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Title: Age Of Despair Or Age Of Hope? Palestinian Women's Perspectives On Midlife Health

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ABSTRACT

There is limited evidence about women's experiences of the midlife, beyond a narrow – frequently biomedical – focus on the menopause. The broader (physical, social, cultural, political) dimensions of women's midlife health are poorly understood, particularly in low and middle-income countries. Our study seeks to understand how women in the West Bank (occupied Palestinian territories) conceptualise, experience and manage their health in the midlife. We generated qualitative evidence using in-depth life history interviews in 2015 with women (n=35) living in the West Bank, analysed thematically. Women's understandings of good health draw on indigenous and biomedical knowledge and include a calm psychological state, ease of movement, as well as physical appearance and complexion. Exposure to political violence was understood as impacting mental and physical well-being. Most women articulated a positive view about midlife and ageing as a natural process. A range of terms and expressions were suggested by women experiencing this transition, internalised differently according to marital and motherhood status. For many women, the menopause was merely one – often relatively unimportant – aspect of changes associated with ageing. In dealing with midlife health issues women used multiple strategies, or health pluralism, sequentially or simultaneously; drawing on multiple sets of accrued resources. For never-married or childless women, formal healthcare services represented a site of social exclusion. Our evidence highlights the importance of considering the broader dimensions related to midlife health for understanding women's health maintaining and care-seeking behaviours as they age.

KEYWORDS

occupied Palestinian territories

gender

health

midlife

menopause

health pluralism

INTRODUCTION

Midlife or the middle years of adulthood was until recently understood as little more than a "staging area" toward older age (Baruch & Brooks-Gunn, 1984 p.1). Lifecourse approaches, however, identify midlife as a distinct stage of life (Moen & Wethington, 1999). This follows the conceptual emergence and widespread acceptance of adolescence as a distinct lifestage. Together with adolescence, perimenopause has been identified as one of the "extremes of reproductive life" (Penney, 2006: 20). Processes of change, whilst often linked explicitly to biological transitions (eg: puberty, menopause), encompass much broader processes of social change and demand a biosocial approach to understanding people's experiences of health – and health-seeking behaviours – across the lifecourse. This draws attention to the ways in which health intersects with its social determinants, reflecting the importance of socio-ecological context within which women age (Melby et al., 2005; Obermeyer, 2000). For example, evidence from Thailand highlights women's accounts of the midlife as involving transformation and adaptation, but that was nonetheless negatively stereotyped in their socio-cultural context (Arpanantikul, 2004). By identifying more fine-grained understanding of the lifecourse we can identify the disparate ways in which individuals conceptualise, navigate and experience role transitions.

The boundaries of midlife – as with any other lifestage – are fuzzy; an age range of 35 to 55 years is a crude proxy for diverse trajectories of individual change. The health concerns of women in midlife have been neglected in low and middle income countries (LMICs) (Bustreo et al., 2013). Health services tend to focus on reproductive needs, and as women age their needs are neglected (Palacios et al., 2005). Healthcare provision, or its absence, can operate as a site of social exclusion across intersectionalities, including gender and age.

Gaps in healthcare provision are an indicator of the privileging of some needs (eg: reproduction) above others (eg: menopause). Or, where healthcare is provided, social exclusion occurs because perceptions about that care, including its content and quality, act as barriers to use (Hossen & Westhues, 2010).

In high income settings accounts of women's midlife have tended to be negative, emphasising: loss, physical debilitation; emotional trauma; and, the challenges of navigating multiple concurrent transitions (eg: menopause and adult children leave home or parents age and die) (Dare, 2011). Menopause is most closely associated with the negative connotations of the midlife, although studies from high and middle income countries find that attitudes towards menopause are more positive or neutral than negative (Ayers et al., 2010; Winterich, 2003). In resource-poor settings many women may not seek healthcare because of a presumption that age-related needs are normal or natural and do not warrant care (Elias & Sherris, 2003; Jejeebhoy et al., 2003).

Compared to high income settings, evidence for women's experiences of the midlife in LMICs is sparse (Harlow et al., 2012). In work from LMICs focusing on women's health, the absence of a focus on menopause might represent two different silences: a "culture of silence" (Senanayake, 2000 p.63) surrounding older women's health reflecting the lack of attention paid by providers or researchers; or, an extension of the "silent endurance" (Khattab, 1992 p.1) of women's reproductive lives into their post-reproductive years. Silence around menopause is highlighted in an ethnographic study of rural Egypt that identifies a range of transitions (birth, circumcision, menstruation, marriage, pregnancy, motherhood, widowhood), with menopause only mentioned in passing (Lane & Meleis, 1991).

