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THE QUALITY OF LIFE OF PALESTINIANS UNDER A CHRONIC POLITICAL CONFLICT: ASSESSMENT AND DETERMINANTS

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Abstract

This paper assesses the quality of life of Palestinians and its determinants; and compares the results to similar assessments from 17 other developed and developing countries. An adapted version of the WHOQoL-Bref instrument was administered to a sample of 1008 adults selected from the general Palestinian population. Factor analysis and multiple regression techniques were implemented to determine the association between principle demographic and socioeconomic characteristics and scores of extracted principal determinants, and estimated overall and domain-specific QoL scores. Chronic and acute exposure to violence and entrenched conflict over generations has resulted in significantly lower QoL of Palestinians.

ملخص

تقيس هذه الورقة نوعية حياة الفلسطينيين ومحدداتها وتقارن النتائج مع 17 دولة متقدمة ونامية. وقد طبقت صيغة معدلة من أداة بريف لمعرفة نوعية الحياة طبقاً لمنظمة الصحة العالمية على عينة من 1008 من البالغين اختيروا من مجموع السكان الفلسطينيين. وتم تطبيق كل من آلية التحليل العاملي وآلية مضاعف الانحدار لتحديد الترابط بين الصفات الرئيسية الديموجرافية والاقتصادية الاجتماعية وعشرات المحددات الرئيسية المستخرجة وكذا عشرات التقديرات الخاصة بنوعية الحياة كلياً وفي نطاقات محددة. وأدى التعرض الدائم والحاد للعنف نتيجة الصراع المستمر عبر الأجيال الفلسطينية إلى تدني نوعية الحياة بصورة ذات بال بين الفلسطينيين.

1. Introduction

The impact of the long-running Palestine/Israel conflict on the health and well-being of inhabitants and citizens living in the Occupied Palestinian Territory (OPT) and Israel has been devastating. In addition, the entrenched conflict has altered social welfare and health care delivery systems in ways that pose challenges beyond those seen in other conflict or post-conflict situations. Having valid and reliable information on population health is essential for effective implementation and management of public health programs. Yet, a large portion of the disease burden, and risk factors, in the OPT cannot be accurately measured, given that adequate tools for the assessment of survivors of chronic exposure to violence – individuals and societies – are lacking. The challenge for researchers, planners, policymakers and health care practitioners consists of improving the empirical understanding of well-being and its determinants in order to rebuild the needed social protection systems. Today, information about well-being in this conflict area – and others – is largely restricted to mortality and morbidity rates, access to health care and other services, and paradoxically in the local context, childbirth at Israeli army checkpoints. For the respective governments, attempting to address the well-being of their populations, the situation can only be described as a chronic complex emergency, which immediately exposes the limitations of existing public health guidelines for responding to such emergencies (Salama, 2004).

The Palestinian case begs a re-conceptualization of complex emergencies in more than one respect. Generations of Palestinians have lived knowing only conflict, with interspersed calmer periods. The large majority of those living in the OPT were born during the years of Israeli military occupation beginning in 1967; they experienced the intensified conflict period of the first uprising; they underwent the disappointments of the peace-building period of 1993-2000; and they fell into the second uprising period with accumulated physical and psychosocial vulnerabilities. As with many conflicts, the fabric of societies under such stress is stretched and torn when accompanied by physical upheaval and dislocation. Indeed, many Palestinians continue to live in refugee camps inside and outside the OPT.

