STATE OF ELDERLY
IN OIC MEMBER COUNTRIES
2018









ORGANISATION OF ISLAMIC COOPERATION

STATISTICAL, ECONOMIC AND SOCIAL RESEARCH
AND TRAINING CENTRE FOR ISLAMIC COUNTRIES

THE STATE OF ELDERLY IN OIC MEMBER COUNTRIES

Responding to the Needs of Elderly

ORGANIZATION OF ISLAMIC COOPERATION

THE STATISTICAL, ECONOMIC AND SOCIAL RESEARCH AND TRAINING CENTRE FOR ISLAMIC COUNTRIES (SESRIC)

Kudüs Cad. No: 9, Diplomatik Site, 06450 Oran, Ankara –Turkey
Telephone +90–312–468 6172
Internet www.sesric.org
E-mail pubs@sesric.org

ISBN: 978-975-6427-69-9

Cover design by Savas Pehlivan, Publication Department, SESRIC.

For additional information, contact Research Department, SESRIC through: research@sesric.org

CONTENTS

"Your Lord has commanded that you worship none but Him, and that you be kind to your parents. If one or both of them reach old age with you, do not say to them a word of disrespect, or scold them, but say a generous word to them. And act humbly to them in mercy, and say, 'My Lord, have mercy on them, since they cared for me when I was small" (Holy Quran, 17: 23-24).

Narrated Abdullah ibn Amr ibn al-'As: The Prophet said: Those who do not show mercy to our young ones and do not realize the right of our elders are not from us (Sunan Abu Dawud).

ABBREVIATIONS

BPP	Basic Pension Programs
DALY	Disability-Adjusted Life Year
DB	Defined-Benefit Pension Schemes
DC	Defined-Contribution Pension Schemes
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
ILO	International Labour Organisation
ILOSTAT	International Labour Organisation - Labour Statistics Database
KILM	Key Indicators of the Labour Market
LFPR	Labour Force Participation Rate
MIPAA	Madrid International Plan of Action on Ageing
NDC	Notional Defined-Contribution Schemes
OIC	Organization of Islamic Cooperation
PF	Provident Funds/Public Managed Defined-Contribution Pension Schemes
TPP	Targeted Pension Programs
UPP	Universal Pension Programs
UN DESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
WHO	World Health Organization

FOREWORD

Ageing is a natural phenomenon that has deep impacts on economy and society. Ageing becomes a demographic concern when fertility and mortality rates decline consistently over a long period of time, creating a discrepancy between the number of older people and youth. Over the last decade, populations are ageing at a faster rate across the world, making it an important policy issue for developed and developing countries.

This issue is particularly relevant for OIC member countries given the increasing size, proportion and longevity of elderly people. A failure to address this demographic change has the potential to negatively affect the well-being of elderly people as well as the development of member countries in the long run. Fortunately, increasing number of OIC member countries have started to develop plans, programmes and policies to address challenges faced by their elderly people. Nevertheless, it is important to provide a comparative analysis on the matter to get a clear understanding in the light of data regarding the relative performance of OIC member countries.

This report fills an important gap in knowledge concerning the social and economic realities of ageing in OIC member countries. The findings of this report can help form the basis for later policies that are helpful for transforming challenges posed by ageing populations into opportunities. Additionally, there is also a requirement for practices that promote intergenerational solidarity to foster socially and economically inclusive societies that can better cater to ageing populations.

To encourage further deliberation on this issue, this report highlights key trends of ageing in OIC member countries. It analyses demographic trends, social and economic well-being of elderly, institutional arrangements pertaining to elderly, and the cultural dimensions of ageing using quantitative and qualitative datasets in a comparative manner. This report concludes with policy recommendations that are presented for the consideration of policy-makers to better address the growing needs of elderly people in OIC member countries.

Amb. Musa Kulaklıkaya

Director General
SESRIC

ACKNOWLEDGEMENTS

This report has been prepared by a research team at SESRIC led by Cem Tintin and comprising Tazeen Qureshi, Ayse Sena Kosger and Neslihan Cevik. The research process has been coordinated and supervised by Kenan Bağcı.

Contribution of authors to the specific sections of the report is as follows: Section 1 on Introduction and Section 6 on Concluding Remarks and Policy Recommendations are prepared by Cem Tintin. Section 2 on Elderly Demographics and Section 4 on Institutions for the Elderly are prepared by Tazeen Qureshi. Ayse Sena Kosger contributed to the preparation of Section 3 on Social and Economic Well-Being of Elderly with Tazeen Qureshi. Section 5 on Cultural Dimension of Ageing is prepared by Neslihan Cevik.

EXECUTIVE SUMMARY

Twentieth century advancements in science and medicine are responsible for the changing demographic landscape of the world. One such change is the increase in number of elderly persons in developed and developing countries. The social and economic implications of this phenomenon are profound and extend far beyond local borders. To better explain the phenomenon of ageing in OIC countries, this report presents a review of trends concerning elderly demographics, the social and economic well-being of elderly, institutions for the elderly, and the cultural dimension of ageing.

Elderly Demographics: Past, Current, and Future Trends

Fertility and life expectancy rates are the two main demographic determinants of ageing. Although fertility rates have declined in OIC countries in recent decades, they remain, on average, higher than those of non-OIC developing countries and developed countries. The life expectancy rate at age 60 increased from 16.4 years to 18 years in the period between 1990 and 2015 and by 2030, it is further projected to rise by another 0.8 years. Nonetheless, the average life expectancy for OIC countries is lower than that of non-OIC developing countries and developed countries.

It has been observed that the speed of ageing in OIC countries between 1990 and 2015 was slower than non-OIC developing countries and developed countries. However, between 2015 and 2030, the speed of ageing in OIC countries is projected to accelerate; thereby increasing the share of population aged 60 or over to 9.3% by 2030.

OIC countries have a relatively lower old-age dependency ratio when compared to developed countries and non-OIC developing countries. And this ratio advantage will remain relatively lower until 2030 that provides a window of opportunity for OIC countries.

Social and Economic Well-Being of Elderly

An increase in the size of the older people, relative to other age groups, challenges existing family relationships, the capacity of health services, and social security

programs. In this regard, there are major differences between different country groups concerning residential arrangements. While multigenerational co-residence is less common among developed countries, skipped-generation family consisting of grandparents and grandchildren are more common in many developing countries including OIC countries.

Health care (mortality and diseases) is another important aspect of elderly welfare. According to the findings, Ischaemic heart disease and stroke are the leading causes of death at the global level, followed by chronic obstructive pulmonary disease, lower respiratory infections and Alzheimer's disease. In OIC countries, non-communicable diseases are the major cause of moderate and severe disability among persons aged 60 years and over.

Social security is a key policy instrument that can improve the support provided to ageing people. The statutory retirement age in OIC countries is 60 years and only 13 of the 37 OIC member countries have retirement age between 55 and 60. It has been also observed that 87.5% of OIC member countries implement mandatory retirement that requires an individual's complete withdrawal from all employment as a condition for receiving retirement pension. Yet, less than 50% older persons in OIC member countries receive an old age pension.

Institutions for the Elderly

Development of institutions for the elderly ensures their inclusion (and representation) in society and policy making processes. Many OIC countries have already developed a specific institutional arrangement or entity within a Ministry, Department or Agency to address the issue of elderly.

In terms of institutional arrangements on education, OIC countries still need to exert more efforts as the literacy rates among elderly are found to be the lowest when compared with non-OIC developing and developed countries. As education and literacy play a key role in social integration and participation of older people in the society, this should be a key area of concern for policy-making.

The level of concern about the size of working-age population significantly varies across developed, non-OIC developing, and OIC countries. Only 12 out of 52 OIC countries with data available considered the growing proportion of older persons and its consequences for health and social welfare provisions as a major concern. In terms of social security arrangements, the data also shows that 25 OIC countries did not take any measure to address population ageing in 2015, based on the UN DESA survey.

The Cultural Dimension of Ageing

Although ageing is a biological process, it has implications on culture and values. On the other hand, the demographic transformation and rapid change in socio-cultural norms also influence values and customs regarding care of elderly people in OIC countries. Such emerging trends including change in demographics and cultural values interact with each other and bring new challenges for policy-makers to address. Therefore, it is essential for OIC countries to find policy-solutions to address these challenges such as through adopting life course perspective and implementing integrated health care systems along with home-based care.

*

In the light of above discussions, there is obviously a need for OIC countries to take policy actions in a timely manner in order to address challenges faced by elderly people and improve their well-being. Improving social security systems, developing healthcare mechanisms, reviewing education policies, and addressing labour force participation among elderly are some of the major policy recommendations that were presented for the consideration of policy-makers in the Report. Nevertheless, it is also necessary to consider the impacts of ageing on cultural values and norms as well as changing family dynamics in OIC countries while devising policies on elderly.

CHAPTER ONE

Introduction

Previously being a priority concern for developed countries, the issue of population ageing has been gaining an increasing importance in developing countries in the 21st century. Globally, the proportion of older persons is climbing up at a faster rate when compared to other population groups. This change in population structure and share has local and national impacts that can be managed with timely policy responses. For developing countries including OIC countries, population ageing presents challenges such as the sustainability of pension funds, strain on the provision of social and health services for elderly, employment opportunities tailored for elderly.

In this context, the Madrid International Plan of Action on Ageing (MIPAA), adopted at the Second World Assembly on Ageing in 2002, marked a major turning point in how the world addresses the challenge of "building a society for all ages". MIPAA provides a framework for governmental, non-governmental, and other actors highlighting the opportunities and challenges of ageing in the twenty-first century focusing on three priority areas: (i) older persons and development, (ii) advancing health and well-being into old age, and (iii) ensuring enabling and supportive environments (see Annex I).

Despite the adoption of the MIPAA, older persons are often excluded from policies, programs, research, and data collection in areas such as poverty, health, food security, and gender. To ensure the inclusion of elderly in various policy areas, it is imperative to rethink priority areas in the post-2015 agenda.

Most developed countries define elderly as persons above the age of 65. This is the age at which a person can receive pension benefits. In many developing countries, elderly persons include people aged 50 or even 60 and above. This discrepancy is also reflected in data and indicators used by research institutions. For example, United Nations

classifies elderly as 60+ for life expectancy studies and 65+ for old age dependency studies.

Regardless of these differences in definitions, this report looks at the state of elderly people in OIC member countries by using internationally comparable datasets. It analyses demographics, social and economic well-being of the ageing populations, institutions for the elderly, social integration of older residents, and provides a discussion on the nexus of culture and ageing. The report concludes with policy recommendations that can serve policy-makers in OIC countries in shaping policy actions and strategies for elderly people.

CHAPTER TWO

Elderly Demographics: Past, Current, and Future Trends

Over the recent decades, ageing has resulted in an increase in the proportion of elderly and a decrease in the proportion of youth. While, rapid ageing has been a common occurrence in developed countries for the a few decades, it has only recently gained momentum in OIC and non-OIC developing countries. Rapid ageing has significant social and economic impacts that require immediate policy responses. In response to rapid ageing, one of the most important policy requirements for OIC countries is to ensure social and economic well-being of elderly. In this regard, this section provides an overview of elderly demographics in OIC countries in comparison to non-OIC developing countries, and developed countries. It highlights the demographics determinants of ageing, changes in population structure between 1990 and 2017, and elderly participation in the labour force.

2.1 Demographics Determinants of Ageing

Population ageing is a phenomenon that is said to occur when the median age of a population increases as a result of declining fertility and rising life expectancy. This subsection discusses fertility and life expectancy – the primary determinants of ageing.

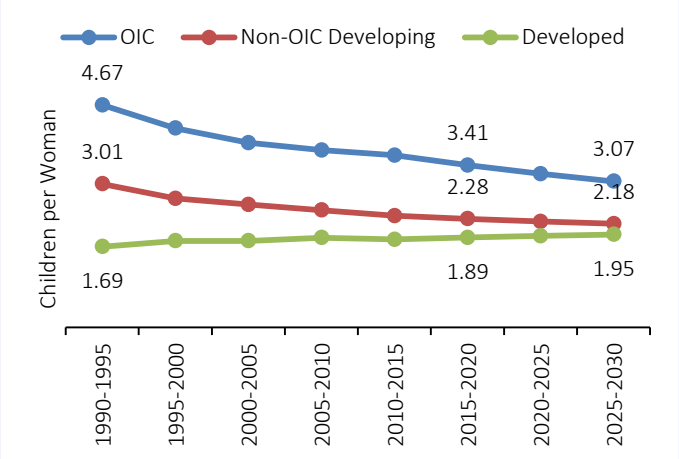
2.1.1 Fertility

Fertility rates indicate the number of live births per woman in a country. To naturally maintain a balanced population, a replacement fertility rate of 2.1 children per woman is considered adequate. While, fertility rates above the replacement rate indicate a growing population, very high fertility rates can result in socio-economic difficulties for families.

On the other hand fertility rates below the replacement rate indicate a population that is growing older and declining in size, simultaneously. Like very high replacement rates, low replacements rates can also result in socio-economic consequences that need to be addressed through public policy and institutional adjustments. Figure 2.1 shows fertility rate trends for OIC countries in comparison to other country groups.

As the figure shows, OIC countries have experienced a decline in fertility rates over the past two - three decades. Yet they remain, on average, higher than those of non-OIC developing countries and considerably higher than those of developed countries. In the near future, the average fertility rate in OIC countries will continue to be above the replacement rate. While, in non-OIC developing countries it is expected to fall to the levels close to the replacement rate, in developed countries the average fertility rate will continue to be below the replacement rate.

Figure 2.1: Fertility Rates

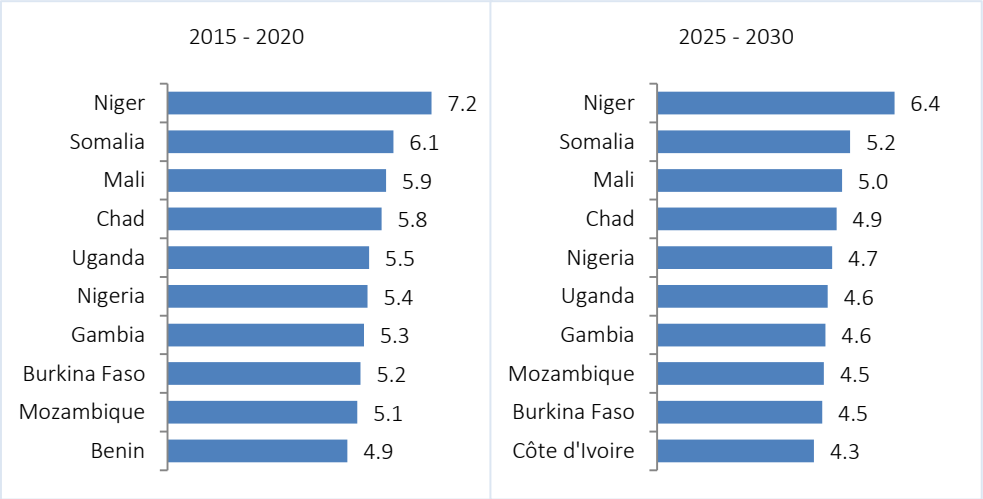


Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries.

It should be noted here, that there are wide differences in fertility rates seen across OIC countries. Figure 2.2 shows the OIC countries with the highest fertility rates (left) between 2015-2020 and 2025-2030. Between 2015-2020 and 2025-2030, OIC countries with the highest fertility rates are located in Sub-Saharan Africa.