The midlife has also been identified as a time of personal growth, satisfaction, creativity, pleasure and power (Friedman & Pines, 1992; Friedman et al., 1992), emerging from women's own accounts and meanings of their midlife, "hearing midlife voices" (Wadsworth, 2000 p.645), although much of this evidence is from high income settings (Dare, 2011). Our study seeks to understand how women conceptualise, experience and manage their health in the midlife. Women's accounts can reveal differences between biomedical discourses and women's understandings, highlighting different midlife meanings and experiences in context (Wray, 2007).

Context

Palestinians in the occupied Palestinian territories (oPt) live in two administratively segregated areas: the Gaza Strip and the West Bank (WB). Compared to men, women in oPt have lower labour participation rates and higher unemployment rates (PCBS, 2016a). Inequities persist despite gender parity in achievement of Bachelor degree awards (PCBS, 2016b). Palestinian women's health needs are constrained by structural barriers to health care, with men forming the majority of policy makers and physicians providing services (Giacaman et al., 2003). Health policy in oPt is influenced by donor strategies emphasising reproductive health care (Giacaman et al., 2003). Health services for women who are unmarried or beyond childbearing, are under-resourced and scarce (UN, 2013). Use of the phrase *age of despair* by some medical professionals to refer to the menopause highlights negative biomedical attitudes (UN, 2013). At older ages, a lack of social security means that family – especially children – serve an important welfare function. Poorer and older women

96 who are never-married or divorced or childless, experience increasing vulnerability and
97 marginalisation with age (Giacaman, 1997).

98 The socio-political context (political violence, stress, insecurity, Israeli blockades restricting
99 movement including for healthcare), deteriorating living conditions and resource-
100 constrained Palestinian healthcare system (donor dependency, out-of-pocket-payments and
101 corruption, fragmented services) are well established (Batniji et al., 2009; ESCWA, 2009;
102 Giacaman et al., 2009; Husseini et al., 2009; Rahim et al., 2009). Studies of women's health
103 in oPt focus on reproductive health (Giacaman et al., 2007; Hassan-Bitar & Narrainen, 2011;
104 Wick et al., 2005). A study of women's health seeking behaviours in rural oPt found reliance
105 on self-treatment, delayed seeking of formal healthcare, and low levels of preventive health
106 care, all mediated by women's gendered position in oPt society (Majaj et al., 2013). Some
107 aspects of religion (faith, prayer, participation in religious practices) have been identified as
108 being protective of women's health in oPt (Sousa, 2013).

109 There is substantial evidence on the links between political violence (and its mediators) and
110 health and well-being in oPt (Abu-Mourada et al., 2010; Abu-Rmeileh et al., 2012; Hobfoll et
111 al., 2012; McNeely et al., 2013). Females are more likely to be at risk from negative health
112 effects of political violence than males, linked to lower socio-economic status and access to
113 resources (Al-Krenawi et al., 2007; Hobfoll et al., 2011; Punamäki et al., 2005). Women are
114 more prone than men to a range of psychopathologies, including depression and PTSD, with
115 the effects of violence compounded by their roles as mothers and wives (Al-Krenawi et al.,
116 2007). A study following the winter 2008-2009 Israeli attack on the Gaza Strip revealed that
117 women had worse health related quality of life than men (Abu-Rmeileh et al., 2012).
118 Although both men and women experienced insecurity, women reported higher levels of

119 human insecurity, due to their roles as primary caregivers, and stresses and fears
120 associated with a possible loss of a male breadwinner (Ziadni et al., 2011).

