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STRATEGY AND PLAN OF ACTION ON DEMENTIAS IN OLDER PERSONS

Introduction

1. More people are reaching an advanced age in the Region: between 2025 and 2030, life expectancy in Latin America and the Caribbean will be 80.7 for women and 74.9 for men, and in North America it will be 83.3 for women and 79.3 for men (1). Although the majority of older people will enjoy active and healthy aging, a significant number will be affected by chronic conditions, mainly multiple chronic conditions,¹ including dementias and other conditions that lead to disability,² dependence³ and the need for long-term care.⁴ In the next few years, this will be one of the main challenges that social protection systems, in particular the health system, will have to face.

2. The prevalence of dependence increases with age and exceeds 13% in people aged 60 years and over (6), and worsens in settings that are not appropriate for persons with special needs. While there are no reliable data on dementias per se, according to the World Health Organization (WHO), between 2000 and 2020 there will be an increase of 47% in the prevalence of severe disabilities affecting this population group in Latin

¹ Multiple chronic conditions: two or more concurrent conditions that together affect health, functionality, and quality of life, requiring complex health care management and decision-making (2).

² Disability: “persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” [Definition prepared by PASB, based on language from the United Nations Convention on the Rights of Persons with Disabilities (3)].

³ Dependence: “the state of permanent nature for which people, for reasons of age, illness or disability, and linked to the loss of physical, mental, intellectual or sensorial autonomy, require attention/care by one or more persons or assistance for basic activities of daily living or, in the case of persons with intellectual disabilities or mental illness, of other support for their personal autonomy” [Article 2 of Law 38/2006 (Spain) on the promotion of personal autonomy and care for persons in situations of dependence (4)].

⁴ Long term care: “system of activities undertaken by informal caregivers (family, friends, and/or neighbours) and/or professionals (health, social, and others) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment, and human dignity” (5).

America and the Caribbean, and an increase of 20% in developed countries, including Canada and the United States (7). These disabilities respond to three fundamental causes that are often concurrent: unhealthy lifestyles, disabling conditions,⁵ including dementias, and frailty⁶ associated with aging.

3. Dementias affect the cerebral cognitive functions of memory, language, perception, and thinking (8). This cognitive deterioration particularly, but not exclusively, affects older persons and is erroneously considered a natural consequence of aging. Dementias affect individuals, families, and communities and are increasingly a cause of disability that leads to dependence and the need for long-term care. They are a complex and diverse reality, with different stages, that requires coordinated action if it is to be effectively addressed—action that today must be a priority for the Region.

4. The need for long-term care has increased significantly in the Region. Families, especially women, have been the main responders to this need; however, the change in demographic structures and other determinants will make it more challenging for families to keep taking on this task, leading to increasing pressure on social protection systems and the health system in particular.

5. This Strategy and Plan of Action proposes recommendations to the Member States aimed at strengthening the response capacity of the health system, with a multisectoral approach and a focus on human rights, gender equality, and equity. Its actions are directed at achieving quality care for dementias, reducing risk factors associated with these conditions, preventing dependence, and providing long-term care that is community-based with multisectoral responsibility and civil society participation. It also includes actions to provide care and protection to families and caregivers (formal, informal, and non-remunerated).

Background

6. This Strategy and Plan of Action takes note of the WHO Director General's declaration that "...the need for long-term care for people with dementias strains health and social systems, and budgets. The catastrophic cost of care drives millions of households below the poverty line. The overwhelming number of people whose lives are altered by dementias, combined with the staggering economic burden on families and nations, makes dementias a public health priority..." (8). The Strategy and Plan of Action follows up on the statement made in the Health Agenda for the Americas 2008-2017 on

⁵ Disabling conditions: refer to those conditions of health (diseases, injuries, degenerative processes) in an individual producing an alteration or loss of capacity and performance, creating progressive and long-term dependence and disability [Definition prepared by PASB, based on language from the United Nations Convention on the Rights of Persons with Disabilities (3)].

⁶ Frailty: the process of progressive decline of physiological systems associated with age that lead to a decrease in the reserve of the functional capacity and causes an extreme vulnerability to the endogenous stressors and expose the individual to a high risk of negative effects in his/her health (WHO Frailty Expert Group, 2014) Not available, in process of publication.