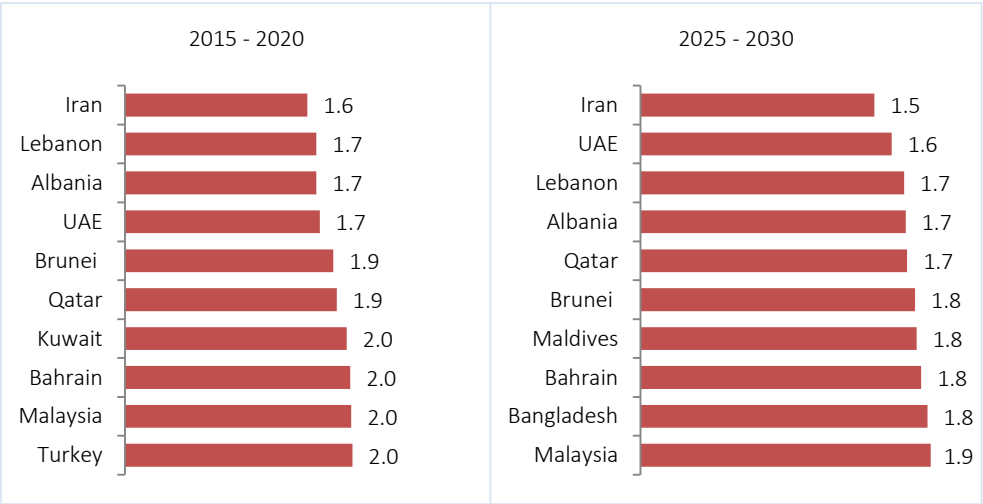
Similarly, OIC countries with the lowest fertility rates are shown in Figure 2.3. All the countries in this figure have borderline fertility rates or fertility rates that are lower than the replacement rate. With an average of 1.6 children per woman, Iran has the lowest fertility rate over the period 2015-2020 and it is further expected to decrease to 1.5 children per woman over the period 2025-2030.

Figure 2.2: 10 OIC Countries with the Highest Fertility Rates



Source: UN World Population Prospects: The 2017 Revision

Figure 2.3: 10 OIC Countries with the Lowest Fertility Rates



Source: UN World Population Prospects: The 2017 Revision

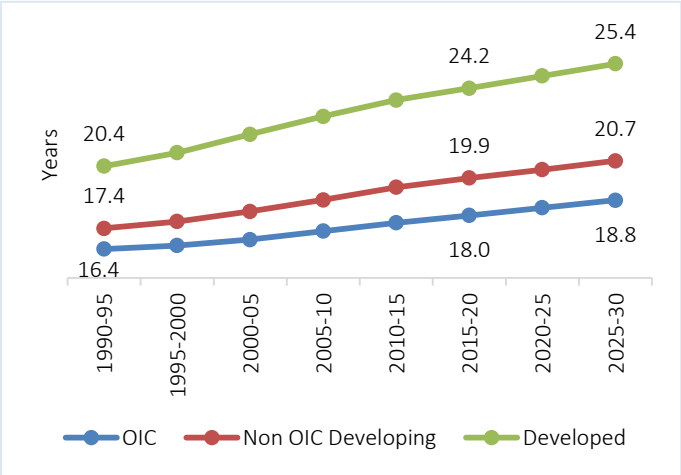
2.1.2 Life Expectancy of Elderly

In the 21st century, people tend to live longer all across the globe. An increased life expectancy is a testament to the advances in science and medicine such as better nutrition, sanitation, health care, education, and economic well-being. Figure 2.4 shows life expectancy for elderly people.

As compared to two decades ago, elderly people in OIC countries live longer in 2015. The average life expectancy of elderly at age 60 in OIC countries increased from 16.4

years to 18 years between 1990 and 2020. By 2030, the average life expectancy at age 60 for OIC countries is expected to further increase by 0.8 years. However, the level of increase in OIC countries is lower than that of non-OIC developing countries and developed countries between 1990 and 2030. In this period, the life expectancy at age 60 is expected to increase by 5 years for developed countries, 3.3 years for non-OIC developing countries, and only 2.4 years for OIC countries.

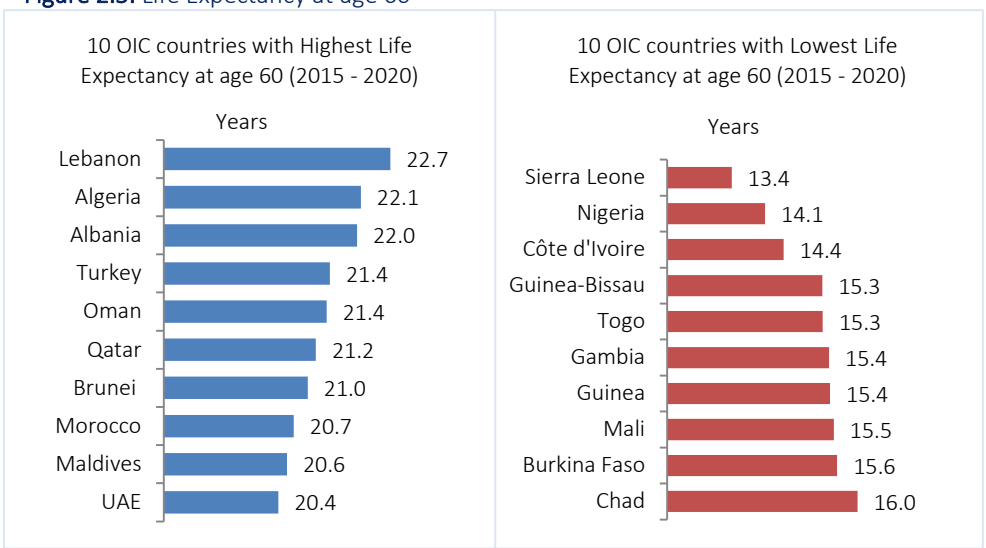
Figure 2.4: Life Expectancy at age 60



Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries

Similar to fertility rates, OIC countries are not a homogenous group when it comes to the life expectancy at age 60. Figure 2.5 displays the OIC countries with the highest (left) and the lowest (right) life expectancies at age 60.

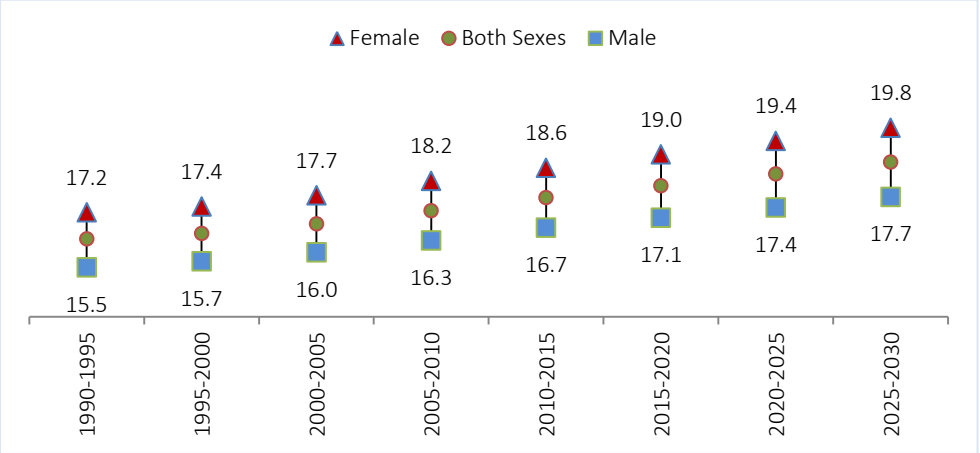
Figure 2.5: Life Expectancy at age 60



Source: UN World Population Prospects: The 2017 Revision

From a gender disparity perspective, women are expected to live longer than men in OIC countries, which is consistent with the global trends. Figure 2.6 shows a breakdown of the life expectancy at 60 for male and female elderly in OIC countries.

Figure 2.6: Life Expectancy at age 60 by Gender for OIC Countries



Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries

The gap in life expectancy at age 60 between female and male population has widened over the past two decades. Between 1990 and 1995, elderly women were expected to live 1.7 years longer than men, which have increased to 1.9 years between 2015 and 2020. This gap is expected to further increase to 2.1 years in 2030.

2.2 Changes in Population Structure towards more Elderly People

Following the discussion of declining fertility rates and increasing life expectancy, this section maps the changes in population structures in OIC countries by looking at share of elderly in total populations and old age dependency ratio.

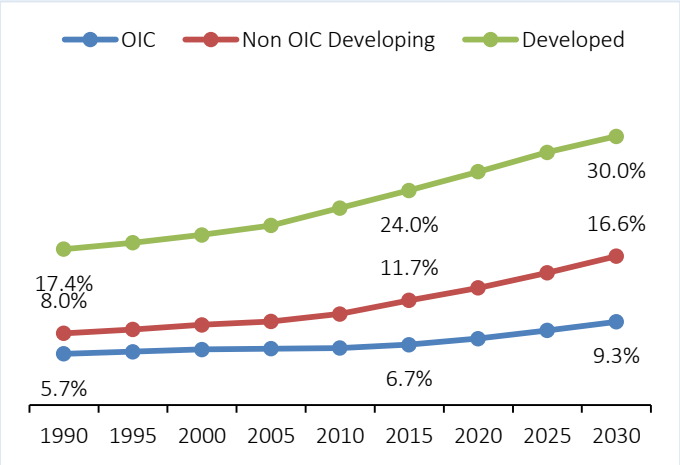
2.2.1 Share of Elderly People in Total Population

As people live longer, population structures undergo changes that result in an increase in the share of elderly population (aged 60/65 or over) at the expense of other age groups such as working age population (aged 15-59/15-64) and children (aged under 15). Figure 2.7 shows the share of elderly people in total population in OIC countries in comparison with other country groups.

As the figure shows, ageing is a global phenomenon. However, populations in various country groups differ in their phases and speeds of ageing. In OIC countries, the share of population aged 60 or over was somewhat stable between 1990 and 2015, increasing

slightly from 5.7% in 1990 to 6.7% in 2015. In the same time period, the share of population aged 60 or over increased from 8% in 1990 to 11.7% in 2015 in non-OIC developing countries and 17.4% in 1990 to 24% in 2015 in developed countries. This clearly demonstrates that the speed of ageing between the years 1990 to 2015 in OIC countries is considerably slower than non-OIC developing countries and developed countries. However, the speed of ageing in OIC countries is projected to reach 9.3% in marking an increase in the speed of ageing.

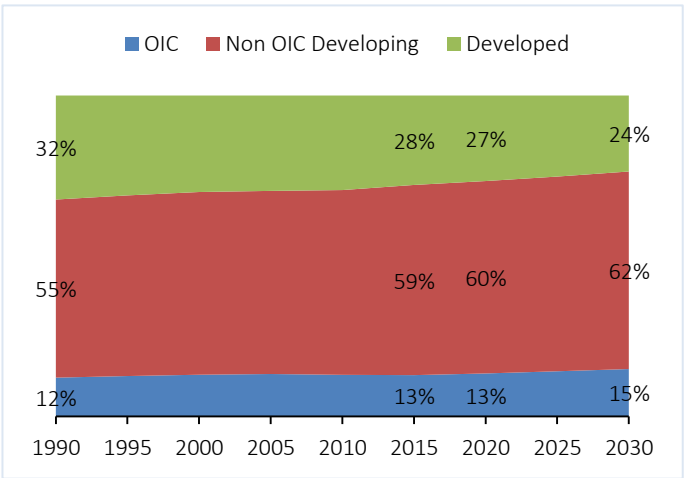
Figure 2.7: Share of Population aged 60 or over



Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries

In 1990, 32% of the world's elderly lived in developed countries, 55% lived in non-OIC developing countries, and 12% lived in OIC countries (Figure 2.8). Nevertheless, over time, the share of elderly in developing countries has expanded. In 2015, 13% of the world's elderly lived in OIC countries (an increase from 12% in 1990) and estimates indicate that the share will further increase to 15% by 2030. A similar trend is observed in non-OIC developing countries where 55% of elderly populations were living in non-OIC developing

Figure 2.7: Geographical distribution of World's Elderly

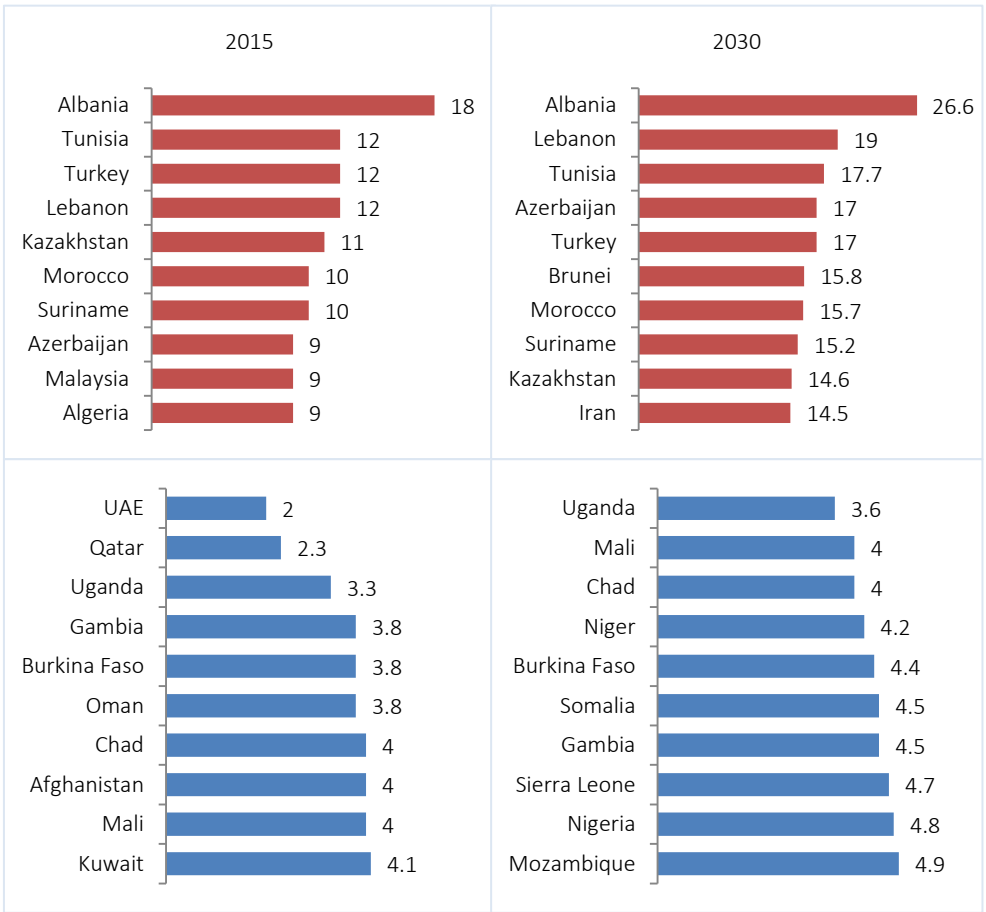


Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries

countries in 1990 that increased to 60% in 2015. It is further estimated to reach 62% in 2030. On the other hand, an opposite trend is observed in developed countries that the share of elderly populations living in developed countries represented 32% of the world's elderly. This share went down to 28% in 2015. It is further estimated to decrease to 24% in 2030.