Since September 2000, the circumstances of Palestinians have worsened considerably. The Israeli army instituted closures of border crossings which are economic lifelines, enforced strict curfews, and accelerated the 'bantustanization' of Palestinian land with the erection of the Separation Wall that divides communities. These events have induced a severe economic crisis and spiraling poverty levels affecting not less than 2/3 of the population (The World Bank, 2004), in addition to the excessive exposure of civilians to violence of all sorts. Lately, the cuts in humanitarian aid for the public sector as a result of the election of the Hamas government in January 2006, prompted various UN and other bodies to warn against an impending humanitarian disaster, heightened levels of violence and a rapid decline of the public health system towards a possible collapse (World Health Organization, 2006). A 2005 study of humanitarian workers found the OPT in the top five countries with most acute levels of violence, high prevalence and misuse of guns and highest perception of threat (Buchanan, 2005). Even by the end of January 2006, results of an assessment of the OPT by UN agencies highlighted the sharp deterioration in the humanitarian situation over the short period since the January elections, in particular due to Israel's additional tightening of security procedures (United Nations. Humanitarian Update, 2006).

Despite the abilities of individuals and communities to adapt, such factors are bound to negatively affect civilians' health and well-being in ways that cannot be measured with traditional morbidity indicators alone. Adding Quality of Life (QoL) measures and indicators had shown promise in more accurately assessing health status and outcomes (Cotrufo, 2005; de Oliveira, 2005; Fellinger, 2005; Hanh, 2005; Kazlauskaite, 2005). Combining these measures may provide a deeper understanding of the impact of protracted conflict on

population health. Investigating QoL and well-being and their determinants may also provide important clues for developing appropriate public health responses in the OPT.

This study uses the WHOQoL-Bref (Skevington, Sartorius, 2004) instrument to assess the quality of life and well-being of a representative sample of the Palestinian population. The WHOQoL-Bref was developed to contribute to the assessment of health and well-being beyond objective descriptions of fatal and non-fatal health outcomes, and includes individual subjective affective and cognitive appraisals of one's own health state. The paper starts by describing the study instrument and the sampling procedure, followed by a comparison between OPT QoL results with those obtained from the WHO's 'International Field Trials (IFT)' which took place in 24 centers from 23 higher and lower income countries (Skevington, Lotfy, 2004). Finally, the principal determinants of Palestinian QoL (PQoL) are described before concluding with some recommendations about the potential use of the study results.

2. Methods

2.1 Instruments

Translation, adaptation and testing, for the purpose of validation, of the WHOQoL-Bref instrument were completed in 2005 (Giacaman, 2007). This was accomplished by conducting 13 focus group discussions (FGD) with OPT residents from a wide range of ages, socioeconomic conditions and political realities. In-depth discussions within the participant groups helped identify potential context-specific QoL items and determinants. These adaptations were incorporated into the final survey instrument, without affecting its consistency and face validity. The added questions were intended to identify the extent of daily anxiety and its components, satisfaction with day-to-day life activities and freedoms. Specific questions were included to assess levels of distress, financial status, and the degree to which individuals are affected by both the current acute conflict and the chronic complex emergency situation. A decision was made to exclude Question 21 in the original WHOQoL-Bref, asking about satisfaction with sex life, from the final PQoL instrument.

2.2 Sample

A multi-stage cluster sample design was used to select a sample of 1023 adults (18 years and older) from the general population living in the West Bank and Gaza Strip. Twelve households were selected in each of the pre-selected 84 enumeration areas using systematic sampling. One respondent from each household was then selected using Kish Table techniques. The interviews were conducted over a three-week period at the end of 2005 by the Palestinian Central Bureau of Statistics, and were completed exactly a month before the Palestinian Legislative Council elections of January 25th, 2006.

As for the WHO IFT, study samples comprised 'healthy' respondents from the general population (53%) and patients (47%) drawn from health services.

2.3 Analysis

Descriptive uni- and bivariate analyses were conducted to understand item distributions and inter-groups variations. Four domain-specific scores (physical, psychological, social and environmental) were estimated using the algorithm proposed by the WHOQoL team (Skevington, Lotfy, 2004). Differences in means and analysis of variance tests were used to assess differences in distributions across socioeconomic and demographic groups. Results from the PQoL were compared to age- and sex-standardized data from the WHO IFT (Skevington, Lotfy, 2004) after obtaining the raw data from the authors.

