World Dementia Council
Leading the Global Action Against Dementia

Brain Health and Cognition in Latin America

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Transcript

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Welcome and Opening of Day Two

Lenny Shallcross, *Executive Director, World Dementia Council, United Kingdom*

Good morning, everyone. I will be brief by way of introduction, which is to say this is the start of Day Two and we have a few sessions that are going to run throughout the day.

First off, we're going to look at the policy question around implementation. As you will know from some of the conversation yesterday, there is a splendid track record of projects being developed, evidence being gathered and then implementation taking years or not happening at all. In the UK we are particularly good at running pilots in our health system and particularly bad at those pilots ever leading to system change. There is a big question, as we transition into adopting policies around brain health, of how you have impact at scale when implementation can so often take 15, 20 years — and in this field, at this time, we don't have 15 or 20 years.

Then after that we have a second session, which is a question around what evidence we have, what science, what more science we need. We talked a lot yesterday around the case for things like World-Wide FINGERS having come from trials — that there is the evidence there to persuade people, to make the case. As you think about brain health, and the diversity that we have around the world, and where trials have been done to date, what more do we need to make a persuasive case for brain health?

And then there's a third session around how do we persuade? I think it's one of the challenges we face as a community. The medical profession is extraordinarily good at wanting people to do things, that large numbers of the public don't want to do and have no intention of doing. We are very good at identifying how people should behave and very bad at actually changing people's behaviour. And we're also actually quite bad at persuading decisionmakers to make the change, there's lots of evidence for public health interventions, on air pollution, on the built environment and so on that sits on the shelf. Our third session asks how do you persuade?

And then finally we will wrap with a session around what we do with the last day and a half: what follows on from this, what we've learnt, what we want to achieve in the years ahead.

With that, what we are going to do on Day Two is actually have two moderators throughout the entire morning session, which is Joanne Pike and Paulo Caramelli. They are somehow going to juggle the fact that we've got one podium between the two of them. No slides today, it's just going to be in conversation format. That does actually mean that you can also participate in the conversation, and the moderators will encourage you to be part of the conversation that we are going to have this morning. With that, thank you very much, and over to you two.

Session 1: From Sites to Systems — What Would It Take?

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Good morning. Today we are going to focus in on how we bring evidence to action, and in particular the lens we need to bring from a global policy perspective: thinking about taking what we have learned and then building the environment around it so that we can be successful. Policy gives us the lever in order to do that.

This first session, *from sites to systems*, asks what it is going to take to move to system implementation. We have three speakers joining us. We have Matthew Baumgart, the Senior Vice President of Health Policy for the Alzheimer's Association; Matthew also oversees public health and the work that we do at the Association. We have Dr Gustavo Sevlever, Director of Education and Research at FLENI, and Dr Ana Luisa Sosa, researcher in Medical Sciences at the Instituto Nacional de Neurología. If all three of them can join us, we'll get started.

This session, as I mentioned, is really looking at evidence to action: how we bring public health to scale. As you heard Lenny say, we know that taking evidence and bringing it to community takes far too long. If we look at interventions in other diseases, we know that some things take 15 to 20 years. Knowledge does not always translate to action, and so we have an opportunity to think about how we bridge that gap.

There are a few examples of that I might highlight. One is cervical cancer. We introduced the HPV vaccine back around 2006. We now have several countries who have a generation of women without cervical cancer. It took us 20 years, but we were able to do that. On the opposite end of that spectrum, we learned around 1980, as a global public health community, that obesity caused cardiovascular disease. Despite that, we continue to get a wider waistline. There are successes in public health and there are failures in public health, and we have an obligation to learn from both of those.

Today we're going to take a few minutes, very similar to what we did yesterday. Each speaker will have some time to talk about sites to scale, and then we will come around for conversation — both questions from Paulo and I, along with conversation from you. This doesn't necessarily have to be question and answer. We want to also hear from your experience: what are the comments you might have about this as we consider policy to action.

With that — and thank you, Paulo, for being co-chair with me today — Matthew, I will turn it to you for first comments.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

In thinking about this issue, there are two overarching comments I want to make. One is actually related to something Lenny said in his opening remarks. When I think in the abstract about what is holding us back from moving from the site to the system, as the title of this session is, a big part of it is what's sexy.

And I think back to yesterday, when we were talking about the results of the FINGERS trial, the results of U.S. POINTER, and everybody just clapping at the successful results; I'd be willing to bet that there aren't going to be lots of rounds of applause when we get implementation studies done. Because

implementation studies aren't sexy. The POINTER trial, the LatAm-FINGERS trial — those found the answer, or the key to the treasure chest in a way. They found what works. And this is a big moment. It's not as sexy to figure out how does it work? How do we get that into the community? That's not the sexy thing. Funders don't like to fund it. The news media doesn't like to cover it, and researchers tend not to do it. The money isn't there. The glory isn't there, if you will, to be blunt about it.

In much the same way that Lenny said, we have money for pilots in the UK and then never money for doing it in the system — and in part that's for the same reason, because the pilot is trying to find what's the answer. And if somebody finds the answer, that's significant, that's seen as important, but figuring out how to just make it work in everyday practice isn't. And I think that's a big barrier to overcome. And it's the reason that the money isn't as significant in that space, and so there isn't as much work there, and that can delay getting from sites to systems.

The other thought I had is — if we're talking generally about brain health, I think I can make that case to policymakers and to health systems. In general, improve brain health and you will save money. But when you're talking about a specific intervention that you want them to do or to fund, then it becomes a little bit harder — they want to know more.

Most of my life I spent on the policy end. At the end of the day, I'm going to be the one trying to sell this specific intervention — the LatAm-FINGERS intervention, the U.S. POINTER intervention — to the payers, whether the payer is government or insurance. And they're going to want to know two things. That the thing they're paying for works. They are not paying for a clinical trial. The thing they're paying for is actually something in the community, in the system. That's why the implementation studies that you heard about yesterday are so important, because that's what a payer is eventually going to pay for: the thing in the community.

But second they're going to want to know is that the thing they're paying for is worth the price. And so that gets into: can you show that that specific intervention brings a return on the investment? And that's why I say, if I'm talking abstract in the brain health talk, I can say: if we can just get people to do X, Y and Z, if we can educate them, if we can teach them, if we can do things on brain health, we can reduce the number of people with dementia in the long term. And that works in the abstract concept. But if I'm going to say I want you to pay specifically for this intervention, they're going to want to know that there's a return on that investment. And that makes it more difficult to go from site to system. That's a hurdle.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you, Matthew. I don't know if the audience was ready for public health to be compared to sexy interventions, but I appreciate your thoughts — certainly also on who is paying and how we reach the payer, regardless of who that is, system or government. That is incredibly important as we think about moving implementation out. Ana Luisa?

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

Good morning. I have to say that I feel I'm in a slightly strange position. Because I have beside me three gentlemen: one of whom is an academic specialist, one of whom is an expert in politics, and one of whom is a teacher in an institution that has led Latin America.

I want to talk to you about the approach I have taken. I have almost always started from having nothing — as one of our FINGERS colleagues put it at some point — and wanting to have everything. And I'm going to tell you how I have, intuitively, been trying to get what I think I need for my centre. What I'm going to tell you will be a brainstorm of ideas.

First, I think we have to continue generating evidence, such as that which we presented to our colleagues in the first day. We need new projects, new actions that will be converted into evidence.

The second thing that I think is that what we do needs to be adopted by the state. We have to make the state feel that our project is theirs, that they are owning it and leading it. Because I think that that is something that we are proposing, but it is something that they are giving to the community, and that makes them really involved in the project.

To give you an example, as you know the capital of Mexico, it is very large and we have a great number of older adults. We submitted a project for the protocol of LatAm-FINGERS — but coinciding with a very fortunate situation. In Mexico, Mexico City has begun creating healthy green spaces called Utopías. And in these spaces, of which there are more than ten across Mexico City, there is a specific space dedicated, with resources, to older adults. By building our project into this it will allow us to have our LatAm-FINGERS project across the whole city, yes.

In our project of LatAm-FINGERS I have the honour to say that we have been awarded — we have been given the financing. Now we are going to work on a project financed by the state. And this is going to be a project financed by the state. And this will be their evidence. Also, we are at a very good moment, because the government needs to make itself popular, right? — and to talk about everything it is doing for older adults. In Mexico, older adults are the ones who always vote. It's a population they care about.

Then, I think we also have — as has been said several times yesterday and today — the general rather than particular is an approach that has impact. We have seen how the Global Burden of Disease is putting brain health problems at the top of the policy agenda: they are the diseases with the highest cost, both in years of life lost to disability and in deaths. All the mental health and neurology problems are grouped together, and it makes a huge package. And also, as was said yesterday, what are we without a healthy brain? We can't do anything. If we talk, for example, about more general aspects, such as brain health and healthy ageing, I think we also have more weight, more force.

And another aspect, also very important, that we have to use, is those programmes that already work: the programmes for prevention of [chronic] diseases, for cardiovascular disorders; and also to learn from the examples that we have from other areas of health. For example, in Mexico, for HIV, we have 400,000 people affected by the disease, and we have triple the number of people affected by dementia. But the patients with HIV have a right — they have a right to everything they need for their disease: treatment, diagnosis, at no cost. And well, that is one of the few programmes of this kind that we have in Mexico. And who achieved it? Civil society. The social groups that pressured the government to get it. We need to unite, and my friend Daisy [Acosta] has always told me that too often we forget civil society! We have to have the Alzheimer associations on our side. And I think that is something truly very important: to learn the lessons and bring civil society with us.

And lastly, I would like to tell you that together we are stronger, yes — that we have to continue together, because this pressure at the regional level will always make us stronger. In addition to how good it is to get together and work with our colleagues from the region. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you, Ana Luisa. I think you brought up an incredibly important point there at the end, which is that public health movements don't happen without grassroots people advocacy — using their voice to change what a government invests in. Thank you for saying that — and I know we're going to come back to that today at some point throughout the day. Gustavo?

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

First of all, Ana Luisa began by saying that she usually starts programmes with nothing — and it is remarkable, because she secured the first public funding for a LatAm-FINGERS-like project in a city. I think this is one of the biggest achievements we have seen, and I want to ask for a round of applause for it. But one of the key questions for all of us is how to make this attractive — "sexy", in some way — for public health and public policy. This is a great achievement for Ana Luisa, of course, and for Mexico, but it is also one for all of us, because it shows a road ahead that can be useful and fruitful.

I have some questions I want to pose. The first is whether our health systems can absorb what science produces. This is a dilemma we always face between clinical trials and public health: clinical trials are a highly rigorous, somewhat artificial environment in which we generate evidence. But when we have to translate that evidence into real life, many problems arise, because the patients we see at large scale are not the patients who were selected for the trial. The evidence has to be translated, and that is neither an easy nor a smooth process. We have to adapt it to real life — and this happens with every clinical trial, even in pharma. We have to take care of that translation, and we are the people equipped to do it: to carry the evidence from the clinical trial to the real-world scale.

Adoption depends on champions. That is our experience in every country and every community. But champions retire, budgets rotate, projects end — so we have to move to systems. The system is what remains. For sustainability, we have to design and implement within the system, moving from individual champions to system-level implementation.

Another challenge, as we discussed yesterday, is that dementia risk reduction cuts across many domains — fields that barely speak to each other: cardiovascular health, hearing, education, air quality and the environment, social care, physical activity, nutrition, sleep, cognitive engagement. No single ministry owns it and no single budget pays for it. Yesterday we discussed ownership, and I think that is a symbolic step we have to take: ownership of the brain health project, precisely because it is so fragmented. But that vacuum is also an opportunity. We have the pieces; what we need is assembly. What is missing is not invention but the assembly of what is already there.

And we need measurement. We cannot scale what we cannot measure. This is a critical point for all of us: measuring impact at large scale, across all communities.

We have many things working against us, but also some very important things working for us: community health workers, dense primary care networks, and examples of successful scaling we can build on, such as tobacco and HIV. I am convinced we need a regional structure with a clear mandate and accountability to champion this. I think we are in a position to implement something of that kind, linked to the question of ownership.

We have the evidence; we have some delivery infrastructure. What we are missing, in my view, is assembly, ownership, funding — a budget — and measurement. That is a political task more than a scientific one. But it is ours, definitely. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you, Gustavo. You raise a very important point — money, but also how we can come together to measure a very similar outcome. As part of that, you mentioned something important that was raised yesterday by Cristóbal [Cuadrado] in the panel at the end of the day: there are other chronic conditions that affect, and can be a part of, the sharing of this money as well, as we think of commitment.

Thank you to all three of you. I hope you have begun to think about questions or comments or things that you raise as concerns as we think about going from research sites to systems and how we have interventions. But I want to turn it over to Paulo first, to see if there's anything you want to ask or comment on from the panel.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Joanne. Thank you all three for these excellent points of view. Well, I think you covered very interesting aspects of this great challenge we have ahead of us, and I was thinking about the following aspects.

A great part of the politicians in our countries — US, Argentina, Mexico, Brazil — are aged 60 or 65 and older. At the same time, we all know that the demographic transition is running in our countries. For example, in Brazil, we expect that in 20 to 25 years, 21% of the entire population will be composed of people aged 65 and older. And this is a phenomenon that is occurring worldwide. And these individuals are taxpayers for longer periods, are voters for longer periods. But on the other hand, this does not translate into greater attention and resources for programmes touching or tackling ageing, successful ageing, promoting brain health and so on.

If you could comment briefly: how do we explain the discrepancy between the demographic transition and not too much interest from politicians, from society? And what do we need to turn on the light? What would you think would be one possible strategy to turn on the light in this scenario? Matthew, can you?

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

I actually am going to disagree slightly with something you said, because I look at the United States, and in the United States a good chunk of the federal budget is actually spent on people older than 65, between the Social Security system and Medicare, the healthcare system. A lot of money is spent on it. But I think where you're really going with that is that that is almost sustenance. I don't know if that's exactly the right word, but it's: I'm giving you social security so you have something to live on when you're older; I'm giving you Medicare so that if you get sick, we can take care of you. And what's not there is the "how do I age successfully? How do I age in a healthy way?" — which actually needs to start before you get to the point of being 65. And that to me takes a big mind shift, because I think we're so used to healthcare being taking care of you after you get sick, and it requires a fundamental shift.

But I think there is something to be said — and I hate keeping going back to the economics of the situation — but I do think there's an economic argument to be made. If I can get people to healthy ageing, or more healthy ageing than is happening now, I can extend the time in which you can be a worker, which means you can pay taxes. I can compress, perhaps, the time in your older age when you're sick with chronic diseases, whether it's dementia or heart disease or something else. If I can

compress that time, I can reduce the cost of having to care for you. I think there is an economic argument to be made, and that may be an important aspect — the economics of healthy ageing, and starting that before you get old: thinking about getting old before you get old.