As Figure 2.9 shows, the share of elderly people in total population is not uniform across OIC countries. In 2015 OIC countries with the lowest share of population aged 60 or over include countries in the Asia, Arab and African regions. By 2030, all these countries will be from the Sub-Saharan Africa region (Figure 2.9, bottom-right). On the contrary, in 2015, Albania had the highest share of population aged 60 or over, closely followed by Tunisia. It is important for OIC countries with a relatively high share of elderly people to design and implement policies to provide better services for these people.

Figure 2.9: OIC Countries with the Highest (top) and Lowest (bottom) Share of Population aged 60 or over (%)



Source: UN World Population Prospects: The 2017 Revision

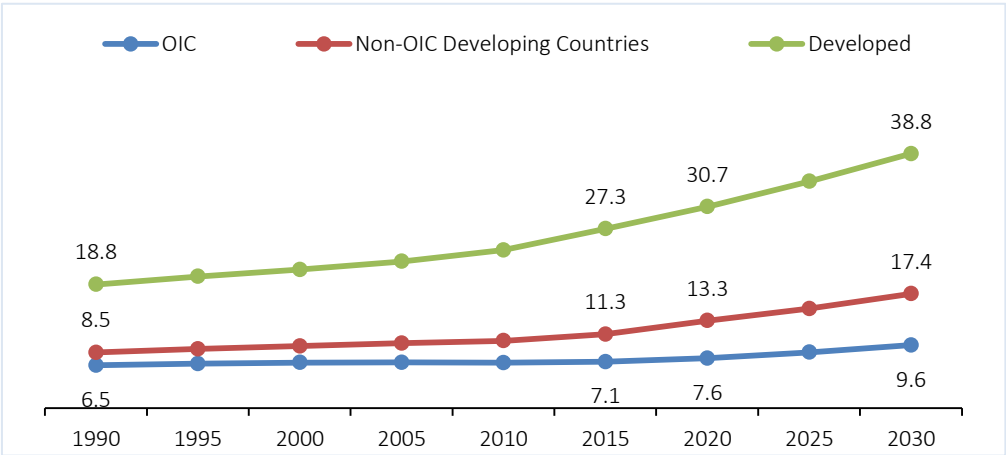
2.2.2 Old Age Dependency Ratio

Old age dependency ratio indicates changes in population structures. Old age dependency ratio measures the number of "elderly dependents" that need to be supported by working age population. It is calculated by dividing the number of elderly people aged 65 or over by people aged 15-64 as follows:

$$\text{Old Age Dependency Ratio} = \frac{\text{Number of people aged 65 or over}}{\text{Number of people aged 15 to 64}} \times 100$$

The comparison between OIC countries and other country groups in reference to old age dependency ratio is shown in Figure 2.10. The figure shows that the old age dependency ratio in developed countries and non-OIC developing countries has been continuously increasing since 1990, and will continue to increase till 2030. However, in OIC countries, old age dependency ratio has been stable between 1990 and 2015, but is projected to accelerate between 2015 and 2030. Figure 2.10 also shows that in developed countries this ratio will be 30.7 in 2020 and is projected to increase to 38.8 by 2030. This ratio is relatively moderate in non-OIC developing countries (13.3 in 2020; projected to increase to 17.4 by 2030). On the contrary, OIC countries are in an advantageous position of having a relatively lower old-age dependency ratio (7.6 in 2020; projected to increase to 9.6 by 2030). This can prove to be an opportunity for OIC countries to align their elderly policies with their development goals till 2030.

Figure 2.10: Old Age Dependency Ratio



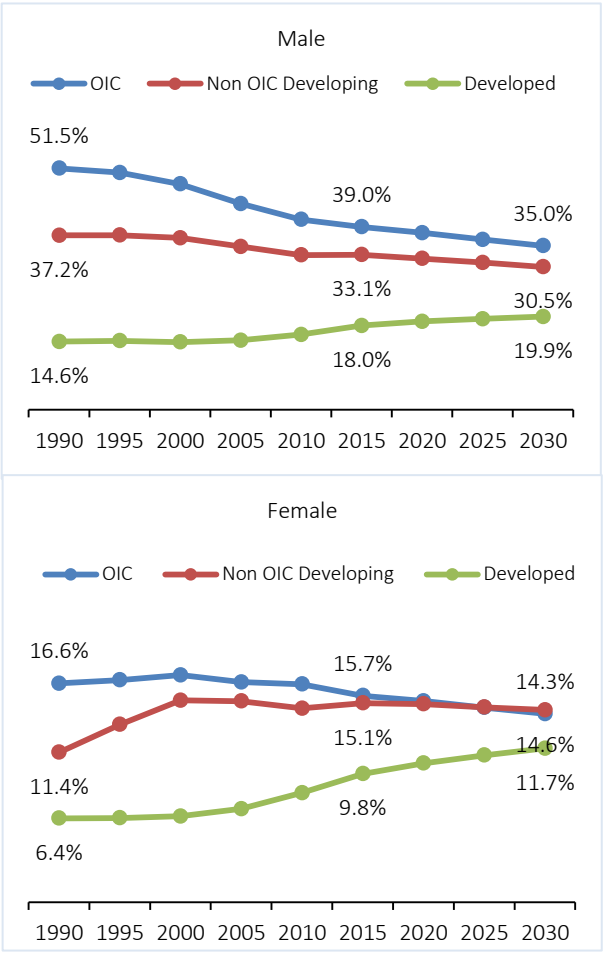
Source: SESRIC staff calculations based on the UN World Population Prospects: The 2017 Revision. Data weighted by country populations so that more populous countries affect the average more than smaller countries.
Note: The UN World Population Prospects 2017 now calculates Old age dependency ratio calculation as persons aged 65+ divided by population aged 15 – 64, instead aged 60+.

2.3 Labor Force Participation of Elderly People

At age 60 or 65, elderly populations are expected to retire and avail social benefits in the form of pension, social security, etc. However, as Figure 2.11 reveals, a large portion of elderly population continues working after the age of 60 or 65 in the developing world (OIC and non-OIC countries).

Labour force participation rate (LFPR) of elderly is used to determine elderly's participation in the economic activities by measuring their engagement in the labour market through production of goods and services.

Figure 2.11: Labour Force Participation Rate of Elderly People (aged 65+)



Source: SESRIC staff calculations based on ILO, Key Indicators of Labour Market (KILM), 9th edition. Data weighted by country populations so that more populous countries affect the average more than smaller countries.

Elderly in the OIC and non-OIC developing countries continue working even after 60 or 65 years of age owing to the limited coverage of social security schemes and insufficient amount of the pensions provided by social security systems. Nevertheless, the declining labour force participation of elderly in OIC countries might indicate some improvements in social protection for elderly people. Similarly, increasing labour force participation of elderly in developed countries might reflect a deterioration in the adequacy of social security schemes and pensions or/and an increase in the statutory retirement age.

Figure 2.11 shows discrepancies in labour force participation for elderly male and female population. Labour force participation for elderly women is significantly lower than that of men. Labour force participation for females has declined from 16.6% in 1990 to 15.7% in 2015;

whereas, for males the rate dropped significantly from 51.5% to 39%. In other words, the participation of elderly men into labour force has been declining relatively faster when compared to women in OIC countries.

Numerous factors influence labour force participation among older persons such as economic conditions, retirement policies, health-related challenges, and reductions in physical strength, etc. Moreover, older workers are more likely to work in agricultural sector or informal sectors which results in a lack of retirement benefits, lower wage rates, and limited training opportunities. Furthermore, older people also face discrimination in hiring, promotion, and access to job-related training. A growing number of countries are adopting laws to combat discrimination against older workers. According to the ILO, some form of legislation against age discrimination in employment exists in approximately 50 countries around the world.

CHAPTER THREE

Social and Economic Well-Being of Elderly

An increase in the number of elderly people, relative to other age groups, poses challenges to family relationships, health services, and social security systems. Therefore, understanding elderly peoples' potential to contribute to their families, communities, and society is important to better tackle any challenges. In this regard, the following section provides a profile of the older populations in OIC countries with respect to their social and economic characteristics such as living arrangements, health, and social security.

3.1 Living Arragements of Elder in OIC Member Countries

The living arrangements of older persons are determined by cultural norms and familial support. In an ageing population, older persons tend to have relatively fewer children and grandchildren. As a result, older persons in ageing societies are less likely to live in multi-generational households and are more likely to live independently with a spouse or alone.

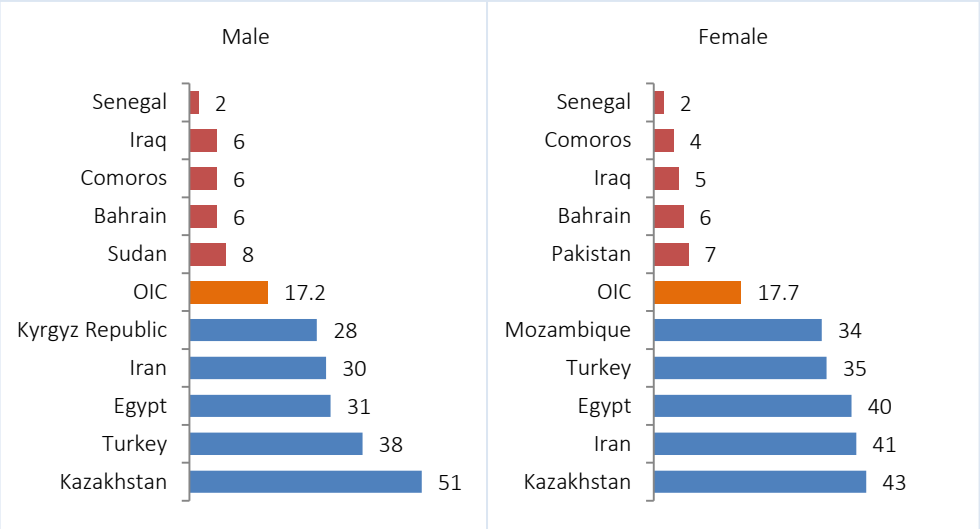
In developed countries where older persons have sufficient economic resources, including pensions and asset income, living independently is a sign of economic self-sufficiency and higher standards of living. On the contrary, this type of living arrangement might be undesired for older persons that have limited sources of revenue or are heavily dependent on their children.

In this context, there are major differences between countries regarding residential arrangements of older persons. While multigenerational co-residence is less common in

developed countries, skipped-generation family, consisting of grandparents and grandchildren, is relatively common in many developing countries. These arrangements emerge as a response to several challenges. Children may stay with grandparents if one or both of the parents have died, if parents have migrated for work, or if divorce makes it difficult for parents to raise their children. Noticeably, older women are more likely to live in a skipped-generation family.

Figure 3.1 shows ten OIC Member Countries with the highest percentage of older men and women living alone in 2012. In Kazakhstan, 51% of elderly men and 43% of elderly women live alone. On the other hand, in Senegal only 2% of elderly men and women live alone.

Figure 3.1: 10 OIC Countries with the Highest and Lowest Proportion Living Independently, 60 years or over, men (left) and women (right) (%), 2012

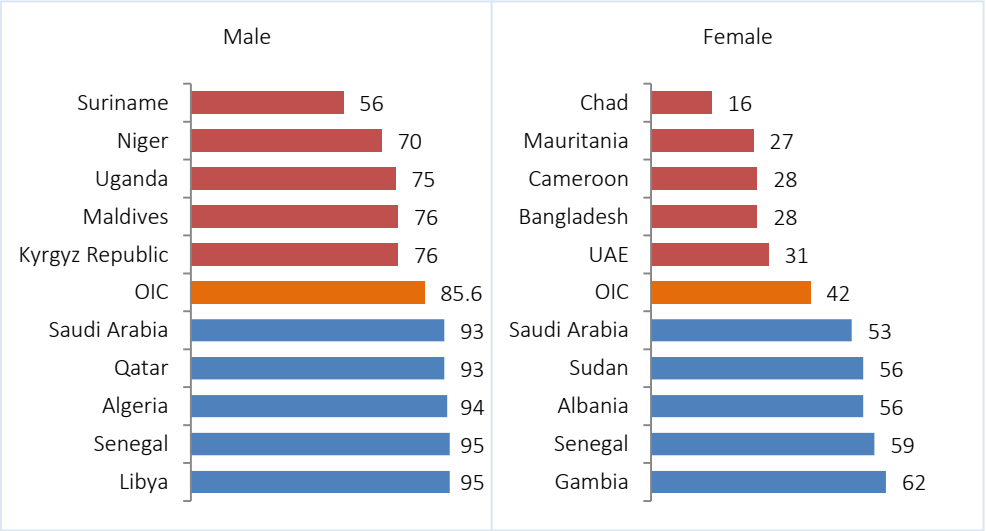


Source: United Nations, DESA. *Note*: In this chapter, the data of persons aged 60 years or over represents the sum of persons aged 60-69 and 70+ data

The marital status also affects many aspects of older persons' well-being. For example, spouses can be primary sources of material, social, and emotional support during times of illness and hardships. Older persons living alone are more likely to be lonely and depressed than those living with a partner. Therefore, living together with a spouse has advantages for an older person.

As shown in Figure 3.2, 56% of older men were married in Suriname in 2012, while 95% were married in Libya making it the highest proportion of married older men in OIC countries. On the other hand, Chad had the lowest percentage of older women currently married at 16% and Gambia had the highest rate at 62%. Overall, with an average of 85.6%, older men are more likely to be married than older women in OIC countries.

Figure 3.2: 10 OIC Countries with the Highest and Lowest Proportion Currently Married, 60 years or over, men (left) and women (right) (%), 2012



Source: United Nations, DESA.

3.2 Health of Elderly in OIC Countries

A leading document on the welfare of elderly, the Madrid International Plan of Action on Ageing (MIPAA), lists advancements in health and well-being into old age as a priority. Older individuals in good health can enjoy a greater sense of well-being and actively participate in economic, social, and cultural and political life. To better understand the causes of mortality for elderly people in OIC countries, the following section highlights the leading causes of death, chronic conditions, and impairments.

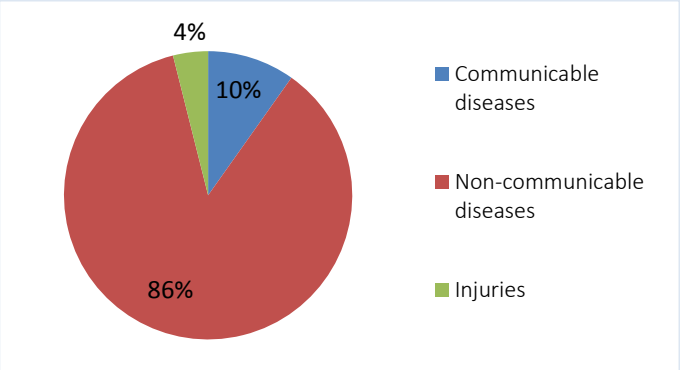
3.2.1 Leading Causes of Death

Mortality rates have declined in the 20th century. Between 1950 and 2015, the chances of surviving to old age improved remarkably in all country groups. In 2015, people who are able to survive beyond the age of 60 can expect to live longer. As mentioned in the previous chapter, the life expectancy at age 60 increased from 16.4 years to 18.8 years between 1990 and 2015. However, it is unclear as to what portion of elderly life (past 60) is spent in good health. Success in controlling communicable diseases has led both to lower mortality rates and a shift in the major causes of death.