121

122 **Methodology**

123 We collected (n=35) in-depth life-history interviews (February-August 2015), drawing on
124 two related strands of qualitative research within social and public policy: the call for more
125 use of life history methods to understand policy processes (Lewis, 2008); and, the 'reality
126 check approach' to gain insights into how people experience and engage with policy worlds
127 (Lewis, 2013). The question guide [INSERT LINK TO ONLINE FILE A] for this study was
128 developed, piloted (n=4) and refined. Questions sought to understand the lives of women
129 aged 40-55, with emphases on health. Interviews were conducted in the local Palestinian-
130 Arabic dialect. The question guide helped direct the conversation, but the interviewee led
131 the narrative direction. Conversations began with asking women about their life - where
132 they are from, education, marriage and family, employment, lifestyle - gradually moving on
133 to past and current midlife health concerns, including the menopause. Probing questions
134 focused specifically on health in older age, including questions about their mother's health
135 and experience of the menopause and descriptions of what 'good health' in the midlife
136 entails. Interviews were conducted in pairs, with the lead author guiding and responding to
137 the conversations, and a second interviewer taking detailed verbatim notes. Women were
138 interviewed in a location of their choice.

139 We used a purposive sampling approach to maximise heterogeneity for region of residence
140 (north, south and central WB), place of residence (rural, urban, camp) and socio-economic
141 indicators (education, employment, marital status). We were unable to interview women

from East Jerusalem due to restrictions denying access to WB researchers at the time of the research, reflecting broader challenges of conducting research in oPt (Khatib et al., 2017). Women were identified and recruited through personal and professional contacts, with snowballing from earlier interviewees. This sampling approach brings all of the limitations inherent in a non-probability sample, including the risk of a biased sample. To minimise this we used an initial set of respondents that was as diverse as possible. There were no refusals to participate.

Ethical approval for this research was sought and obtained from Birzeit University and London School of Economics. Participants were presented with oral and written informed consent and confidentiality statements in Arabic, and indicated whether or not they agreed to participate in the study and to audio recording [INSERT LINK TO ONLINE FILE B]. All participants agreed to oral interviews and detailed note-taking; eight respondents refused recording. Informed consent and recording preferences were documented and signed by the researchers prior to beginning each interview. Direct and indirect identifiers are removed from quotes presented below.

For recorded interviews, verbatim Arabic transcripts were produced. After each interview, researchers documented observations of emotion, body language and setting descriptions. These notes were used to produce an analytical memo of the key emerging themes to draw attention to data derived from each narrative, as well as an ongoing comparative analysis building sequentially on earlier interviews. For unrecorded interviews, the detailed second interviewer notes were used to produce equivalent memos. Transcripts were read and re-read for emerging themes and sub-themes and key elements were translated. Words and phrases in Arabic without direct equivalency in English have been transliterated into several

words to capture their essence. Both transcripts and analytical documents were read and regular contribution was made by team members to highlight key issues, and to ensure reflexivity across the team. Data presented below are drawn from a range of interviews to maximise for heterogeneity. Our qualitative interview guide did not set out to establish women's socio-economic status. We indicate a woman's socio-economic status on the basis of information she provided (eg: occupation, education) supplemented by contextual observations made by the interviewers.

Results

We first describe interviewees' general understandings of (ill-)health, and then health in the midlife, with a particular focus on the menopause. Finally, we present women's approaches to maintaining health and dealing with ill-health in the midlife. A key theme that cross-cuts our analyses is women's biosocial understandings of (ill-)health incorporating an array of biomedical and social (cultural, religious, spiritual, political) explanations. The implications of these understandings for healthcare behaviours – both preventive and curative – is analysed in the final sub-section.

Women's understandings of (ill-)health

Women's understandings of health combine indigenous and biomedical knowledge, and include psychological health (*raha nafsiyeh* and *hadat al-bal*), ease of movement, physical appearance and complexion. *Raha nafsiyeh* can most closely be translated to 'psychologically relaxed'; *Hadat el bal* can be most closely translated to 'calmness of the

mind' or 'peace of mind'. Women note that ill-health can be seen in the face, using the phrase *'her face would look yellow'*.

Three idioms important to understandings of good health include *hamm, za'al,* and *nakad.* They have no direct equivalency in English. *Hamm* is a combination of worry, disquiet, upset, uneasy, grief, anxiety, sorrow, and affliction. Z*a'al* is a combination of feelings including anger, distress, frustration, grief, incapacitation, worry, and sorrow. *Nakad* is a combination of distemper, bitterness, disturbing, troubling and sombreness. These idioms of distress which are often linked to ill-health were used by women irrespective of background:

> *Health has a hereditary factor, or it is related to za'al. Sometimes someone diabetic has no family history of diabetes, but za'al caused the diabetes.* [49 years, married, 10 births, South WB, rural]