And that's hard to do, because nobody wants to think about getting old. I just hit a recent milestone birthday — I'll let everybody else guess what that milestone was. I'm not happy about getting old. I don't want to think about getting old. And so I don't want to think about how I get old in a healthy way, because I just don't want to think ageing full stop. And so there's a mindset shift that needs to happen too. Thank you.

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

I think that is something difficult to answer. If I had the recipe, I would already have used it. But I think it has something to do with, as Goethe said, that ageing was gradually stepping back from the world of appearances. As we age we become more invisible in society.

This is what I have seen — for example, in Mexico, we have the National Health and Nutrition Survey (Encuesta Nacional de Salud y Nutrición), which is a part of the government planning. After much effort, together with Mexico's National Institute of Geriatrics, in 2012 we got older adults included in the survey — it was as if before they didn't exist. I used to say to them: well, do you think older adults are Martians, are foreigners? Why aren't they included in the National Health Survey? No? And we achieved it. But you have to keep pushing. Next year we are going to do it again.

And to persuade people? Sometimes the way to make these people aware is when the father of one of them had Alzheimer's. I don't know much about politics — but making people sensitive, that make people recognise that ageing is a very important process. And something that I think can serve us well.

I read in an English article that said that we have to invest to earn in health. If we can convince them that, in fact, they are going to be able to do it, and if we can demonstrate it — that would be a good argument.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

People over 65 are the fastest-growing group in every country in the world. In Argentina they are growing faster and faster, and the region is ageing faster than Europe did. This is a new political issue, because people over 65 have specific needs — cultural, political, and in terms of health and the health system. And there is also ageism — discrimination on the basis of age.

Again, I think we should take HIV as an example. HIV was fundamentally a political problem, and the agenda was set by the people working on it — by the patients and their families. There was a close relationship between discrimination and healthcare, and that political agenda is what secured treatment. Today treatment is free in every country — as Ana Luisa said of Mexico, Argentina is exactly the same: treatment is free, paid for by the government, because of that close link between politics, discrimination and a concrete health problem. We have a lot to learn from that example.

Economics matters; it is the language of the people who spend the money. The budget is critical, but I insist on advocacy and public opinion — going to the public and putting research and treatment on the agenda. At the same time, this population over 65 is genuinely new: fifty years ago it did not exist as a political issue. We have to take advantage of that, because these are the people who will benefit

from prevention programmes. It is a very important political and communication issue to place on the public agenda, and I think it is our responsibility, because we generate the evidence, we know the evidence, and we can work on translating it into public health.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

I think there's a lot to be learned from the HIV example. There's one huge difference between that and dementia. The people who were getting HIV and dying of AIDS were young. And there was a huge difference — even though it was mostly in a marginalised community at the time — seeing and thinking about young people getting a disease and dying is very different from society's attitudes toward an older person getting a disease and dying. Because I think there is a lot of ageism and stigma about getting old. And I think there's a lot to be learned from HIV, but we have to overcome an additional hurdle, I think, in the stigma of old age. As Ana Luisa mentioned, they weren't even in the survey — older people weren't even in the survey. Keep that in mind; that's an additional barrier that we have to overcome.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

But that is also an opportunity. That vacuum is an opportunity, and we have to be careful about the kind of message we craft for society. Implementation studies are not sexy, as you said — and ageing is not sexy either.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

Well, I disagree on the last point! But I have a conflict of interest.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I think we all do! Let's open it up to the floor. Anybody with questions, comments, responses that you may want to bring — maybe a disagreement that you have. Also, for anybody online, we are monitoring the Q&A in the chat if you want to ask a question or bring a thought up. But anyone with thoughts on going from research to systems? Yes — Ana Luisa.

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

Now that we are talking about younger people, I would like to think that maybe we could talk in the name of the carers. We can also make use of this — and it's a reality — that we have to advocate for carers, who are young people. Many of them stop working, or stop studying, or stop eating properly, to care for older adults. Here we have to advocate for older adults and for their carers, which is also a strong argument.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you very much. Anyone in the group? Yes.

Audience member, *From the floor*

Thank you. I've been really enjoying all of the talks and the sessions yesterday and today. Yesterday, at around Session 2, I started to brew up the question: do we start to lose traceability of that implementation, because people start to adopt the interventions, or the more general, say, brain health concepts, as Matthew was talking about? If people start to talk generally about what makes brain health accessible and how you can do more exercise — so the sort of flexible interventions, or the not-so-trackable community conduct in general — if it were to improve in the following years, how will the evolution of these conferences be in a couple of years, when we come back and maybe people have implemented these sorts of interventions? That's basically the question: about the evolution of the research and the conferences, and losing traceability of what's being done.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

It's going from the controlled intervention — from the controlled lab setting — to the public policy, a real-life public health education model, right? And being able to track that over time. Are there any thoughts from the group on this? It would be great — we could be so lucky as to have people starting to adopt brain-healthy habits. The trackability, though, I think is the bigger, broader issue.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

The trackability is something I wasn't even thinking of, but, that's a big issue. I think, as much as I think general education about brain health is important — in the Alzheimer's Association, we have 10 Healthy Habits. We have a Brain Health Habit Builder, where you can answer questions and get a personalised plan of things to do, and that includes how to help make the habit stick, not just what to do.

And so, as much as I believe in that — there were some focus groups done in the United States by the CDC Foundation, and they were working on a hypertension campaign. This was part of the development of a hypertension campaign. And they found in those focus groups — the focus groups were of people with hypertension — that the thing that made everybody sit up in their chairs was when they said: oh, you know what? Your hypertension can screw up your brain later in life and can be connected to dementia. And the people who were conducting the focus groups told me that they had people almost screaming at them: why has no one ever told me that my hypertension is going to screw with my brain? Because they weren't controlling their hypertension when they thought it was just about their heart. But the minute they heard that it was about their brain, it's like: I've got to do something about this.

I do think there is something to be said for general education, general knowledge, promoting exercise, hypertension control and prevention, diabetes, etcetera. But I also think that history is replete with examples of just trying to rely on people to do things themselves not always working. I do think that the notion of having a structured programme that is available to people, especially people who are at higher risk — something like a FINGERS or POINTER — is really important, because I think individual effort will only get us so far. Thank you.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

I think we have to make the most of something: the brain as a symbol. The brain is sexy now. Everyone is talking about the brain. People love anything "neuro": neuro-this, neuro-that. The brain has replaced the double helix as a symbol — for a long time the double helix was the symbol of biology, and now it is the brain. People talk about the brain; people are fascinated by it.

This is a problem and an opportunity at the same time, because many people talk about the brain on very fragile evidence, saying incredible things that have nonetheless taken root in society. Again: advocacy, and our responsibility. We know what the brain is, as far as anyone does, and this is an opportunity to say: the brain is fascinating because you are your brain. We are human because of our brain. If something happens to our liver, we remain the same person. If something happens to our brain, we may change and become someone else.

That is the opportunity: to take the brain as a symbol in society and provide the advocacy, information and everything else needed to take care of it. Taking care of your brain is taking care of yourself. This education programme — through publicity and advocacy — can run from very early, in schools, to very late in life. But again, we as neurologists, as people who work on the brain, have the responsibility to provide good information backed by good evidence, and to make the most of the brain as a symbol in society.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you.

Ricardo Allegri, *Director of the Memory and Ageing Center, FLENI; Professor of Neurology, Universidad de Buenos Aires, Argentina*

Matthew and Gustavo told us about the fact that dementia is caused by many diseases and many other conditions can be influenced by acting on that information, not just dementia. If primary care physicians are aware of our research, they can make a real difference. This is not just society in general as a whole — of course it is — but rather one where primary care physicians serve as primary drivers of change. We must convince them, because at the moment they think that there is not any way to prevent dementia. Persuading them is essential to achieve change. Every physician should explain to their patients that high blood pressure, obesity and other factors play a fundamental role in the onset of the disease.

But the second thing that I want to tell you, which is a crucial aspect for Latin America, is the fact that dementia starts earlier in our countries. We have many studies that show that the overall prevalence of dementia is similar to European countries, but the prevalence is higher among the 60 to 70 age group. The prevalence in the 70 to 80 age group is lower due to mortality rates —in other words, life expectancy is shorter. This similarity in overall prevalence is explained by the fact that, in our countries, there are more cases of dementia between the age of 60 to 70, while prevalence decline thereafter because individuals pass away at an early age.

Why does dementia appear at an early age in Latin America? Because of low cognitive reserve. This, in turn, depends on several factors. This point is significant, because people develop dementia while they are still in a productive stage of their lives — after all, individuals remain productive at 60 or 70 years of age. The onset of dementia during this phase entails a greater cost for our country. It is an issue that warrants our reflection.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you. Ana Luisa?

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

Yes, I think what Gustavo mentioned is an opportunity: that we take the brain as our banner. Before, we used to put the heart and the brain, right? The heart, the emotions. But now, with the popularity of neuroscience, we know that everything is there. And above all, with it we can also promote prevention across the life course, not focus it only on older adults.

Because I think that certainly the argument "this damages your brain"... I once had a well-known visual artist in Mexico who drank a great deal, and I told her that alcohol was bad for her health — her brain. She said to me: "Nobody has ever told me that. If they had told me — who knows, right? — if they had, I would have stopped drinking", no? But anyway, it surprised her. I think that fortunately we can change behaviour through knowledge.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you. We have a comment online that Paulo is going to go through really quickly.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

I'll read it. "The future is old age, and in the era of artificial intelligence it is [difficult] to understand that health is everyone's issue, not just some people's. Public policy must support the development of research and promote healthy habits, so that people who today live longer live more healthily. And this will always be cheaper than waiting for the problem to become massive. It is just a reflection. Thank you very much." It's a very good comment. Would anyone like to comment on that?

Panellists

I agree. I agree. I agree.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Yes, right here.

J

João, *From the floor, Brazil*

I'm a psychologist. I think I have an unpopular opinion here, but I think it must be said. The other day I was listening to a podcast about public opinion regarding religion and the creationism discussion, and they asked, in sequential surveys in the US: what is the origin of the universe? And over the years every time people answered: it was created by God. And researchers concluded: oh, OK, we need to teach more about the Big Bang in the schools. But at some point, they changed the question and they asked: what do you think the scientists say about the origin of the universe? And when they asked this question, the majority of the people answered: the Big Bang.

This is an interesting case to show that many times the people already know what they have to do. And I think this is especially so, at least, in our country, or at least in our city, in Belo Horizonte. I think many people already know what they have to do regarding health habits. But we have, in a behaviourist way of seeing this, to think how to make this behaviour super easy to put into practice. And it's my personal opinion that is many times more important than education.

For example, in our city, we have a policy called Academia da Cidade — they are literally gyms in the streets, around the city. We have gyms, public gyms, with the equipment. And this is a super successful policy, because the older people from the neighbourhood that walk around that gym every day start to go — and we don't need to talk to them — they start to go to the gym, because this behaviour is becoming easy.

Right now in Brazil we are having a heavy discussion regarding the six-by-one scale, where people work six days a week and just have one day to rest. And we from health say: OK, this is not compatible with brain health, because if you have to work six days a week, we don't have time to go to the supermarket. I really think this is a brain health public policy. People cannot work six-by-one in our country while we wait for health behaviours from them. From my perspective, I think this is as important as education: to make these behaviours easier to put into practice.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

I don't think that's a controversial opinion at all. I think it's a very insightful one. And from a public policy perspective, an incredibly important role that governments and policy can take is creating the environments that make the better behaviour possible. I talk often about — I can tell you to exercise all you want; if you live in a neighbourhood that is not safe, that doesn't have sidewalks, that doesn't have a park, if you can't afford a gym membership, you're not going to be able to do much exercise. I can tell you to eat healthily, but if the stores in your neighbourhood are all — I don't know if you have 7-Elevens in Argentina — but if the only store in your neighbourhood is a 7-Eleven, and you don't have access to broccoli and all the things you're supposed to eat, it becomes harder. I really do think there's a role for public policy in creating the environment that allows me, or encourages me, to make those right choices.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I saw a hand — yes. Yes, you.

J

Jorge, *From the floor, Costa Rica*

I was just thinking about maybe some other comments, from other people. Lucía [Crivelli] yesterday showed a picture saying we should think outside the box. And thinking outside the box, for me, is also trying to implement this FINGERS trial into society, where we've been focused on the health system. But what about some other stakeholders that should be involved in this project? Thinking about the Ministry of Labour (Ministerio de Trabajo), or some other entities — it would be nice to hear their comments on this kind of project.

Second, we've been struggling for men to be part of this project. And most of them, in my experience in Costa Rica, have to work, and so they don't have time four times a week to go and train and do exercise and all the implementation of this kind of trial. Thinking outside the box, what about some other stakeholders that might help in implementing this kind of project? Besides the health

department, some other entities that would allow the workers to go and train, allow the workers to go and buy the healthy food? And so, what about some other stakeholders? My question goes around: should we stay in the health system, or think outside the box and take this to some other departments?

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

I agree that we have to widen our spectrum. There are many new factors — environment, air quality, sleep, other diseases, hearing, and more. But the wider we go, the more we need ownership to coordinate it all, because dementia prevention and brain health cut across everything. There has to be clear ownership — or a clear joining-up of all the pieces — because we have to speak with people, societies and institutions that usually do not talk to each other productively. We have to go wider, and we need new stakeholders, as you say, but all of that has to be coordinated into a fruitful product.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

I agree. If we're going to stick to the health system, we're not going to succeed in the space of brain health and prevention. And you mentioned the workplace. At the Alzheimer's Association, we launched earlier this year our Brain Health at Work programme, because we do think, for example, one of the places is the workplace. This is where you're going to find people in their 40s and 50s, when you would really want to start — if they haven't started already — on healthier behaviours. And how can businesses not only educate, but what sorts of things can they do within the environment of the workplace to make it brain-healthier? And so I agree: if you're going to rely only on the health system, we're not going to be successful.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

I want to add that perhaps it is not a yes-or-no question. We need both. We need the health system, and we need to think outside the box, because there is a great deal outside the box that we have to do. It is clear that we need the health system and its infrastructure for other things as well. Again, this is a time of assembly and coordination — and we need both.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Ana Luisa?

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

I think this point helps us to highlight something that has also already been said: that intersectoral participation would be the Ministry of Health, the Ministry of Labour, the Ministry of Public Education, the Ministry of Social Support. I think that would be the best way to approach it.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Great. Thank you. We have time for one more question, and then we'll close out.