In 2015, 10% of elderly deaths were due to communicable diseases, while 86% of deaths were due to non-communicable illnesses such as cardiovascular disease, stroke and cancer, and 4% of deaths were caused by injuries (Figure 3.3). Non-communicable diseases count for a significantly greater proportion of deaths among older people.

In this context, the 20 most frequent causes of death among persons aged 60 years or over are shown in Figure 3.4. Ischaemic heart disease and stroke are the leading causes of death, followed by chronic obstructive pulmonary disease, lower respiratory infections, Alzheimer disease, trachea, bronchus, lung cancers and other circulatory diseases.

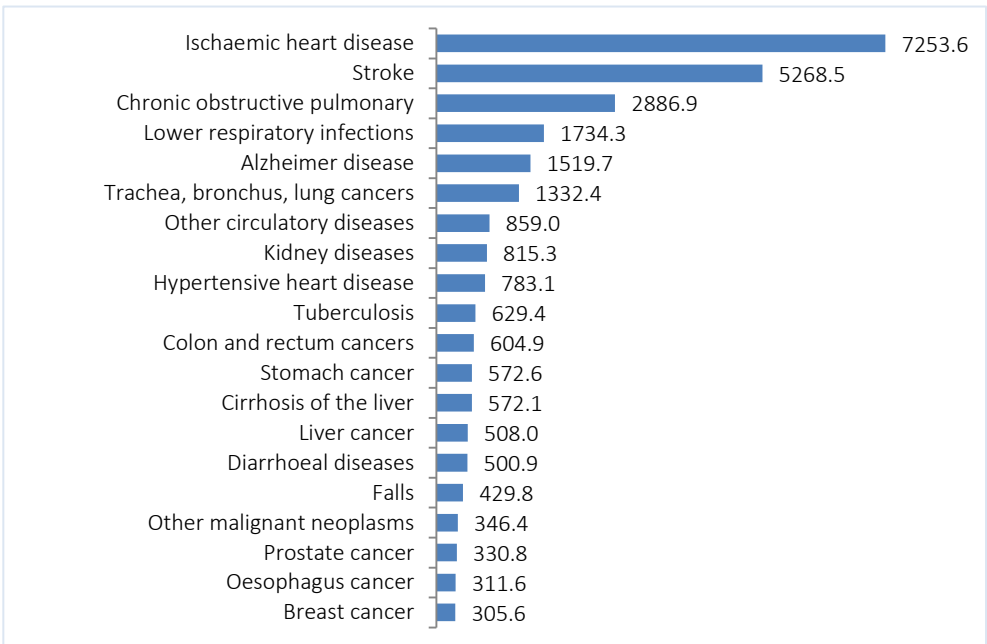
Figure 3.3: Causes of Global Death among persons aged 60 years or over, 2015



Source: Global Health Estimates, WHO.

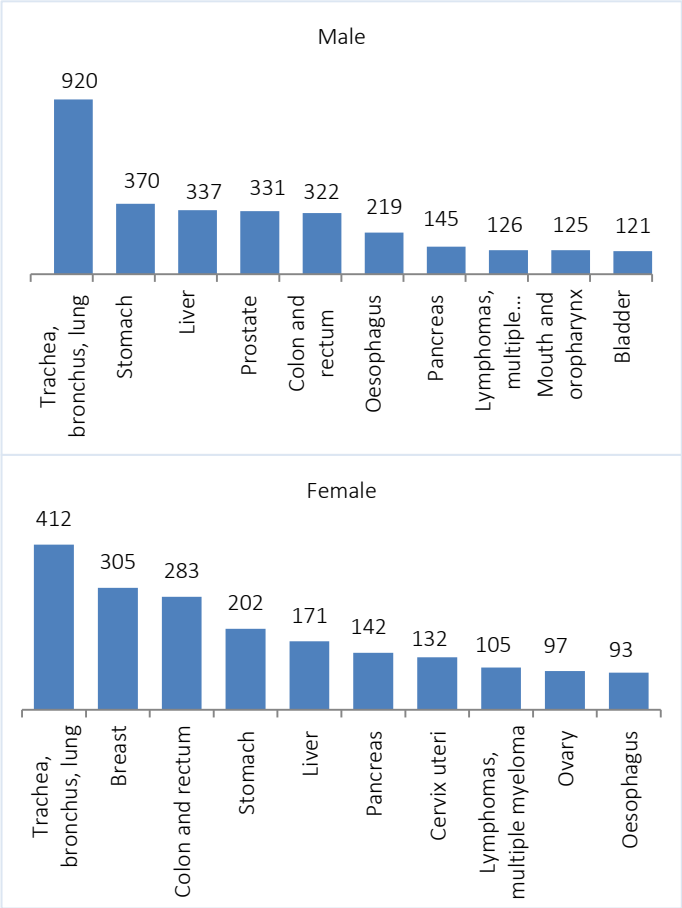
The most commonly seen types of cancers, in terms of numbers of deaths among persons aged 60 years or over in the world, are summarized in Figure 3.5. Globally, trachea, bronchus, lung cancers are the most common cause of death from cancer among both

Figure 3.4: Leading Causes of Global Death among persons aged 60 years or over (millions), 2015



Source: Global Health Estimates, WHO.

Figure 3.5: Cancer Mortality among men and women aged 60 years or over in the World (thousands), 2015



Source: Global Health Estimates, WHO.

men and women. Amongst male populations above 60, stomach cancer, liver cancer, prostate cancer, and colon and rectum cancer are also common (Figure 3.5). While for women, breast cancer, colon and rectum cancer, and stomach, liver and pancreatic cancer represent leading causes of cancer deaths globally (Figure 3.5).

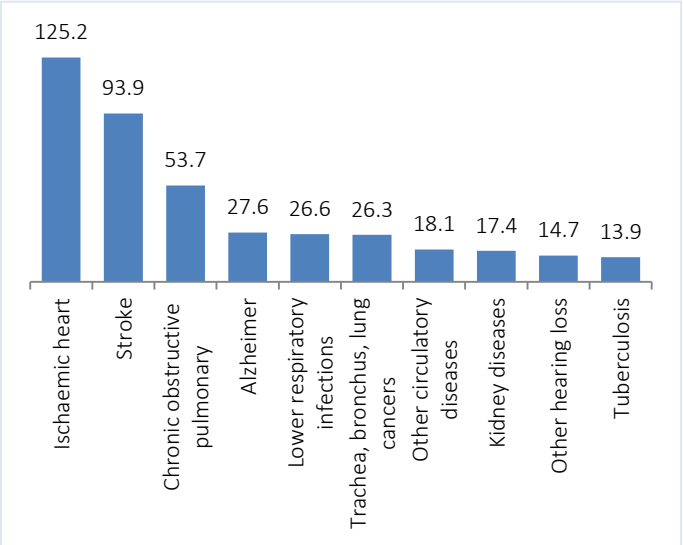
3.2.2 Chronic Conditions and Impairments

The average global prevalence of moderate and severe impairment is about three times higher among persons aged 60 years or over than among those aged 15-59 years. In both developed and developing countries, women's advantage in life expectancy is accompanied by a greater burden of chronic disease and impairment in old age. In other words, women live longer than men but spend a greater proportion of their older years in poor health.

The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death. It was developed in the 1990s as a way of comparing the overall health and life expectancy of different countries.

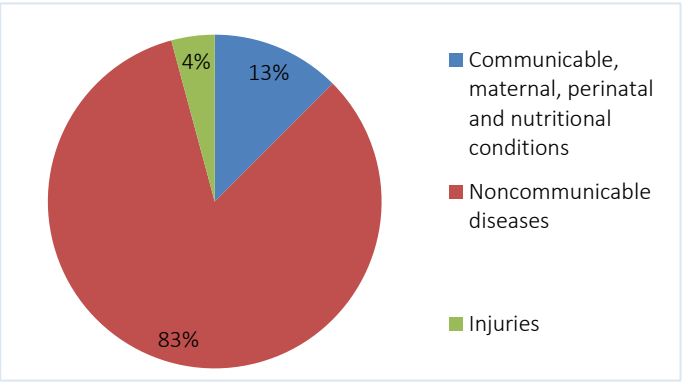
Ischaemic heart disease, stroke and chronic obstructive pulmonary diseases are the most common causes of impairment among persons aged 60 years or over (Figure 3.6). Persistent conditions such as Alzheimer, lower respiratory infections and lung cancers are especially common at higher ages.

Figure 3.6: 10 Leading Causes of Moderate and Severe Disability among persons ages 60 years or over in the World (millions), 2015



Source: Global Health Estimates, WHO.

Figure 3.7: Causes of Moderate and Severe Disability among persons ages 60 years or over in OIC Member Countries, 2015



Source: Global Health Estimates, WHO.

Developing countries tend to have high rates of impairment caused by preventable causes such as injuries. In addition, elderly in these countries often lack access to basic health services such as eyeglasses, cataract surgery, hearing aids or assistive devices that can keep functional limitations from becoming disabling.

In OIC Member Countries, non-communicable diseases represent the leading cause of moderate and severe disability among persons aged 60 years or over (83%), followed by communicable, maternal, perinatal and nutritional conditions (13%), as depicted in Figure 3.7. Furthermore, rising levels of obesity, increased tobacco and alcohol consumption, the emergence of new infectious diseases including HIV/AIDS, and the resurgence of malaria undermine advances in healthcare among older persons.

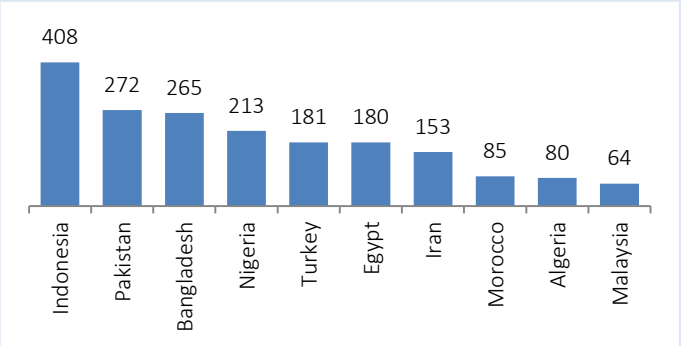
3.3 Mental Health

In developing countries a higher proportion of older people suffer from depression, loneliness, and anxiety. These problems arise with major life changes such as the death

of a spouse or a sudden decline in health. Depression often occurs simultaneously with other disorders such as dementia, heart disease, stroke, diabetes or cancer. Although depression can be treated, the condition is often overlooked among the elderly because of a lack of knowledge among caregivers and health professionals. In developed countries, an estimated 1-3% of people over the age of 65 suffer from severe depression and an additional 10-15% people suffer from milder forms of depression (UN, 2011).

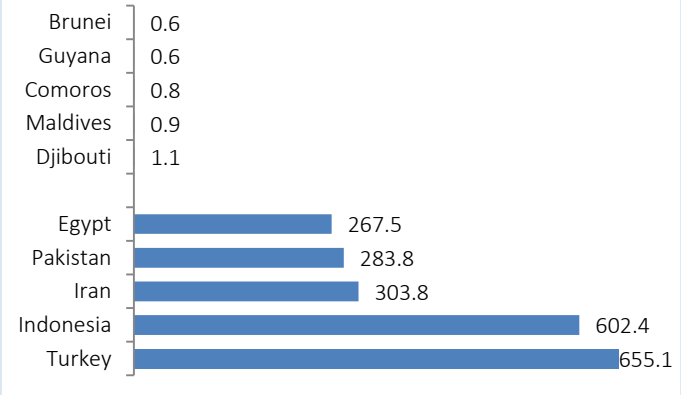
Figure 3.8 shows ten OIC Member Countries with the highest number of mental behaviour disorders among persons aged 60 years or over in 2015. Indonesia has the highest number of mental behaviour disorders (408 thousands elderly people) followed by Pakistan and Bangladesh.

Figure 3.8: 10 OIC Countries with the Highest Number of Mental Behavious Disorders among persons aged 60 years or over (thousands), 2015



Source: Global Health Estimates, WHO.

Figure 3.9: 10 OIC Countries with the Highest and Lowest Number of Alzheimer's Disease and other Dementias (thousands), 2015



Source: Global Health Estimates, WHO.

In 2010, an estimated 36 million people worldwide were living with dementia and the number is projected to double every 20 years (UN, 2011). People with dementia are often specifically excluded from residential care and are sometimes denied admission to hospitals. Turkey, Indonesia, Iran, Pakistan and Egypt have the highest incidence of Alzheimer's disease and other dementias among OIC member countries (Figure 3.9). On the other hand, Brunei Darussalam, Guyana, Comoros, Maldives and Djibouti have the lowest incidence of Alzheimer's disease and other dementias. Based on the available data, the incidence of Alzheimer's disease and other dementias is more

frequently encountered in elderly population ages 70 and above in OIC Member Countries.

3.4 Social Security of Elderly

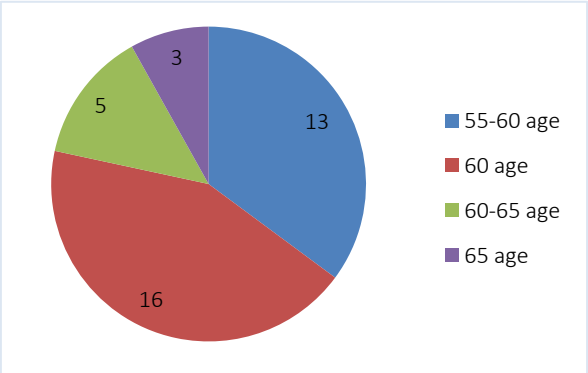
Generally, majority of elderly people are excluded from access to well-paid jobs. For these people, private savings and intra-family transfers are not sufficient to guarantee income security until the end of their lives. Therefore, public social security pensions remain a key element of support for ageing people. In most countries, qualifying for pension benefits requires a minimum period of contributions. Additionally, old age income security is dependent on access to social services such as health care and long-term care. When affordable access to such services is not guaranteed, older people are more vulnerable to poverty. In this regard, the following section looks at the statutory retirement age and social protection for elderly people.

3.4.1 Statutory Retirement Age

Most countries have a statutory retirement age at which employees covered by a system receive a pension and other retirement benefits. The most common statutory retirement age in OIC member countries is 60 years (Figure 3.10).

In OIC, 13 out of 37 countries enforce a retirement age between 55 and 60. In many cases, workers who retire before the retirement age can claim reduced benefits. In the absence of retirement benefits many older people have to work beyond the age of 60.

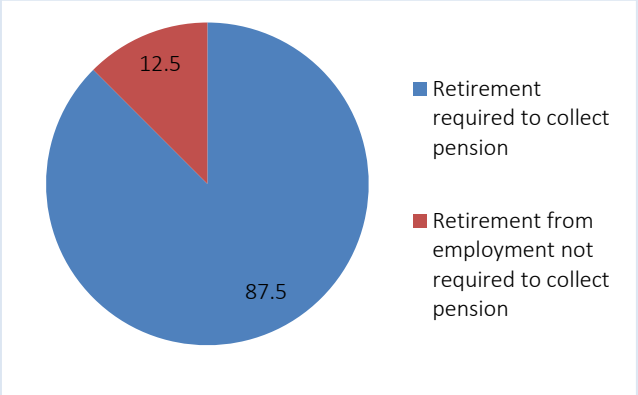
Figure 3.10: Statutory Retirement Ages in OIC Member Counties (number of countries), 2015



Source: ILO.