Hamm is said to be embodied, and visible in a woman's appearance. One woman cited a proverb '*akbar samm el hamm'*, rhyming in Arabic, meaning that *hamm* is the biggest of poisons. Health issues were often connected to life events, such as widowhood, economic hardship or political violence. These events were considered to cause health deterioration, both physical and mental. Some women made connections to the past, referring to times of heightened political tension and violence, such as during the two Palestinian uprisings, or *intifada.* For other women, depending on residence and the degree to which they had been exposed to political violence, these were very much matters of the present. Area C refers to an area, accounting for more than 60 per cent of the WB, where there is almost exclusive control over law enforcement, planning and construction by Israel with significant consequences for the population (eg: uncertainty and threats of demolition orders, aid

dependency, exposure to violence and disrupted livelihoods) (UNOCHA, 2017; UNOHCHR, 2016). One participant living in Area C reported:

> *The problems with the military, Israel, affects psychological health. When you are afraid, you get shaken up, depressed from your life… The children are frightened, and the mothers feel helpless and unable to do anything.* [46 years, no formal schooling, housewife, married, 6 births]

Women's experiences of periods of heightened violence informed contemporary fears and anxieties. For example, a woman living in a WB area that is now subject to fewer Israeli military incursions, noted:

> *This kind of anxiety is one that I constantly think about … I do not cross any checkpoints, because I do not go far. That experience* [Second Intifada] *really impacted me, so I cannot imagine the people that cross checkpoints everyday, and suffer on a regular basis, the humiliation…If I were one of those people, I would look 20 years older… You either keep in the anger and suppress it, or you want to scream. And either way, you are impacting your health negatively.* [50 years, married, employed, 7 births, Master's level education, urban]

Health in midlife

The midlife was an important phase for women, both in its own right and representing a transition from younger adulthood to older age. The women we interviewed were acutely aware of being in their midlife; but this extended to much more than simply the menopause. Many women articulated a positive view about midlife and ageing as a natural process, not meriting particular significance:

Any person is like the seed of the plant, it slowly develops, reaches a peak with blossoming and then slowly starts to deteriorate. Humans are also like this and must accept this is a matter of life. [47 years, married housewife, primary education, 4 births, rural]

Women referred to menopause by saying that the menstrual cycle has 'been cut from her' or that '*el-kabar 'abar*,' which rhymes in Arabic [lit. ageing has entered]. A range of expressions were suggested by women, including: 'age of despair' (*sin el yaas),* 'age of hope' (*sin al amal*), 'age of the 40s,' 'age of power,' 'age of life' and 'age of security' (*sin al amman*). Reflecting on the various phrases, one woman noted:

It's not despair, hope, safety or anything, it is just a phase like any other phase in life such as adolescence, or adulthood and it has its own issues and concerns. I don't like to live through it, but I deal with it and I don't think about it as a negative thing—this is my age and this is the phase that I am living with. [50 years, married housewife, secondary education, 6 births, urban]

Another woman suggested that this lifestage should be called the 'age of security,' because:

Practically speaking, women during this time do not get pregnant and do not have young children, so there is peace of mind and relaxation in that sense. She can live her life for herself, before that, her life is not hers. It is for her family, her children and her husband. [42 years, married, working, college diploma, 3 births, Central WB, rural]

Age of despair was often ridiculed, although there were generational differences:

I heard women say the 'age of despair.' Our generation says the 'age of despair' but those before us just used to say that "after 50, it [her period] split from her". [53 years, married, previously employed, secondary education and vocational training, 3 births, South WB, urban]

We just say it's the period of your menses coming to an end. I hear some women saying it is 'the age of despair' but not our mothers. It is this [younger] *generation that refers to it in that way.* [49 years, married, employed, secondary education, 10 births, South WB, rural]

Another woman laughed when the researcher mentioned the 'age of despair', noting that

> *it is the age of 40s, not the 'age of despair'* [47 years, married, not working, rural, secondary education, 4 births]

One woman wondered why it would be associated with negative feelings:

I don't know why it's called 'age of despair,' the end of menses does not mean that life is over [48 years, married housewife, secondary education, 4 births, Central WB, rural]

One woman laughing noted:

How can it be called the 'age of despair' when this is the age of power and control? The woman becomes a mother-in-law, and a grandmother. She is the head of the house! [41 years, married, employed, post-secondary education, 5 births, South WB, urban]

Use of the term *age of despair* in common parlance may be linked to its established use among – overwhelmingly male – doctors (UN, 2013).