CD

Carolina Delgado, *Neurologist, Hospital Clínico Universidad de Chile, Chile*

One way, perhaps, of bringing together the concepts we have discussed is the concept of brain health — salud cerebral — which has lots of definitions, and if you look at them, they include cognition, emotion, care of the brain; all the measures to care for the brain are usually included in the definitions. And perhaps it's a concept that people can understand: that looking after your blood pressure means looking after your brain. And it's a concept that can be kinder than just talking about dementia — a concept that can take in all of healthy longevity and everything we have talked about in terms of care across the life course. As Gustavo said yesterday, brain health doesn't belong to neurologists; it belongs to everyone — to all the people who take measures, across the life course, to look after the brain. Perhaps the concept of brain health can be understandable to people, to politicians. That's what I wanted to say.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you. We have two minutes. We're going to do a quick rapid-fire from our panellists — any parting thoughts on sites to systems. And Ana Luisa, I'm going to start with you.

Ana Luisa Sosa, *Researcher in Medical Sciences, Instituto Nacional de Neurología y Neurocirugía; Professor, UNAM Faculty of Medicine, Mexico*

I think we have a lot of work to do and a lot to learn, and surely, in the search for this path — of wanting to keep the brain healthy to reduce the prevalence of dementia — we will keep learning. And I think that if some centre, some strategy works, we have to share it. Thank you.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

I think the success of the Mexican city with LatAm-FINGERS is something to share. For me, at least, it was the most important thing in this meeting, and I would ask Ana Luisa to share that experience with all of us, because we have a lot to learn from it.

To wrap up: what we are missing is assembly — putting together everything we have been discussing: ownership, in a symbolic sense; advocacy; budget; and measurement. We cannot scale what we cannot measure. All of these things together. For me, at least, this is one of the main lessons of these sessions. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Matthew.

Matthew Baumgart, *Senior Vice President of Health Policy, Alzheimer's Association, United States*

I think the trials were the beginning, not the end. And I think we need to make sure that we see it that way, and that others see it that way — that knowing what can be done to improve people's cognition isn't enough. It's the start of the journey to get people to the point of taking care of their brains. And if we think of this as the beginning of the process, we're more likely to succeed. If we think of this as the end of the process — that we've checked off the box and we now know what to do — we are not going to succeed in the long run.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you to each of our panellists, and thank you for a great start to the conversation. You got all of the juices flowing. We're going to keep it going for the rest of the morning. We're going to switch out our panel; Paulo's going to take over at the podium, and we'll be right back.

Session 2: What More Do We Need — The Unfinished Science Agenda

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Good morning. I'm pleased to co-chair this World Dementia Council activity this morning with Dr Joanne Pike. I'm Paulo Caramelli — Lenny already introduced me.

In the second session, we'll discuss different aspects of these ideas and of the environment we are discussing here. Latin America is genetically diverse — actually, it is one of the most diverse populations we have worldwide. It is also diverse in the things that may shape brain health long before anyone reaches a clinic: education, employment, income, air pollution, violence, migration, among others. LatAm-FINGERS showed that a multidomain prevention programme could be delivered across 11 countries at once, and that it worked. Designing what comes next asks more of the science. It is the cornerstone of building implementation models. This session now aims to discuss what more do we need: the unfinished science agenda.

And it's my pleasure to introduce and invite the speakers to the podium.

First, Dr Maria Carrillo, Chief Science Officer and Medical Affairs Lead of the Alzheimer's Association. I also take this opportunity, as the chair, to thank Maria in person for her very important role in supporting science in Latin America, in supporting the dementia agenda in Latin America — to thank the Alzheimer's Association, but I know you had a very important role in being sensitive to this matter in our countries. Thank you so much, Maria. We are all here because of your work. Thank you so much.

Dr Diego Fernández Slezak, Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina. Diego, please.

Dr Sylvia Josephy Hernández, behavioural neurologist and neuropsychiatrist, Caja Costarricense de Seguro Social, San José, Costa Rica.

And Professor Claudia Suemoto, Associate Professor and Director of the Biobank for Aging Studies of the University of São Paulo in Brazil, and Full Professor at the University of Texas Health Science Center at San Antonio. Thank you very much, Claudia.

The topic here, as I said, is what more do we need: the unfinished science agenda. I'll invite Maria to start with some comments, and then we'll follow with Diego, Sylvia and Claudia, and then open to the audience. Maria, please.

Maria Carrillo, *Chief Science Officer and Medical Affairs Lead, Alzheimer's Association, United States*

Thank you so much, Professor Caramelli. It's great to be up here, although I am not a public health expert, so I will just share with you my thoughts on what we have accomplished together, not only in the United States but now in Latin America. It really is a Pan-American effort that I believe in very strongly, and I'm really grateful that all of you also believed in it and joined us on this journey.

But I do think this is just the beginning. We have demonstrated that this intervention is important — it does work, and it can reduce costs. We now have to actually convince other people about it.

One of the biggest criticisms we did receive, at least in the United States — and that you may have received in your own countries — is that it costs too much money and it's too difficult to implement. I think one of the aspects of implementation science for us is to try to demonstrate, with all of you in partnership, how we can in fact implement these types of programmes and then measure their impact, as Dr Gustavo Sevlever has said, because you do have to continue to measure.

At the Alzheimer's Association, thanks to leadership from our CEO, Dr Joanne Pike, have established a health services line of research, whose role is actually that measurement science: how do you measure the services you're providing to make sure that they're doing what they're supposed to be doing — not only for individuals and their health, but that they are cost-effective? Because a government, a city, a public health programme, a hospital system — that's what they're all looking for.

I think this is our beginning. There is no one size fits all. That's why we have 16 implementation science programmes right now that we're funding, trying to work with all of you to figure out what is the secret sauce for one country that might be different for another. But it may not be that different, and some countries might be able to learn from others. Like we're going to learn from Dr Ana Luisa Sosa's success in Mexico City. How wonderful that we can now potentially embed the LatAm-FINGERS programme across a city as large as that, with over 25 million people. There are things that we can learn from each other.

This is definitely our beginning. But we wouldn't even have got here if we hadn't worked together to demonstrate that we believe in multidomain interventions, and now that they work. We need to take that next step. Thank you.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Maria. Diego.

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

Thank you, Paulo and Lenny, for the invitation to be here. I'm very happy. I'm talking from an artificial intelligence perspective, very different from where you come from — neuropsychology or neurology or brain health. From my perspective, what I see in the FINGERS and POINTER interventions is that they are very human-intensive interventions. And this is a problem, and the results show that if you do not do the systematic intervention, it works, but less than if you do the systematic one. I think that artificial intelligence has a great opportunity here to scale up. And I would ask: how can we make these kinds of human-intensive interventions into more AI-first or AI-flexible interventions? That's a question, not an answer.

I will quote a phrase that I've been discussing with Ismael many times in recent weeks. In the last month, the number one influencer on artificial intelligence, Demis Hassabis, the founder of DeepMind, said: this is marvellous — we have made sand think. We converted sand to silicon, then to electricity, and electricity with the silicon made the chips, and the chips the neural networks, and from neural networks came thought, in artificial intelligence. If we were capable of making sand think, how can we make artificial intelligence help us get these human-intensive interventions to people without the problem, of course, of money and the cost associated with human intervention?

And I think there are three main lines to follow in that sense. First, as Gustavo said, we have to measure. And let me translate the word: we have a first opportunity of using these kinds of techniques — artificial intelligence, social networks, smartphones and all these technologies — to detect people and bring them to these kinds of brain health interventions.

Then we have monitoring. In brain health interventions, we are based on measures that are taken maybe every six months, every 12 months, or every 24 months. And now, with technology and with AI, we may be able to monitor more continuously across the full intervention, or the full life. We have to think about that.

And the third one is about genetics and diversity, which you raised when you opened this session. The diversity in Latin America and in the world is a very important part of the discussion, and here we have an example of 12 or 11 countries that participated in LatAm-FINGERS. Artificial intelligence can help us to identify this diversity and see if we can find genetic differences, cultural differences, language differences, and this kind of stuff, that could help us be more precise in the kind of interventions.

I do not come with answers, only with questions — and let's make AI-first interventions to help in brain health and dementia.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Excellent points. Thank you, Diego. Sylvia?

Sylvia Josephy Hernandez, *Behavioural neurologist and neuropsychiatrist, Caja Costarricense de Seguro Social, Costa Rica*

Hello. Thank you so much for the invitation. It's a true honour to be here on this panel. I've thought about several things — about what the region needs to advance science, and what science can do to advance the region. And I think Latin America, as we all know, is a very heterogeneous region. The needs that we face in Costa Rica may not be the exact needs that are faced elsewhere.

For example, one of the things that I struggle with is trying to convince my bosses of why research is important, because science and research are sometimes seen as a luxury, as something that doesn't address the immediate clinical needs of our patients. But the case for research is the role that science can serve to actually prevent disease and to help our patients. I think that there are some things that can be discovered in some places in Latin America that can be applied to all of Latin America, but there are also individual needs that vary from region to region.

And I'll just also share that there is a lot of ingenuity in our countries. In the Caja Costarricense de Seguro Social, which is the public health system in Costa Rica, the soap dispensers were changed this year. The bags of soap that were used in the old dispensers don't fit the dispensers we have now. The problem was that there were so many bags left over from the old dispensers. And I was very happy, in the hospital, seeing the thousand ways in which each department ingeniously hung up the bags of soap so that people could wash their hands. There were lots of them — some quite creative, right? I think that in part shows that each place is going to have a different need, but that there's a lot of creativity and ingenuity, and that we can use the things we already have to get a result. To what Jorge

was saying just now about what Lucía said yesterday, about thinking outside the box, right? I think that in part we can do that: we can think about what we have, what we need, and how we use what we already have.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Sylvia. It's interesting when you talked about creativity. I do agree that we are very creative in our countries in Latin America. Brazil, for example, is considered a case of success in creating these memes, these figures on the internet that are shared over WhatsApp. People should use this creativity for other, more important things, I would say, in our countries. Thank you so much. Claudia, please.

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

First of all, thank you so much to the Alzheimer's Association and the World Dementia Council for organising this meeting. I think it's so important to get together and discuss with stakeholders. I would like specifically to thank Lenny Shallcross for inviting us.

I think, first of all, I totally believe that the unfinished agenda is related to data. There is so much data in Latin America. We are super lucky, at least in Brazil, because we have Dr Cleusa Ferri, who is doing such an amazing job implementing things, using all the data that we have there, for public policy. She has this very close relationship with the Minister of Health, and a lot of the data that we are generating is being used to develop a lot of programmes. For example, we discovered that, unfortunately, in Brazil 80% of dementia cases are not diagnosed. We have this contrast: we are talking about advancing early diagnosis, while 80% — 8 out of 10 people — don't have a diagnosis. And some of them have moderate to severe dementia.

Another example, that I participate in, is the population attributable fraction calculations. We work with Professor Gill Livingston from the Lancet Commission. They share their code. You must know about this, because this data has been shown here. We reproduced the calculations first for Brazil, then for Argentina, and then we extended these, with Dr Calandri and Dr Delgado, to seven other countries. These statistics that we've been using — that 54% of dementia cases in Latin America are related to 11 risk factors — were created with publicly available data in your countries. Recently, we reproduced the code for the 14 risk factors, and instead of 45%, 60% of dementia cases are preventable in Brazil.

We have done a lot of work with the media in Brazil to show this data. And a funny story is that one reporter called me and said: I'm so worried about the 60%. It seems a lot. It seems horrible. I said: no, that's very good news. We have a huge window to prevent dementia in our country, and let's work on the risk factors. And Professor Cleusa Ferri has done a great job on that. The other day I was at home, wasting time on Instagram, and I saw the Ministry of Health's Instagram account, and they have the 14 risk factors explained, telling lay people how they could prevent the risk factors. That's the way that I see the unfinished agenda being connected to data.

One thing that I've been working on right now, together with Dr Livingston and Dr Ferri, is economic analysis. I'm a geriatrician, and we have talked a lot in the previous sessions about how we make people interested in our ageing population. I don't know if this is a very polemical idea, but I think we should use economic analysis. We've been reproducing analyses that were done in England in 2020, showing how much we're going to save if we prevent hypertension, diabetes, hearing loss and tobacco

smoking. We are producing this calculation for Brazil based on what they have done in England, and for Brazil we are probably saving more than England, but we are underestimating, because there's so little data about the economic costs of dementia in our country, so a lot of things we had to guess. I think the unfinished agenda is also to generate reliable data so that we can do this calculation.

And finally, I want to highlight research funding. We are very, very grateful to the Alzheimer's Association for the capacity-building international dementia research funding that we received two years ago. This has been transformative funding for us. The Alzheimer's Association has given us large funding for five years, and I'm using it to increase our collection to 6,000 donors with full neuropathological evaluation, but we're also doing genetic analysis. And I learned from doing genetic analysis in Brazil, where we have large numbers of donors of African descent, that the benefit is not simply one of equity. There is a benefit for science: the DNA from people of African descent has smaller pieces, and it's easier to discover new genes in this population. We want to expand our reach. We need other donors. For example — we are talking about this with Dr Sosa and Dr Daisy Acosta — Native American descendants because there are new variants that we can discover.

The last thing that I would like to say is also about the brain bank data. We saw — and probably it applies to all of Latin America — that vascular dementia is so important in our brain bank; I believe it's almost equal to the prevalence of Alzheimer's disease. And of course, this is related to all the things that we've been talking about here — dementia prevention and implementation of these trials — because cardiovascular risk factors are probably more important in our region than in other countries. And that's why I think most of the larger effect that we saw in LatAm-FINGERS is related to that too. I think that's it. Thank you.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Claudia. Joanne, would you like to make some initial comments? And then I'll open to the audience, please.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I am struck by several things in this conversation. One of the things that I've been reflecting on since the LatAm-FINGERS results came out is that not only did you conduct an outcome study on an intervention — you conducted a research study on conducting research studies. It was a social experiment on collaboration that requires us all to think about the public health implications of what you just built as a network, and how you continue to maintain that public health network going forward. And it's incredibly important. My hope is that you recognise and value that among each other as well.

Diego reminded us that we live at a pivotal moment — not just because of the knowledge that we're building on brain health, but because technology and artificial intelligence are compounding that knowledge at a rate that we have to attempt to keep up with. And so using technology to supplement what we need to know, and using artificial intelligence to help us build the metrics and the outcomes and understand them, is going to be critical as we think about the necessary tools that we continue to need.