A closer examination of the requirements in OIC countries reveals that 87.5% of these countries implement mandatory retirement that requires complete withdrawal from all employment as a condition for receiving retirement pension (Figure 3.11). In 2014, OIC countries that enforce this condition include Algeria, Bahrain, Benin, Lebanon, Niger, Turkey and Uzbekistan. On the other hand, 12.5% of OIC countries have a dedicated classified as having a pensionable age that foregoes any obligations to retire from work in order to collect a pension.

Figure 3.11: Retirement in OIC Member Counties (%), 2015

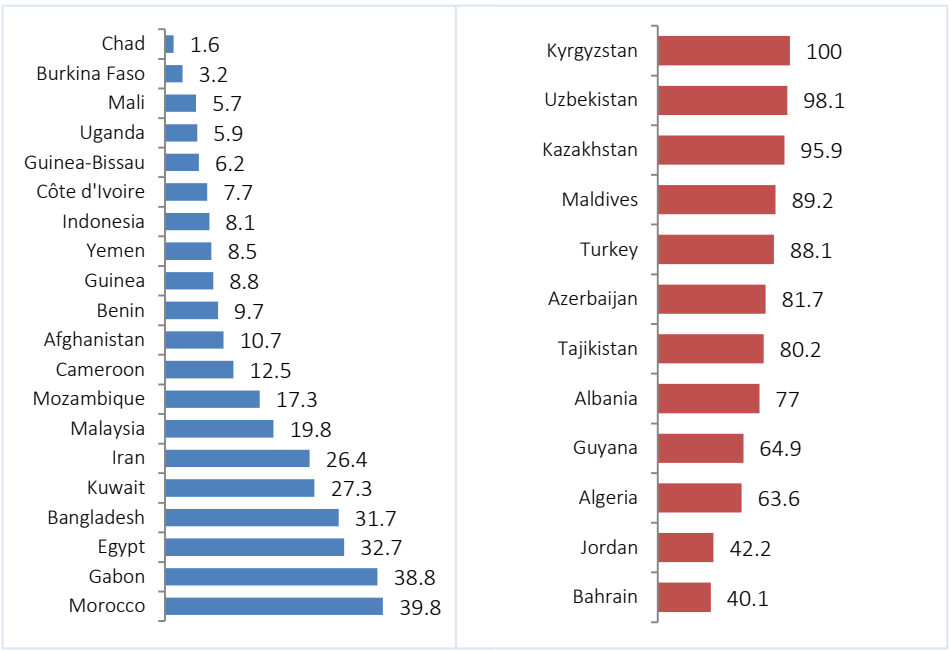


Source: ILO.

At the OIC level, the share of population above statutory retirement age receiving an old age pension by contribution is shown in Figure 3.12. Despite an extension of pension coverage in many countries, significant inequalities persist among country groups.

For example, in OIC countries, less than half of older persons receive an old age pension which can grant them income security. Across OIC countries, the share of populations receiving old age pension is highly unbalanced. Over the period 2008-2012, while only 1.6% of population was receiving an old age pension in Chad, in Kyrgyzstan all people above statutory retirement age benefited from an old age pension. These figures show that access to

Figure 3.12: Highest (right) and Lowest (left) Share of population above statutory retirement age receiving an old age pension by contribution in OIC (%), 2008-2012



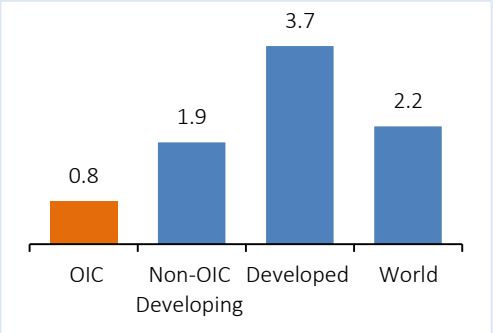
Source: ILO.

income security in old age is closely associated with the conditions surrounding the statutory retirement age, the existing inequalities in the labour market, and employment conditions.

3.4.2 Social Protection

The objective of a social protection system is to assist and elderly people in need through financial and non-financial means. Between 2008 and 2012, only 0.8% of GDP was allocated to public social protection expenditure for older persons in OIC countries (Figures 3.13). In contrast, developed countries spend 3.7% of their GDP on public social protection expenditure for older people giving elderly people a change at comfortable retirement and income security. It is worth mentioning that variations among country groups are influenced by differences in the demographic structure of the population and also by different methods of regulating public and private provision of pensions and social services.

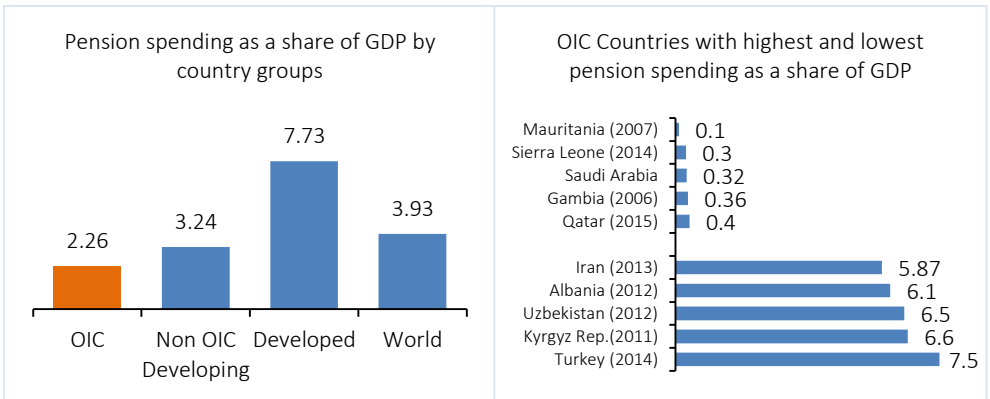
Figure 3.13: Public Social Protection Expenditure on Benefits as a percent of GDP by 65+, 2008-2012



Source: ILO.

Figure 3.14 (left) compares pension spending as a percentage of GDP in different country groups between 2006 and 2016. Pension spending as a share of GDP in OIC countries (2.26%) was significantly lower than other country groups and the world average (3.9%). Developed countries spent 7.7% of their GDP on pension spending, while developing countries spent 3.2% of their GDP on pensions.

Figure 3.14: Pension spending as a share of GDP (%), 2006-2016



Source: World Bank Pensions Database, most recent data since 2006.

As shown in Figure 3.14 (right), Mauritania spends the lowest on pensions as a share of its GDP at 0.1%, while Turkey has the highest spending at 7.5%. It is also important to note that since 2000s, many OIC countries increased their threshold for pension coverage for the elderly people in order to improve their conditions of living. For example, Tunisia improved pension coverage for the self-employed, domestic workers, farmers, fishermen, and other low-income groups in 2002. It also increased the proportion of pension beneficiaries among people aged 60 and over from 33.9% in 2000 to 68.8% in 2006 (UN, 2011).

CHAPTER FOUR

Institutions for the Elderly

In many countries, elderly people are excluded from the formulation and implementation of policies and programmes. An important way to prevent this from happening is to develop institutions and mechanisms that represent elderly people's interests.

In order to bring the issue of ageing to the fore, governments have to recognize the importance of dealing with these challenges using national development policies. Policies aimed at the elderly will impact the future generations advertently. In this context, the following section highlights the issues of social integration and participation of older people, national level policy analysis of older population, human rights, and pension funds for elderly.

4.1 Social Integration and Participation of Older People

The MIPAA highlights the importance of older persons' participation in the decision-making process. It encourages "the establishment of institutions of older persons at all levels to represent older persons in decision-making". When elderly persons have opportunities to contribute to society, they are more likely to participate. Elderly persons have the ability to contribute to communities through economic activities, familial roles such as head of households, caregivers, or even social roles such as volunteers. In turn, active participation in the community can help elderly people combat some of the mental disorders such as depression.

4.1.1 Institutional Arrangements

In most countries, these institutions dealing with the elderly people are located within the ministries of labour, health, and social affairs. Their objective is to provide governments with a coherent response to ageing. These arrangements can also include inter-departmental, inter-agency and inter-ministerial bodies, national focal points on ageing, councils and commissions. However, in some countries, there is no institutional mechanism to manage ageing and address challenges faced by elderly people.

Fortunately, almost all OIC member countries have some form of an institutional arrangement within a Ministry, Department, or Agency to manage ageing (Table 4.1). For instance, in Tunisia, "older persons" are part of the Ministry of Women's Affairs, Family, Children and the Elderly (Office of Elderly Care). This Office of Elderly Care is tasked with developing an inter-departmental strategy to address ageing.

For countries that do not have a specific body on ageing within a Ministry, at least one body usually deals with ageing under the supervision of a Ministry. For example, in Bahrain, Cameroon and Lebanon, the specialised body on ageing is located under the Ministry of Social Affairs.

There are countries such as Indonesia who have set up the National Commissions on Ageing that serves as advisory bodies to governmental institutions. Such commissions help ensure that elderly welfare is being considered while policies are being made. The establishment of such institutions also enables younger populations to view older persons engaged activities that benefit local communities. In other words, this process helps foster intergenerational relations.

Table 4.1: National Institutional Arrangements on Ageing

Country	National Institutions
Afghanistan	Specialized body within the Ministry of Labour, Social Affairs, Martyrs and Disabled (MOLSA)
Albania	Specialised body within several Ministries (Ministry of Labour, Social Affairs and Equal Opportunities, Ministry of Health,Ministry of Education and Science, Ministry of Finance)
Algeria	Specialised body within the Ministry of National Solidarity, Family and Women
Bahrain	Specialised body within several Ministries (Ministry of Health and the Ministry of Social Affairs)
Bangladesh	Specialized body within the Ministry of Social Welfare and National Committee for Older persons
Benin	The Ministry of the Family, Social Affairs, National Solidarity, Handicapped People and Senior Citizens
Brunei Darussalam	Specialised body, Social Issues National Council

Burkina Faso	Specialised body, National Council for Older Persons
Cameroon	Specialised body within the Ministry of Social Affairs, Directorate for Social Protection of Handicapped People and Older People
Côte d'Ivoire	Specialised body within several Ministries (Ministers of State, Social Affairs, Employment and Professional training)
Egypt	Specialized body within the Ministry of Social Solidarity (High Committee on Ageing)
Gabon	National Human Rights Commission and Specialized body within the Ministry of Health
Gambia	Specialized body within the Ministry of Health and Social Welfare
Guyana	Specialised body within the Ministry of Labour, Human Services and Social Security, Social Security and Senior Citizens Welfare Department
Indonesia	Specialised body, National Commission for Older Persons
Iran	Specialized body, National Council of the Elderly and Ministry of Cooperatives and specialized body within the Labour and Social Welfare (MoCLSW) and Ministry of Health and Medical Education (MoHME)
Iraq	Specialized body within the Ministry of Health (Elderly Health Division) and Ministry of Labour and Social Affairs (Department for the Care of People with Special Needs)
Jordan	Specialised body within the Ministry of Social Development, Department of Elderly Health Promotion within the Ministry of Health and National Follow-up Committee on the Implementation of the National Strategy for Senior Citizens in National Council for Family Affairs
Kazakhstan	Specialised body within the Ministry of Labour and Social Protection of Population
Kuwait	Specialized body within the Ministry of Health (National Committee for Elderly Care) and the Ministry of Social Affairs (The Department of Elderly Care of the Social Welfare Department)
Kyrgyzstan	Specialized body within the Ministry of Social Development
Lebanon	Specialized body within the Ministry of Social Affairs (Permanent National Commission for Elderly Affairs and Department of Family Affairs)
Libya	Specialized body within the Ministry of Social Affairs (Department of Social Institutions) and Scientific Committee for Disability and Elderly in National Centre for Disease Control
Malaysia	Specialized body within the Ministry of Women (National Advisory and Consultative Council for the Older Persons and The Department of Social Welfare), Family and Community Development, National Advisory and Consultative Council for the Elderly (NACCE), and specialized body within the Ministry of Health
Maldives	Specialized body within the Ministry of Health and Family (MoHF) (National Social Protection Agency (NSPA))
Mali	Specialized body within the Ministry of Social Development, Solidarity & Elderly People

Mauritania	Specialized body within the Ministry of Social Affairs, Children and Families (Department of Social Action and National Solidarity)
Morocco	Specialized body within the Minister of Family, Solidarity, Equality and Social Development (Office of the Family, Children and the Elderly)
Mozambique	Specialised body within the Ministry of Women Affairs and Social Action, Department of Older Persons
Oman	Specialized body within the Ministry of Health (Elderly Care Section, Primary Healthcare Support Unit) and Ministry of Social Affairs (Department of Elderly Affairs and Committee for Elderly Affairs)
Pakistan	Senior Citizen Welfare Council (Ministry of Rural Development, Ministry of Health and Family Welfare, Ministry of Finance, Ministry of Home Affairs, Ministry of Railways, Ministry of Civil Aviation, Ministry of Law, Justice and Human Rights (Federal), Ministry of Social Welfare (Provincial), Ministry of Population (Provincial), Ministry of Human Rights (Provincial))
Qatar	Specialized body within the Ministry of Interior (Elderly and special needs department) and Ministry of Social Development (Department of Elderly and People with Disabilities)
Saudi Arabia	Specialized body within the Ministry of Social Affairs (Office for the Care of Elderly under the General Administration of Social Care and Guidance) and National Committee for Older Persons within the Ministry of Labour and Social Affairs
Senegal	Specialised body within the Ministry of Social Actions and National Solidarity, Divison of Older Persons
Sierra Leone	Specialized body within the Ministry of Social Welfare, Gender and Children's Affairs
Sudan	Specialized body within the Ministry of Welfare and Social Security (National Committee for the Elderly)
Suriname	Specialized body within the Ministry of Social Affairs and Housing and the Ministry of Health
Palestine	Specialized body within the Ministry of Social Affairs (Department for Elderly Care) and National Committee for Older Persons
Togo	Ministry of Social, Women Affairs, Protection of Children and Old People
Tunisia	Ministry of Women's Affairs, Family, Children and the Elderly (Office of Elderly Care)
Turkey	Specialised body within the Ministry of Family and Social Policies
Uganda	Specialised body within the Ministry of Gender, Labour and Social Development, Department for Persons with Disabilities and Older People
United Arab Emirates	Specialized body within the Ministry of Community Development
Uzbekistan	Specialized body within several Ministries (Ministry of Health, Ministry of Labour)

Source: Multiple National sources collected by SESRIC Staff

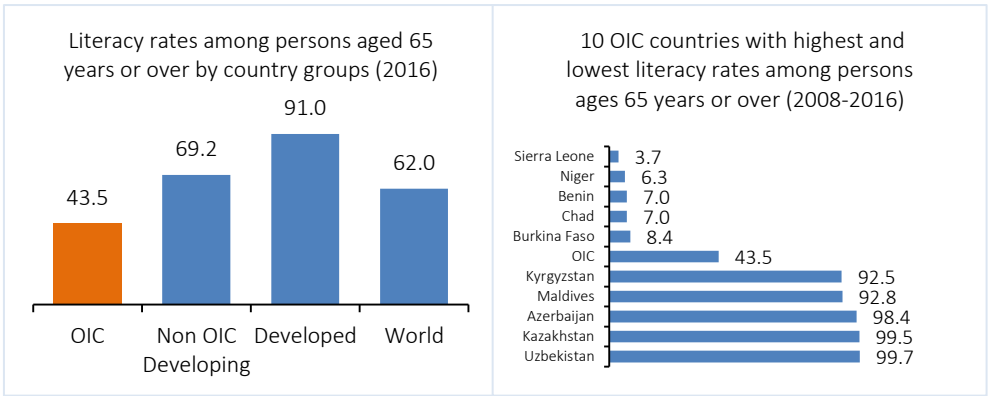
4.1.2 Literacy and Education

Education and literacy play a key role in social integration and participation of elderly people. Although global levels of education and literacy have risen significantly over the past century, they tend to be lower for older persons than for younger people.