Factor analysis was used to reduce the 96 added variables to a parsimonious set of determinants. Variables with excessive missing values and not applicable responses were

deleted. For the remaining variables, for which the maximum missing was <2%, missing values were replaced with the median value for that variable. Variables were reversed scaled so that all variables in a group were in the same direction. Principal component extraction with varimax rotation using Stata 9.2 on the remaining 76 variables was used to explore the data and its limitation, and to ascertain the number of factors from eigenvalues. The maximum number of factors is 20 (eigenvalues greater than 1). Retention of 20 factors was not considered feasible. A screen plot was then used and revealed a five factor solution to be appropriate. Squared multiple correlations (smc's) were used to screen for outliers among variables. Variables with low smc's and/or low loadings on all important factors were deleted. Complex variables – variables that load equally on more than one factor – were deleted. Several runs were conducted on the remaining 50 variables to obtain the optimum number of factors. The five extracted factors were used in a Confirmatory Factor Analysis (CFA), which was conducted using MPlus software (Muthen, 2004). Factor scores were obtained using weighted least-squares using means and variances (WLSMV).

Four stepwise multiple regressions were performed to identify determinants of the four estimated QoL domains' scores. In view of the proven item response theory properties of the eight item WHOQoL score as a measure of overall QoL (Power, 2003) a fifth stepwise multiple regression was performed to identify the determinants of this score. Individual demographic and socioeconomic characteristics, and scores of extracted factors following CFA, were introduced in the model to assess significant associations. Analysis was conducted using Stata 9.2.

3. Results

3.1 Sample

A total of 1008 adults (487 men and 521 women) consented to participate in the study with a response rate of 98.5%. Respondents' ages ranged between 18 and 86 years, with a median age of 34 years. More than half of respondents (57%) resided in urban localities, 27% in rural areas and 16% in Palestinian refugee camps – of those 66% resided in the West Bank and 34% in Gaza Strip. Of the total, close to 14% of respondents reported needing to cross one or more Israeli army checkpoints 'a lot' in order to get to work, school or to access services, and less than half of the respondents (48%) reported never needing to cross checkpoints. Just fewer than 30% of respondents reported having experienced the death or imprisonment of a family member by the Israeli army. Almost 20% of the respondents living in the West Bank reported living close to the Separation Wall and 27% near an Israeli settlement – inhabitants of the Gaza Strip had indeed recently experienced the withdrawal of Israeli military and settlements from the territory.

3.2 Quality of Life Assessment

Estimated QoL domains scores are summarized in Table 1 below. For all three locations the social domain scored the highest followed by the physical, psychological and environmental domains. In contrast, 42% of respondents rated the physical domain as the most important factor in affecting their QoL compared to only 4% for the social domain, when requested to rank the importance of each domain in contributing to one's own assessment of QoL.

3.3 Comparisons with the WHO 'International Field Trials

The PQoL results were compared to pooled and country-specific results from the WHO IFT. For comparison purposes, data from Portugal was added to the WHO IFT countries, centers with small sample sizes were omitted, and the three centers in India were pooled together. Cases in the WHO IFT where the age or sex was missing and where the age was less than 15 years were also deleted. The resultant sample size from the remaining 17 countries was 11049 respondents. The WHOQoL-Bref mean domain scores were based on age- and sex-

adjusted estimates, given the differences in age and sex distributions between the PQoL study sample and samples used in the WHO IFT. The WHO Standard (Ahmad, 2001) as used as the reference population.

Comparing QoL and health satisfaction responses to self-rated global health results from the WHO IFT and PQoL revealed that the OPT population reported significantly worse QoL than the WHO IFT pooled population (all countries). Almost 11% of the WHO IFT population reported 'poor' or 'very poor' QoL compared to almost 26% for the OPT population ($p<0.01$). Because the WHO IFT respondents were taken from populations with known conditions, it was expected that respondents selected from the general population for the PQoL would on average be healthier. This was reflected in the results for health assessment, with OPT respondents reporting better satisfaction with health compared to WHO IFT populations. Almost 23% of the WHO IFT population reported being 'dissatisfied' or 'very dissatisfied' with their health compared to about 14% in the OPT population ($p<0.01$).