And I think all of you talked about the fact that we have to think about these not just from a cultural resilience and adaptation standpoint, but also the cost-effective models that we need in order to build the public health argument that brain health, and continued investment in understanding the intervention, is incredibly important. I take away that we have so much opportunity. Some of the opportunity has been built, and it's a matter of understanding where we can go from here.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Joanne. I would like to now hear from you. Please, when you use a microphone, identify yourself and say where you work. Please, Gustavo.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

A question for Diego. This is the era of precision medicine, and we are working with data of very different kinds: epidemiological data; genetic data, which means a lot of bioinformatics; MRI, CT and PET imaging; and clinical data. One of our aims is to bring all of these together in a single system, to understand the relationships between the different measurement systems and achieve some clinical impact — not from each type of data separately, but from the whole, and from how the different data systems interact. I think that is one of the things we are lacking, and I would like your opinion on it.

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

Thank you. We have been trying to work on that together with FLENI, so it's a very important question. I think it's more a political question than a technological question. The data is already there in every department — the genetics department, the MRI department, and so on. The main problem is data integration between the different departments. The mathematical models and artificial intelligence involved in analysing that are, I would say, 20 years old now. The main problem is the integration of data: how we get this information into a unified platform to be able to analyse.

Multi-domain models are now gaining a lot of fame in artificial intelligence: the same models can handle audio or text or images, and they represent the information in a unified way so that we can study it. We can study a patient from the speech perspective and the audio perspective and the image perspective in the same model — even with missing data from one data centre or department, you can still analyse different patients. The technology is already there, and my opinion is that the problem is the politics — the humans behind the data governance. It's principally a data governance problem.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Gustavo. Thank you, Diego. Lucía, and then Ismael.

Lucía Crivelli, *Head of Neuropsychology, FLENI, Argentina*

Hello. Thank you for your wonderful presentations. I think that if we try to integrate what was discussed yesterday and what has been presented today, we are seeing some words that repeat themselves, and some gaps that we can find. And mostly those are in bridges. We have to build bridges between data and research and the people who do the actual work in the field. We have to build bridges between the policymakers and the academics. There's a lot of miscommunication and obstacles on the road. I was wondering — on the panel we have specialists from different areas — what would be your suggestion, in your area, for building those bridges with other areas of work?

Sylvia Josephy Hernandez, *Behavioural neurologist and neuropsychiatrist, Caja Costarricense de Seguro Social, Costa Rica*

I've been talking to Jorge about that these couple of days, in terms of people with lived experience. I think that's a good angle. Thinking about politicians who may themselves have had, or who have a close relative with, a dementia diagnosis. Because then they'll have that lived experience, and you can tap into that lived experience to talk about how we slow down progression, how we prevent this from happening at a community level. That would be one thought.

Maria Carrillo, *Chief Science Officer and Medical Affairs Lead, Alzheimer's Association, United States*

I think that's a great question. And there are a lot of probably local — neighbourhood, city, municipality — and then even larger systems to work with. The trick is: where do you start? And I think that there is no right answer. You need to think what connections do you have? For example, Cleusa, who has a connection with the minister? This is something to utilise. And Joanne can talk to this, as the executive director of our lobbying arm, about our relationship with US politicians, and how we sway them to think about what we do at the Alzheimer's Association to protect the people that vote for them. There are ways that we can describe that, and each government will work very differently. It's not going to be one size fits all.

But at a programme level we can share. For example, in Chicago, especially in the Latin American community, we are a little segregated. There are Puerto Ricans here. There are Dominican Caribbean people here. Mexicans — we've got a lot of Mexicans, so we've got a lot of Mexican neighbourhoods. And there are community centres there that take care of individuals during the day. And wouldn't it be amazing if we shared our programme with them and they incorporated it? They want programmes, and they want programmes that work. That would be an opportunity, just even locally in a neighbourhood. And that can spread. These are bridges that we can build.

The challenge is: where do we start? And I think that's what these conversations here have been meant to do — to alert us to the fact that we have to start, and all work together on how we might do that. It's a big elephant, but we can eat it one bite at a time.

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

I will bring your question to my point of view, from research and computer science. You can ask the same kind of question about interdisciplinary research: how can you bridge from medical doctors and neuropsychological studies to computer science and this kind of stuff? The main problem in science is that every discipline and sub-discipline is very jealous of going beyond.

For example, I'm a computer scientist. When I go for competitions, grants and whatever, they always ask me: what is your science in computer science? What have you done to understand computers? And I say: nothing. I use computer science to try to understand mental health and do interventions. In that sense, I think the bridges are about trying to go outside and create networks — human networks, like this one and many others. And this goes for medicine too: at FLENI you have the neuropsychological department, the neurological department, the psychiatric department, and they are very jealous about talking to each other. The same thing that happens to me in computer science happens in the medical community, and in the political community I imagine!

One case I know that had this same problem and solved it, from my point of view, is Rockefeller University in New York. I had the opportunity to visit many times. At Rockefeller, they just dissolved all the schools and departments and everything, and they just created labs for studying something. You have the Marcelo Magnasco lab — Marcelo Magnasco, an Argentine physicist, does beautiful science. The last paper I read from him is trying to understand how dolphins sing. That's what he studies. And he has this lab, and it doesn't matter if it's neuroscience, computer science, physics, mathematics or medicine. I think that creating networks and opening the borders and frontiers between disciplines is one of the main pathways to create these bridges and try to help dementia from every point of view and every research line.

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

I think in Brazil we are doing this. I'm very positive about it. We are building on what Dr Nitrini and Dr Caramelli have built over the last decades, there are researchers around Brazil, from north to south, doing great research. For example, we work together with the Brazilian Alzheimer's Associations — we have two, FEBRAZ and ABRAz. We have noticed something; the congresspeople are long serving, they may change parties, but they are re-elected. This may happen across Latin America. These are the people who can approve the national law for dementia. I know it's still a law, it's not super effective, but it can be over time. And we are working with ABRAz to feed them the numbers that these people need to work with. And I think little by little we are doing that.

Professor Ferri is also doing something that I think is really interesting. For diabetes, hypertension and high cholesterol, Brazil has a wonderful programme. They offer free medication for everybody, like metformin and antihypertensives. This treats the heart but also treats the brain. I think we have to know what is available in our public health system and use it. Do we need to say: oh, this is also good for your brain? Probably yes, but I think it doesn't make a lot of difference in the end, if we capitalise on the things that are already built.

It is those two things: working with the people that stay in power for a long time and also taking advantage of the public system that we have that is already in place and works.

We can build on successful public health interventions as well. For example, the smoking approach is wonderful in Brazil — I think it halved the prevalence of smoking. We should do the same for alcohol consumption. It's hard; it involves a lot of vested interests. And ultra-processed food— it's super bad. And also, a real challenge in Brazil is road safety. The use of seat belts is great for brain health, because people hit their heads less, so there's less traumatic brain injury. In Brazil we need to do something about motorcycle accidents. It's crazy reckless driving habits as they go between cars. But what smoking shows is that it is possible to do public health interventions.

There's a lot of public health approach that needs to be at population level. Because LatAm-FINGERS and U.S. POINTER are focused on high-risk participants. That's great. But I think, for the population level, we should take advantage of the people that are in power and the public system that is already in place for other things, and probably increase awareness. I think increasing awareness in the population is great, but I totally believe what he said — the nudge approach at population level is the way to go, and we should take advantage of what we already have in our public health systems.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Claudia. Joanne, I'm sure everybody would like to hear from you also on this one. I appreciate your expertise and experience in advocacy work with Congress in the US.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I was looking ahead to our agenda, and our next session is on what persuades. And I thought to myself: what a great segue — a little advertisement for our next session about what persuades. Because quite honestly, what has persuaded in the US is votes, and members of Congress realising that Alzheimer's and dementia matter to the individuals that are voting for them. And in that way, creating champions in both parties, and mobilising people to talk about their stories, to raise their concerns, to ask for investment, has resulted in a bipartisan commitment to Alzheimer's and the cause year after year, regardless of who's in office — for decades, versus who's there for a couple of years. But it takes people, and it takes voice, and it takes coordination with civil society in order to make that come together. We will revisit grassroots persuasion, I have no doubt, in the next session as well.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Joanne. We have Ismael, and then Gladys, and then Andrea. Ismael?

Ismael Calandri, *Neurologist, FLENI, Argentina*

My question is for Diego. First, thanks for bringing the thinking sand to the table. Thinking about the lifestyle interventions we have, one of the cornerstones is socialisation. It's really hard to separate the effect of that part of the intervention from the rest of the lifestyle intervention. I think there is little evidence at this point, but it's also my feeling that AI can work against socialisation. How do you think AI can be a tool for the implementation of lifestyle interventions, overcoming that barrier?

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

When I started speaking, I talked about the three research challenges we had. That would be the third one: the intervention part. That's the more difficult one. And I agree with you: AI is making people less social by every measure you can take. For sure the intervention part is the most difficult one to answer, but the first two parts of the research challenge are still there and should be addressed as soon as possible. The numbers Claudia gave about 80% not being detected in Brazil — in Argentina it must be almost the same – is amazingly big. And that's something that must be solved as soon as possible using AI tools, and that doesn't affect socialisation. I would expect to start using this kind of technology on monitoring and detection first, and then think about how we can do intervention — if we can do intervention without making socialisation a problem. I would start with the first two avenues of research.

Gladys Maestre, *Professor, University of Texas Rio Grande Valley (UTRGV), United States*

Thank you and thank you for this very interesting panel. I'm going to advocate for the poor. Implementation of an intervention is different when you live in real poverty, in Latin America and in low-resource settings. And I'm not talking only about Africa: low-resource settings are everywhere, even in high-income countries. I think we need — in trying to bring LatAm-FINGERS and U.S. POINTER to the community — to really assess the environment and the conditions, and to implement what can be done by the majority of people.

In Latin America, the majority still do not have access to smartphones — at least in Venezuela. We don't even have consistent electricity in Venezuela. And I was talking to Daisy, and she was saying: yes, in the Dominican Republic it's the same thing with electricity — many hours a day without electricity, and no water. When you go and talk about brain health and healthy ageing and all that, if you don't account for this, then the result of implementation in the community is going to be: this doesn't work here.

Where I am right now, in South Texas, on the border with Mexico, for example, when we ask people what helps you age better, they say: praying, seeing my kids at weekends, having my grandkids here — because that's free. We need to account for ways to intervene and to stimulate these real-life practices. And how can we really track how we are implementing, so that we really learn whether this is something that is going to work?

The Diabetes Prevention Program has shown that even in the US, with all the resources, there are differences in the outcomes. And the effect of the DPP is even larger than for U.S. POINTER. We could end up implementing something and politicians are going to say: this is not worth investing in. My call is to think of the poor, and their conditions, and the strengths they have to show us how to live to become healthy. We all know people who are extremely poor and very resilient. We need to find out why, and how to bring that to our laboratories as well.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you for raising this important point, Gladys. Sylvia, would you like to comment?

Sylvia Josephy Hernandez, *Behavioural neurologist and neuropsychiatrist, Caja Costarricense de Seguro Social, Costa Rica*

I think that's an excellent point, Gladys. And at least what I've seen in Costa Rica is that a very important part of addressing this issue is taking ownership of public space. When there's insecurity, that means that you can't go out. But there are strategies I've seen where it is the community being present in a specific area that makes it safe, and that then allows people to leave their homes. I run with a community group — all ages, all everything — and we run from five to six in the morning in an area where, if it weren't a group of us, 10 people running together, perhaps one person alone would feel unsafe. But because there are so many of us, and there's the coach from the municipality, that space is safe not only for us but for people who may be walking next to us. I think that is one strategy that makes it possible for people to be able to leave their houses and feel safe in their community.

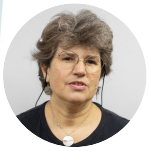
Maria Carrillo, *Chief Science Officer and Medical Affairs Lead, Alzheimer's Association, United States*

I would agree. You're co-opting public spaces, right? And this is one of the biggest reasons why we wanted to invite University of Texas Rio Grande Valley to be a part of the implementation: because we're looking for different settings to be able to demonstrate, and we look to you, an expert in that area, to tell us what would work. How could we then convince the state health department in Texas to fund this, to make it a part of their brain health programme? This can happen, but we do have to co-opt those community settings.

Like the centres in our community in Chicago — they're free; they are actually city-supported. If we can embed this information in that programme, they can begin to implement it. And we're co-opting that programme because those people are there: they don't have money for respite care, they don't have money for daycare or a paid caregiver at home. They're sending them to these programmes, and those programmes have activities. Why can't this be one of the activities? I think we do need to co-opt, but we need expertise like yours to know where and how.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Sylvia. Thank you, Maria. We go to Andrea, then to Gustavo.



Andrea Slachevsky, *Professor, Universidad de Chile; Director, Memory and Neuropsychiatric Center (CMYN), University of Chile and Hospital del Salvador*

I'm talking about the data, but I think it's important to ask how the data can matter and speak to people — and perhaps that's something that sometimes falls short. I'll tell you something that happened in my country.

In Chile, at a certain moment, they started to talk not about the crime figures but about the sense of insecurity. Actually, Chile, which is not an insecure country but is one of the countries with the most fear in the world. And with that, there are people who won elections. In that case, I think, they started using data to be meaningful for people. Indeed, they were able to change the perception of reality. But I think it's important to ask how all the data being generated that we have in brain health, in dementia, can become data that turns into a story that has an impact.

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

I have a response to that, Andrea. There is research — a survey done this year in Brazil — that shows that the largest fear of the population is dementia. And this is among middle-aged people; I think that's the most surprising thing. Cancer and cardiovascular disease come after dementia, and that was something that really surprised me. I think you commented on that too for some newspapers, Paulo. And people are afraid of losing their autonomy, because that's what dementia really takes: independence and autonomy, the power of decision. I think we don't work with this information a lot — people are afraid of dementia the same way, maybe, they are afraid of violence and other things.

And another thing that I would like to add. There's a paper, I think from 2008, called 'The Mental Capital of a Nation' that argues a nation's prosperity is really related to its mental health. A nation that ages with a lot of dementia and dependence cannot prosper economically. I think we don't work with that information much with politicians and policymakers: that living with dementia, and mental health, is going to be a large economic burden. And we don't make this case much in public policy.

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

I can say something from the data perspective. There's a phrase that a friend of mine, Daniel Steingart, uses: torture the data until it says what you want. And that's something that happens. I think your comment is more about politicians and people who talk with the data than about the data itself. We should be able to train people and talk about this: almost any data can be used to say one thing or another.

Gustavo Sevlever, *Director of Education and Research, FLENI; Director, Fleni–CONICET Institute of Neurosciences, Argentina*

I was struck by the figures Claudia mentioned — about 80% of cases without a diagnosis. If we have the same, or nearly the same, in Argentina and across Latin America, it changes the landscape of what we are doing, because the numbers are completely different. It even changes the perspective on implementing preventive medicine. I wonder — and I want to ask the panel — whether we need to set up a diagnostic programme for dementia along the lines of the Papanicolaou test. I am a pathologist, and the Pap smear changed the landscape of cervical cancer — enormously. It is a success story in going from science to implementation, policy and public health. Papanicolaou should have won the Nobel Prize, because he changed everything in cervical oncology. So I ask the panel: do we need a detection programme wider than the one we have today?

