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Comment on the paper *Ageing in the Middle East and North Africa: A Contemporary Perspective* by Jamie P. Halsall and Ian G. Cook

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In *Ageing in the Middle East and North Africa: A Contemporary Perspective*, Halsall & Cook (this issue) have outlined a comprehensive account of the discourse on ageing in the context of social policy in the Middle East and North Africa (MENA). There are several points of contention that need to be brought onboard for discussion of the ageing population in the MENA region.

First, rather than MENA, the region covered by the authors appears to have captured 22 countries classified as 'Eastern Mediterranean' (EM) by the World Health Organization (WHO). These countries transverse Asia and Africa. Some of these countries are part of West Asia while some are in the Mediterranean basin stretching from North Africa to Asia Minor. The Gulf States, as well as those lying adjacent to the Arabian Sea and those in the Horn of Africa, are part of the WHO's EM region. The region has approximately 583 million people. Few countries are indeed 'heavily populated' but there is an overall maldistribution of the population and the region is the 'epicenter' for the influx and efflux of refugees.

Furthermore, the economic activities in the EM are increasingly moving towards the urban areas. With the high rise in the literacy and empowerment of women, traditional lifestyle is increasingly being replaced with capitalism driven lifestyle. The extended family is increasingly eroded by the emerging nuclear family. Such factors are likely to affect the well-being of the elderly and frail who are impeded from having a meaningful existence in the emerging metropolises of EM countries. The phenomenon has been termed the 'urbanization of poverty' (Benna et al., 2017). The emerging working poor have little recourse to contribute to the well-being of the weak and frail.

It may also be relevant to explore the existing 'time bomb' in the EM region whose breadth and depth are parallel or surpass those of the elderly (Al-Sinawi et al., 2012). The EM has its own vulnerability. As per the findings from the Global Burden of Diseases, Injuries, and Risk Factors 2015 study (Kassebaum et al., 2017), EM is witnessing a significant improvement in the survival rate of those individuals who are likely to have succumbed to early death . The burden of disability in the EM is further exacerbated by the cultural practice such as consanguinity, noted to be rife with EM (Fareed et al., 2017). Many lives in the EM are likely to be affected by endless conflict and wars in the region (Bruneau et al., 2017). The region has a 'silent epidemic' of lifestyle diseases and unintentional injuries (Mokdad et al., 2016). Some of the diseases often seen in the elderly population are rising and obtruding the young generations (Al-Sinawi et al., 2012). Presently, the medical model which is leaning towards professionally-driven and cure-oriented is unfortunately ill-equipped to cope with the emerging trends (Mokdad et al., 2016) As a result, disability and dependency are rampant among youth who would need a type of palliative care often reserved for the elderly.

Grouping the countries of the East Mediterranean together and treating them as a unified or monolithic entity ignores their contrasting demographics, economics and health care systems. Despite their geographical proximity and historical connectedness as the cradle of civilization, they represent a wide variety of circumstances. While some of the countries are the most affluent in the world, a few possess characteristics of the 'third world' or developing countries and some are in between. A fraction of them are 'recovering' from the civil wars and a few have been labelled as highly stable. These differences, in turn, shape the well-being of a senior citizen. Therefore, labelling the EM as monolithic entity humbles the well-known mosaic of diversity of the region.

Lastly, the authors have employed what they called 'qualitative theorizing research'. In addition to this approach, the authors could simultaneously glean the existing demography and socio-cultural trends in the EM using the theory known as demographic transition as previously expounded by Thompson (1929) and Omran (2005). Demographic transition posits society's fluctuations in birth and death—for that matter, even the discussion of longevity—should be understood differently whether the country in the midst of pre-industrial or industrialized economic system. The EM has most of the characteristics of the 'second phase of the demographic transition' except for those countries that are or have been marked by civil strife and Arab Spring (Kuhn, 2012). Prevailing plasticity of longevity, the preponderances of 'youth bulges', rapid urbanization and lifestyle diseases alongside the challenges of environment-related and infectious diseases in the

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EM are a phenotypical presentation of 'second phase' (Omran, 2005). It is therefore premature to equate the contemporary situation in the EM to those of the industrialized countries, an example is Japan (Kojima et al., 2017). Once the EM will have industrialized economic system, there would be an inevitable increase in the ageing population. Therefore, concerted efforts should be directed towards creating the conditions for a meaningful existence for youth in the EM who, in turn, will provide meaningful existence to their ageing parents.

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