“maintaining the quality of life of elderly people” (9); and considers essential the statements made in the Strategy for Universal Access to Health and Universal Health Coverage “...to offer the necessary short-, medium-, and long-term care...” and “...the importance of the contribution and value of the unpaid work done by women in providing health care services in the home for sick, disabled, and older persons who cannot take care of themselves...” (10).

7. Other global and regional programmatic documents and resolutions of relevance to this document have been approved.⁷ In addition, this Strategy and Plan of Action is aligned with the Strategic Plan of the Pan American Health Organization 2014-2019 (19) and complements the efforts and recommendations of the following regional mandates: Plan of Action on the Health of Older Persons including Active and Healthy Aging [CD49/8] (20); Strategy and Plan of Action on Mental Health [CD49/11] (21); Plan of Action for the Prevention and Control of Noncommunicable Diseases [CD52/7, Rev. 1] (22); Plan of Action on Disabilities and Rehabilitation [CD53/7] (23); and Plan of Action on Mental Health [CD53/8, Rev. 1] (24). However, its emphasis is on the response to the need to prevent dependence and to provide long-term care associated with dementias, taking into account community participation.

8. To produce this document, several virtual and face-to-face consultations were held with representatives of health ministries and other ministries in the Region involved in this issue. Individual face-to-face consultations were also held with the representatives of the Region who had participated in the First WHO Ministerial Conference on Global Action against Dementia in Geneva. Feedback and comments were also received through virtual consultations with groups of experts from diverse academic and research institutes, civil society, collaborating centers, and other international partners.

Situation Analysis

9. The health costs associated with older populations have increased significantly more than for younger populations (25) and these increases raise concerns for the sustainability of social protection systems, particularly the health system. Costs are also

⁷ UN: Principles of United Nations in favor of older persons, approved by the resolution A/RES/46/91 of the United Nations General Assembly of 16 December, 1991 (11); Inter-American Convention to Eliminate all the forms of discrimination against people with disabilities (Organization of American States [OAS] 1999 (12); Towards an International Consensus on Policy for Long-Term Care of the Ageing (WHO, 2000) (5); Program of Action for the Decade of the Americas for the Rights and Dignity of Persons with Disabilities (2006-2016) (OAS, 2006) (13); Resolution CD50.R8 Health and Human Rights, (PAHO 2010) (14); Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (United Nations, 2011 (15) Dementia: A Public Health Priority (World Health Organization, 2012) (8); Outcome document of the high-level meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond, (UN, 2013) (16); Integrated Plan of Action on Mental Health, (WHO, 2013) (17); and the call for action by the First Ministerial Conference on Global Action Against Dementia (2015) (18).

borne by communities, families, and individuals (18). Between 2010 and 2050, the worldwide dependent population will rise from 349 to 613 million and the dependent older population will increase from 101 to 277 million, with particularly dramatic increases in low- and middle-income countries; dementias is among the main causes of this increase (6).

10. The global burden of disease has changed, but health systems continue to focus on acute care and are not sufficiently focused on providing care to prevent functional capacity loss and avoidable dependence. Although the survival rate for health events associated with chronic diseases has improved, there is an associated increase in functional loss, dependence, and need for long-term care. Basic functional capacity is affected in 20% of people aged 65 and over, requiring high-cost care at home or in institutions; most of these people live with multiple chronic diseases that require the use of many drugs and frequent hospitalizations (26-27). The majority of illnesses and chronic conditions, including dementias, have common risk factors, and preventive interventions continue to be the most cost-effective way to limit the onset of these conditions, as well as their development and resulting disability and dependence (22, 28).

11. Changes in cognitive function occur during aging.⁸ However, the majority of older persons reach advanced ages without these changes significantly affecting their functional capacity and intellectual life. Maintaining a high level of cognitive function is a priority for the majority of older persons. It is therefore important to take action to promote intellectual health and prevent or mitigate risk factors, as this can have a real impact on helping to maintain these capacities longer (29).

12. Although the need and importance of searching for an effective treatment capable of preventing or eventually curing conditions involving cognitive deterioration, such as Alzheimer's disease and other dementias, in the short or medium term are undeniable, the priority should be to promote action for timely diagnosis to maintain the functional capacity and quality of life of persons living with these conditions (30).