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

I would just like to add that it's not only our problem. Of course it's worse here, but it's also a problem in high-income countries. The numbers for the US and, for example, England are around 50%, as far as I know. And we have a paper that was published last year by Dr Aliberti comparing data from the HRS — the Health and Retirement Study — and ELSI. And of course they have less than we have in Brazil, but it's not that much difference. And, more related to what Dr Maestre said, it's much higher in people with lower socioeconomic status, because they have less access. I think it is a great problem, and I would love to hear how else people think we can solve it. We have done something — Paulo can say; he participated a lot with the Ministry of Health. If you can tell a little bit of this story —

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

No, you can explain. Go ahead.

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

Once we had this number, which came from the national report — and I think that's something every country should have: a national report where you know your numbers — Dr Ferri, Dr Caramelli, Dr Nitrini, and I contributed a little bit, developed a small protocol to be applied in primary care by primary care staff, not even physicians: a three-to-four-minute evaluation that asks about memory problems, and if positive, it goes through primary care for evaluation. This raises the idea that the diagnosis may be [made], but it creates another problem. Dementia requires neuroimaging. In Brazil, this is a very strong problem too. You see, we solve a little bit of the primary care, but then we need to improve the technology after that too.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

I agree that this has been a very important step from our Ministry of Health, and we're very glad to have collaborated with it. On the other hand, it also creates another problem, because these cases were hidden in some way. Now they are in the system, so they need blood tests and imaging, and to go into a care pathway. We'll see how it happens, but of course this needs to be done, and fortunately the Ministry of Health thought about this. Diego?

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

Yes, I can talk about it from the artificial intelligence side: how to scale up detection. That's the main problem. We have been working with Lucía for two years on a project on how to do neuropsychological tests without the need for neuropsychologists to go to the places, so that you can scale up — a similar test, a similar detection; not a diagnosis, but a first set of alarms to get people to the hospitals or clinical centres or wherever. That's the first step.

I went with that project to the Province of Buenos Aires, and they were talking about exactly the same problem you were describing. They told me, literally: what do I do if I detect the 80% of people with dementia? The project, instead of building the AI tool to go everywhere and try to get people into the system, became: let's take one hospital or two hospitals and go to the neighbourhoods. The scale-up is really slow. Because if we detect the people with dementia, we have a public health problem: we are not able to attend to those people. But I agree, we have to measure those people who are invisible now. And we are working on it.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Diego. We are approaching the end of the session, so I would like to invite our panellists to a final comment — maybe just to provoke. I understand that yesterday and today we have been discussing risk reduction, but also the care of people who already have a diagnosis, or who have dementia without knowing the diagnosis. These are two very large issues, very large challenges we have. And what goes first, in terms of attention from policymakers — or can we go at the same time? Let's begin with Sylvia, and then Maria, Diego and Claudia.

Sylvia Josephy Hernandez, *Behavioural neurologist and neuropsychiatrist, Caja Costarricense de Seguro Social, Costa Rica*

I think that there are tools that can be used in both settings, in the sense that what was shown by FINGERS and POINTER was also shown by Dean Ornish in terms of slowing the progression of Alzheimer's. If we create these opportunities, these strategies to prevent dementia, we can actually use those same tools to slow the progression of dementia once it's diagnosed. I think you are solving two issues: if we do diagnose the people that haven't been diagnosed, then they could potentially use the same resources to slow the progression of their disease that we're already using to prevent the disease in a different population.

Maria Carrillo, *Chief Science Officer and Medical Affairs Lead, Alzheimer's Association, United States*

I think one of the things I'm really excited about — the possibility; it could be just a dream, I don't know, it could be that we don't get there — is that with our Pan-American study, and now being able to have a long-term extension for LatAm-FINGERS, as we do also in the United States with U.S. POINTER — which the Finnish study actually never had — we have the ability to follow individuals longer and maybe make even bolder statements about progression, or time to event.

These individuals all originally started as more or less cognitively intact. That's what we looked for in the populations. Could we follow them and look at time to event for those that were in the structured versus the flexible arm? Could we look at that in our next study — which we hope will have some Latin American sites, where we will try to test a structured lifestyle intervention, maybe 'structured light', something a little bit lighter, but combine it with maybe a pharmacological metabolic agent, like a GLP-1, and see if we get a boost, and follow long enough, again, to see if we can slow that time to event?

Because time to event is what people resonate with: I don't want to have mild cognitive impairment. I don't want to go there. If there are things I can do to delay or avoid it — governments would want that, public health would want that, citizens would want that. And so these are different messages. My hope is that, working together, we can create that type of narrative, one that is evidence-based. I think we all know this; we have to actually show it. Thank you.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you. Diego?

Diego Fernández Slezak, *Director, Applied Artificial Intelligence Laboratory, Universidad de Buenos Aires, Argentina*

While FINGERS, POINTER and these studies plan and design the future interventions, I would say that from the artificial intelligence point of view we should be focusing on detection and continuous monitoring. How can we get these 80% of people into this world of information about cognitive impairment and dementia, and how can we make technology help us with the intervention — not doing the intervention, but continuously monitoring the progress of cognitive decline — and maybe with genetic diversity and cultural diversity. I would say that these first two steps are absolutely needed and should be addressed as soon as possible.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Diego. Claudia?

Claudia Suemoto, *Associate Professor and Director of the Biobank for Aging Studies, University of São Paulo; Full Professor, University of Texas Health Science Center at San Antonio, Brazil*

I echo all the panellists. And I would also like to add that, at least from our perspective in LatAm-FINGERS, there's so much data that we can generate to understand how people adhere, and who benefits from adhering more, and this could bring some messages to the public. And I would also like to add — I totally agree with the implementation session yesterday — that with LatAm-FINGERS, one of the main criticisms that we get is the high education of our participants. How are we going to translate this for the real people who are going to consume it? I think this is a great research agenda for us: to understand, for example, from the data that we have — we have a few people with lower education, thanks to Dr Daisy Acosta and other centres — what are the best ways to reach them, to evaluate them, and to make them adhere to the intervention. We're looking forward to producing this research. I totally believe that we should be supported by our data. And I'm very excited about the next chapter.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Claudia. Joanne?

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I keep coming back to community, and where we started this conversation around what we still need from an evidence base. And I think what we've established here is the need to understand what communities need from a policy intervention. How do we build the environment to be successful? Whether that's parks that are accessible, or whether it's a strategy around funding at the city, county or municipality level, in order to ensure that these interventions are continued and looked at. As a public health professional, I'm always going to want to know how we get to the community and how we ensure that people can benefit from any type of intervention. I think that's the biggest next step.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Joanne. Very good final words. Before going to the break, I ask for a round of applause for our panellists and our co-chair. Thank you so much. We break for 30 minutes, and we'll be back for Session 3.

Session 3: Making the Case — What Persuades

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Welcome back. Thank you again for all your engagement and questions, but also for the discussion, comment and opinion. I think that's the way we move forward; that's the way we advance science. We don't always have to agree. And in fact, science advances better when we don't agree, but we have the opportunity to discuss it. Let's continue with that thought in mind, about what persuades decisionmakers. And those decisionmakers could be people, individuals that need to change behaviour, or they could be policymakers that need to make investments within interventions.

We have an incredible panel joining us today for this conversation. We have Dr Nilton Custodio, the head of the Instituto Peruano de Neurociencias; Irene Hartmann, the staff writer at the Society section, Clarín; Profesora Noemí Medina, member and former president of the board of directors of Alzheimer Iberoamérica, here in Argentina; and Dr Jorge Neira, president of the Academia Nacional de Medicina de Buenos Aires.

As we face public health and trying to change opinion and build on where we are, let's engage in a conversation about how do we then bring people along, and bring the policymakers along — the decisionmakers that we know we need to include. We've talked about multisectoral needs, bringing others under the tent to be with us. We've talked about grassroots advocacy and having people tell their story to persuade policymakers. And we also heard Gustavo talk about Papanicolaou and the work he did on the Pap smear. But there's an important part of the story I could add to Gustavo's, and that's the advocates — the women who demanded to receive a Pap smear after that innovation came about. We wouldn't have seen mass use of the Pap smear just as a result of that innovation. It needed advocates. It's both sides of this. And how do we bring that all to light? Let's start, if we can, with our introductions and commentary on this. Irene.

Irene Hartmann, *Staff writer, Society section, Clarín, Argentina*

Thank you very much for inviting me. My name is Irene Hartmann; I work at the newspaper Clarín, in the Society section, and I mostly cover health and science. And what unsettled me a little about the proposal for this session was the word "convince", because the truth is you have to bear in mind that, although we in journalism are often the ones who bring down to earth the information that you develop — that you seek, to get out to society — we as journalists never seek to convince; if anything, that would be a serious journalistic error. What we seek is to inform. We don't seek to generate, an action in the person, but we do seek to put issues on the agenda. I was thinking, regarding Alzheimer's, of five aspects that I'll try to summarise briefly, and I hope they won't be boring for you, who already know the subject amply — but, from the journalistic perspective

On the one hand, Alzheimer's, for us as a subject, has the capacity to speak to everyone. And that, from a journalistic point of view, is super powerful — it's really very powerful — because everyone knows someone who has Alzheimer's or knows someone whose family member does. And that is making the topic easier.

But we have something on the horizon that has to be borne in mind, and not all colleagues always bear it in mind: that information overload about Alzheimer's can also generate fear, yes, and fatigue and wearing out of the subject. It's always a question of balancing in that sense: not arousing fear and not exhausting people with too much information on the subject.

The second point is as a journalist — I'm talking about myself – how do I go about it when I have to tackle this subject? One is tempted to write an encyclopaedia, "Alzheimer's", but that doesn't work. Comprehensive reports on the subject do work, as a way of reaching people, of putting the subject on the agenda; but what works better are focused stories. It is the focused question that one sets out to answer in an article. What about such-and-such a symptom that many people have? What about such-and-such a behaviour that one could adopt with a view to avoiding a certain thing? What about this particular treatment? In putting a topic on the agenda you have to try to avoid the encyclopaedic.

And the third is that stories have a lot of value. Life stories have a lot of value because you manage to bring feeling to a subject that may feel remote to many readers. And the life story of a person — for example, not an older adult, but someone fairly young who is beginning to have symptoms of Alzheimer's — is a way of putting the subject on the agenda without aiming to convince but showing the relevance of the subject. And that is a valid journalistic strategy which, as long as one isn't claiming that the general can be projected from the particular, has, I think, a lot of value.

The fourth also points to detail — but not the detail of a person's life story; rather something I found after many years of covering science, and after fighting with many editors. Sometimes I'm interviewing one of you — a doctor, a scientist — and at some point I ask: but how exactly does that process work, that biomolecular mechanism? And they say: well, it's very technical — and they don't want to explain it to me. And I realised that it's very valuable for them to explain it to me, because if I can explain it to the reader, the reader cares about knowing it. There is always a group of readers who want to know how things work, who want to understand — especially since the pandemic: what happens with such-and-such a drug or such-and-such a tumour cell, or even, in Alzheimer's, what the processes in the brain are like. It's something that's interesting to bear in mind and shouldn't be left aside, I think, because the reader feels empowered when they understand without needing to be filled with technicalities.

The fifth point is something fairly obvious: Alzheimer's, like many diseases, is subject to a big problem, which is misinformation. And so, one thing that particularly concerns me when communicating is — without trying to convince — not trying to get too many people to read my article either. Avoid misleading headlines, avoid exaggeration, and give transparent and solid information. Credibility and transparency are two fundamental values for me from a journalistic point of view, precisely so as not to hold back what may not be good news about what one is communicating.

The last thing: I am aware that we have three types of readers, the ones that were set out here: the general public, health professionals and decisionmakers, who may be funders, may be legislators, people who are going to develop access policies. And the truth is that they are all potential patients for us. Of course, each topic focus will go more to some and less to others, but they are all potential patients. And ultimately, I think there are many shared interests from a journalistic point of view. Thank you very much.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you. And I appreciate how you started, even with a point of contention in the title: not persuading, but informing. Thank you very much. Jorge.

Jorge Neira, *President, Academia Nacional de Medicina de Buenos Aires, Argentina*

First, thank you very much for the invitation. It really is a pleasure to share some experiences. I find what Irene was just saying about information very interesting. I'm going to tell you a story from our work. We share a sponsor with Gustavo Sevlever, which is the Fundación Pérez Companc, and almost 20 years ago the Fundación Pérez Companc asked us to do a project on the care of trauma patients. And when we talk about trauma — that's why we created Fundación Trauma many years ago, we wanted to make the issue of trauma visible.

Trauma is a disease, and it is the disease that kills and disables the most young people, between 1 and 45 years of age, worldwide and 90% of trauma deaths occur in low- and middle-income countries. Four and a half million people die every year from some type of trauma, and 10% of those are children. It is a disease that really matters a great deal, and nobody recognises it as a disease. In 1966, in the United States, there was a publication by the IOM — at that time the Institute of Medicine — that said: trauma is the "neglected disease of modern society". And one might ask today: how many of us still think trauma is still the neglected disease? Because in reality, if you ask most people whether trauma is a disease, they are unlikely to say so. That was the objective we had first: to make it visible.

And following what Irene was saying on the question of how to report it: in reality trauma is often broken up. You can talk about vehicle crashes on the one hand, about homicides, suicides, and it seems they are all different things. Yet in reality they are part of the same disease, which is the exposure of the body to any form of energy, or the absence of heat and of oxygen. All those diseases are the ones you have to take into account. And those diseases can be intentional or unintentional: intentional, when there is intent to cause harm; unintentional, the ones that happen every day with falls, vehicle collisions and so on. And this is easy to say and difficult to get across, because, as Irene was just saying, how do we get people to understand this?

And so our project was how to make it visible. And when you say "how do I make it visible?", what I have to look at is not only having the levers, or the means, I need to do it, because that's very difficult. Rather it is generating changes to make those barriers disappear.

The first thing we said has to do with a registry: a data registry, a registry of trauma patients in public hospitals, which allows us to know what is happening and to work with accurate data — with data that, as Irene said, is credible. And to me this seems to have been the foundation of our programme. The first thing is the data. Of course, data don't in itself change things. If I give people all the data, people are persuaded only little by little, so we have to look for other strategies. And its impact varies depending on the audience - data is useful, for example, perhaps to persuade governments, or to persuade institutions about how we need to proceed.

The other thing is training. Training the people that work in hospitals in trauma patient care. That's our second foundation: that the professionals all have a similar language, a single language, that allows the treatment to flow.