When comparing the WHOQoL-Bref mean domain scores, the OPT population ranks significantly lower than the 17 pooled WHO IFT countries (at the 5% significance level), except for the social domain (see Table 2 below). It is important to note the omission of the question asking about satisfaction with sex life (which falls into the social domain) in the PQoL instrument. Even with the physical domain, considering that the WHO IFT respondents included a large proportion of patients while the OPT sampled persons from the general population, PQoL responses were significantly worse than the WHO IFT pooled results. If Palestine is compared to the 17 individual countries, it ranks better than only Argentina in the environmental domain, better than Argentina and Bulgaria in the psychological domain and is tied 13th out of 18 countries for the physical domain. Here again it is worth noting that the samples for Argentina and Bulgaria were very small — 106 and 216, respectively.

3.4 Factor Analysis

Principal component extraction with varimax rotation revealed a five factor solution to be optimal. Loadings of items on components, communalities and percents of variance and covariance are presented in Table 3 below. Communalities are generally low. Loadings of 0.4 or more was used for inclusion of an item in interpretation of a factor. Loadings less than 0.4 were replaced with zeros in the Table. The five factor solution accounts for 43 percent of the variance in the variables. The items included within each factor were found to pertain to the following list of components: level of distress, financial status, freedom of expression, fear, anger and conflict.

A CFA was conducted using WLSMV in MPlus. The five factor confirmatory solution was assessed for overall model fit. The main criteria used to assess model fit included: Bentler's Comparative Fit Index (CFI), the Tucker-Lewis Index (TLI) and the root mean square error of approximation (RMSEA). Values of the CFI and TLI greater than 0.9 are considered good model fit while RMSEA is expected to be less than 0.1. The five factor model exhibited a satisfactory fit with CFI=0.79, TLI=0.89 and RMSEA=0.10.

3.5 Multiple Linear Regression

The factor scores generated from the CFA together with age, sex, and years of schooling were used as predictors of the estimated overall WHOQoL score and the domains (physical, psychological, social and environmental) specific scores, using multiple linear regressions. From Table 4, it is evident that significant differences exist between men and women for all except the physical domain ($p<0.01$). A significant negative association exists between age and all domain scores ($p<0.01$ for three of the domains and $p<0.10$ for the environmental domain). Years of schooling was positively associated with the overall WHOQoL score and

the physical and psychological domain scores ($p<0.01$ for the domain specific scores and $p<0.10$ for the overall WHOQoL score).

Looking at the factors scores, there is a significant positive association between distress levels and the overall WHOQoL score and all four domain scores, indicating that low distress levels are associated with a better QoL. Variables were reversed scaled therefore a high distress score is synonymous with low distress levels. Better financial status correlated with higher domain scores for all except the social domain ($p<0.01$ for the overall WHOQoL score and the physical and environment specific domains scores; $p<0.10$ for the psychological domain score). In addition, higher levels of freedom of expression were associated with higher scores for all domains except the environmental domain ($p<0.01$). Finally, the fear level was significantly associated only with the environment specific domain score ($p<0.01$). R^2 values ranged between 0.18 and 0.50 for the domain specific scores, and attained 0.57 for the overall WHOQoL score.

4. Discussion

A PQoL instrument was developed to assess the social suffering of Palestinian people in the context of a recently intensified chronic political conflict. The instrument was initially based on the WHOQoL-Bref, which was further refined to accommodate the local Palestinian context. Results obtained from the study in the OPT were compared to those obtained from the WHOQoL-Bref *International Field Trails*. Quality of life determinants were then assessed using factor analyses.

