he was Lebanese, they moved to Lebanon.

Yared asserts that her husband was very supportive right from the start. He had great respect for her and was very understanding: "I really can't complain for I've been very lucky

with my husband and in my family life. My husband stood by me and I must admit it is really thanks to him that I was able to fulfill my dreams. I believe that since my husband was brought up by his mother and only his mother made him respect women."

Since she has always had a job, Yared was never a full-time house-wife. She taught Arabic for 32 years (1950 - 1982) at the "College Protestant". She asserts: "Those years were the nicest in my life. I was very happy. I love Arabic Literature and managed to transfer this love to my students. if anything, I can say that I am a very good teacher." Together with a full teaching load, she was studying for an MA in Arabic Literature at the American University of Beirut (AUB). After she got her Masters degree, she decided to go for a Ph.D. which she received in 1976 when the war had already started. She asserts: "I owe it all to my husband. It took me seven full years to finish my Ph.D. To have a man sitting there, without going out, or receiving, staying there with a wife who is immersed in books was very unselfish of him."

Coping was not easy according to Yared yet she managed. She had hired help at home to take care of the house work, and her husband looked after the kids in the evenings: "Given that teaching is a flexible job, I was able to fix my hours in such a way that I would feed my child in the morning, go and give my classes, come back at noon for their noon meal. In the afternoons and evenings my husband took over while I was away teaching and attending my classes. I can't say it was easy, it was very difficult."

Yared admits that she always had a guilt feeling about neglecting her children. So she would make up for lost time with her children during holidays and the summer vacation. According to her there were many advantages in teaching particularly the three whole months of holiday during which she spent a lot of quality time with her children. However, she asserts that she never felt that her children were deprived because she was a working woman. She holds that it is very important for women to work because idle married women feel emptiness after their children go off to school. Yared maintains: "Being lonely they try to pass the time visiting others, playing cards, etc. and I don't think their children turned out better than mine. It is my conviction that a mother who is really willing to put an effort to bring up her children will never sacrifice them no matter what her job is. So this is how I coped. I strongly believe that cleaning, cooking, washing, etc. can be done by anyone. It is mainly the children that need to be looked after, and I definitely looked after my children and never sacrificed them for anything in the world."

Dr. Yared goes on to say: "In 1978 I left the 'College Protestant' and took another job at Beirut University College (BUC presently LAU). At that time Arabic courses were given either as electives or as college requirements, so it was more difficult to make students experience the pleasure one derives from reading Arabic Literature. At the Baccalaureate level things were different. I managed to really influence my students by making them love and appreciate our beautiful Literature."

Yared admits that she always dreamt of becoming a writer. She explains: "To me writing was always a dream. Being a writer was the most wonderful thing in the world." She wrote her first novel in 1983 after her children were off to college. She holds: "Yet, prior to writing novels she concentrated on literary criticism because, in her opinion, it was less time consuming and didn't need as much concentration as creative writing.

Yared is one of the first who talked openly about domestic violence.

Her latest novel Al-Zekrayat Al-Mulghat (1998) deals with the status of Lebanese women. It touches upon gender relations, economic need, violence against women, the war, prevalent discriminatory laws, etc. According to Yared, "the events take place during the Lebanese war. The novel traces the life of a married couple who owing to a lot of external and internal factors get divorced. The book highlights the moral abuse that women are subjected to, patriarchy, the oriental mentality, the status of women in the personal status laws, as well as the damaging impact divorce can have on the children.

Yared is one of the first who talked openly about domestic violence. She holds that there is dearth in statistics on battered women in Lebanon and collecting such data is very difficult. She recounts: " I didn't know that the problem even existed until I met a lady called Tina Naccache. The problem gripped me since no one around me had ever faced such a situation. Tina and I worked together for some time collecting information, and we discovered that there were quite a few battered women (physically, psychologically, emotionally, etc.) in Lebanon."

Yared is currently working with one of her colleagues at the Bahithat on a project which entails a full bibliography of Lebanese women writers from the mid 19th to the mid 20th century. Many of them are women who nobody have heard of or who only wrote in journals." She maintains: "What is interesting about my work with the Bahithat is that I got to know intellectually active women working in different fields of research. To me what is enriching about it is that we come from different educational and intellectual backgrounds. We meet once or twice a month and discuss our current projects. I enjoy being with them."