As shown in Figure 4.1 (left), the rate of literacy among the older population vary widely among country groups. Over the period 2008-2016, developed countries have the highest literacy rates among persons aged 65 years or over (91%), followed by non-OIC developing countries with 69.2%. On the other hand, OIC countries, as a group, have the lowest rate of literacy among older people with only 43.5% of elderly populations being literate.

At the OIC country level (Figure 4.1, right), the highest rate of literacy among older people was observed in Uzbekistan (99.7%), followed by Kazakhstan (99.5%). On the other side of spectrum, Sierra Leone had the lowest rate of literacy among older population with only 3.7% followed by Niger (6.3%).

Figure 4.1: Literacy Rates among persons aged 65 years or over (%), 2008-2016



Source: UNESCO

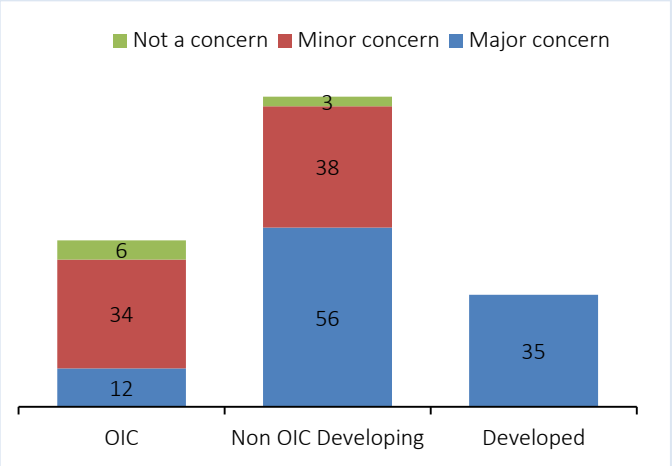
It is worth mentioning that older persons residing in rural areas are more likely to be illiterate than other parts of the population. People in rural areas are not able to attend school due to economic and cultural barriers. The illiteracy rate tend to be higher among older women because "they were not exposed to educational opportunities at a time when tradition was more in control of their lives, denying them the right to education" (UN, 2013b).

An illiterate person is more likely to find a low-wage job which fails to provide social security and health care benefits at a later age. Additionally, the lack of appropriate health care and retirement income increases the possibility of a person suffering from ill health and poverty during old age. Education and literacy are also important for empowering older persons to ensure that they are knowledgeable of their rights and benefits.

4.2 National Level Policy Analysis of Older People

Since 2002, some OIC countries have introduced policies or strategies that allow ageing concerns to be translated into existing and new laws, policies, and programmes. Most of these policies and programmes reflect the level of social protection and well-being offered to elderly people. Traditionally, developed countries offer better social support schemes and institutions for elderly as compared to developing countries. In this regard, the following sections highlight the level of governments concern about the ageing people, the size of the working-age population, and the measures adopted to address population ageing.

Figure 4.2: Levels of Concern about Ageing of the Population (number of countries), 2015



Source: Population Policies Dataset, UN DESA Population Division

4.2.1 Levels of Concern about Ageing of the Population

Level of concern about ageing of the population indicates the government's level of concern about the growing proportion of older persons and its consequences for health and social welfare provisions.

In 2015, the majority of OIC member countries considered the growing proportion of older persons in the population a minor concern. Only 12 out of 52 OIC countries with data available considered the growing proportion of older persons and its consequences for health and social welfare provisions as a major concern. Six OIC countries, namely Cameroon, Djibouti, Egypt, Niger, Oman and Yemen indicated that they do not have any concern about the ageing population or the challenges that growing size of ageing will bring in the future in the UN DESA Survey conducted in 2015.

Contrarily, population ageing has been a major concern for all developed countries over the same period. In 2015, 35 developed countries considered the issue as a major concern. On the other hand, a higher proportion of non-OIC developing countries consider population ageing as a major issue. In 2015, governments of 56 non-OIC developing countries accepted growing size of elderly people in the population and related consequences as a major challenge, 34 as a minor challenge, and 3 of them were not concerned about it at all.

4.2.2 Levels of Concern about the Size of the Working Age Population

Change in the share of working-age population (ages 15 to 64) can impact the country's economy and welfare of elderly. As compared to other population groups, a smaller working-age population affects the economic outcome of a country. Smaller proportion of working-age population also impact welfare of elderly persons because pensions, social security, etc. are all dependent on the income of working-age populations. For example, 45 OIC countries implement defined-benefit schemes where the pensions come from contributions of workers. Therefore, a decline in the share of working-age population has the potential to negatively influence elderly well-being programs including pensions (Figure 4.6).

Factors such as age limit, health issues, lack of awareness concerning newer technologies, discriminatory behaviour, etc. are responsible for the decline in elderly participation in the labour force. While the working-age population shrinks, employing elderly populations can be effective for their welfare and the economy.

Based on the Population Policies Datasets, UN DESA, the level of concern about the size of the working-age population indicates government's level of concern regarding the current size of the working-age population in relation to the domestic labour market or in relation to the size of the dependent populations.

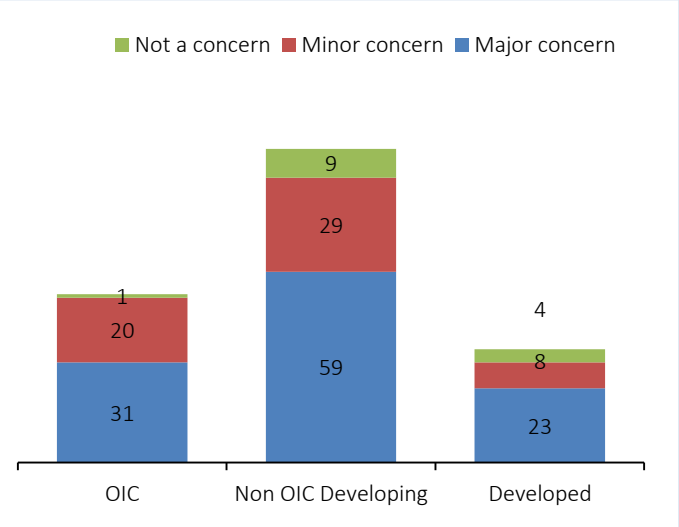
As shown in Figure 4.3, the level of concern about the size of working-age population significantly varies across developed, non-OIC developing, and OIC countries. In 2011, 59 non-OIC developing countries considered the size of the working-age population a major concern compared to 31 OIC countries, and 23 developed countries. Meanwhile, 20 OIC countries indicated that the size of working-age population as a minor concern in 2011. The country groups that had a higher share of older populations are naturally more concerned about the size of their working-age populations.

4.2.3 Measures Adopted to Address Population Ageing

In most countries, measures and policies adopted to address population ageing depend on economic determinants and government strategies. For example, if the share of working-age population is higher than older population, it would make sense to decrease the statutory retirement age to maintain a higher employment rate. In this case, decreasing statutory retirement age will translate into an increase in pension spending. On the other hand, early retirement is not a viable option for elderly when social support schemes are not as comprehensive as employment benefits. To counter such situations, governments need to implement schemes that are conducive to the welfare of elder persons.

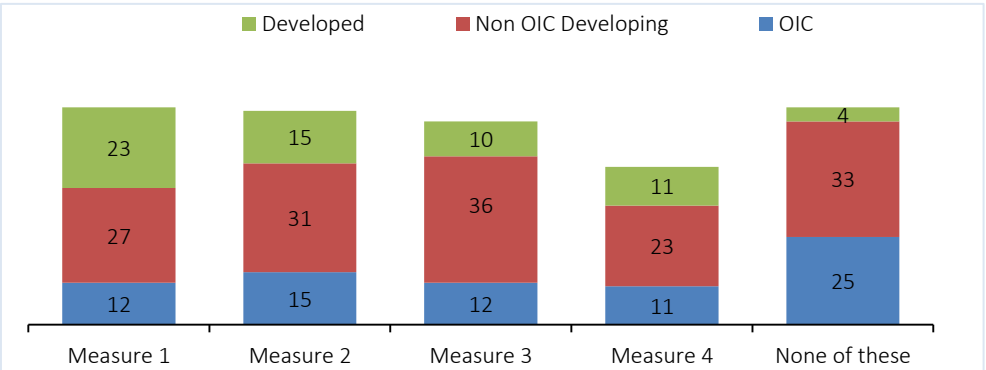
Figure 4.4 shows popular measures adopted by countries between 2008 and 2015 to address population ageing in the country. These measures include increasing the minimum retirement age, raising social security contributions of workers, introducing non-contributory old-age pensions and promoting private savings schemes for retirement.

Figure 4.3: Levels of Concern about the Size of Working-Age Population (number of countries), 2011



Source: Population Policies Dataset, UN DESA Population Division

Figure 4.4: Measures Adopted to Address Population Ageing (number of countries), 2015



Measure 1: Raised the minimum retirement age
Measure 2: Raised social security contributions of workers
Measure 3: Introduced or enhanced non-contributory old-age pensions
Measure 4: Promoted private savings schemes for retirement

Source: Population Policies Dataset, UN DESA Population Division
Note: One country can adopt and implement more than one measure in the same year.

In 2015, 25 OIC countries did not adopt any of the four measures to address population ageing. The remaining OIC countries adopted one or more than one measure to address population ageing. Among OIC countries, the most widely adopted measure was to increase social security contributions of workers. 12 OIC countries raised the minimum retirement age. The third measure, introducing non-contributory old-age was also

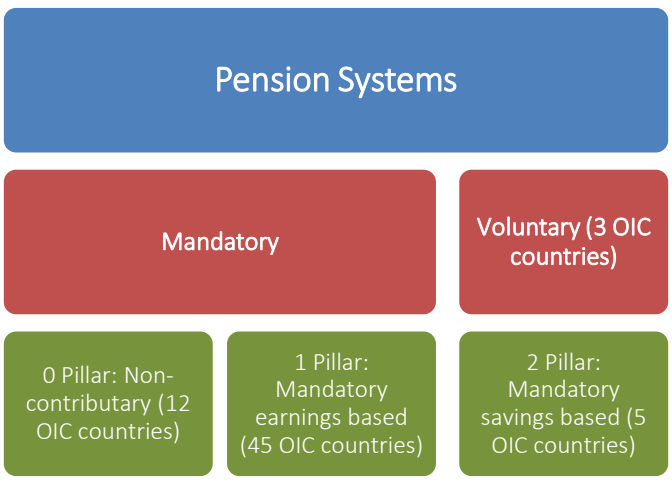
adopted by 12 OIC countries. Lastly, 11 OIC countries decided to promote private savings schemes for retirement in 2015. Among non-OIC developing countries, the most common measure adopted was to introducing non-contributory old-age pensions. In developed countries group, 23 countries chose to increase the minimum retirement age which is line with an increased life expectancy in these countries.

4.3 Pension Funds for Elderly

Pensions have become important institutional solutions to guarantee income security in old age. Pension savings are mandatory for all participants of the labour force and deducted from the employee's earnings. The World Bank classifies mandatory pension systems under 3 pillars: zero pillar, pillar 1 and pillar 2 (Figure 4.5). As shown in Figure 4.5, 12 of 48 OIC countries with the data available use a combination of multiple pillars at the same time such as pillar 1 and pillar 2. Only Kazakhstan, Kyrgyzstan, and Tajikistan implement voluntary pension scheme in addition to the mandatory schemes, as shown in table 4.2.

According to the World Bank, zero-pillar is also called the social pension system and includes pensions that are allocated to reduce poverty among elderly people. This scheme has a flat rate and aims to target elderly populations with the lowest old-age incomes. Beneficiaries of this scheme are elderly people that do not qualify for the pillar 1 and pillar 2 schemes. 12 OIC member countries introduced this system in addition to the pillar 1 and/or pillar 2, except Bangladesh that uses only pillar 0 (Figure 4.5).

Figure 4.5: Pension Systems Design in OIC Countries (number of countries)



Source: World Bank Pensions Database. *Note:* Data are available for 48 OIC member countries of which 12 OIC member countries use multiple pillar pension systems. See Table 4.2.

Majority of mandatory pension systems in the world (around 80%) can be categorized as Pillar 1 schemes. Among OIC countries, 45 out of 48 countries use the pillar 1 pension scheme as a primary method for generating pensions (Figure 4.5). In this system, governments allocate pensions to all citizens and the amount of

pension an individual receives depends on their own contribution during the employment period. Elderly people who reach certain ages (60 for women and 65 for men) and have worked a certain number of years (25-35) are eligible to receive pensions under the Pillar 1 pension scheme.

The Pillar 2 pension scheme is where individuals pay a part of their earnings as savings to privately managed financial institutions. The fund manager can invest collective savings within the bounds of regulation and legislation. In order to protect citizens from risky investments, regulators strictly monitor pension funds in order to limit the size of investments. Five OIC countries, namely Kazakhstan, Kyrgyzstan, Tajikistan, Maldives and Niger implement the second pillar but these countries use it in combination with pillar zero and/or pillar 1.

As shown in Table 4.2, a total of 12 OIC member countries adopted multiple pillar pension systems. As mentioned above, only Kazakhstan and Kyrgyzstan use all three pillars (Table 4.2).

Table 4.2: OIC Member Countries that adopted Multiple Pillar Pension System, 2007-2012

№	Countries	Pillar 1	Pillar 0	Pillar 2	Voluntary
1	Albania	✓	✓		
2	Azerbaijan	✓	✓		
3	Brunei Darussalam	✓	✓		
4	Egypt	✓	✓		
5	Kazakhstan	✓	✓	✓	✓
6	Kyrgyzstan	✓	✓	✓	✓
7	Malaysia	✓	✓		
8	Maldives		✓	✓	
9	Nigeria		in two states	✓	
10	Tajikistan	✓		✓	✓
11	Turkmenistan	✓	✓		
12	Uzbekistan	✓	✓		

Source: World Bank Pensions Database. *Note:* For more information see, Annex II

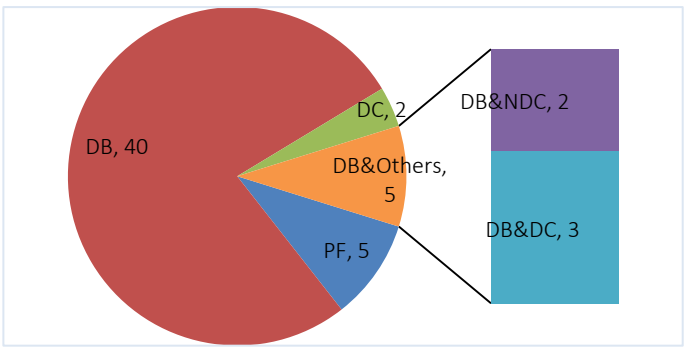
Pension systems can also be classified into different groups based on management type and financing mechanism. Generally, public institutions manage pension systems however, since early 2000s the market share of private pension funds has increased significantly. According to the World Bank, 82% of pension funds worldwide are publicly managed and 18% are privately managed.