The results clearly indicate a lower quality of life for Palestinians in the OPT when compared to most other countries used in the comparisons here, and this in spite of the differences in the study populations (general and clinical populations for the WHO IFT versus respondents from the general population in the OPT). Palestinians reported significantly worse QoL when compared to the pooled WHO IFT respondents. In a population that has endured generations of war-like conditions and chronic exposure to violence, the results point to the influence of the political context in explaining QoL differences. A deeper understanding of QoL determinants is needed to fully delineate the impact of entrenched conflict on the well-being of people in the OPT.

In line with findings elsewhere (Zahran, 2005), physical QoL declined with age ($p<0.01$). As we know, ageing constitutes a myriad of interacting factors, including biological and social vulnerabilities, resulting in a particular health status at older ages. The case of inhabitants in the OPT demonstrates the additional negative impact of exposure to life-long conflict, violence and insecurity (Naess, 2006). The interacting dynamics of these issues are manifested by the significantly lower QoL scores (overall and domain specific scores) for older adults in the sample. It is suggested that the somatization of accumulated psychological and physical distress results in tangible declines in well-being and quality of life on top of 'normal' ageing processes.

Men and women reported differences in their overall and domain specific QoL scores, with a significant trend for higher QoL domain scores for women in the sample. These results are perhaps surprising given that Palestinian women – as is the case elsewhere – are generally disadvantaged compared to men, due to socio-cultural norms embedded in a patriarchal social order that discriminates against them and restricts their freedoms. However, our results suggest a paradoxical protective effect of the public/private divide, restricting women's abilities to move outside the home, and pushing men to move beyond the domestic sphere in search of family livelihood. These days, men's world beyond the home is fraught with daily threats of violation and distress when crossing checkpoints, being held, stripped, detained, not allowed to cross, and humiliated (Giacaman, 2006). If we combine men's daily life events

with the frustration and despair they must feel for not being able to find work in conditions of spiraling poverty, these results can become understandable, and suggest that there is a need to pay more attention to men's life quality, well-being and health – an orientation that is sometimes missing from the classical gender relations paradigm.

Education was important in determining physical and psychological QoL scores, with better QoL reports with increasing education – a finding comparable to the findings of the WHO IFT study (Skevington, Sartorius, 2004). These results are likely due to education improving a person's ability to rationalize and problem solve, and therefore potentially better take care of their health and better cope with external stressors.

Finally, the factors from the CFA were found to be very significantly associated with the different QoL scores. Lower distress levels have a positive impact on all the estimated QoL domains scores. Better financial status has a positive impact on all except the social domain while greater societal and familial freedom impacts positively on all except the environmental domain. Although, the anger component did not reveal significant associations with the different QoL domain scores, a general negative trend is suggested by the results from the regression analysis.

Many of the expected patterns in QoL reporting were validated by this survey. However, the unique conflict aspects and importance of the political context in determining quality of life of Palestinians indicates the need to develop a separate political domain for QoL assessments in the OPT, and possibly other conflict and post-conflict zones. This study corroborates the view that conventional explanations of 'poor' health need to include aspects that are often ignored, such as the way society is organized as a causal framework (Marmot, 2006). The consequences of social, economic and political exclusion in the OPT (including the lack of basic freedoms, disempowerment, fear and distress) are part of our conception of a causal framework for 'poor' health and well-being. While it is true that this is a cross-sectional study, and as such, it is not possible to determine the direction of causality, the low quality of life and 'poor' health are strongly suggested to be the consequences of social inequalities stemming from political and physical violence.

5. Conclusions

This study clearly indicates that Palestinian quality of life is 'very poor'. If one also considers the timing of the fieldwork (December 2005), the worsening economic and security situation as a result of the international and Israeli response to Hamas' victory in the January 2006 general elections intimates the magnitude of the imminent humanitarian disaster.

These results are an indication of the need for more contextually and culturally appropriate model of QoL for the social, environmental and psychological domains for the OPT. This may well be achieved through the introduction of a new political domain, entailing an assessment of its effect on the model as well as possible cross-correlations with other domains.