13. Dementias are a chronic, degenerative condition that leads to progressive deterioration of memory, thinking, language, behavior, and the ability to perform everyday activities (8). Dementias syndrome is associated with various brain pathologies; however, Alzheimer's disease is responsible for 60%-70% of cases (8). Dementias are not a result of aging, but their incidence increases with age. In the Region of the Americas, their prevalence in adults aged 60 and over ranges from 6.46% to 8.48% (8), and it is estimated that the number of people living with dementias will nearly double every 20 years, increasing from 7.8 million in 2010 to 14.8 million in 2030. Latin America and the Caribbean will be the most affected regions, going from 3.4 million people with dementias in 2010 to 7.6 million in 2030, surpassing the projected

⁸ Cognition refers to the mental functions involved in attention, thinking, understanding, and learning, as well as remembering, problem solving, and decision-making (IOM, 2015) (29).

7.1 million people in the United States and Canada (31). In 2010, the estimated cost of dementias was \$604 billion⁹ worldwide and \$235.8 billion in the Americas (31).

14. People with dementias are more likely to have chronic co-morbidities; they have a higher prevalence of risk factors for cardiovascular diseases and other chronic noncommunicable diseases including hypertension, diabetes mellitus, ischemic heart disease, stroke, and tobacco use (32). Depression is another comorbidity associated with dementias that is commonly found in older persons. People with Alzheimer's disease and one other chronic condition have health costs 60-300% higher than persons with just one chronic condition (33). A lack of interventions leads to an avoidable pressure on social protection systems, particularly the health system. According to the Economic Commission for Latin America and the Caribbean (ECLAC), the average annual health spending on 90-year-olds is four times higher than the average for children and seven times higher than the average spending on 30-year-olds (34).

15. Dementias are the most important contributor to disability and dependence among older persons worldwide (6, 35-37). Dementias cause the second largest burden of years lived with disability (11.9%) (32) and are a driver of the need for long-term care (38). Unlike other chronic conditions, people with dementias may need care starting in the early stages of the disease, making them dependent on caregivers as their condition worsens (6). The proportion of people needing care for dementias rises with age, from 30% in the 65-69 years age group to 66% of those aged 90 and over (6).

16. In Latin America and the Caribbean, families and especially women (90%) are the main providers of care as a non-remunerated service; family caregivers in Latin America cut back on up to 20% of paid work to provide care to older persons (8, 39-40). Around 43% of caregivers, mainly informal/family caregivers, show symptoms of depression and anxiety (41). It is estimated that, compared to non-caregivers, caregivers have twice the risk of heart disease and injuries (42). In addition, when care is provided in conditions of poverty, without training or resources, and lacking social or institutional support, there is increased risk of morbidity among caregivers, as well as increased risk of neglect and abuse of the elderly by overwhelmed caregivers (43).

17. Today, changes in family structure and the increased participation of women in work and social life make it difficult for the family alone to ensure care, exponentially increasing the likelihood of older people being institutionalized. Frequently, the conditions of care provided in these institutions do not necessarily meet minimum quality standards and in some cases may violate an individual's human rights. Therefore, several international instruments¹⁰ have emphasized that institutionalizing older persons should be the last viable option for care; and have urged countries to take effective and appropriate measure to ensure that persons with disabilities have the opportunity to

⁹ Unless otherwise indicated, all monetary figures in this document are expressed in United States dollars.

¹⁰ World Assembly on Ageing, Vienna International Plan of Action on Ageing (1982) (44).

choose their place of residence and where and with whom they live on an equal basis with others.¹¹

18. Many of the Region's social and health systems are just beginning to recognize and address the need for long-term care. The Region does not have a comprehensive perspective on this health issue or a suitable response to it. The majority of the countries of the Region do not have sufficient resources or infrastructure to ensure quality long-term care services, nor do they have strategies to support caregivers (formal, informal, and/or unpaid). In addition, little is known about the availability of human resources in the social and health sectors and their degree of competence in terms of meeting the demands of long-term care. Furthermore, monitoring and quality assessment is hindered by a lack of comprehensive information on long-term care indicators.

19. In this context, it is now imperative to foster health interventions that help prolong independent living, reduce risk factors, delay the dependence associated with dementias, and support caregivers, and to develop strategies that enable health systems to adapt to these new demographic and epidemiological realities.