The third is quality. How do I maintain quality? That is done in two ways: one is having the data and knowing what I have to do for quality to be sustained; but, in addition to that, having funding that makes the model sustainable.

That is the model. It started with the Fundación Pérez Companc, the same as FLENI and the same as other structures that had the Foundation's support. But we have now diversified. We have several sponsors. And the interesting thing is that in reality it's public–private participation. What we do is work with private funds so that the public structure receives not the funds, but the elements needed

to change what we have to do. And this is something important, because starting from a private activity one can improve — make big changes — especially when one improves the management of the place.

There we have how to convince governments, how to convince institutions, how to convince people and how to convince funders. And this is, in a way, the feasibility project you have to do to say: how do I work with all four at the same time, and get them to join the effort? And it seems to me that, based on everything you know and are working on, what you are going to do is commendable. I hope it can be developed quickly, because I think it is a problem that deserves the attention of the community, both medical and non-medical.

At the Academy — now I'm putting on the other hat — at the National Academy of Medicine, what we often do is try to bring institutions together to come and discuss an issue, and then for that issue to reach not only the medical community but the general community. And it seems to me that the general community is fundamental, because it's like translational medicine — you do it from the laboratory or from the medical community, you have to transfer it to the community. And for that, it seems to me that what Irene was saying — this link with communicators, who I believe don't have to convince but have to inform — can be extremely useful.

I'm simply not going to go on piling up data, because we have 20 years of work, but I think it's interesting to think in this sense: that you have to spread the objectives across different levels so that this is sustained, because otherwise it often happens that you get the budget, you work in one place, but you can't keep moving forward because you lack state support, or government support, or the institution's support. We always insist that the programme, when it goes into public institutions, belongs to the institution and not to Fundación Trauma. There has to be ownership of the project. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Jorge, I think you started with exactly one of the themes we've been hearing constantly: that your argument, your persuasion or your information has to start with data and metrics, and we need to have that to keep having a long-term impact. Thank you. Noemí.

Noemí Medina, *Member and former President of the Board of Directors, Alzheimer Iberoamérica, Argentina*

Good morning, everyone. The view of this panel is clear: scientific evidence rarely persuades on its own. In Latin America and Ibero-America, if we present a decision-maker with the prevalence chart we will compete with a hundred other public health priorities. For the message to be heard, brain health must sound like something they already love, already understand, and feel they cannot afford to lose.

I am a member of the Board of Directors of Alzheimer Iberoamérica. This year the president is Dorita Quesada of Mexico, of the Federación Mexicana de Alzheimer. We have a scientific committee. There are 21 countries, but each country in turn has associations: CEAFA, the Spanish Alzheimer's Confederation, is 300 organisations; the Federación Mexicana de Alzheimer, more than 22 organisations; Federação Brasileira das Associações de Alzheimer (FEBRAZ) is also a federation. And in Argentina we have organisations in different provinces. A network is being formed which say, has been working formally for years, but now needs legal status.

Alzheimer Iberoamérica has found that the most effective arguments in our region don't come from laboratories, but from popular culture, shared passions and the life stories of public figures.

I'm going to highlight three cases. First, using football and popular culture to influence public policy. The Asociación Lucha contra el Mal de Alzheimer y Alteraciones Semejantes (ALMA) has run Argentina's Football versus Alzheimer's project, which has been going for some years. What works in this project? Football — our country's greatest cultural passion — was used as a bridge to connection and memory. The collaboration with the University of Barcelona and the magazine Líbero evolved into an alliance with the publisher Torneos y Competencias to print a special edition of the legendary magazine El Gráfico — which hasn't been published for years, but was reissued for this project — full of reminiscence exercises.

What persuaded the authorities? They saw the value of prevention integrated into local popular culture. The Instituto Nacional de Servicios Sociales para Jubilados y Pensionados (PAMI), the national social security institute for older adults and pensioners, took on the mass distribution, through its branches for older adults throughout the country. The lesson: turn brain health into an accessible, festive and cultural — not medical — tool.

Another example, also of demystification — La cima de la vida, the summit of life. This was carried out in Ecuador by Trascender con Amor, Servicio y Excelencia (TASE). To convince society and legislators that Alzheimer's is not normal ageing, it was necessary to break down stigma with the help of national icons. TASE used Ecuador's most famous mountaineer Iván Vallejo, who climbed Everest six times, and, more recently, the moving reality of the football coach Edgardo "Patón" Bauza, and the journalist Alfonso Lasso. Why does it persuade? Because it moves the problem from cold statistics to the loss of living heritage and national identity.

But what did Fundación do with these very well-known and famous personalities in Ecuador? They made documentaries. Iván Vallejo climbed Cotopaxi and, as he went, told the story of his experience as his mother's carer. This was shown on every screen of a cinema chain across Ecuador. This was very important. You always need someone to back you in these projects.

Recently, as we said, there's the moving experience of coach Edgardo "Patón" Bauza. He was a very famous coach; he's Argentine but lives in Ecuador; he has a teenage son; he is fairly young. He is now in a Fundación residence, his disease is quite advanced. But the idea again was a documentary that would also be shown throughout the country. And it ended with an appearance, after this showing, at the packed stadium in Quito. He went with his wife and son, and they applauded him. You have to see these documentaries.

Another example, a very recent one, is from Peru. This is also a documentary that won three Effie awards. The Asociación Peruana de Alzheimer (APEAD) worked with McCann Lima on a public awareness campaign that won gold, silver and bronze at the 2026 Effie Awards. It shows how dementia can move beyond clinical discussions and reach people through popular culture. In the film, a character gradually loses his memory and his connection to his community. The story makes that experience visible in a way that is both accessible and moving. You should see it. It's beautiful.

Another example, this one highlighting how everyday language has to be taken apart, done by ALMA called Demencia Registrada. The strategy of this campaign was to trademark a popular idiom we have, "fingir demencia", which means to feign dementia. It is a phrase people use to mean deliberately ignoring something. ALMA registers this slogan, and, with humour, starts serving notice on influencers and public figures who used the expression, to remind them: dementia isn't feigned it is a

real condition. Why does this campaign persuade? It captures the attention of young people and content creators in a disruptive way, forcing a conversation about mental and brain health in digital spaces where the subject had been invisible.

Turning from public awareness to policy, Chile shows what sustained civil society engagement, in the case of Chile from the Corporación Alzheimer Chile, can achieve. Dementia came to be treated as a public health priority requiring a coordinated response across the country. Chile introduced its first National Dementia Plan in 2017 and has since updated it for 2025–2035, with greater attention to implementation in different regions. Its experience shows the value of keeping government, health services and civil society engaged long after a plan is announced.

Argentina offers another example of how that pressure can be translated into policy. The milestone in Argentina is that this year, after years of advocacy, the national Ministry of Health made official the Plan for Alzheimer's and related disorders. Yesterday we heard Dr Manes mention that the national bill on Alzheimer's and dementia has also been approved in the Chamber of Deputies. It now has to go on to be considered in the Senate, and we associations are working to influence the senators to approve this bill. What persuaded the legislators in this case? Showing them that a National Plan is not an expense but an investment to mitigate the collapse of family care systems and standardise clinical processes. They were persuaded by taking dementia out of the private sphere and placing it as a human right and an unavoidable macroeconomic challenge. The argument that convinced the Ministry of Health and the legislators was that of human rights, standardisation and relieving the burden on family carers, backed by the push of organised civil society.

To conclude: what should the case for brain health in Ibero-America sound like, to be heard by the unconvinced? It shouldn't sound like hospital costs or irreversible decline. It should sound like football, like our everyday sayings, like protecting the summit of life and, finally, like sustainable public policy. Those who make political decisions react when they understand that legislating on dementia means protecting the identity, the dignity and the economic future of their own people. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you, Noemí. You highlight exactly the role of civil society in bringing forward people's voice and personal stories, to bridge that to advocacy in so many different ways. And as a side note, I moderated a panel with the researcher who did the magazine — with the researcher who did the magazine on the football story for ALMA, at Alzheimer's Disease International last year. It was a good connection. Nilton.

Nilton Custodio, *Head, Instituto Peruano de Neurociencias, Peru*

Thank you very much to the World Dementia Council for inviting me. Allow me to reflect on why I think we could fail in transferring the science from our laboratories to communities.

First, I want to raise this dilemma: when we clinicians see patients and prescribe them not pills, not medicines, but advice "*put on your trainers and go and exercise*" the reaction is they stare at you as if to say "*and this is what I came here for?*". And we have the same conversation with cardiologists, with endocrinologists. It's a stigma that we health professionals have: the person who comes looking for help must leave with a medicine.

Second, Latin America reflects total socioeconomic and structural inequity. I'll take Peru as an example. Peru. Despite our macroeconomic growth — 10% growth in real terms over the last decade with 3-4% growth over the last couple of years— about a quarter of the adult population did not complete primary education, and almost 40% of rural older adults are illiterate. We have a big challenge.

And third, it has to do with the deficient health systems in our countries. Significant unmet health needs, especially in rural areas. A shortage of hospital beds. Costs to be met by households.

It's easy to deduce that if we manage these three points, we could get closer, reach the people who need help.

And I want to take up what Noemí said. The associations have taught us that people say: "Nothing about us without us. You work on research, you work on creating medicines or on helping us with carers, but we aren't directly involved in the decisions and in the design of the projects". And that's very important.

I think, in that sense, first we must get rid of the stigma that we health professionals are obliged to produce medicines. I think journalism and all of civil society should work on this. Second, person-centred care, with the real conviction that we are not all the same, that there are people we don't reach. It's true that we are working on that. Democratising diagnosis and democratising treatments should be an urgent task. It doesn't depend only on scientists; it depends on all of civil society and on decisionmakers. And finally, government support so that every health centre can make a timely diagnosis for every person, regardless of socioeconomic, cultural and educational level.

Happily, work is being done in that direction. A large project in Peru is called IMPACT Salud, with funding from the British Government: using a tablet with a brief cognitive and functional assessment, a community health worker interviews people at community health centres. And we have since validated that this correlates with neuropsychological assessment, and we believe it will work at all levels of care. And then the Pan American Health Organization will recommend to the Ministry of Health whether it is useful, following the path of the community mental health centres, which work very successfully in Peru. I think that if we take these observations on board, we can reach the ideal in the future. Thank you very much.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Nilton, you gave us three challenges right there, and I think that's a great way to transition to Paulo. Nilton gave us the challenge of equity within this. Very, very difficult challenge to overcome everywhere, but not least in Latin America. Thank you so much.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

I think we heard complementary and very interesting viewpoints from the four of you. Just a quick comment — I would like to leave space for the audience to comment and make questions — but it's interesting that, I think, some of you — not only Noemí and Irene, but also Jorge, because of trauma — have seen how cases in young people have an impact on the public.

For example, recently in Brazil we had a very well-known YouTuber who was diagnosed two months ago with Creutzfeldt-Jakob disease — a very rare form of dementia, one case in one million population. But this has raised an interest in the public, and so many interviews, so many stories in newspapers, on TV channels, about such a rare form. But given he is a very well-known person, and

young, this has changed things completely. And probably what you have said here — some of the examples you gave, for example of Bauza in Ecuador, and others this is a way of telling the story that has impact.

I also remember, in the United States, the story of Bruce Willis, for example, when he was diagnosed— the impact, because he was a very well-known people, but because he was relatively young. And we go back in a way to what was discussed in the previous session: the impact on someone who is still in a very productive phase of life, in economic terms, compared with someone who has retired; and also, in a way, breaking the idea that this only affects older adults. It can affect young people.

Irene Hartmann, *Staff writer, Society section, Clarín, Argentina*

I was going to comment because my impression is that, since people are also having children later and later, and children live with their parents until later, it is more common that the person who starts to have symptoms of dementia isn't the grandfather, it's the father. This starts, it seems to me, to show up among young people, perhaps in their thirties, who perhaps don't have children yet, and even live with their parents, who are quite old. Not counting, well, the cases, of genuinely younger people who can develop the disease. It's very interesting.

I wanted to add a comment to what the Professor Custodio says, because in Argentina — I don't know how many of you are from Argentina, but — the big problem at the Ministry of Health is always the budget. Everything to do with older adults the insurance scheme in Argentina, Programa de Asistencia Médica Integral (PAMI), is the biggest burden that falls on the budget. It is a big pot of money, and very attractive in lots of ways to those who runs PAMI. Then the other issue is high-cost medicines. This is what represents the biggest problems, I think, not only in Argentina but in many countries.

Now, the FINGERS study shows that in fact, as far as I understand, with my limitations, what is required of the patient and of health professionals is a change of lifestyle. But that is really high-cost. Because in a country like Argentina, or even in Peru, it isn't just a change of lifestyle; it is a change in life possibilities. And that involves the authorities. And they should invest much more so that there is much less of the population with deprivation of all kinds. You will know this well: it's very easy to tell the patient to eat healthily, but how much does the healthy food basket cost, and so on? There are many, many problems of access. What seems not to be high-cost perhaps is, at least in some countries.

Jorge Neira, *President, Academia Nacional de Medicina de Buenos Aires, Argentina*

Just a few comments on what has been said. It seems to me that equity is an issue for our country. The issue is access to health with equity. That is the hardest thing to achieve and what creates the most difficulty. And I agree that this is one of the concrete objectives. Having data is very important for us. It's a country with erratic data, and it seems to me that what data are for is to make strategic interventions based on the data. We have 100,000 patients in the trauma database, so we can establish some intervention strategies. The problem is how that intervention can reach the community so that the community changes its attitudes, which is much more complex, and I think that for that what is needed are consortiums of organisations that work on the issue.

And it seems to me that patients — or, in this case, family members of patients — are something one should bring into the decisions of the project, because we always have, as was said before, the well-known person, the person who had trauma, who had a head injury, who had such-and-such. Those are the cases that raise awareness.

But in reality what you have to look at is everything to do with prevention, and everything that can be done. For example, the work Gustavo was talking about, where there are some things to do with changes in attitudes, which can be easier to implement. People are waiting to be given a pill to cure themselves, when in reality there are many things that can be done.

The issue is how to reach the community, and it seems to me that this consortium should be made up of many of us, because the communicators can't do it alone. We have to tell the communicators what we believe needs to be done — and we doctors are bad communicators. The support of the communicators is very important, because they have to say how to do it so that the community receives that information. These are all different strategies that have to start working together. There has to be planning of the strategies so that they work to raise awareness in different ways. Thank you.

Noemí Medina, *Member and former President of the Board of Directors, Alzheimer Iberoamérica, Argentina*

The associations work with our scientific committees. Dr Ricardo Allegri is the president of ALMA's scientific committee, for example. That dialogue is essential. They understand what we associations do; they help us, they collaborate. I remember when Miia Kivipelto came to FLENI. We said, as an association: what can we do? This was pre-pandemic. We designed a workshop for healthy older adults. We wondered who is going to come. But people signed up. Not many — I think there were 19 people. But a sufficient number. Just one man. All older adults. It turned out that they were all university-educated people.