According to the World Bank classification, the pillar 1 pension system is a mandatory publicly managed scheme. Based on the financing mechanism, defined-benefit schemes (DB) adopt a special formula, different points, or rating mechanisms that help determine an individual's pension based on their employment history. Notional defined-contribution schemes (NDC) benefit individuals depending on the amount of contributions made and notional interest rate which correspond to the average wage growth. Through Provident Funds/Publicly managed defined-contribution schemes (PF), benefits depend on the amount of contributions and the investment returns that individuals earn. Pillar 2 refers to the mandatory privately managed schemes that exist in two forms such as defined benefit (DB) or defined contribution (DC) which are fully funded. Lastly, as mentioned above, a zero pillar does not depend on individual contributions and earnings, thus it has no financing mechanism and pensions are allocated through flat rate estimations of an individual's incomes and needs.

45 OIC countries implement a DB scheme. Out of those, five countries use it in combination with NDC or DC schemes (Figure 4.6). The DB pension schemes are unfunded which means that the pensions are paid from the contributions of workers. According to Pallares-Miralles et al. (2012), 48% of total pensions worldwide are unfunded.

Only two OIC countries implement an exclusively DC scheme and three countries in combination with a DB scheme (Figure 4.6). A DC scheme can be fully funded which means that pensions are paid from the individual's contributions through their employment history. At the global level 27% of pension schemes are fully funded. A DC scheme can be partially funded which signifies that one part is paid by the government and the other part is collected from an individual earnings during an active employment period. 25% of total pension schemes worldwide are partially funded (Pallares-Miralles et al., 2012).

Figure 4.6: Pension Schemes in OIC Member Countries (number of countries)



Source: World Bank Pensions Database. *Note*: For more information see Annex II

4.4 Human Rights of Older People

International human rights treaties apply to older persons in the same way they apply to other segments of society. The primary international instrument protecting the rights of older persons in the UNGA Resolution 67/139, adopted in

December 2012, titled: 'Towards a comprehensive and integral international legal instrument to promote and to protect the rights and dignity of older persons' under the Open-Ended Working Group on Ageing (OEWGA). A formal convention has yet to result to be proposed and ratified by the General Assembly.

In addition to Resolution 67/139, two international human rights instruments contain explicit references to old age. First, Article 7 of the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families includes "age" in the list of prohibited grounds for discrimination. Second, the Convention on the Rights of Persons with Disabilities includes references to age in articles 8, 13 and 25 on the right to health, as well as in article 28 on the right to an adequate standard of living and social protection. Article 25 of the Convention requires that health services should be "designed to minimize and prevent further disabilities, including among older persons".

The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights include relevant provisions concerning the protection of human rights of older persons including the right of all individuals to good health, an adequate standard of living, and freedom from torture, their legal capacity, and equality before the law.

The International Covenant on Economic, Social and Cultural Rights recommends that health policies should take into account the needs of the elderly, "ranging from prevention and rehabilitation to the care of the terminally ill", and has highlighted the importance of "periodical check-ups for both sexes, physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons, and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity".

The Convention on the Elimination of All Forms of Discrimination against Women and the International Convention on the Elimination of All Forms of Racial Discrimination also contain provisions which promote and protect the human rights of older persons. Human rights mechanisms have identified older men and women as being particularly vulnerable to human rights violations and requiring specific measures of protection. For example, the risks to which older persons are exposed are explicitly recognized in article 16 of the Convention on the Rights of Persons with Disabilities. WHO (2008) estimates that 4-6% of older persons suffer some form of abuse at home and in their community which is a violation of their rights.

On the other hand, the OIC Charter contains specific provisions for the promotion and protection of human rights and fundamental freedoms including the rights of women, children, youth, elderly and people with special needs as well as the preservation of Islamic family values (Chapter I, Article 1.14).

CHAPTER FIVE

Cultural Dimensions of Ageing

It is widely recognized that the "medical approach" that merely sees age as a matter of medical intelligence limits our understanding of ageing, in turn our capacity and effectiveness in producing policies (Reid-Cunningham, 2009). This realization has led to a shift to the 'sociocultural model'. The sociocultural model recognizes that age is defined by the cultural and societal norms about body, personhood, and community (Al-Aoufi, Al-Zyoud & Shahminan, 2012; Ingstad & Whyte, 1999) and, as such, suggests a wider approach that places ageing fully in the dynamic interplay of social structures and embodied human agency (Yuill, Crinson & Duncan, 2010). This wider approach also brings into attention the interplay between existing inequalities and ageing, thereby highlighting the responsibility on society and governments to remove political, legal, social, and physical barriers that inhibit quality of life for elderly people.

Following the social model, this section recognizes that the surrounding social environment shapes and informs:

- How people define, interpret, and conceive of health related matters, from ageing and elderly;
- The kind of strategies individuals and communities develop in dealing with elderly; and
- Political attitudes and policies regarding health, and allocation of resources to ageing and associated matters.

The cultural nature of ageing is another key issue. Although the social model highlights the societal aspects of age, the notions of ageing is still dominated by a Western-centric approach (Hasnain, Shaikh & Shanawani, 2008; Colerigde, 2009; Bywaters et al., 2003). While ageing is biological, what is considered young and old, and the attitudes towards,

both positive and negative, culturally defined and shaped (Löckenhoff et al., 2009). Such differences should be taken into account in developing state policies such as shaping the health care system.

The following definition of culture needs to be highlighted: "…the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them" (Lederach, 1995, p. 9). It is important to improve understanding on the cultural dimension of ageing that there is a gap between policies and what is actually practiced in everyday life either by families, caregivers, or healthcare professionals. The gap is in part due to the lack of serious understanding of cultural attitudes and beliefs, which may at times undermine or conflict with policies. For policies to be accepted and internalized by individuals, cultural values and value change must be taken into account.

5.1 Cultural Dynamics and Elderly in OIC Countries

People living in OIC societies are diverse in many ways. Nevertheless, there are commonalities as well such as a communitarian culture, where the needs and interests of community are given higher moral value over mere self-interest and atomistic-individualism. In regards to family, this cultural environment honours close intergenerational relations and support. In specific regards to elderly, this family structure allots a special place for seniors in the community, venerating affection towards the elderly and emphasizing their prominent role in re-affirming traditional identities (Kronfol, Sibai & Rizk, 2013). In the family hierarchy, elderly are praised for their wisdom and life experiences (Kronfol, Sibai & Rizk, 2013), and children are usually obligated to serve and provide care and financial support to parents and grandparents (Hoodfar, 1997; Sibai & Yamout, 2012; Yount & Rashad, 2008).

Indeed, for the family-centred OIC societies, it is often considered shameful to send an elderly parent to a nursing home, because it would violate the general social and religious feelings of commitment towards family and community (Elsaman & Arafa, 2012). Co-residence, as such, has been one of the key means by which families fulfil the support due to their older relatives keeping the number of institutionalized older adults low in most OIC countries (Khadr, 1997).

This cultural setting is further enforced and affirmed by Islamic teachings. The two foundational sources of Islamic law—the Qur'an and the Sunnah—contain principles and precepts that create family obligations to afford physical, mental, and emotional comfort and security to the elderly (Elsaman & Arafa, 2012). Islam's positive attitudes towards the elderly are not limited to the confines of the nuclear family; in fact, "the provision of financial and emotional support for the elderly is one reason why Islam extends close familial relationships beyond the nuclear family" (Kronfol, Sibai & Rizk,

2013). In addition, Islam also mandates that states and societies provide social insurance and security practices for the elderly, and for the disadvantaged, as exemplified by the historical practice of Waqf and the moral obligation of Zakah (Kronfol, Sibai & Rizk, 2013).

Overall and so far, in OIC countries, concerning elderly population trends and the prevalence of a family-based culture together have led informal family care and intergenerational support system to function as the main channel for accommodation of elderly needs; as such, taking over the state's social policy responsibilities to a great extent.

However, emerging population and cultural trends since the 2000s have been signalling the coming of drastic changes that will indeed continue in an intensifying way. To begin with, the demographic profile of OIC countries will shift generating new and larger needs for the elderly care. These are considerable changes in themselves. Yet, even more, this demographic shift interacts with equally significant and major socio-economic and socio-political changes (Hussein & Ismail, 2016). Together, these transformations are expected to threaten traditional family structure, the viability of long-term informal care in the family unit, and close intergenerational familial relations (Hussein & Ismail, 2016), calling the OIC countries to respond to the newly moulding conditions such as through implementation of wider and deeper social protection programmes.

5.2 Emerging Challenges: Demographic and Cultural Changes

Emerging demographic conditions tend to interact with various other transformations at the cultural front. An increasingly older population expected to live longer, and social changes that pose threats to the traditional familial relations may hinder family-based care to a great extent.

To begin with, rapid modernization and urbanization have set a new economic environment marked by higher inflation, inequality, and unemployment, and increased cost of living, eroding traditional family structure and economic support system. In the modern urban context, families are already income-constrained and caring for one's parents can be quite costly depleting family savings, especially given the lack of social insurance systems and supplemental funds for supporting home care in most OIC countries (Sibai, Tohme & Yount, 2012). This economic strain is already evident in the declining rates of co-residence of three generations or more in most OIC countries (Sibai, Tohme & Yount, 2012).

Urbanization and modernization have altered social structure and norms beyond economic difficulties by bringing with them new lifestyles that are oriented towards the individual and individuality, challenging the plausibility of family-centred values.

Another upcoming challenge to family care and traditional family values is associated with declining fertility rates and an increase in women's participation in the labour force. Traditionally, in family-based OIC societies, females are usually portrayed and expected to be the main source of care (Hussein & Ismail, 2016). The ongoing demographic changes, however, will heighten the pressure on women's well-being, time and energy through a combination of competing demands (Hussein & Ismail, 2016). On the other hand, these shifts will likely reduce the availability of female caregivers for management of needs of elderly relatives (Hussein & Manthorpe, 2005; Hussein & Manthorpe, 2007).

The increased life expectancy of the elderly brings with it new challenges too. Many informal caregivers are not qualified for the type of care associated with ageing. With longer years of dependent elderly life and with rates of non-communicable diseases (NCDs) increasing at an alarming rate and exceeding at times those of developed countries (report), the informal care provided by family members will be less effective intensifying risks associated with elderly health, and will require expanded support and training (Hussein & Ismail, 2016).

These upcoming demographic changes, overall, signal that past practices will no longer be sustainable even for the near future. Although OIC states were somewhat able to rely on informal care through limited reform and support until now, rapid demographic shifts accompanied by cultural transformations have already started to call for serious adjustments for public welfare and policy or strategies that would address emerging shifts (Sibai & Yamout, 2012; Yount, 2005).

5.3 Addressing Emerging Challenges

5.3.1 Integrated Health Care System and Home-based Care

One of the most immediate concerns is to strive for an integrated health care system. Integration of elderly health care, on the one hand, requires establishment of sustainable formal long-term care provisions and multiplying care channels, from private and primary care to specialized and palliative care in hospitals and nursing homes. On the other hand, an integrated health care system requires active facilitation of and systematic support to informal caregivers (Sinunu et al., 2009). In other words, formal and informal care should not be considered as alternatives to one another, but as complimentary aspects of a thorough and effective elderly care. Integration indeed refers to a 'hand-in-hand' approach between all care providers, creating a mixed workforce operating with varying intensity, carrying out complimentary roles, and sharing care service towards the provision long-term care.

Such a mixed model would allow policymakers to move beyond over-reliance to informal family-based care while, however, still being able to capitalize on the role of the

family in the care of older relatives and embrace the informal care givers as a resource of care. The existing shared cultural codes in OIC countries provide member states with a unique social capital that would allow policymakers to build an effective integrated model.

One key channel to make intergenerational support and family solidarity sustainable is to foster regulated and well-organized home-based care services; support for such a system may include financial incentives, training, home based palliative care, and family welfare programs. The availability of formal care within the home environment or the community needs to be considered by almost all OIC countries (Hussein & Ismail, 2016).

5.3.2 Women and Gender in Elderly Care

Policymakers should also address the increasing burden women shoulder in the elderly care given traditional gender codes that expects women to be the main caregiver. Mixed model that combines formal and informal care would help ameliorate the competing demands on women should be introduced.

5.3.3 Services and Medical Know-How

The increase in the older persons in OIC countries and the concomitant rise in chronic degenerative diseases make gerontological education an urgent need. In facing the changing circumstances, member-states should give attention to education and training of professionals, mainly physicians and nurses, at the primary, secondary and tertiary levels of health services (Sibai, Tohme & Yount, 2012). It is imperative that these training initiatives include clinical practice, with priority given to the creation of multidisciplinary teams both at the cancer centres and for home-based services (Hajjar et al., 2013) More broadly, a geriatric approach should be mainstreamed in to economic, social, and health development in OIC countries generally.

5.3.4 Adapting a Life Course Perspective

Health in old age reflects the living circumstances and actions during the whole life span. Thereby, a core message in promoting health and well-being in old age is adopting a life-course perspective for prevention and control, embracing the framework of 'active ageing' while investing in health promotion, disease prevention and early screening.

5.3.5 Positive Values and Active Ageing

Although both cultural and religious teachings in OIC countries inform an ageing friendly culture, under the pressure of recent demographic and cultural changes, negative images of older people has begun to prevail; such as, connotation of ageing with physical, and mental health declines and decrease in financial resources and loss of autonomy. Such negative stereotyping occurs both at the personal and institutional level. One way to combat negative images is to promote elderly public participation, in

economy, social life, and political arena. To promote active participation throughout society, member states may consider micro credits and loans to establish small projects as well as voluntary and primary work opportunities in NGOs and in political formations. Promotion of positive images is not just a moral exercise; on the contrary, the more positive the society's attitude, the more likely that policymakers vote in favour of resources for older persons (UNFPA & HAI, 2012). NGOs can also help to fight against emerging negative stereotypes regarding the elderly.

To summarize, ageing of population coupled with changing cultural social and economic conditions, maintaining health autonomy and social integration of the elderly will become increasingly challenging for the OIC countries. This challenge mandates the states to adopt a new model and approach to ageing and the elderly. Of primary and immediate concern is the establishment of integrated health care system where capacities of the state are combined with unique social capital of OIC societies.

In addition to coordinated health care systems, broader measures should include stronger pension and insurance systems, enacting new laws and regulations addressing emerging needs of the elderly, building geriatric knowhow and philosophy in medical and health care services, promoting of a life course perspective in health, and facilitating public participation of the elderly.

CHAPTER SIX

Concluding Remarks and Policy Recommendations

This report looked at the state of elderly in OIC member countries through focusing on a set of dimensions including demographics, social and economic wellbeing, institutions for the elderly and cultural dimension of ageing.