Proposal

20. The general goal of this Strategy and Plan of Action is to promote universal access to health and universal health coverage (10) with quality interventions¹² for people with or at risk of dementias, in order to help them recover or maintain their functional capacities, prevent or avoid dependence, and improve their quality of life and the well-being of their families and caregivers.

21. Persons with dementias should have access to programs and services that respect and recognize differences of ethnicity, culture, and gender. Members of populations in conditions of vulnerability or with special needs will require priority consideration. Therefore, this proposal uses the cross-cutting approaches of the Pan American Health Organization Strategic Plan 2014-2019 (19): gender, equity, ethnicity, and human rights.¹³

22. To support the implementation of this Strategy and Plan of Action, PAHO will promote collaboration with governments, NGOs, academic and research institutions, patients, and caregivers, among others. Furthermore, it will adopt a holistic approach that encourages the participation of different national and subnational sectors, recognizing the

¹¹ Article 19 of the Convention of Rights of Persons with Disabilities (3).

¹² Includes promotion, prevention, screening, diagnosis, treatment, rehabilitation, and care (short, medium, and long-term care.)

¹³ Some international human rights norms and standards that protect older persons have been included in Annex B of the *Plan of Action on the Health of Older Persons, including Active and Healthy Aging* (CD49/8, 2009), available from: <http://www2.paho.org/hq/dmdocuments/2009/CD49-08-e.pdf>. In addition, in 2015 the General Assembly of the Organization of American States by resolution adopted the *Inter-American Convention on Protecting the Human Rights of Older Persons*, available from: http://www.oas.org/en/sla/dil/inter_american_treaties_A-70_human_rights_older_persons.asp

different roles and jurisdictional responsibilities in this area. PAHO will also identify and strengthen cooperation with external donors to search for new sources of funding, and will mobilize political, social, and economic backing necessary for the implementation of this Plan of Action. The proposal has a five-year period of implementation (2015-2019).

Strategic Lines of Action

23. The Plan contains the following strategic lines of action to guide the Member States in accordance with their contexts and priorities:

- a) Promote plans, policies, and programs that promote and respect human rights to address risk reduction, prevention, reduction of dependence, and provision of care (including long-term care) associated with dementias.
- b) Establish, in health systems and health services networks, interventions for prevention and quality care for persons with or at risk of dementias.
- c) Implement a quality long-term care system that addresses the needs of dependent persons, their families, and caregivers, based on a primary health care approach, respect for human rights, gender equality, and equity, within the strategic framework of universal access to health and universal health coverage (10).
- d) Develop or strengthen the necessary human resources training to address health needs of persons with or at risk of dementias.
- e) Improve research and surveillance capacity to generate and collect quality information to address the social and health needs of persons with dementias.

Strategic Line of Action 1: Promote plans, policies, and programs that promote and respect human rights to address risk factor reduction, prevention and reduction of dependence, and provision of care (including long-term care) associated with dementias

24. Dementias are a public health challenge that requires an integrated and comprehensive response from the health system, other government sectors, international organizations, family, community, and civil society.

25. It will be crucial to develop policies, plans, and integrated care programs, in accordance with the needs and context of each country, and to implement rights-based educational interventions aimed at society as a whole in order to fight all forms of stigma, stereotypes, and discrimination that affect these persons and their families. It will be essential to protect and guarantee the human rights of persons with these conditions and their caregivers, and to promote active and healthy aging and improve the quality of life of all stakeholders.

Objective	Indicator	Baseline (2015)	Target (2019)
1.1 Formulate or strengthen policies, plans, and programs for risk factor reduction, prevention, and care, including long-term care associated with dementias	1.1.1 Number of countries and territories that have a policy, plan, and/or program on dementias, either independent or part of another national program, (e.g. for mental health, the elderly, or the disabled)	7	13
1.2 Systematize interventions with a human rights approach to reduce stigma and stereotypes associated with dementias, and educate about the prevention and care of these conditions	1.2.1 Number of countries and territories that have included in their plan specific interventions to reduce stigma and stereotypes and improve the understanding of these conditions	5	16

Strategic Line of Action 2: Establish in health systems and health services networks, interventions for prevention and quality¹⁴ care for persons with or at risk of dementias

26. Some research¹⁵ has shown a relationship between the development of cognitive impairment and lifestyle-related risk factors such as hypertension, diabetes mellitus, hypercholesterolemia, smoking, and obesity, among others. The onset of depression in the initial stages of the disease confuses the diagnosis, which calls for timely and effective interventions. Therefore, health services, particularly primary care, should promote quality implementation and evidence-based interventions for health promotion, prevention, and reduction of risk factors with a life course approach, as they emerge in the scientific literature, within the framework of the Plan of Action for the Prevention and Control of Noncommunicable Diseases (22).