It was a prevention workshop that we called "Mi cerebro, ¡cuidado!" [My brain: watch out!]. In this workshop we had memory stimulation, music, movement and memory, topics on heart health, a nutrition specialist and, especially, film discussion. Tuesdays and Thursdays, two hours. The first group finished fascinated — one notary even told us it was just what she had been waiting for. We couldn't repeat it afterwards: the pandemic came.

Those of us who work in Ibero-America, with different countries, different organisations, there are issues of the sociology of organisations that influence the work, the tasks and the services that are offered. Although the advocacy mission is totally shared, there are those with more resources, which have been able to get through a period that was really challenging. For example, the Fundación Ermita in Guatemala, as its day centre couldn't operate, had to pay compensation to its employees. And recover from that. It's essential I think in this network, and this way of working in a network, is now getting a little stronger, that an association and its leadership understand what is happening: for example, what the science is, and how to translate it to the community.

Nilton Custodio, *Head, Instituto Peruano de Neurociencias, Peru*

A final comment about the role of society — specifically the associations, and how they help us deal not only with the issues of patients with dementia, but with prevention of brain ill health. In all cities there are what are called community agents: volunteers in the centres of every city in all the countries. We can try to empower those community agents on issues related to dementia. It's a very dreamy project. But I think it's possible if all of us — agents, researchers, society and the people — make it easier, not only for people who are ill but also for people who are at risk, and change the perception of the brain from primary education onwards. And there comes the other problem: how to do it. Now we have to invite primary school teachers, the Ministry of Education, and we are complicating the situation more. That is what makes it complex, but I think it is the way to go. Thank you.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you, Nilton. Ricardo.

Ricardo Allegri, *Director of the Memory and Ageing Center, FLENI; Professor of Neurology, Universidad de Buenos Aires, Argentina*

Yes, just a comment — well, two comments. The first: Argentina. This is the third time a ministry has made a plan without having the necessary funds. When you read the health ministry plan that came out three months ago, the second item of the plan says: there are no funding. A plan without funds, in reality, doesn't exist. It's nothing, and that is the day-to-day reality.

The second: honestly, I congratulate this panel, because it is bringing us down to the reality of Latin America. The reality of Latin America and the reality of its people. The main challenge we face is how to reach people and how to reach the politicians. Politicians don't listen; politicians don't respond. That is the reality. And Latin America has what you were describing, what Nilton mentioned. Just ten blocks from here lies the poorest area in Argentina. Years ago I conducted an epidemiological study there, and when we began to identify patients, we didn't know where to refer them, because we overwhelmed the health system. That is the challenge.

Jorge Neira, *President, Academia Nacional de Medicina de Buenos Aires, Argentina*

A very good comment. I wanted to tell you that we at the Academy are among those who suffer from the lack of a state budget. But it seems to me — you know that the Chinese word for crisis means danger and opportunity. This is the danger we now have of not having a state subsidy. And perhaps one has to look at how to diversify income. When we have this crisis situation, I think it's the best moment to work in a network, in consortiums of intermediate organisations, and among those organisations to have some strategies that don't depend on state funds. Rather than depending on the government — even to get a law passed, it's good to work as a team, but to include a lot of actors. And this is what we tend to do.

Last night I was at a meeting at the Academy — it was an Ibero-American federation on cognitive neuroscience — and the number of people there, and the commitment, was striking. I think these things are good, because that is what allows structures to be maintained that persist over time, which is sustainability. When one has erratic sustainability, which is what I just mentioned — today you have it, tomorrow you don't — that's no good for planning. Whereas if one works in a diversified way and, above all, together, building consortiums, have an advantage: everyone keeps their own identity, but they work for a common goal.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Any other comments from the room? Yes. I think you can just start.

NA

Natalia Acosta-Baena, *University of Antioquia, Colombia*

I wanted to make three comments: First, fostering intergenerational understanding and consciousness within families. Second, journalism must maintain ethical rigor by providing balanced, comprehensive coverage of these health issues. Third, encouraging both personal agency and community co-responsibility in shaping public wellness.

The first is that, with the LatAm-FINGERS study in Colombia, when we were carrying it out, one of the patients said to us: what I value most about this study was the awareness. And that awareness crosses into other generations. Most of them are grandparents — grandmothers who pass that awareness on to their grandchildren. In Colombia it's almost always the grandmothers who look after the grandchildren most. That passes from generation to generation; it's a form of education. On the other hand, embedding these kinds of things in the community is very difficult.

Which brings me to my second comment: how those outreach and information activities can generate those kinds of changes in people. I think the challenge is there — you said it very well. It may not be about persuading through communication but about informing. But I also think it's worth informing from every point of view — not just one side, but ethically, understanding that there's the soft drinks company selling us one thing, but there's also the other side of taking the decision about what I should eat. There are choices that can be very costly —olive oil in our countries, almonds, that type of diet. But there are also other things that are not costly and are easy to implement, like fruit and salads. We're in a rural setting, where it's easy to get those kinds of things. There are things we can do. And that's what people need to know. People first need to know that it works, and that's the point.

Finally, the third point: how do we start getting people to take ownership of that knowledge, and also to become participants and co-responsible for that health? Yesterday and today we've talked all the time about how the government can contribute. About how we have to convince them to help us implement this — and obviously that's very important so that we can make all this a reality. But there's also an individual component. The individual component of each person makes societies change, makes generations change, and allows us to improve and transform this. Thank you very much.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you very much. I wanted to quickly — we have five minutes. Let's start with you, to respond, and then we will keep going down.

Irene Hartmann, *Staff writer, Society section, Clarín, Argentina*

Perfect. Thank you. I think that in Argentina more than 40% of the population is in the city of Buenos Aires and what we call the conurbano — that is, almost half the country lives in an urban area. The possibility of accessing healthy food through growing it, as would happen in a rural population, is not so simple. But also because fruit and vegetables in some cases are expensive, and because they also require preparation — cooking, cleaning, and so on. The cleaning of vegetables is never guaranteed by the distributors. And that requires time, in the context of a completely exploited population that doesn't even have time to look after its own children. The social fabric is so broken that even something so elementary is not easily achieved.

Journalism, I think, is a crucial tool in bringing information down to people — it is a constant challenge. But beyond getting information to the public, with any advice from the health field, of something one could do, or something to avoid and so on, the question is whether the people who read it will be able to do what you're informing them about.

And one more thing, and with this I'll close. Bear in mind that today most of the public consume the news not through traditional media but through digital media. There is a set of rules governing how information has to be distributed, from which no company escapes: headline, articles with keywords. And so a piece of information that says, of course, that you should eat apples — apples aren't difficult to get and aren't expensive — is going to be headlined: "They find an ingenious way to avoid

dementia". That is, in a way that inevitably generates the click, and then the reader is frustrated reading the information — either because they can't access what's on offer, or because what they're told is trivial. It's very easy to fall into a relatively misleading offer of information, and that is a great challenge for us.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

A very useful comment, very interesting. We have just a short time, so I'm just going to ask everybody to be really quick in their final comments.

Jorge Neira, *President, Academia Nacional de Medicina de Buenos Aires, Argentina*

I think this idea of consortiums, of organisations, of networks, is that not all networks do the same thing. For example, if our strength is data, another's will be communication, others will be implementing a policy. Being able to speak the same language is not a minor matter. It's a matter of putting pressure on the level of the information, because otherwise the information that arrives is so dispersed that it is sometimes counterproductive. Thank you.

Noemí Medina, *Member and former President of the Board of Directors, Alzheimer Iberoamérica, Argentina*

I wanted to say something: the first thing we also have to tackle is our own prejudices — that people aren't interested, that people don't learn or can't. Then, act. The Alzheimer Iberoamérica organisations have, almost every year, an activity we call Universidad Alzheimer Iberoamérica, where leaders of the associations meet to discuss precisely these issues. What do we do? How do we do it? How can we do it? We even produced a carer profile for Latin America, right? We did it among the associations and shared it in Quito, Ecuador.

What I think is that we have to do it, no matter what. We have to move forward. There is awareness in civil society organisations of their role, their limits, their capabilities, but they move forward. Organisations move forward. They sometimes stop because there are political changes, or something arises in the political context that means they fear civil society organisations and avoid engagement, or worse. But it doesn't happen everywhere, and it's cyclical.

And we can change. There are conferences on Zoom happening all over Latin America. At the start of the pandemic, a month in, people asked how do you run a support group, what will happen with people isolated at home? The first association that dared to run a support group on Zoom proved it could be done. Who would have thought? You might have thought that nobody would attend a support group on Zoom but they did. We mustn't be afraid — mustn't have those prejudices that it can't be done. Always try, no?

And, from the associations' point of view, you always have to fight — together with the communicators — because the journalist who accompanied Bauza, in La cima de la vida with Bauza, also worked with Fundación TASE. As you say, there needs to be a united force. Thank you.

Nilton Custodio, *Head, Instituto Peruano de Neurociencias, Peru*

Thank you. I want to use these brief minutes to reflect on something that occurs to me, and that someone else has also mentioned and is thinking about: why couldn't these agents of change for brain health and dementia prevention be our LatAm-FINGERS participants? They are the best example that it has worked for them, and we could empower them with communication skills to be ambassadors for change in their communities — just to start. Thank you very much.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

Thank you. Thank you to all of our speakers. And we're going to move now to our closing session. Thank you.

Closing Session: Will Brain Health Take Off?

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

We move to our last session, whose topic is: Will Brain Health Take Off? I would like to invite to the podium Professor Ricardo Allegri, Director of the Memory and Aging Center, FLENI, in Buenos Aires, and Professor of Neurology at the University of Buenos Aires, Argentina; Lenny Shallcross, Executive Director of the World Dementia Council, United Kingdom; Professor Andrea Slachevsky, Associate Professor and Head of the Memory and Neuropsychiatric Center at the Universidad de Chile and Hospital del Salvador in Santiago, Chile; and Professor Rachel Whitmer, Professor of Public Health Sciences and Neurology, University of California, Davis, United States.

As we have seen, Day One set out what is being done. Today, Day Two asked what it would take to go further. This session now turns to where the region, and brain health, goes from here. I would like to start by asking Ricardo, then Rachel, Lenny and Andrea. Ricardo, please.

Ricardo Allegri, *Director of the Memory and Ageing Center, FLENI; Professor of Neurology, Universidad de Buenos Aires, Argentina*

First of all, I would like to thank the Alzheimer's Association and the World Dementia Council for organising this meeting in Buenos Aires. But I would like to thank especially Dr Maria Carrillo for her support of research in Latin America. Maria has been principally responsible for this network. It's important to acknowledge that.

I had two options. One was to do a summary of what we have been discussing. But there was another option, which Lenny had proposed and which was more interesting: to imagine that 10 years have passed and I'm sitting in a café on Avenida 9 de Julio, thinking about what happened with all this — what happened with LatAm-FINGERS, what happened with the impact. And when I sit there 10 years later, looking back and seeing the value of all this, first I ask myself: what does LatAm-FINGERS mean for Latin America?

It would be quite simple to claim that its importance lies in having demonstrated the feasibility of prevention in Latin America. However, given that Miia Kivipelto had already demonstrated prevention in Finland, and U.S. POINTER study had done the same in the United States, it was highly likely that the result in Latin America — a region with a higher burden of risk factors, as those who presented showed — it was sure to be positive. That was, in fact, exactly what we expected when we launched the project. My concern wasn't whether the result would be positive; rather, I had two questions: would we be able to hold the group together, and would the participants be able to sustain the intervention? Those were, at the very least, the two challenges I foresaw.

Secondly, I found myself thinking about The Lancet — specifically its cover — and honestly, we're all very proud of it. It is a significant milestone for "The Lancet", as it features the work of groups that do not typically appear in its pages. And for us it's a source of great pride. But what is the reality of LatAm-FINGERS? In my view, this represents a turning point for research in Latin America. Prevention is just the justification, looking back, and something we're going to have to implement going forward. But it's a turning point because of the reality of 11 countries collaborating, working

together over the last five years and generating results that meet international standards and deserve to be published — with more publications to come. Eleven countries working together, something that had never happened before in Latin America.

What concerns me, and has always worried me, is that, when you are in low- and middle-income countries, researchers are often relegated to the role of mere providers of data or samples for high-income countries. But, honestly, with the LatAm-FINGERS group, with Maria's support, with the Alzheimer's Association's support, what we have achieved is a group that works, makes decisions, plans, and that does it for its own community. And I think that is the most important thing — 10 years later, having coffee on Avenida 9 de Julio.

Now, the second part raises a question: how can we promote brain health in Latin America? And honestly, there are many difficulties. That's why I said during the previous panel: there is a reality in Latin America. Latin American countries have a few very rich people and a lot of very poor people. That is the reality of the region. Inequality, and inequity, are structural features of Latin American societies. If we don't recognise them, we are actually trying to cover up what the reality is. And the risk factors depend directly on poverty. Poverty is the primary driver that increases the risk factors: low levels of education, lack of control of vascular factors, and so on. Everything that Gill Livingston described as risk factors, poverty generates much more, and in a way all of that is what we have to be fighting. Poverty. A low share of GDP for health.

And then politicians who don't respond — or lie in their responses. As I mentioned early: there is talk of a plan, a programme... but there is no funds! It's just to get into the newspapers. Don't lie to me; there's nothing else behind it. I attended meetings of Alzheimer's Disease International on three occasions, and heard people speak about plans in Argentina that, in reality, did not exist. That was the reality. And this latest plan, that was mentioned is great, but it doesn't exist; it doesn't work.

And that's what we have to do to move forward. We are researchers. I know how to conduct research. My father used to say that you cannot talk to politicians, or with the population, about science, in the same way that you would. To talk with a politician, he said, you have to have an elevator pitch. The rest doesn't count. And that is what we need to do in the future: how we reach the population, and how we reach people. LatAm-FINGERS has put research — and, of course, dementia research — in a place where the big challenge now is not getting there; the big challenge is how we stay. And I really think the network gives it support, if this continues: it gives it the support to address the real world with real regional data that can be used.

