

Accepted Manuscript

Age of despair or age of hope? Palestinian women's perspectives on midlife health

Doaa Hammoudeh, Ernestina Coast, David Lewis, Yoke Meulen, Tiziana Leone, Rita Giacaman



PII: S0277-9536(17)30329-5

DOI: [10.1016/j.socscimed.2017.05.028](https://doi.org/10.1016/j.socscimed.2017.05.028)

Reference: SSM 11240

To appear in: *Social Science & Medicine*

Received Date: 7 November 2016

Revised Date: 9 May 2017

Accepted Date: 10 May 2017

Please cite this article as: Hammoudeh, D., Coast, E., Lewis, D., Meulen, Y., Leone, T., Giacaman, R., Age of despair or age of hope? Palestinian women's perspectives on midlife health, *Social Science & Medicine* (2017), doi: 10.1016/j.socscimed.2017.05.028.

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

SSM-D-16-03402R1

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

Doaa Hammoudeh

St Antony's College, Oxford University and Institute of Community and Public Health,
Birzeit University

Ernestina Coast (corresponding author)

London School of Economics
Houghton Street, London, WC2A 2AE, UK
e.coast@lse.ac.uk

David Lewis

London School of Economics

Yoke Meulen

Institute of Community and Public Health, Birzeit University

Tiziana Leone

London School of Economics

Rita Giacaman

Institute of Community and Public Health, Birzeit University

Acknowledgements

We are grateful to the women who gave their time and insights in our interviews. Thanks to Salam Abu Ghoush for her dedicated assistance with fieldwork. We thank the anonymous reviewers for their comments and suggestions. The research was funded by a grant from the Emirates Foundation through the LSE Middle East Centre.

1 ABSTRACT

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

22 **KEYWORDS**

23 occupied Palestinian territories

24 gender

25 health

26 midlife

27 menopause

28 health pluralism

ACCEPTED MANUSCRIPT

29 **INTRODUCTION**

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

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

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

56 In high income settings accounts of women's midlife have tended to be negative,
57 emphasising: loss, physical debilitation; emotional trauma; and, the challenges of navigating
58 multiple concurrent transitions (eg: menopause and adult children leave home or parents
59 age and die) (Dare, 2011). Menopause is most closely associated with the negative
60 connotations of the midlife, although studies from high and middle income countries find
61 that attitudes towards menopause are more positive or neutral than negative (Ayers et al.,
62 2010; Winterich, 2003). In resource-poor settings many women may not seek healthcare
63 because of a presumption that age-related needs are normal or natural and do not warrant
64 care (Elias & Sherris, 2003; Jejeebhoy et al., 2003).

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

74 The midlife has also been identified as a time of personal growth, satisfaction, creativity,
75 pleasure and power (Friedman & Pines, 1992; Friedman et al., 1992), emerging from
76 women's own accounts and meanings of their midlife, "hearing midlife voices" (Wadsworth,
77 2000 p.645), although much of this evidence is from high income settings (Dare, 2011). Our
78 study seeks to understand how women conceptualise, experience and manage their health
79 in the midlife. Women's accounts can reveal differences between biomedical discourses and
80 women's understandings, highlighting different midlife meanings and experiences in context
81 (Wray, 2007).

82

83 Context

84 Palestinians in the occupied Palestinian territories (oPt) live in two administratively
85 segregated areas: the Gaza Strip and the West Bank (WB). Compared to men, women in
86 oPt have lower labour participation rates and higher unemployment rates (PCBS, 2016a).
87 Inequities persist despite gender parity in achievement of Bachelor degree awards (PCBS,
88 2016b). Palestinian women's health needs are constrained by structural barriers to health
89 care, with men forming the majority of policy makers and physicians providing services
90 (Giacaman et al., 2003). Health policy in oPt is influenced by donor strategies emphasising
91 reproductive health care (Giacaman et al., 2003). Health services for women who are
92 unmarried or beyond childbearing, are under-resourced and scarce (UN, 2013). Use of the
93 phrase *age of despair* by some medical professionals to refer to the menopause highlights
94 negative biomedical attitudes (UN, 2013). At older ages, a lack of social security means that
95 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; Hussein 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

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

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

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

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

172

173 **Results**

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

181 Women's understandings of (ill-)health

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

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

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

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

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

209 dependency, exposure to violence and disrupted livelihoods) (UNOCHA, 2017; UNOHCHR,
210 2016). One participant living in Area C reported:

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

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

218 *This kind of anxiety is one that I constantly think about ... I do not cross any*
219 *checkpoints, because I do not go far. That experience [Second Intifada] really*
220 *impacted me, so I cannot imagine the people that cross checkpoints everyday, and*
221 *suffer on a regular basis, the humiliation...If I were one of those people, I would look*
222 *20 years older... You either keep in the anger and suppress it, or you want to scream.*
223 *And either way, you are impacting your health negatively.* [50 years, married,
224 employed, 7 births, Master's level education, urban]

225 Health in midlife

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

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

235

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

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

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

247 *Practically speaking, women during this time do not get pregnant and do not have young*
248 *children, so there is peace of mind and relaxation in that sense. She can live her life for*
249 *herself, before that, her life is not hers. It is for her family, her children and her husband.*
250 *[42 years, married, working, college diploma, 3 births, Central WB, rural]*

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

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

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

260 Another woman laughed when the researcher mentioned the ‘age of despair’, noting that

261 *it is the age of 40s, not the ‘age of despair’ [47 years, married, not working, rural,*
262 *secondary education, 4 births]*

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

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

266 One woman laughing noted:

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

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

272 Our findings confirm studies reporting that Arab women in Qatar (Murphy et al., 2013),
273 Jordan (Mahadeen et al., 2008) and Bahrain (Jassim & Al-Shboul, 2009) were critical of the
274 term *age of despair*. A study of Palestinian-Arab women in Israel found that women aged
275 45-55 years reported an increase in perceived power in midlife compared to younger
276 women (Friedman & Pines, 1992). In only one study (Lebanon) did some women fear the
277 menopause as a “hopeless age” (Azar et al., 2016 p.12). In our study, women’s general
278 rejection of the phrase could be interpreted as micro-resistance to an externally (male,
279 medical) conceptualised construction of a female lifecourse phase. The negative biomedical
280 aspects of menopause were rather less important than the positive socio-cultural accrual of
281 power through age. Women internalised this differently according to marital and
282 motherhood status. One unmarried woman explained:

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

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

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

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

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

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

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

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

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

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

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

326

327 Managing midlife health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

449

450 **DISCUSSION**

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

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

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

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

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

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

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

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

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

544

545

- 546 Abu-Mourada, T., Koutis, A., Alegakis, A., Markaki, A., Jildeh, C., Lionis, C., et al. (2010). Self-reported
547 health complaints in a primary care population living under stressful conditions in the Gaza
548 Strip, Palestine. *Medicine, Conflict and Survival*, 26, 68-79.
- 549 Abu-Rmeileh, N.M.E., Hammoudeh, W., Mataria, A., Hussein, A., Khawaja, M., Shannon, H.S., et al.
550 (2012). Health-related quality of life of Gaza Palestinians in the aftermath of the winter
551 2008-09 Israeli attack on the Strip. *European Journal of Public Health*, 22, 732-737.
- 552 Ahmed, S.M., Evans, T.G., Standing, H., & Mahmud, S. (2013). Harnessing pluralism for better health
553 in Bangladesh. *The Lancet*, 382, 1746-1755.
- 554 Al-Krenawi, A., Lev-Wiesel, R., & Sehwal, M.A. (2007). Psychological symptomatology among
555 Palestinian male and female adolescents living under political violence 2004–2005.
556 *Community mental health journal*, 43, 49-56.
- 557 Arpanantikul, M. (2004). Midlife experiences of Thai women. *Journal of Advanced Nursing*, 47, 49-56.
- 558 Ayers, B., Forshaw, M., & Hunter, M.S. (2010). The impact of attitudes towards the menopause on
559 women's symptom experience: A systematic review. *Maturitas*, 65, 28-36.
- 560 Azar, M., Kroll, T., & Bradbury-Jones, C. (2016). Lebanese women and sexuality: A qualitative inquiry.
561 *Sexual & Reproductive Healthcare*, 8, 13-18.
- 562 Baruch, G., & Brooks-Gunn, J. (1984). The study of women in midlife. In G. Baruch (Ed.), *Women in
563 midlife* (p. 404): Springer US.
- 564 Batniji, R., Rabaia, Y., Nguyen-Gillham, V., Giacaman, R., Sarraj, E., & Punamaki, R.-L. (2009). Health
565 as human security in the occupied Palestinian territory. *Lancet*, 373, 1133-1143.
- 566 Bustreo, F., de Zoysa, I., & de Carvalho, I. (2013). Policy directions to improve women's health
567 beyond reproduction. *Bulletin of the World Health Organization*, 91, 712-714.
- 568 Daoud, R.T.E. (2008). Studies on folkloric medicinal plants used by Palestinians in the Qalqilia district.
569 Faculty of Graduate Studies (p. 134). Nablus, Palestine: An-Najah National University.
- 570 Dare, J. (2011). Transitions in Midlife Women's Lives: Contemporary Experiences. *Health Care for
571 Women International*, 32, 111-133.
- 572 Elias, C., & Sherris, J. (2003). Reproductive And Sexual Health Of Older Women In Developing
573 Countries: Women And Their Healthcare Providers Face Unique Needs And Challenges. *BMJ:
574 British Medical Journal*, 327, 64-65.
- 575 Erol, M. (2009). Tales of the Second Spring: Menopause in Turkey through the narratives of
576 menopausal women and gynecologists. *Medical anthropology*, 28, 368-396.
- 577 Erol, M. (2011). Melting bones: The social construction of postmenopausal osteoporosis in Turkey.
578 *Social science & medicine*, 73, 1490-1497.
- 579 ESCWA. (2009). Social and Economic Conditions of Palestinian Women 2006-2009. (p. 26). New York
580 and Geneva: Economic and Social Commission for Western Asia.
- 581 Friedman, A., & Pines, A.M. (1992). Increase in Arab women's perceived power in the second half of
582 life. *Sex roles*, 26, 1-9.
- 583 Friedman, A., Tzukerman, Y., Wienberg, H., & Todd, J. (1992). The Shift in Power with Age Changes in
584 Perception of the Power of Women and Men Over the Life Cycle. *Psychology of Women
585 Quarterly*, 16, 513-525.
- 586 Gerber, L.M., Mamtani, R., Chiu, Y.L., Bener, A., Murphy, M., Cheema, S., et al. (2014). Use of
587 complementary and alternative medicine among midlife Arab women living in Qatar. *Eastern
588 Mediterranean Health Journal*, 20, 554-560.
- 589 Giacaman, R. (1984). Planning for Health in Occupied Palestine. Occasional Paper (p. 16):
590 Community Health Unit, Birzeit University.
- 591 Giacaman, R. (1997). Population and fertility: Population policies, women's rights and sustainable
592 development. Palestinian women: A status report (p. 28): Women's Studies Institute, Birzeit
593 University.
- 594 Giacaman, R., Abdul-Rahim, H.F., & Wick, L. (2003). Health sector reform in the Occupied Palestinian
595 Territories (OPT): targeting the forest or the trees? *Health policy and planning*, 18, 59-67.