27. Health services, particularly in primary care with continuous levels of specialized care, should provide quality care for the growing number of persons who have already developed dementias, including persons with multiple chronic conditions, who experience a high incidence and prevalence of disability and a progressive increase in dependence. Multisectoral integration will be essential in this process, as will the involvement of the community, family, caregivers, and the individuals themselves. These actions will be essential in promoting the recovery or maintenance of functional capacity and preserving the independence of persons so that they are able to stay in their homes and communities for as long as possible, and to improve the quality of life of these people, their families, and caregivers.

¹⁴ Quality means integrated, comprehensive, continuous, progressive, and evidence-based.

¹⁵ Studies from the 10/66 Dementia Research Group. Available from: <http://www.alz.co.uk/1066>.

Objective	Indicator	Baseline (2015)	Target (2019)
2.1 Include, in health services, evidence-based interventions for health promotion, prevention, and care for persons with dementias to prevent dependence, as these interventions emerge in the scientific literature	2.1.1 Number of countries and territories with guidelines or protocols for the care of persons with dementias ¹⁶	5	15
	2.1.2 Number of countries and territories with guidelines or protocols for health promotion and risk prevention and reduction with a life course approach	4	15
2.2 Implement evidence-based preventive, community, or intersectoral interventions to help maintain the functional capacity and independence of persons with or at risk of dementias	2.2.1 Number of countries and territories that have evidence-based community interventions to help maintain functional capacity and independence	7	15

Strategic Line of Action 3: Implement a quality long-term care system¹⁷ that addresses the needs of dependent persons, their families, and caregivers, based on a primary health care approach, respect for human rights, gender equality, and equity within the strategic framework of universal health access and universal health coverage (10)

28. As can be the case with other disabilities, persons with dementias who are highly dependent and require a great deal of care, need long-term care, particularly in a family environment that ensures the respect of the human rights of all members involved. These health problems generate psychological, social, financial, and legal difficulties for the persons who suffer from them and for their families and caregivers. The care-related burden can cause the onset of new diseases or exacerbate existing diseases, anxiety, depression, and the symptoms of caregiver syndrome. Also, it can threaten the care and integrity of persons highly dependent on care. Therefore, it will be essential to provide resources, services, and programs at the community level to allow caregivers to improve their skills and their ability to provide quality care to persons with dementias (38), and to develop community services such as day centers or respite centers that may be an alternative to comprehensive care services. Similarly, it will be crucial to ensure psychological, physical, social, and financial protection and support systems for caregivers, as well as regulatory systems and monitoring and quality control mechanisms for community and institutional care services (47).

¹⁶ WHO Mental Health Gap Action Programme (mhGAP) (45).

¹⁷ Long-term care system: “A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are dependent for an extended period of time on help with basic activities of daily living (ADL). This personal care component is frequently provided with basic medical services, nursing care, prevention, rehabilitation or palliative care. Long-term care services can also be combined with lower-level care related to help with so-called instrumental activities of daily living (IADL) (e.g., domestic help, help with administrative tasks, etc)” (46).

Objective	Indicator	Baseline (2015)	Target (2019)
3.1 Establish integrated, community-based networks between social and health systems, providing quality care to dependent persons, with family participation	3.1.1 Number of countries and territories with quality, integrated, community-based networks for the care of dependent persons	5	15
3.2 Create multisectoral care and training programs for informal and formal caregivers, to protect their rights, address their needs, and promote their health and social protection	3.2.1 Number of countries and territories with care and training programs for caregivers	12	25
3.3 Establish or review legal and regulatory frameworks and implementation mechanisms, based on international standards that allow national authorities to guarantee quality care and protection of rights of persons who receive long-term care in the community or in care facilities	3.3.1 Number of countries and territories where the national authority has a continuous evaluation system for providers of long-term care (community or care facilities)	10	20

Strategic Line of Action 4: Develop or strengthen the necessary human resources training to address health needs of persons with or at risk of dementias

29. Dementias require trained and qualified personnel who provide interventions designed to reduce risk of cognitive impairment and the provision of quality care to persons with these disorders and to their families and caregivers. It is therefore necessary to promote the inclusion of competencies on dementias as part of undergraduate and graduate education, as well as continuing education programs for all health professionals.