Rachel Whitmer, *Professor of Public Health Sciences and Neurology, University of California, Davis, United States*

Before I share my thoughts about moving forward, I do want to thank the Alzheimer's Association and the World Dementia Council for putting this event on. It's really wonderful to be here, and what I really love about the focus of the Alzheimer's Association and the World Dementia Council is that it's not centred on thinking locally. It's thinking globally. And this is a global challenge that we have to tackle and that we have to take on. I just want to give very deep thanks for that. I also want to acknowledge, and just add my reverence for, all the PIs for LatAm-FINGERS, because — I know, because I ran a site in the United States — I know how hard this study was to do and to run. And I just think it's an incredible thing. We had five sites in one country. You have all these different countries. And so I just want to pause for a moment and give a round of applause for LatAm-FINGERS. That's why it's really so wonderful to be here and to be part of this discussion, and talk about how to move forward and how to really think globally, because we all have challenges, and the challenges are really different depending on the local ecosystem and the context.

I'm going to move now to U.S. POINTER, and take what was presented to me, which was: how do we turn the corner? How do we make a change in brain health? I'll be drawing on my experiences as a PI and a scientist in the United States, but also as someone very committed to changing disparities in brain health. As I talked about yesterday, U.S. POINTER was done in five sites — in one country, a large country, with a lot of heterogeneity. We have really large differences in culture, in education level, in green space, temperature, climate across these five sites. These five sites are very, very different. Texas is really different from California. California is very, very different from Chicago. And I think this was a wonderful and brilliant move from the leadership of U.S. POINTER, to do this in five different sites. The easier way would have been to choose sites that have a long history of recruiting people very, very quickly. Instead, the leadership took a step back and said: let's have five sites in different geographic regions and different parts of this country, so that we can ask: can we answer this question? And can we answer this question in people who reflect our country, and not just one part of our country?

As I said yesterday in my talk, when I started in this field, almost 30 years ago, the majority of what we knew about risk factors and protective factors for Alzheimer's disease, dementia and cognitive decline was based on studies of people who were highly educated, white, and tended to live near an academic medical centre or in an urban area. That is where the field was several decades ago. The field was also at a place where, if you had a history of stroke, you didn't get included in a study of cognitive ageing or Alzheimer's disease. We have a much more nuanced understanding today of the multifactorial things that happen to create someone who presents to you clinically with cognitive impairment. And the field has come quite a long way and said: we can't just recruit people into studies who are easy — who happen to come to your memory clinic, who tend to be the worried well. We need to get out into the community.

I really love that for U.S. POINTER we had five different sites that were very different, and we had a focus on community engagement. And as someone who's been in the field for a long time, it was really wonderful and beautiful to see how the community engagement that we had, and that we continued to build, led to successful recruitment. In U.S. POINTER, 31% are from groups that have historically been underrepresented in brain health research in the United States. And 31% doesn't sound like a fantastic number. But to put it in context, the average percentage in the United States in a clinical trial of Alzheimer's disease or dementia tends to be much lower. And there's been a lot of work on this — looking at how we can change and improve this. That's one of the other wonderful pearls from U.S. POINTER: not just how we can improve brain health, which was already huge on its own, but how we

can change engagement and change recruitment. And the reason this is so important is that we don't want to come away with answers for one tiny subgroup of the population. We want to come away with information, knowledge and answers for everyone.

This has really led to — and again, the Alzheimer's Association has taken this very seriously — the question: what is the science of recruitment? What is the science behind inclusion and engagement? And we've answered that question in U.S. POINTER, of how we can work with these communities. Now we are faced with the question of dissemination. Now we need to share this knowledge. And again, we want to share it with everyone; we want to help everyone, at a population level.

In the United States we have large differences in people's health. We have some cities where the difference between those at the highest level of socioeconomic status and the lowest is really large, and these people are actually living quite close to each other. I live in an area like that, where you go one mile and there is a marked difference in safety, in the resources for that neighbourhood, in access to healthcare — and, as I said before, in green parks and space. And a very famous study came out of the UK quite a long time ago — I think it was in the late 1980s or maybe the early 1990s — that did an analysis not just of the amount of low socioeconomic status, or the amount of poverty, but of the differential: the difference between the lowest and the highest. This was a study by Michael Marmot. It's a foundational study in social epidemiology. And it found that the size of the difference was the biggest predictor of health and mortality for everyone. Even if you were of high socioeconomic status, if you lived in a region that had a large differential and a large disparity, that region had a higher mortality rate for everyone, a lower life expectancy, and a much greater risk of all cardiovascular diseases and chronic diseases.

When I talk with different stakeholders and people who have a vested interest in brain health, I like to talk about that, because I think some of the people who have a lot of resources don't understand. I have to point out to them: it's bad for your health too. It's not just that, if you have resources and access to good healthcare, you're fine — it is affecting your health too, at a population level. We have this differential in the United States, as was talked about today. We have this differential in a lot of the countries that are part of LatAm-FINGERS. And so, when we're thinking about brain health, we need to step back and think, again: how can we help everyone, and get to everyone? As Dr Gladys Maestre mentioned yesterday, she has done really nice work in a very special community, and I love that work because it's a very unique community — but those are the kinds of communities we also need in research. We need to reach out and help with brain health.

I think we're really at a pivotal moment here, where we have this incredible success story with U.S. POINTER and with LatAm-FINGERS. You all did this, and it was beautiful, and it worked — in the context of all these challenges, more challenges than we had in U.S. POINTER — and it had a greater magnitude of effect. We have the success story; we have the evidence. Now we need to turn that success story into implementation, going out into our communities and changing brain health. In tandem, at the same time, we need to do what some of our wonderful colleagues here are doing on the policy side: understanding and working with politicians and stakeholders on how important brain health is.

And I liked some of the conversation yesterday that brought up money and economics. We need to be able to demonstrate to our politicians, and to the people who change policy, that this is not just good for health; it's good for the economic stability of our countries, of our region. This is something that has far-reaching consequences. And I really loved the quote yesterday from Joanne Pike, when she was putting into context that the results of U.S. POINTER gave one to two extra years. Within a 24-month period, one to two extra years of cognitive health. Stepping back, just think for a moment what that

means at a population level — what that means for you, for your family, for your loved ones. But on a macro level, what does it mean for that society and the success of that society? It means someone staying in a job longer; it means someone who is contributing.

We need to be able to make those connections and build those bridges to the people in our local regions, in our local areas, who are in charge of policy and change. Our job is to be able to talk about that and make that connection, and make it crystal clear, so that people who are in positions of power to make changes for health, for resources, for access to care really, really understand that it's not just about your mother or your grandmother knowing who you are for another two years. It is so much more than that. That is the tip of the iceberg. This has enormous implications, but of course the most successful results will be downstream. It's not something you can change and see in the next week. Again, it is our job, as scientists and as policy leaders here, to be able to explain that and translate it to the people who are in positions where they can make changes for us, so that we can help change brain health.

And finally, not to beat a dead horse, but I want to come back to what I said yesterday and earlier today: successfully working with everyone in communities, and changing the inclusion of who ends up in your science and who ends up in your implementation programme — how to do that successfully is a science in and of itself. And I am so grateful that the Alzheimer's Association has realised that. And we all have an opportunity, on all the studies we've worked on, whether it was U.S. POINTER or LatAm-FINGERS, to go back and look at our data and really understand what worked and for whom, and really translate that and use it on a broad scale.

Lenny Shallcross, *Executive Director, World Dementia Council, United Kingdom*

I think that one of the things that we sometimes don't talk about very often is how innovation enables behaviour change. If you think about what Matthew was saying earlier, about the important role of governments in changing the architecture of the communities that we live in to enable people to change their behaviour — that's absolutely true. But I'll give you an example from London, where I live. For the last 15, 20 years there have been efforts by the London administration to encourage people to cycle more, which is very beneficial for your health. We've put in lots of bike lanes and so on and so forth. And I've cycled in London for years, and most people who cycled looked like me: white, middle-class, in their mid-forties. That was the type of person who cycled. And then along came innovation and — whether you love them or hate them — the development of things like Lime bikes and Uber bikes completely changed the population of who cycles. It is diverse: all sorts of body shapes, all sorts of ages, all sorts of respect for the rules of the road. But lots more people cycle. If you are talking about how you change behaviour, we need to think about how we enable the private sector to innovate and develop solutions that come to market.

And the second thing I would say is around meeting people where they are. Back when I was at the end of my time in government, one of the things we funded — we were very aware that girls and young women in the UK take less exercise than boys and young men. Over time there was a public awareness campaign around the benefits of exercise developed. In focus groups, it completely bombed, because a lot of the problem wasn't that people weren't aware of the benefits of exercise. The problem was much more around the perception, and the sexism in society, about a girl or a young woman exercising, and the impact of body image and so on. It wasn't health that was the problem; it was stigma, barriers in society. And the campaign that ended up running was called This Girl Can, which was all about the positive idea of girls and young women being able to exercise, and the freedom that came with that.

When we look at achieving change, think about innovation — but also think about what the actual barriers are that are stopping people changing their behaviour, and develop activities that address those, and not the things that we care about, which is often the health question.

Andrea Slachevsky, *Professor, Universidad de Chile; Director, Memory and Neuropsychiatric Center (CMYN), University of Chile and Hospital del Salvador*

After being here these two days, one can feel hopeful, but also a little overwhelmed by the different responsibilities that arise. I think one is creating the evidence. Research. We're here at a research meeting, and I think there's a certain consensus that we have to move from research in trials to evidence that can positively inform public policy, and for that we have to study the results of research in the real world. And I think it's important to thank the Alzheimer's Association for the effort that allows us to do what we can't do with the support of our government. There is now the implementation of LatAm-FINGERS, and in Chile they have funded something unthinkable: the REMEMVER (Red Memoria Viva Electronic Registry) that will allow us to create a real database of people with dementia attended in public hospital memory units — seven memory units. And I think this is also generating, in different ways, the evidence to inform public policy.

I think it's very important to be humble about the results of our research and to ask what evidence informs public policy. We know that research is generating results. To effectively inform public policy, we need to build scientific consensus based on evidence generated across diverse contexts and real-world settings, reflecting different realities and populations. But what comes after the trial, and how does it translate to the real world? Ultimately, that is what scientific research is about: generating evidence that can improve practice and help shape public policy. And I thank you again, because precisely what the Alzheimer's Association is doing with implementation, with real-world study, is what will generate the evidence that will allow us to really inform public policies. What is being done in Chile, building a real-world data platform, is allowing us to know the experience of people with dementia in the real world. And one can also dream of a similar platform for Latin America.

But the third point is — you have research, the evidence for public policy — but also need to make the change. I think we have to talk about the success of many policies. But be aware not everything is the same. I think we have to look at the differences between the Papanicolaou campaigns, the treatment of high blood pressure, and the similarities with brain health prevention and the treatment of dementia. We need to consider what we can learn from it, rather than adopting it automatically. But in the end, we also have to look at politicians. Perhaps we could also be empathetic with politicians. A good politician does good politics, but a good politician gets elected — and, also, a good politician gets re-elected. When someone gets into politics it's not easy to be elected. I stood as a candidate for class representative at the university — it was a very bad idea; I was soundly defeated. I learned that good speeches don't matter; you have to have a discourse that reaches people. And people don't vote for a distant future, people vote for their own future in the short term.

I think our exercise is to translate what we know is good for brain health and what is important in dementia care into something that is meaningful in people's daily lives. And I think there are some ideas. One was mentioned — the example from Costa Rica — where people go to the park: that's not only for brain health; it also helps improve security. And here, for the Latin American population, one of the biggest problems is the feeling of insecurity — and that's also the case I believe in the United

States. Prevention and security both matter and could go together. And another important element is also that brain health and mental health, promoting brain health, means people feel well: exercise and sociability make societies more united. I think we have to be able to create those links.

Supporting carers means people feel less marginalised in society, because we don't only marginalise older people, but carers and people with dementia. We can ask ourselves why civil society is so weak in dementia. It's so weak in dementia because caring for a person with dementia leaves no time to do anything else. Caring for a person with dementia is absolutely overwhelming. Supporting the carer is allowing people — often young people, women — to have a life in which they are not marginalised. I think our exercise is to transform what we think is useful in prevention — what we believe, and are showing, is useful in brain health prevention, what we believe is useful in dementia care — into something that makes sense to society, and that makes sense to people, changing their life today, and not in 10 years.

Joanne Pike, *President and CEO, Alzheimer's Association; Chair, World Dementia Council, United States*

I want to reflect on something Lenny said, but then tie it to an area that we keep talking about a little bit more, and that's that innovation can drive equity, or it can drive equitable access. And what you have done with LatAm-FINGERS is innovation. It's a matter now of creating the investment and the economic argument to support that. We have talked about the personal story and the data, but at the end of the day, unfortunately, we also have to think about the economies of scale that drive persuasion for some of our policymakers. That is the big question — and the big opportunity, in my opinion.

Paulo Caramelli, *Professor of Neurology, Faculty of Medicine, Universidade Federal de Minas Gerais; Vice Chair, World Dementia Council, Brazil*

Thank you, Joanne. This session is shorter than the previous ones — only 45 minutes — so we are already at the end. Unfortunately, we will not be able to open for questions and discussion. But of course the panellists will be here, and also at lunch, so feel free to approach them and discuss. We are a kind of family here.

Before we close, I would like to tell you a quick story. In 1994 I was a young PhD student at my first international conference on Alzheimer's disease, which was pre-AAIC: ICAD, the International Conference on Alzheimer's Disease and Related Disorders. I was there with my mentor, Professor Ricardo Nitrini, who is here. There was also another colleague from Brazil, so there were just three of us from Brazil. Professor Ricardo Allegri was there, with Carlos Mangone as well — so a few people from Argentina. I don't remember any other colleague from Latin America. And now, 32 years later, we are here with more than 100 colleagues. Every year, hundreds of Latin Americans invade the space of AAIC. We have dedicated sessions with a growing number of colleagues and friends who have made connections — friendships, but most importantly also scientific connections — and we have built this wonderful network, LatAm-FINGERS, which has been published and has proven successful. We have proven able to ask the question and answer the question, working in these not very friendly environments that we all know in Latin American countries. But we have proven it is possible. Now we can move beyond — we can take off, as the title of this session says — and I'm sure there's much to be done.

Usually in Latin America we're a bit pessimistic, because of our political situations, all our history. But when we look back, at least in our field, from 1994 to 2026, it's incredible what we have been able to do. I'm confident that, with the support we have received from the Alzheimer's Association, and now hopefully from other partnerships, we'll be able to deliver something even more grandiose and important.

Before closing, I would like to thank Joanne Pike for co-chairing this session with me. It's a pleasure to work with you, and with Lenny. I would like to thank Laura Cilmi, who is here. Thank you to the Alzheimer's Association for providing this — for bringing us here and giving us the possibility to be together here in beautiful Buenos Aires. Thank you, Maria, Heather and Joanne, from the Alzheimer's Association. I would like to thank all the technical support people who came from far away. Thank you so much. Thank you to the technical team from Buenos Aires. Thank you, simultaneous translators. And with this, we close the session. Thank you so much, and let's move on.

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