- 596 Giacaman, R., Abu-Rmeileh, N.M.E., & Wick, L. (2007). The limitations on choice: Palestinian
597 women's childbirth location, dissatisfaction with the place of birth and determinants.
598 *European Journal of Public Health*, 17, 86-91.
- 599 Giacaman, R., Khatib, R., Shabaneh, L., Ramlawi, A., Sabri, B., & Sabatinelli, G. (2009). Health status
600 and health services in the occupied Palestinian territory. *Lancet*, 373, 837-849.
- 601 Halabi, H. (2007). Profile of Single Women in Palestine. *Review of Women's Studies, Birzeit*
602 *University*, 4, 27-46.
- 603 Harlow, S.D., Gass, M., Hall, J.E., Lobo, R., Maki, P., Rebar, R.W., et al. (2012). Executive summary of
604 the Stages of Reproductive Aging Workshop + 10: addressing the unfinished agenda of
605 staging reproductive aging. *Fertility and Sterility*, 97, 843-851.
- 606 Hassan-Bitar, S., & Narrainen, S. (2011). "Shedding light" on the challenges faced by Palestinian
607 maternal health-care providers. *Midwifery*, 27, 154-159.
- 608 Hobfoll, S.E., Hall, B.J., & Canetti, D. (2012). Political violence, psychological distress, and perceived
609 health: A longitudinal investigation in the Palestinian authority. *Psychological Trauma:*
610 *Theory, Research, Practice, and Policy*, 4, 9.
- 611 Hobfoll, S.E., Mancini, A.D., Hall, B.J., Canetti, D., & Bonanno, G.A. (2011). The limits of resilience:
612 Distress following chronic political violence among Palestinians. *Social science & medicine*,
613 72, 1400-1408.
- 614 Hossen, A., & Westhues, A. (2010). A socially excluded space: restrictions on access to health care for
615 older women in rural Bangladesh. *Qualitative health research*, 20, 1192-1201.
- 616 Husseini, A., Abu-Rmeileh, N.M.E., Mikki, N., Ramahi, T.M., Ghosh, H.A., & Barghuthi, N. (2009).
617 Cardiovascular diseases, diabetes mellitus, and cancer in the occupied Palestinian territory.
618 *Lancet*, 373, 1041-1049.
- 619 Jassim, G.A., & Al-Shboul, Q.M. (2009). Knowledge of Bahraini women about the menopause and
620 hormone therapy: implications for health-care policy. *Climacteric*, 12, 38-48.
- 621 Jejeebhoy, S., Koenig, M., & Elias, C. (2003). Community interaction in studies of gynaecological
622 morbidity: experiences in Egypt, India and Uganda. In S. Jejeebhoy, M. Koenig, & C. Elias
623 (Eds.), *Reproductive Tract Infections and Other Gynaecological Disorders: A Multidisciplinary*
624 *Research Approach* pp. 140-147). Cambridge: Cambridge University Press.
- 625 Khatib, R., Giacaman, R., Khammash, U., & Yusuf, S. (2017). Challenges to conducting epidemiology
626 research in chronic conflict areas: examples from PURE-Palestine. *Conflict and Health*, 10,
627 33.
- 628 Khattab, H.A. (1992). *The silent endurance. Social conditions of women's reproductive health in rural*
629 *Egypt*. Amman, Jordan: Population Council, Regional Office for West Asia and North Africa.
- 630 Lane, S.D., & Meleis, A.I. (1991). Roles, work, health perceptions and health resources of women: A
631 study in an Egyptian delta hamlet. *Social science & medicine*, 33, 1197-1208.
- 632 Lewis, D. (2008). Using life histories in social policy research: the case of third sector/public sector
633 boundary crossing. *Journal of social policy*, 37, 559-578.
- 634 Lewis, D. (2013). Reconnecting development policy, people and history. In T. Wallace, F. Porter, & M.
635 Ralph-Bowman (Eds.), *Aid, NGOs and the realities of women's lives: A perfect storm* pp. 115-
636 126). Rugby, UK: Practical Action Publishing.
- 637 Mahadeen, A., Halabi, J., & Callister, L.C. (2008). Menopause: a qualitative study of Jordanian
638 women's perceptions. *International nursing review*, 55, 427-433.
- 639 Majaj, L., Nassar, M., & De Allegri, M. (2013). "It's not easy to acknowledge that I'm ill": a qualitative
640 investigation into the health seeking behavior of rural Palestinian women. *BMC Women's*
641 *Health*, 13, 1-10.
- 642 McNeely, C., Barber, B.K., Spellings, C., Giacaman, R., Arafat, C., El Sarraj, E., et al. (2013). Prediction
643 of health with human insecurity and chronic economic constraints in the occupied
644 Palestinian territory: a cross-sectional survey. *The Lancet*, 382, Supplement 4, S25.
- 645 Melby, M.K., Lock, M., & Kaufert, P. (2005). Culture and symptom reporting at menopause. *Human*
646 *Reproduction Update*, 11, 495-512.