Objective	Indicator	Baseline (2015)	Target (2019)
4.1 Integrate basic competencies about dementias into undergraduate and graduate programs, and into continuing education in the social and health sciences	4.1.1 Number of countries and territories that have incorporated a set of basic competencies into undergraduate and graduate programs, and into continuing education for social and health services personnel	0	8

Strategic Line of Action 5: Improve research and surveillance capacity to generate and collect quality information to address the social and health needs of persons with dementias

30. The increase in research on these health problems remains limited, hindering decision-making and assessment of the impact of interventions. Research in this area—clinical components, health promotion, reduction of risk factors, and prevention, as well as care and treatment services—is crucial in order to improve the response of the health system to the health needs of persons with or at risk of dementias.

31. It is therefore necessary to encourage national research (basic, clinical, epidemiological, and social) on dementias in order to generate new knowledge that will provide better management and care for these conditions, and optimize the quality of life of persons affected by these conditions, and their families and/or caregivers, and to create permanent epidemiological surveillance systems to monitor cases of dementias and provide comprehensive, quality care. It will be essential to have tools to design and develop specific indicators to evaluate the impact achieved by the countries on this issue. Methods of improving this capacity may include increasing investment, developing partnerships and collaboration with other sectors, and/or supporting innovation and testing of new ideas and interventions. It is also a priority that this action should translate into continuous improvement of care for these persons, both in terms of organizing services and in clinical and social interventions to provide care for them (48).

Objective	Indicator	Baseline (2015)	Target (2019)
5.1 Include, in national health information systems, indicators of dementias, disability, dependence, and long-term care	5.1.1 Number of countries and territories that have included a set of indicators of dementias, disability, dependence, and long-term care	2	8
5.2 Promote research, evaluation, and dissemination of outcomes, good practices, and innovative models of care and treatment for persons with dementias	5.2.1 Number of countries and territories that have conducted national research studies on dementias	10	16

Evaluation and Monitoring

32. The achievements of this Plan will be measured by indicators that have a baseline and a target for their year of completion (2019). A progress report will be presented at the end of the 2016-2017 biennium to the Executive Management of the Pan American Sanitary Bureau. In 2020, a final report will be presented to the Governing Bodies of the Organization to assess achievement of objectives and targets, and identify the strengths

and weaknesses of the general implementation, as well as the determinants of success and failure and future actions.

33. Data collection will be based on: *a)* national information systems; *b)* other country reports related to the indicators of this plan, requested from the ministries of health, ministries of social protection, and others; *c)* reports from national and international civil society organizations on this topic; and *d)* compilation of research.

Financial Implications

34. The estimated cost of implementing the Plan over the five-year period (2015-2019) will be \$9.3 million. The estimated gap is 32% of the total amount budgeted. The permanent staff of the Aging and Health, Mental Health, and Disability programs is sufficient to cover the implementation of the Plan of Action over the next five years. The funding gap is primarily due to operating expenses for technical cooperation with the countries, and the temporary contracts needed for expert support in specific activities. Similarly, it is expected that the Member States will prioritize the issue and allocate resources to improve their programs and services to address dependence and long-term care for older persons with dementias, at the family, community, and primary health care levels. It will be important for countries to cooperate and share experiences, and to forge partnerships and identify donors to support the Plan.

Action by the Directing Council

35. The Directing Council is requested to review the information provided in this document and to consider approving the proposed resolution presented in Annex A.