Learning English

By Rachid El-Daif
Beirut: Al-Nahar, 1998
Reviewed by Samira Aghacy

Rachid El-Daif's latest novel *Learning English* is a brilliantly executed work of fiction, the work of a writer arrived at startling maturity. If the majority of Lebanese male writers tend to accord the woman a marginal role in their works, El-Daif's latest work focuses on a woman whose transgressive role in a patriarchal society exposes the myth of male control and domination . In an unprecedented attempt in Arabic fiction at uncovering taboos related to woman's physical power, El-Daif's subversive novel presents the narrative through the focalizing consciousness of Rachid, the narrator, who sets out to tell the story of his life and solve the enigma of his origin, the fear that he may not be his father's biological son.

The novel begins with the murder of the narrator's father who is killed and buried without the narrator being informed about it since none of the members of his family, including his mother and his uncles, bother to inform him. Coming across it by accident in the newspaper, the news of his father's death shakes Rachid and resurrects old and deeply ingrained feelings of anxiety about his dubious origin.

Having received a Doctorate from France and making his abode in Beirut, Rachid rejects outdated customs and traditions represented by his hometown Zgharta and congratulates himself on the new life he has made for himself in the city. From the start, the narrator is keen on projecting himself as part of the modernizing process and tells us that as a rational human being, he has abjured all primitive practices. He insists that he cannot bear but to be contemporary and that computers, numbers, and modern technology and telecommunication have become part and parcel of his existence. In the city, he tells us, he has managed to free himself of the restrictive provincialism and the protective framework of the small community.

Despite such assertions, the past returns to plague him and to claim what legitimately belongs to it. He admits that he is uttering such civilized words despite other feelings of anger and spite that he feels for the person who has killed his father, his own flesh and blood. Coming from a society strongly structured on revenge, he is obviously shaken by his father's death and wonders at the power that wants to drag him backwards.

In order to ensure his legitimacy, he sets out to retrieve the path back to the father. In fact his story is founded on a profound anxiety about the meaning of masculinity. To have a woman for a mother, can be a traumatic experience for any man in a society that sanctions maternity but rejects sexuality. If he is able to accept his father's numerous affairs with women and the possibility that his father too may have had an illigitimate

daughter, he cannot tolerate his mother's single love affair with a man. He admits that his father is nothing but a murderer and a vicious and cruel man, but despite everything, he insists that he happens to be this man's son. Seeing himself as the guardian of his father's honour, he makes a point of covering up his defects and refuses to compromise his reputation particularly before his mother.

In order to reinstate the father in the position that is his birth right, Rachid has to come to terms with his mother for, after all, she is the cause of his humiliation. What he really wants to know is whether she actually had sexual intercourse with her lover shortly before her marriage to his father, and the spectre of female sexuality which is masked, hidden, and duplicitous begins to haunt him. In his compulsive attempt at finding the truth, he discovers that his mother was planning to desert her own son and run away with her lover. Shocked at this discovery he wonders if any one has ever heard of a mother who is capable of treating her child in that manner. He feels insecure in the presence of her dangerous sexuality and her transgressive behaviour. He sees a positive viciousness in her lack of interest in her own son and resents her for not even bothering to explain to her husband how she came to lose her virginity. The narrator insists on presenting his mother as the culprit and gives examples of her imprudence and indiscretion. He wonders how she managed to keep her lover's letters and some embarrassing photographs of hers in his father's own house. In fact, the tensions and doubts within him can be attributed to her presence and her unconventional behaviour that constitutes a threat that fills him with anxiety, resentment, and doubt.

His desire for knowledge and control derives from his sense that the masculine world and masculine identity are in danger. His mother is seen as fatal to his as well as his father's sense of equilibrium and strength. He feels threatened by her masculine qualities, her keen intelligence, her assertiveness and insistance on equality as well as her indifference to moral standards. Lacking the nurturing qualities that a mother should possess, his mother becomes a threat to his sense of stability and his ability to have a healthy relationship with any woman. His affair with Salwa can be construed as a purely sexual relation inextricably bound up with desires for domination and misogyny. For him, intimacy with women, threatens overdependence, possessiveness, and total absorption, or loss of self. Such feelings spring from his fear of female power manifested in his own mother's transgressive behaviour.

In his story, he likes to project his mother as the stereotypical nurturing mother, but her adultery and deceit destroys all his dreams about what a mother should be like. Unable to hide his strong attraction for and admiration of his mother, he compares her to a ravishing movie star and presents her as a vibrantly passionate woman who excersizes erotic fascination over men. Feeling threatened by such oedipal feelings, he becomes intent on portraying her as dangerous and destructive though he is unable to suppress her sexuality that lurks beneath the surface. If his ultimate aim is to erase these signs of female autonomy and otherness that threaten his identity, he sees the difficulty of achieving such an aim. Despite his attempt to undermine her role, she remains all-powerful, all-encroaching, all-castrating, and he is left with no other alternative but to focus on words, the actual story telling, in his attempt to control experience through language rather than the body.