The change in ageing trends in OIC countries sheds light on issues that can be of importance to policy-makers. For instance, since 2010, population ageing in OIC countries has accelerated and by 2030, the share of older population is estimated to reach 9.6% of the total population. On the other hand, declining fertility rates over the last few decades and increased life expectancy at 60 are expected to bring further socio-economic challenges such as by increasing old-age dependency ratios and decreasing the labour force participation. Such changes in the age structure of the population also impact the social relations and culture to a large extent. To respond to these challenges, OIC countries need to take policy actions that are timely and efficient.

Changes in the social and economic status of older persons in OIC countries are heterogeneous and complex. For instance, as compared with older women, older men are more likely to be married but women tend to live longer and are often widowed. Older persons in developing countries including OIC countries are more likely to live in multigenerational households as opposed to older persons in developed countries that tend to live independently with a spouse or alone.

In terms of health status of elderly people, non-communicable diseases are responsible for a greater proportion of deaths among older people in OIC member countries. Ischaemic heart disease, stroke and chronic obstructive pulmonary diseases are the most

common causes of impairment among persons aged 60 years or over. Nevertheless, the health status of older persons across OIC countries varies greatly.

In terms of labour market arrangements, ageist stereotypes and high levels of unemployment continue to undermine older persons' access to the labour market. In OIC member countries, the statutory retirement age is often 60 years; however, only less than half of retired persons receive adequate old age pension.

Older persons in OIC countries face a number of major socio-economic challenges. As a group, OIC countries have the lowest rates of literacy amongst elder persons. Low levels of literacy and educational attainment hinder the optimum participation of older persons into workforce as well as into the development efforts of their societies. Furthermore, majority of OIC member countries consider growing sizes of older persons as a minor concern. In order to make ageing an important policy item, changing this perception towards ageing is critical.

Generally, the pension systems in the OIC countries are dependent on an individual's mandatory earnings. Only few OIC countries have developed strategies to move from state sponsored pension institutions to privately managed pension funds.

Population ageing presents challenges for governments and society. It also has implications on a society's cultural values and norms. Given the changing demographics in OIC countries, traditional roles of families and children pose newer challenges to elderly care in societies.

Ageing population is a phenomenon that can be predicted, which enables governments to understand the implications of this phenomenon and institute policies well in advance. The following considerations provide guidelines for policies and specific actions concerning elderly in OIC member countries.

Making education, employment, and basic social services accessible for elderly people can help improve their well-being remarkably. Older persons need healthcare services. Therefore, national agencies should guarantee access to "a nationally defined set of goods and services, constituting essential health care". This is particularly important to protect older persons because against health-related poverty. Considering the fact that non-communicable diseases represent the major component of moderate and severe disability among persons aged 60 years or over in OIC countries, special attention should also be given to the issue of developing early diagnosis and appropriate preventive measures and treatment services for older persons, including those who have mental health problems. In this regard, establishing working groups and committees of academics, policy-makers, at local and national levels can create a platform for developing policies and recommendations.

Assuring the income security, flexible employment opportunities, access to affordable housing and transportation, elimination of discrimination, violence and abuse targeted at older people can help tackle major challenges faced by elderly people.

In OIC countries, it is necessary to improve research methods on ageing. OIC countries also need to have better monitoring mechanisms, and be flexible towards the adoption of regulations and instruments that create favourable social and economic conditions for elderly.

From a human rights perspective, OIC countries are recommended to take appropriate legislative, administrative, social, and educational measures to combat abuse against older populations in private and public spheres from perpetrators including families, relatives, or caregivers.

At the OIC cooperation level, efforts should be made to facilitate the exchange of experience and best practices in the area of ageing among the member countries. In this context, the exchange of skills, knowledge and experience among OIC member countries would be a beneficial form of cooperation. For example, the experience of Turkey in establishing institutions for elderly could be considered as a successful model to be transferred to some other member countries. Or the experience of Indonesia regarding the establishment of a "National Commission for Older Persons" to overcome coordination issues would constitute a good example for several OIC countries. In addition, organizing expert group meetings and seminars on ageing related issues could provide opportunities for exchanging knowledge and know-how among the member countries.

The problem of deteriorating old-age dependency ratios will be more significant in the rural areas, particularly in the less productive farming areas of the OIC member countries. Therefore, rural development policies and projects could be seen as a significant contribution to overcome the ageing-related challenges in OIC member countries.

Pension and retirement programs in OIC countries are neither adequate nor comprehensive for meeting the growing needs of elderly people. Therefore, it is essential to exert more efforts towards implementation of effective pension and retirement programs that can help advance the material and social well-being of elderly people in OIC countries.

APPENDIX

Annex I: The Structure of the Madrid International Plan of Action on Ageing

The Madrid International Plan of Action
Older Persons and Development
Issue 1: Active participation in society and development (2 objectives, 13 actions)
Issue 2: Work and the ageing labour force (1 objective, 14 actions)
Issue 3: Rural development, migration and urbanization (3 objectives, 20 actions)
Issue 4: Access to knowledge, education and training (2 objectives, 14 actions)
Issue 5: Intergenerational solidarity (1 objective, 7 actions)
Issue 6: Eradication of poverty (1 objective, 8 actions)
Issue 7: Income security, social protection/social security and poverty prevention (2 objectives, 13 actions)
Issue 8: Emergency situations (2 objectives, 18 actions)
Advancing Health and Well-Being into Old Age
Issue 1: Health promotion and well-being throughout life (3 objectives, 27 actions)
Issue 2: Universal and equal access to healthcare services (4 objectives, 22 actions)
Issue 3: Older persons and HIV/AIDS (3 objectives, 9 actions)
Issue 4: Training of care providers and health professionals (1 objective, 3 actions)
Issue 5: Mental health needs of older persons (1 objective, 10 actions)
Issue 6: Older persons and disabilities (1 objective, 10 actions)
Ensuring Enabling and Supportive Environments
Issue 1: Housing and the living environment (3 objectives, 17 actions)
Issue 2: Care and support for caregivers (2 objectives, 14 actions)
Issue 3: Neglect, abuse and violence (2 objectives, 12 actions)
Issue 4: Images Of ageing (1 objective, 8 actions)

Source: UNFPA, Overview of Available Policies and Legislation, Data and Research, and Institutional Arrangements Relating To Older Persons - Progress since Madrid, 2011

Annex II: Modality of Pension Schemes in OIC Member Countries

Country	Pillar 1	Scheme	Pillar 0	Scheme	Pillar 2	Scheme
Albania	3	DB	3	TPP		
Algeria	3	DB				
Azerbaijan	3	DB, NDC	3	TPP		
Bahrain	3	DB				
Bangladesh			3	TPP		
Benin	3	DB				
Brunei Darussalam	3	PF	3	UPP		
Burkina Faso	3	DB				
Cameroon	3	DB				
Chad	3	DB				
Cote d'Ivoire	3	DB				
Djibouti	3	DB				
Egypt	3	DB	3	UPP		
Gabon	3	DB				
Gambia	3	PF				
Guinea	3	DB				
Guyana	3	DB				
Indonesia	3	PF				
Iran	3	DB				
Iraq	3	DB				
Jordan	3	DB				
Kazakhstan	3	DB	3	UPP	3	DC
Kuwait	3	DB				
Kyrgyz Republic	3	DB, NDC	3	BPP	3	DC
Libya	3	DB				
Malaysia	3	PF	3	TPP		
Mali	3	DB				
Maldives					3	DC
Mauritania	3	DB				
Morocco	3	DB				
Niger	3	DB				
Nigeria			3	UPP in 2 states	3	DC
Oman	3	DB				
Pakistan	3	DB				
Saudi Arabia	3	DB				
Senegal	3	DB				
Sierra Leone	3	DB				
Sudan	3	DB				
Tajikistan	3	DB			3	DC

Togo	3	DB				
Tunisia	3	DB				
Turkey	3	DB				
Turkmenistan	3	DB	3	TPP		
Uganda	3	PF				
United Arab Emirates	3	DB				
Uzbekistan	3	DB	3	TPP		
Yemen	3	DB				

Source: World Bank Pensions Database

- **BPP** - Basic pensions refer to either flat rate or depend on years of work.
- **TPP**- Targeted programs pay benefits only to those with the lowest old-age income.
- **UPP** - Universal: Social pension non-contributory, non-earning related for all the population above certain age.
- **DB** - Defined-benefit schemes have a formula directly related to individual earnings.
- **NDC** - Notional defined-contribution schemes benefits depend on the amount of contributions made and notional interest credited to individual accounts.
- **PF** – Through Provident Funds/Publicly managed defined-contribution schemes benefits depend on the amount of contributions and the investment returns that individuals earn.
- Tajikistan, Kyrgyzstan and Kazakhstan have also complementary pension schemes.

REFERENCES

Al-Aoufi, H., Al-Zyoud, N., & Shahminan, N. (2012). Islam and cultural conceptualizations of disability. *International Journal of Adolescence and Youth*, *17*(4), 205-219.

Bywaters, P., Ali, Z., Fazil, Q., Wallace, L. M., & Singh, G. (2003). Attitudes towards disability amongst Pakistani and Bangladeshi parents of disabled children in the UK: considerations for service providers and the disability movement. *Health and Social Care in the Community, 11*(6), 502-509.

Coleridge, P. (1999). Cultural values and disability: The example of Afghanistan. In Stone E. Leeds (Eds.), *Disability and Development: Learning from Action and Research on Disability in the Majority World* (149-167). The Disability Press.

Elsaman, R. & Arafa, M. (2012). The rights of the elderly in the Arab Middle East: Islamic theory versus Arabic practice. *Marquette University Law School Elder's Advisor, 13*(2), 1-53.

Hajjar, R. R., Atli, T., Al Mandhari, Z., Oudrhiri, M., Balducci, L., & Silbermann, M. (2013). Prevalence of aging in the Middle East and its implications for cancer incidence and care. *Annals of Oncology, 23*, vii11-vii24.

Hasnain R, Shaikh L.C., & Shanawani, H. (2008) Disability and the Muslim perspective: an introduction for rehabilitation and health care providers. *Center for International Rehabilitation Research information and Exchange Development*.

Hoodfar, H. (1997). *Between Marriage and the Market: Intimate Politics and Survival in Cairo*. Berkeley: University of California Press.

Hussein, S. & Ismail, M. (2016). Ageing and elderly care in the Arab region: Policy challenges and opportunities. *Ageing International*, *42*(3), 274-289.

Hussein, S. & Manthorpe, J. (2005). An international review of long term care workforce: Policies and shortages. *Journal of Aging and Social Policy*, *17*(4), 75–94.

Hussein, S. & Manthorpe, J. (2007). Women from the Middle East and North Africa in Europe: Understanding their marriage and family dynamics. *European Journal of Social Work*, *10*(4), 465–480.

ILO (2008), Conditions of Work and Employment Program, Geneva.

ILO (2014a), World Social Protection Report 2014/2015, Geneva.

ILO (2014b), Social Protection for Older Persons: Key Policy Trends and Statistics, Geneva.

ILO (2016), Key Indicators of Labour Market (KILM), 9th edition, Geneva.

Ingstad, B. & Whyte, S. R. (1999). *Disability and Culture*. Berkeley, CA: University of California Press.

Institute for Health Metrics and Evaluation. (2013). *The Global Burden of Disease: Generating Evidence, Guiding Policy*. Seattle: University of Washington.

Khadr, Z. A. (1997). *Living Arrangements And Social Support Systems Of The Older Population In Egypt* (Ph.D. dissertation). University of Michigan.

Knodel, J. & Chayovan, N. (2008). *Population Ageing and the Wellbeing of Older Persons in Thailand*. Ann Arbor: University of Michigan.

Kronfol, N., Sibai, A. M., & Rizk, A. (2013). Ageing in the Arab Region: Trends, Implications and Policy Options. *Economic and Social Commission for Western Asia (ESCWA).*

Lederach, J. P. (1995). *Preparing for Peace: Conflict Transformation across Cultures.* Syracuse, NY: Syracuse University Press.

Lockenhoff, C.E., De Fruyt, F., Terracciano, A., McCrae, R.R., De Bolle, M., Costa, P.T., & Aguilar-Vafaie, et al. (2009). Perceptions of aging across 26 Cultures and their culture-level associates. *Psychology and Aging*, *24*(4), 941-954.

Pallares-Miralles, M., Romero, C., & Whitehouse, E. (2012). *International Patterns of Pension Provision II: A Worldwide Overview of Facts and Figures*. World Bank.

Reid-Cunningham, A. R. (2009). Anthropological theories of disability. *Journal of Human Behavior in the Social Environment*, *10*, 99-111.

Sibai, A. & Yamout, R. (2012). Family-based old-age care in Arab countries: Between tradition and modernity. In: H. Groth & A. Sousa-Poza (eds), *Population Dynamics In Muslim Countries: Assembling The Jigsaw* (63-76). Switzerland: Springer.

Sibai, A.M., Tohme, R., & Yount, K. (2012). The older Arab – from veneration to vulnerability? In S. Jabbour, R. Giacaman, M. Khawaja and I. Nuwayhid (eds.), *Public Health in the Arab World* (264-275). Cambridge, UK: Cambridge.

Sinunu, M., Yount, K. M., & El Afify, N. A. W. (2009). Informal and formal long-term care for frail older adults in Cairo, Egypt: family caregiving decisions in a context of social change. *Journal of Cross Cultural Gerontology*, *24*(1), 63–76.

UN (2002), Political Declaration of the Second World Assembly on Ageing, New York.

UN (2007), Major Developments and Trends in Population Ageing, Department of Economic and Social Affairs, Division for Social Policy and Development, New York.

UN (2011), Current Status of the Social Situation, Wellbeing, Participation in Development and Rights of Older Persons Worldwide, Department of Economic and Social Affairs, Division for Social Policy and Development, New York.

UN (2011), Population Policies Dataset 2011, Department of Economic and Social Affairs, Population Division and Policy Section, New York.

UN (2013b), World Population Ageing 2013, Department of Economic and Social Affairs, Division for Social Policy and Development, New York.

UN (2013c), Neglect, Abuse, and Violence against Older Women, Department of Economic and Social Affairs, Division for Social Policy and Development, New York.

UN (2015), Population Policies Dataset 2015, Department of Economic and Social Affairs, Population Division and Policy Section, New York.

UN (2017), World Population Prospects: The 2017 Revision, Department of Economic and Social Affairs, Division for Social Policy and Development, New York.

UNFPA (2011), Overview of Available Policies and Legislation, Data and Research, and Institutional Arrangements Relating To Older Persons - Progress Since Madrid, New York.

UNFPA (2012), Ageing in the Twenty-First Century: A Celebration and a Challenge, New York.

UNFPA and Help Age International. (2012). *Aging in 21st Century: A Celebration and a Challenge.*

WHO (2008*). The Global Burden of Disease: 2004 Update*. Geneva: World Health Organization.

Yount, K. (2005). The patriarchal bargain and inter-generational co-residence in Egypt. *The Sociological Quarterly*, *48*, 137–164.

Yount, K. M. & Rashad, H. (2008). *Family In The Middle East: Ideational Change In Egypt, Iran And Tunisia*. London: Routledge.

Yuill, C., Crinson, I., & Duncan, E. (2010). *Key Concepts in Health Studies.* California: Sage Publications.