The strength of this study is the validation of the survey instruments in the OPT, but more importantly, it offers new perspectives on how to comprehensively assess the human costs of chronic conflicts. Though still incomplete, the tool provides concrete elements for public health responses in entrenched conflict situations by eliciting the determinants of health status as well as the mechanisms created (individually an collectively) to manage suffering and ensure survival. What the PQoL aims to measure is not simply individual quality of life but also the social quality, or more appropriately, the 'social suffering' as a dynamic concept that integrates the multiple determinants (economic, social, political, and cultural) of health and well-being of a society. The Palestinian people provide a valuable public health lesson with

respect to the broader understanding of health and the problem of ‘medicalization’ of health. Palestinian civilians need protection for their lives, livelihoods, land, rights and society.

This study may be seen as an example of how treating a conflict as a broad public health problem may lead to a change in the conceptualization of the outcomes to be explained (from body count and medical indicators to social suffering due to violation of basic rights) as well as the international response to be undertaken (from humanitarian/medical aid to political conflict resolution and realization of human rights laws). Attempts to measure the social suffering of populations stricken by complex emergencies are therefore part of an overall approach that places the demand for rights and justice at the center of public health.

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Table 1: Summary of Average Domain Rankings by Location.

	West Bank		Gaza Strip		OPT	
	Mean[a]	SD	Mean[a]	SD	Mean[a]	SD
Physical Domain	62.4	20.6	66.8	19.2	63.9	20.3
Psychological Domain	57.0	16.0	59.6	15.2	57.9	15.8
Social Domain	69.4	18.8	70.2	19.6	69.7	19.1
Environmental Domain	45.9	15.2	49.1	13.3	47.0	14.6

[a] Scores are transformed into a [0-100] scale where 0 represents the worst case scenario and 100 represents the best case scenario on the specific domain subscale.

Table 2: WHO "International Field Trial" Pooled and Selected Pilot Countries WHOQoL and Occupied Palestinian Territories PQoL Mean Scores.

	Domain							
	Physical		**Psychological**		**Social**		**Environmental**	
Country	**Mean[a]**	**SD**	**Mean[a]**	**SD**	**Mean[a]**	**SD**	**Mean[a]**	**SD**
All countries (pooled)	14.4	3.0	14.2	2.7	14.4	3.2	13.8	2.6
Argentina	10.5	2.5	9.5	3.1	11.2	3.7	11.1	2.3
Australia	13.9	2.6	13.2	3.0	12.9	3.3	14.1	2.2
Brazil	13.9	3.1	14.7	2.6	15.3	3.4	13.5	2.3
Bulgaria	13.8	3.6	12.7	3.2	13.1	3.4	12.2	2.6
Croatia	13.7	2.9	14.1	2.9	14.7	3.2	13.5	2.7
Germany	16.3	3.0	15.8	2.7	15.5	3.1	15.2	2.3
Hungary	14.2	3.1	13.4	2.5	13.7	3.0	13.8	2.4
India	13.8	2.4	13.2	2.7	13.6	3.1	12.5	2.8
Israel	15.7	2.3	15.0	2.0	15.2	3.0	14.6	2.0
Italy	15.2	2.7	14.9	2.4	14.5	2.8	13.4	2.2
Japan	13.9	2.2	13.2	2.4	12.8	2.5	12.6	2.2
Malaysia	13.2	2.6	14.4	1.8	14.6	2.1	13.9	1.7
Norway	12.5	2.3	14.3	2.3	14.8	3.1	14.8	2.5
Palestine (OPT)[b]	**13.7**	**3.5**	**13.1**	**2.6**	**14.7**	**3.1**	**11.2**	**2.4**
Portugal	13.0	1.7	14.5	1.9	14.8	2.7	13.9	2.1
Russia	13.9	3.1	13.4	2.6	14.0	3.6	12.5	2.8
Spain	13.8	2.9	13.4	2.9	13.1	3.8	12.9	2.6
United Kingdom	15.1	3.3	14.3	2.3	15.2	2.4	14.6	2.0

[a] Domain means are estimated on a range from 4 to 20

[b] The difference between OPT means and pooled means was significant at the 0.05 level for all domains.