Our findings confirm studies reporting that Arab women in Qatar (Murphy et al., 2013), Jordan (Mahadeen et al., 2008) and Bahrain (Jassim & Al-Shboul, 2009) were critical of the term *age of despair*. A study of Palestinian-Arab women in Israel found that women aged 45-55 years reported an increase in perceived power in midlife compared to younger women (Friedman & Pines, 1992). In only one study (Lebanon) did some women fear the menopause as a "hopeless age" (Azar et al., 2016 p.12). In our study, women's general rejection of the phrase could be interpreted as micro-resistance to an externally (male, medical) conceptualised construction of a female lifecourse phase. The negative biomedical aspects of menopause were rather less important than the positive socio-cultural accrual of power through age. Women internalised this differently according to marital and motherhood status. One unmarried woman explained:

> *It is really the age of despair, you feel physically exhausted and you feel you cannot continue. But for me, what made me despair was that I no longer have a future with the possibility of marriage and children.* [50 years, never married, employed, secondary education, 0 births, North WB, rural]

For women who had not been mothers the age of despair indicated their permanently lost chance of having children. Marriage and childbearing in Palestinian society are extremely important for men and women. Married women talk about unmarried women as being more sensitive about the menopause:

> *A woman continues having some faith and hope that she may get married and bear children, but when her period ends, that's it. It would be a sad time.* [50 years, married, working, Master's degree, 7 births, Central WB, urban]

Some married women perceive unmarried women's midlife health to be superior because there were no pressures from childbearing or motherhood. However, these views were dependent upon the unmarried woman's level of economic (in)dependence; unmarried women who are economically independent have access to different forms of social protection than poorer married women.

Women's sources of knowledge on midlife and menopause are almost invariably linked to older women's experiences:

> *You learn from the women. They would sit and talk about how their periods start becoming irregular, or discontinue for three to four months, or six and then eventually cuts off. The knowledge travels from the women and we also read about it.* [49 years, married, employed, secondary education, 10 births, South WB, rural]

Sources of information also included conversations with other women and health-related stories in magazines, television, or educational sources, especially for those with higher levels of education:

> *I used to know a little from my mother and what I would overhear from the women at gatherings. The women used to sit together and talk about how it* [menstruation] *split from them at so and so age. But I learned about it more depth through my studies.* [48 years, never-married, college diploma, employed, 0 births, South WB, urban]

Women assessed the processes of ageing in the midlife by reference not only to changes in menstruation, but also to physical appearance (body weight and size, facial complexion) and their ability to do housework.

I was able to clean the entire house in a couple of hours, all in the same day. Now, I can't. You don't have the energy like before. I break down the work, and finish it in two days, and I get tired. Age plays a big role…you just aren't the same anymore. [43 years, widow, employed, degree, 4 births, Central WB, urban]

The women we interviewed were clear that processes of ageing had started. However, complaint was noticeable by its absence from women's accounts, even among women with reported chronic conditions. While quantitative studies which explicitly ask about symptoms of menopause may find that, for example Moroccan, women complained mostly about hot flashes and fatigue (Obermeyer et al., 2002), in our study complaint was absent despite probing questions specifically on the menopause. Women acknowledged menopausal symptoms but referred to them as natural ageing phenomena.

Managing midlife health

Midlife women in our study deployed a wide range of strategies – preventive pluralism - to prevent ill-health and avoid the use of formal care, including: physical activity; good diet; avoidance of *hamm*; and, engagement with faith, spirituality and *tawakul* (reliance on God whilst also taking personal responsibility). Women emphasised the importance of physical movement, citing a rhyming Arabic proverb, *el-harakeh barakeh* (movement is a blessing):

I do not like sitting, because sitting around and doing nothing brings disease and death. The body needs to move, your movement is your blessing. And it is central to life. [55 years, never-married, college diploma, employed, 0 births, South WB, Camp]

How women achieve physical activity depended on individual circumstances; for wealthier urban women, gym membership was important. For many women – irrespective of their circumstances - walking with friends in the evening was important. In rural areas, women talked about *yisrah*, derived from *sareh* which means to escape mentally or to dream and 'space out'; the physical freedom of walking is integral to, and associated with, mental freedom. Walking was presented as providing relief for both body and soul, and a link to past generations when women did more agricultural work.