- 647 Mitchell, V., & Helson, R. (1990). Women's prime of life: Is it the 50s? *Psychology of Women*
648 *Quarterly*, 14, 451-470.
- 649 Moen, P., & Wethington, E. (1999). Midlife Development in a Life Course Context. In S.L. Willis, & J.D.
650 Reid (Eds.), *Life in the Middle* pp. 3-23). San Diego: Academic Press.
- 651 Murphy, M., Verjee, M., Bener, A., & Gerber, L. (2013). The hopeless age? A qualitative exploration
652 of the experience of menopause in Arab women in Qatar. *Climacteric*, 16, 550-554.
- 653 Nguyen-Gillham, V., Giacaman, R., Naser, G., & Boyce, W. (2008). Normalising the abnormal:
654 Palestinian youth and the contradictions of resilience in protracted conflict. *Health and*
655 *Social Care in the Community*, 16, 291-298.
- 656 Obermeyer, C.M. (2000). Menopause across cultures: a review of the evidence. *Menopause*, 7, 184-
657 192.
- 658 Obermeyer, C.M., Schulein, M., Hajji, N., & Azelmat, M. (2002). Menopause in Morocco:
659 symptomatology and medical management. *Maturitas*, 41, 87-95.
- 660 Palacios, S., Borrego, R.S., & Forteza, A. (2005). The importance of preventive health care in post-
661 menopausal women. *Maturitas*, 52, 53-60.
- 662 PCBS. (2016a). Palestinian Central Bureau of Statistics (PCBS) International Women's Day. Ramallah,
663 Palestine: Palestinian Central Bureau of Statistics.
- 664 PCBS. (2016b). Women and men in Palestine: Issues and statistics 2016 [trans] (p. 74). Ramallah:
665 Palestinian Central Bureau of Statistics.
- 666 Penney, G. (2006). Contraception in adolescence and the perimenopause. *Medicine*, 34, 20-22.
- 667 Pescosolido, B.A., & Kronenfeld, J.J. (1995). Health, illness, and healing in an uncertain era:
668 challenges from and for medical sociology. *Journal of Health and Social Behavior*, 5-33.
- 669 Phillimore, J., Humphris, R., Klass, F., & Knecht, M. (2016). Bricolage: potential as a conceptual tool
670 for understanding access to welfare in superdiverse neighbourhoods'. Birmingham: IRiS
671 Working Paper Series; Institute for Research into Superdiversity.
- 672 Punamäki, R.-L., Komproe, I.H., Qouta, S., Elmasri, M., & de Jong, J.T. (2005). The role of
673 peritraumatic dissociation and gender in the association between trauma and mental health
674 in a Palestinian community sample. *American Journal of Psychiatry*, 162, 545-551.
- 675 Rahim, H.F.A., Wick, L., Halileh, S., Hassan-Bitar, S., Chekir, H., & Watt, G. (2009). Maternal and child
676 health in the occupied Palestinian territory. *Lancet*, 373, 967-977.
- 677 Scott, K., McMahon, S., Yumkella, F., Diaz, T., & George, A. (2014). Navigating multiple options and
678 social relationships in plural health systems: a qualitative study exploring healthcare seeking
679 for sick children in Sierra Leone. *Health policy and planning*, 29, 292-301.
- 680 Senanayake, P. (2000). Women and reproductive health in a graying world. *International Journal of*
681 *Gynecology and Obstetrics*, 70, 59-67.
- 682 Sousa, C.A. (2013). Political Violence, Health, and Coping Among Palestinian Women in the West
683 Bank. *American Journal of Orthopsychiatry*, 83, 505-519.
- 684 Todd, J., Friedman, A., & Kariuki, P.W. (1990). Women growing stronger with age: The effect of
685 status in the United States and Kenya. *Psychology of Women Quarterly*, 14, 567-577.
- 686 Tribe, R. (2007). Health pluralism: A more appropriate alternative to western models of therapy in
687 the context of the civil conflict and natural disaster in Sri Lanka? *Journal of Refugee Studies*,
688 20, 21-36.
- 689 UN. (2013). Building Ties: Towards integrated strategies & policies for empowering Palestinian
690 women. (p. 136). Birzeit University: State of Palestine: Ministry of Women's Affairs & UN
691 Women.
- 692 UNOCHA. (2017). Area C. United Nations Office for the Coordination of Humanitarian Affairs.
- 693 UNOHCHR. (2016). Israeli settlements in the occupied Palestinian territory including East Jerusalem,
694 and the occupied Syrian Golan. (p. 40). New York: United Nations Office of the High
695 Commissioner of Human Rights.
- 696 Wadsworth, G. (2000). Hearing midlife voices: Assessing different methods for researching women's
697 experiences of menopause and midlife. *Women's Studies International Forum*, 23, 645-654.

- 698 Wick, L., Mikki, N., Giacaman, R., & Abdul-Rahim, H. (2005). Childbirth in Palestine. *International*
699 *Journal of Gynaecology Obstetrics*, 89, 174-178.
- 700 Winterich, J.A. (2003). Sex, Menopause, and Culture: Sexual Orientation and the Meaning of
701 Menopause for Women's Sex Lives. *Gender and Society*, 17, 627-642.
- 702 Wray, S. (2007). Women making sense of midlife: Ethnic and cultural diversity. *Journal of aging*
703 *studies*, 21, 31-42.
- 704 Ziadni, M., Hammoudeh, W., Rmeileh, N.M.A., Hogan, D., Shannon, H., & Giacaman, R. (2011).
705 Sources of human insecurity in post-war situations: The case of Gaza. *Journal of human*
706 *security*, 7.
- 707

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