Table 3: Items, Factor Loadings, Communalities, Percents of Variance and Covariance for Principal Component Extraction and Varimax Rotation.

Question	*F1*	*F2*	*F3*	*F4*	*F5*	*h2*
How much bodily pain do you have?	**0.42**	0.00	0.00	0.00	0.00	0.22
To what extent do you feel emotionally safe in your daily life?	**0.48**	0.00	0.00	0.00	0.00	0.31
To what extent do you feel bored?	**0.50**	0.00	0.00	0.00	0.00	0.35
To what extent is suffering part of your life?	**0.47**	0.00	0.00	0.00	0.00	0.43
To what extent are you satisfied with your ability to plan for your daily life?	**0.46**	0.00	0.00	0.00	0.00	0.33
To what extent are you satisfied with your ability to plan for the future?	**0.45**	0.00	0.00	0.00	0.00	0.30
To what extent did you feel unable to control the important things in your life?	**0.55**	0.00	0.00	0.00	0.00	0.35
To what extent did you feel unable to cope with all the things that you had to do?	**0.54**	0.00	0.00	0.00	0.00	0.34
To what extent did you feel worried?	**0.70**	0.00	0.00	0.00	0.00	0.55
To what extent did you feel frustrated?	**0.75**	0.00	0.00	0.00	0.00	0.60
To what extent did you feel incapacitated?	**0.72**	0.00	0.00	0.00	0.00	0.57
To what extent did you feel humiliated?	**0.54**	0.00	0.00	0.00	0.00	0.40
To what extent did you feel lonely?	**0.62**	0.00	0.00	0.00	0.00	0.45
To what extent did you feel anxious?	**0.74**	0.00	0.00	0.00	0.00	0.58
To what extent did you feel sad?	**0.74**	0.00	0.00	0.00	0.00	0.57
To what extent did you feel angry?	**0.62**	0.00	0.00	0.00	0.00	0.42
To what extent did you feel fed up with life?	**0.63**	0.00	0.00	0.00	0.00	0.45
To what extent are you able to receive a medical treatment that you would need?	0.00	**0.40**	0.00	0.00	0.00	0.19
Does your household have enough money to meet your and your family needs?	0.00	**0.75**	0.00	0.00	0.00	0.63
Does your household borrow money to fulfill your or your family needs?	0.00	**0.53**	0.00	0.00	0.00	0.33
Are you or your household in debt now?	0.00	**0.67**	0.00	0.00	0.00	0.47
To what extent does your household postpone paying bills to manage your and your family needs?	0.00	**0.60**	0.00	0.00	0.00	0.37
Is the food that you desire easily available to you?	0.00	**0.68**	0.00	0.00	0.00	0.50
To what extent are you satisfied with your/your family earnings?	0.00	**0.69**	0.00	0.00	0.00	0.56
To what extent are you satisfied with the crowding level in your home?	0.00	**0.46**	0.00	0.00	0.00	0.28
To what extent are you satisfied with your capacity to bear sudden medical expenses?	0.00	**0.63**	0.00	0.00	0.00	0.46
To what extent are entertainment facilities available for you?	0.00	**0.51**	0.00	0.00	0.00	0.34
To what extent are you able to physically access health care services?	0.00	**0.39**	0.00	0.00	0.00	0.25
To what extent are you able to financially access health care services?	0.00	**0.61**	0.00	0.00	0.00	0.44
To what extent are you satisfied with your family?	0.00	0.00	**0.44**	0.00	0.00	0.32
To what extent are you satisfied with the freedom afforded to you by your family?	0.00	0.00	**0.61**	0.00	0.00	0.43
To what extent are you satisfied with the possibility of expressing your opinion at home?	0.00	0.00	**0.67**	0.00	0.00	0.46
To what extent do you feel appreciated and respected from the others right now?	0.00	0.00	**0.65**	0.00	0.00	0.44
To what extent do you feel loved right now?	0.00	0.00	**0.65**	0.00	0.00	0.44
To what extent do you feel freedom at home?	0.00	0.00	**0.69**	0.00	0.00	0.50
To what extent do you feel freedom in the street?	0.00	0.00	**0.45**	0.00	0.00	0.24
To what extent do you feel able to express your opinion at home?	0.00	0.00	**0.72**	0.00	0.00	0.52
To what extent do you feel fear for yourself in your daily life?	0.00	0.00	0.00	**0.52**	0.00	0.32
To what extent do you feel fear for your family in your daily life?	0.00	0.00	0.00	**0.63**	0.00	0.45
To what extent do you currently feel worry/afraid (threatened) of	0.00	0.00	0.00	**0.55**	0.00	0.41