Consuming healthy *(Baladi,* lit. 'from the country') food was also presented as connecting women across generations and incorporated into women's health management. *Baladi* refers to locally-grown, rain-fed (not irrigated), native and chemical-free food:

> *Fruits and vegetables used to be better before, there were no chemicals. They were baladi … people would eat natural fruits and vegetables and never have to deal with a doctor.* [54 years, married, unemployed, primary education, 6 births, Camp]

Food consumption patterns have changed since the 1980s, with military occupation impacting on the population; incorporation of the Palestinian labour force into the Israeli economy, and the opening of oPt to Israeli manufactured products (Giacaman, 1984). Land confiscation and control of water sources led to the neglect of agricultural land, and food consumption shifted towards more processed foods. Women contrasted the food available in the markets for their mother's generation and their own, linked to health. In rural areas some families still grow produce but there is greater reliance on purchased food. In urban contexts, women reported feeling constrained in their inability to buy *baladi* food, and compensated for this by avoiding processed foods.

Women emphasised the need to maintain good psychological health, most frequently expressed as keeping away from *hamm*. Women noted unavoidable stress, anxiety, fear and uncertainty about the future, linked to the political context. Children and grandchildren played a central role in women's descriptions of resources to reduce mental ill-health linked to *hamm*.

> *a main determinant of a woman's health is her children, the grandchildren…this really improves a woman's health.* [50 years, married, employed, Master's degree, 7 births, Central WB, urban]

Women talked about *istislam* (giving in) and its relationship with health; to maintain physical and mental health, one should not give in and instead build internal resistance:

> *I was torn apart when my husband died, I got sick, drained… I needed to get up on my feet, you are forced to get up on your feet regardless of the situation for your children…you need to stand strong, you cannot give in.* [43 years, widow, employed, university degree, 4 births, urban]

Sources of good mental health extended beyond the family; women described a strong sense of collective in coping with difficulties. A commonly repeated saying '*al mot ma' al jama'a rahme,*' (death with the collective is a blessing) among women underlined this need for collective strength.

The importance of faith and *tawakul* for health were essential for understanding and managing health. This does not signify a fatalist attitude however, as women are vocal about having to *do something* to maintain health:

Health is from God, and illness is from God. One must take precautions and seek treatment when needed. I diet and I take my precautions. It's true that it is all from God at the end, but you still have to stay away from what is harmful to you. [54 years, married, unemployed, primary education, 6 births, Camp]

Women identified faith and engagement with religious texts as providing strength.

Women's pluralistic approaches to health maintenance were mirrored in multiple strategies – including biomedical and traditional self-care and formal healthcare – deployed to manage ill-health. In most cases, irrespective of background, women start with traditional practices and remedies and if deemed necessary (and accessible), resort to formal healthcare. This medical pluralism has been noted by other evidence from midlife and older women in oPt (Majaj et al., 2013) and elsewhere in the region (Gerber et al., 2014). Such practices in oPt are based on classical Arabic medicine – *al-tib al-Arabi* - including herbal and dietary remedies along with physical and spiritual forms of healing. Many remedies contain physiologically active compounds with recognised therapeutic value (Daoud, 2008).

Women commonly reported an incrementalist strategy towards curative care, beginning with self-care using a mix of biomedical (eg: drugs) and traditional (eg: herbs) medicine, and resorting to formal services only when they felt unable to manage with self-care. One relatively well-off urban woman emphasised that "*one must be their own doctor".* A much less wealthy camp resident similarly noted:

I treat myself at home—if I have a headache, I take acomol [paracetamol]*, and if my stomach hurts, then I take maramiya (sage)…Mostly, I only go to the doctor for diabetes*

treatment. Herbal remedies, chamomile, sage, mint…the last thing I think about is taking medicine. [54 years, married, unemployed, primary education, 6 births, Camp]

Most women subscribed to an attitude of approaching doctors only when absolutely necessary. This may reflect a pragmatic response to the generally poor availability of healthcare services in oPt. However, we infer it might also indicate older women's feelings of exclusion from healthcare provision, or concerns about the service quality. Women reported a general sense of mistrust and perceived a lack of expertise among formal healthcare providers:

doctors' diagnoses don't always work…I benefit from myself, I don't need anyone to tell me what to do. [49 years, married, housewife, primary education, 9 births, Central WB, rural]