His ambivalent feelings towards his mother drive him to see her in terms of nature as well as decay, admiration as well as revulsion. A great deal of the information that the narrator gets is through the stories that his mother relates to her bosom friend Maryam. It is her stories that keep her going and her need to speak, to tell, is matched by her need to have someone to speak to. When she is no longer able to tell the autobiography of her love and marriage to her bosom friend Maryam, she breaks down and begins to sense the vanity of her life and the emptiness of her existence. The vibrantly passionate woman degenerates into an aging old hag bitten with senility and behaving in a crude and indiscreet manner, having lost all her social grace and finesse. Despite the narrator's desire to marginalize her, the text reveals that she dominates the scene by her courage, assertiveness, defiance and insistence on holding her ground and refusing to capitulate or give in to her husband or son.

The novel ends where it began with the narrator as confused about his genealogy as ever before; however, this confusion makes him all the more determined to embrace the father and erase the mother. His relapse into barbarity, the old world of revenge and aggression, is seen in his eventual return home, his decision to leave the city and be his father's son (or convince himself of this), despite the fact that he has no solid proof . On his way back home, he sees his father's ghost hovering before the car and asserts that in his hometown, if one sees a ghost and fails to promise him instant revenge, he will be haunted by the ghost all his life.

Despite his desire to impose closure, to offer neat resolutions, more is left at the time of writing than is resolved. El- Daif presents a cyclical, many layered narrative that invites exploration rather than arrival. Compelling though the narrator's partial as well as objective investigations are, the force of this outstanding novel lies equally in its strong autobiographical elements, its subtle mixture of generic elements, the suggestive accretion of detail, dreams, stories and tales that highlight, if anything, the flagging and, perhaps, illusive power of the patriarchal order in the face of active and assertive femininity.

Follow Your Heart

By Susanna Tamaro
Reviewed by Lynn Maalouf

In an ultimate bequest for understanding, forgiveness and, above all, compassion, an elderly Italian woman decides to write to her granddaughter in America, revealing in the simplest and most touching words the intricacies of mother-daughter relationships, sewn against a canvas of dramatic events. Three generations of women, each struggling with or against the paradigms of her time, and separated from each other by the "distance that leads from intransigence to compassion" (p.162). Three women whose destinies were shaped by one lie, or rather, one omission to say the truth. "Follow Your Heart" is a poignant testimonial and confession, beautifully written by Susanna Tamaro, a one-way correspondence, and point of no return, leading straight to the 'heart' of a lifetime of choices, decisions, love and pain.

All along those intimate letters, this woman is recounting scenes of her life with her daughter, Ilaria, (killed in a car accident), and with her granddaughter who has emigrated to the United States, in an attempt to explain the origin and reason for their respective lack of communication, or miscommunication. With words of wisdom, which extend far beyond her individual experience to reach universal relevance, she uses strong imagery to explain her vision of events. For example, when describing her complicity with her granddaughter in the early years of her life, she sees it as stemming from the similarity between childhood and old age: "In both cases, for different reasons, there is an element of defenselessness; we are either not yet, or we have ceased to be part of the active world, and our responses can be spontaneous, open.

During adolescence an invisible shell begins to harden around our bodies, and gets thicker and thicker throughout our adult life. Lessons about love, and the failure of maintaining that love, take on the underlying rhythm of the letters. "Had I understood at the time that the first requirement of love is strength, events would most likely have taken a different turn. But to be strong you must have self-respect, and to have self-respect you must have self-knowledge, must know yourself inside out, even the most hidden things, those most difficult to accept. How can we achieve this when life with all its noise and bustle is always dragging forward?"

Within a romantic perspective, the confession and explanation goes on, interwoven with details of her everyday life, and against a backdrop of nature's upheavals. The letters are written during the last couple of months of the year, November and December, when nature is most tormented, reflecting the woman's inner state, and also illustrating the approaching end to her life.

Susanna Tamaro has succeeded in creating a novel powerful in its tenderness, charm and wisdom, which compels the reader to pause and reflect about the core of life... with the last advice to "be still and listen in silence to your heart. When it has spoken to you, rise up and follow it".