losing your home?						
To what extent do you currently feel worry/afraid (threatened) of displacement or uprooting?	0.00	0.00	0.00	**0.57**	0.00	0.45
To what extent do you feel worry/afraid (threatened) about your future and the future of your family?	0.00	0.00	0.00	**0.58**	0.00	0.45
To what extent do you feel fear for your safety?	0.00	0.00	0.00	**0.66**	0.00	0.48
To what extent do you feel fear for the safety of your family?	0.00	0.00	0.00	**0.75**	0.00	0.58
To what extent does your family feel fear for your safety?	0.00	0.00	0.00	**0.60**	0.00	0.41
How often do you feel angry over what occupation does to you?	0.00	0.00	0.00	0.00	**0.78**	0.62
How often do you feel angry over what occupation does to your family?	0.00	0.00	0.00	0.00	**0.77**	0.65
How often do you feel humiliation by military occupation actions?	0.00	0.00	0.00	0.00	**0.69**	0.51
To what extent are you affected by closures and siege?	0.00	0.00	0.00	0.00	**0.59**	0.44
To what extent are you negatively affected by the ongoing conflict and the military occupation?	0.00	0.00	0.00	0.00	**0.61**	0.46
SSL	6.68	4.89	3.88	3.39	2.80	
Percent of variance	13.36	9.77	7.76	6.78	5.59	
Percent of covariance	30.87	22.58	17.93	15.68	12.93	

Factor labels: F1 = Distress; F2 = Financial; F3 = Freedom; F4 = Fear; F5 = Anger/Conflict
h2 communalities

Table 4: Regression Results for Selected Determinants of QoL Domain Scores and WHOQoL Score.

	Domain									
	WHOQoL		Physical		Psychological		Social		Environment	
	β coefficient	SE	*β coefficient*	SE	*β coefficient*	SE	*β coefficient*	SE	*β coefficient*	SE
Constant	64.24	1.63	77.37	2.40	60.20	1.95	71.39	2.88	46.75	1.75
Age	-0.19*	0.03	-0.47*	0.04	-0.16*	0.03	-0.10*	0.04	-0.05**	0.03
Ref Male										
Sex	1.20**	0.65	-1.19	0.95	1.55*	0.77	3.13*	1.14	1.39*	0.69
Education	0.16**	0.09	0.42*	0.13	0.27*	0.11	-0.19	0.15	-0.08	0.09
Distress	8.09*	0.57	11.66*	0.84	9.90*	0.68	6.61*	1.00	4.56*	0.61
Financial	6.25*	0.55	2.83*	0.80	1.23**	0.65	-0.36	0.96	9.43*	0.59
Freedom	2.92*	0.55	1.99*	0.81	4.70*	0.65	7.62*	0.96	0.86	0.59
Fear	0.35	0.61	0.95	0.89	0.16	0.72	1.09	1.07	1.93*	0.65
Anger	-0.67	0.53	-1.09	0.77	-0.82	0.63	-0.45	0.93	0.56	0.57
R^2	0.57		0.50		0.44		0.18		0.48	

*Significant at the 1% level
**Significant at the 10% level