Another woman noted that she only goes to the doctor for something serious:

going to the doctor means wasting a lot of time doing lots of tests, and then trying different medications, with different doctors giving different diagnoses …I felt like they test things on you. [46 years, married, employed, secondary education, 5 births, urban]

For issues related to mental health, particularly in rural areas, women use spiritual and faith-based healing. Mental ill-health and associated symptoms are perceived as related to evil spirits, *sihr* (witchcraft) and *'ain al-hassoud* (the evil eye). Mental ill-health would rarely be addressed using formal healthcare:

it is stigmatized and they don't usually go to the doctor, but if they do, they do in secret. Sometimes, they really just need someone to talk to, but doctors just want to give pills. [42 years, married, employed, college diploma, 3 births, rural]

There is one important sub-group of women - midlife women who were unmarried and/or childless – that emerged as being excluded from healthcare services. Unmarried childless women were perceived, both by themselves and by married women, as being less likely to use health services in general. In part this stems from the emphasis of health services on reproduction in oPt. Women not seeking reproduction-related care are less likely to interact with the health system over their lifetime.

For unmarried women, it is probably more difficult to discuss these issues and attend to doctors. For a married woman, it's more acceptable and she probably has children…She's experienced and has gone through the phases society expects of her. But for an unmarried woman, it is probably very difficult to talk about these things, since she did not experience some of the phases, and she is still a bint [virgin; young girl]*…She has not gone through all of the childbearing phases, and only hears about them, so I would imagine that unmarried women would not go to the doctor.* [50 years, married, employed, Master's degree, 7 births, Central WB, urban]

These women may reach midlife with little or no interaction with the health system since childhood. Not only does this reinforce the perception that services are focused on reproduction, but it also disempowers women from seeking healthcare because they lack familiarity with the health system.

Our evidence shows how women pursue health-maintaining or health-seeking behaviours within and across multiple realms: in/formal services; biomedical/folk medicine knowledge and use; religious and secular constructions of health; and care of the self (including foodstuffs). The midlife women in our study used multiple strategies, sequentially or simultaneously. By midlife many women had accrued multiple sets of resources upon which to draw. Such pluralism has been documented in diverse contexts and is particularly relevant in resource-constrained contexts with complex health systems (Ahmed et al., 2013; Pescosolido & Kronenfeld, 1995; Scott et al., 2014; Tribe, 2007).

DISCUSSION

Our research gives voice to Palestinian women's experiences and management of health in their midlife (after Wadsworth 2000). Globally, there is limited evidence on this beyond a narrow – frequently biomedical – focus on the menopause. The broader (physical, social, cultural, political) dimensions of women's health in the midlife are poorly understood, particularly in low and middle-income countries. Using the midlife as a lifestage lens through which to understand women's health provides unique insights. Women have assembled five decades' of experiences, and are likely to have at least two more decades of life. Eliciting women's voices during the midlife allows us not only to situate their accounts, but also to understand how (and if) women look forward – with apprehension, hope, uncertainty – to their future health as they age.

The women we interviewed were born 1960-1975; and whilst gendered norms are changing in oPt, women's narratives reflected continued emphases on marriage and motherhood

(Halabi, 2007). Exposure to prolonged political violence adds an important contextual layer to women's understandings of their health. Women mentioned the conflict as shaping their health, both directly and indirectly. The influences tended to relate to contemporary issues of access, specifically mobility (Israeli army checkpoint and blockades) restrictions combined with feelings of fear, anxiety, stress and humiliation, rooted in experience. Many women did not, however, refer explicitly to the political context in their life histories; this absence might appear surprising. However, it is exactly that pervasiveness – the normalcy of the political context on peoples' everyday lives – that means that women sometimes felt it too obvious to mention, "normalising the abnormal" (Nguyen-Gillham et al., 2008 p.291). Similar lacunae were identified in qualitative work among rural Palestinian women, which concluded that women "allowed it [conflict] to appear in between the lines" of their accounts rather than mentioning it explicitly (Majaj et al., 2013 p.7). We suggest that overlapping socio-cultural norms of not giving in (*yitsalim*) and gendered expectations of not usually publically complaining are important to understand the silences around health, including the menopause. Many of the women in our study had experienced the symptoms of menopause; but even in response to focused and probing questions, described it matter-of-factly. Silences around complaint may mirror the cultures of silence identified elsewhere in health policy and service provision for older women (Khattab, 1992; Senanayake, 2000). But there are important aspects of women's lives – notably marriage and fertility – that might also explain these silences. Most women who were mothers presented a relatively positive view of their midlife. Social power, particularly within the family, was emphasised as something that changed over a woman's lifetime. When childbearing and childrearing was finished, many women reported a phase of increased social power. A woman's relative social power in a household may alter when she: has an adult son; is no longer co-resident

with her mother-in-law; or becomes a grandmother or mother-in-law. Evidence from a range of settings suggests that increases in social power with age are not independent of socio-economic status; women of higher socio-economic status tend to have more opportunities to take advantage of age-related social power (Friedman et al., 1992; Mitchell & Helson, 1990; Todd et al., 1990). Research among middle class Palestinian-Arab women in Israel showed substantial differences in social power between young women compared to middle-aged and older women, with much smaller differences in power between middle-aged and older women (Friedman & Pines, 1992). We found that mothers in particular felt their social power increased in midlife, attributable to changing familial relationships and status. Even for never-married childless women, perceived by their married counterparts to be less fortunate, perceptions of despair were attenuated by independence (economic, employment) for some. The age of despair appears to be something that some women do not recognise as such; it is a phrase that has been shown to be used by (mainly) male medical professionals (UN, 2013), which, given the power and prestige afforded to doctors, might have influenced the term's societal use, including among women. The age of despair may be internalised to a greater extent by never-married childless women; the absence of a social security system in the oPt can mean destitution in older age. Unless a woman is highly educated and has worked and saved money she will be reliant on her parents and her brother(s) for her older age care.

The reproductive focus of formal healthcare provision meant that it was accessed only as a last resort. Such "socially excluded spaces" of healthcare have been identified in other settings (Hossen & Westhues, 2010 p.1192). In the oPt this social exclusion from healthcare

was magnified for nulliparous women; never having had a pregnancy or birth, these women had little opportunity for engaging with the health system.

The health pluralism evidenced by the women in our study might also be considered as an individual-level, but socially contextualised, form of bricolage. The term bricolage is used here to denote an "emphasis upon making do, restricted resources, innovation, imagination and necessity" (Phillimore et al., 2016 p.3), with women acting as *bricoleuses* (fem., pl.) to manage their health in the midlife. Bricolage is more than simply assembling whatever resources are to hand; it also implies "reordering, subversion and transformation" (Phillimore et al., 2016 p.3). Our evidence suggests that bricolage is a useful way of understanding women's health maintaining and seeking behaviours in the complex environment of the oPt. Whilst bricolage is often constructed as a response to a lack of resources, the women in our study draw on multiple resources (personal, familial, religious, spiritual, financial, physical, time) to navigate their midlife health. Socio-economic status was salient for the kinds of resources that women could access: wealthier urban women with disposable income might go to the gym; women with more developed social networks would use these to seek out health information and advice. Our finding that women using bricolage is not necessarily related to a lack of resources, resonates with a recent study of women using complementary and alternative medicine (CAM) in Qatar who were found to have higher education than women who did not (Gerber et al., 2014). Links between health and *baladi* food is one component of the bricolage that Palestinian women practised. Changes in food systems affect people's health in most societies, but our evidence suggests a micro-politics in which women operate small local sites of resistance to these wider changes as part of strategies for managing their own health. Trying to eat *baladi* food could

be interpreted as one way of not giving in (*yistaslim*) by building resistance from within through food. In many women's accounts, the juxtaposition of stories of older generations having health that was perceived as better because of greater access to *baladi* food, was striking.

Our qualitative evidence highlights the importance of the midlife for understanding women's health maintaining and care-seeking behaviours as they age. In the oPt context, as elsewhere, the midlife is more than just a transition from younger adulthood to older age primarily defined by illnesses. Supporting arguments to reduce the over-medicalization of a natural phase of life (Erol, 2009, 2011), the nuances and complexities elicited in women's narratives attest to the need for broader health policy engagement with women, incorporating their voices and lived experiences into health systems and policies in ways which accommodate the notion of midlife as a social and biological process.

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Highlights

- Women's experiences of midlife health are poorly understood
- Palestinian women combine indigenous and biomedical approaches to managing their midlife health
- Unmarried or childless Palestinian women are socially excluded from healthcare
- "Age of despair" to describe the menopause is rejected by Palestinian women