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Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

54th DIRECTING COUNCIL

67th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 28 September-2 October 2015

CD54/8, Rev. 1
Annex A
Original: Spanish

PROPOSED RESOLUTION

STRATEGY AND PLAN OF ACTION ON DEMENTIAS IN OLDER PERSONS

THE 54th DIRECTING COUNCIL,

Having reviewed the *Strategy and Plan of Action on Dementias in Older Persons* (Document CD54/8, Rev. 1) for 2015-2019;

Recognizing the rapidly aging population and the increased incidence and prevalence of dependence associated with dementias in the Region; and that this is a public health issue, a human rights concern, and a priority for the sustainable development of societies;

Recognizing that older persons with dementias face stigma, social exclusion, and access barriers to social and health care services, which deepens the economic, social, and health concerns and inequalities for these people, their families, and their caregivers;

Recognizing that emerging scientific evidence suggests that it may be possible, through public health and social protection actions, to reduce risk factors associated with dementias and prevent and delay the onset of dependence and the need for care;

Recognizing that older persons with dementias should, by law where appropriate, receive short-, medium-, and long-term care to ensure the highest level of independence, safety, and well-being according to their functional capacities as part of universal health coverage and social protection;

Understanding that families and especially women are mainly responsible for the care given in the Region, that they lack the necessary preparation and support, and that this has a great impact on their physical, psychological, social, and financial well-being; and that demographic and social transformations will, in the near future, limit the capacity of families to respond to dependence and the need for short-, medium-, and long-term care;

Recognizing that the World Health Organization has identified dementias as a public health priority and promotes the need to create policies for the provision of long-term care to older persons that need it;

Considering that this Strategy and Plan of Action is aligned with the PAHO Strategic Plan 2014-2019;

Observing that this Strategy and Plan of Action addresses the key objectives to respond to the countries' needs, in accordance with their national context,

RESOLVES:

1. To approve the *Strategy and Plan of Action on Dementias in Older Persons* (Document CD54/8, Rev. 1), in the context of the specific conditions in each country.
2. To urge Member States, as appropriate and taking into account their context and priorities, to:
 - a) include dementias, disability, and dependence in older persons as priority concerns in national health policies and promote the implementation of plans and programs that help improve education and reduce stigma and stereotypes associated with these conditions; and help facilitate universal and equitable access to social and health programs for the reduction of risk factors, and for prevention and care for older persons with these conditions and persons at risk of acquiring them, including the provision of short-, medium-, and long-term care and end-of-life care;
 - b) strengthen the capacity of health systems and health services networks to promote healthy lifestyles and evidence-based preventive interventions aimed at reducing risk factors, where such interventions have a demonstrated impact in decreasing the incidence of dementias or delaying their onset, as well as related complications;
 - c) strengthen the capacity of health systems and health services networks to provide timely diagnoses and evidence-based interventions for persons with or at risk of dementias, in order to improve or maintain their functional capacity and prevent or reduce dependence;
 - d) increase access to resources, programs, and services in order to provide short-, medium-, and long-term care to dependent older persons, especially those with dementias—in particular, community-based, integrated, progressive care with the intersectoral participation of civil society, the community, and families;
 - e) establish or review legal and regulatory frameworks and implementation mechanisms, with regard to applicable international obligations and commitments, to allow national authorities to protect the human rights of persons with dementias, especially those receiving formal or informal long-term care in institutions or in the community;

- f) support the participation of civil society, communities, and families in the development, implementation, and evaluation of policies, plans, and programs to promote and protect the health and well-being of older persons with or at risk of dementias, as well as their families and caregivers;
 - g) develop processes to improve training for the care of these health conditions, focusing on human resources in the health and social sectors, as well as formal and informal caregivers;
 - h) promote resources, programs, and services to help support families and caregivers, and to contribute to their social and economic protection, and the protection of their human rights, including through attention to their health and well-being;
 - i) improve the collection, analysis, and translation of information about dementias, disability, dependence, and long-term care, through research or in the framework of national information systems that facilitate the design and assessment of effective interventions.
3. To request the Director to:
- a) strengthen cooperation between PAHO and the Member States to promote and protect the quality of life of older persons with dementias, and their enjoyment of the highest attainable standard of independence and well-being;
 - b) support the Member States, when they so request, in the development, review, and implementation of national policies, plans, and/or programs that integrate indicators of dementias, disability, dependence, and short-, medium-, and long-term care;
 - c) promote technical cooperation to strengthen research and health information systems in order to produce, analyze, and use data about dementias, disability, dependence, and long-term care that meet criteria of quality, accessibility, and confidentiality, particularly through the monitoring of indicators to assess the progress and impacts of interventions;
 - d) promote technical cooperation to train human resources in the social and health sectors, as well as formal and informal caregivers, in the care of these health conditions;
 - e) foster partnerships with international organizations and other regional and subregional entities to support the multisectoral responses required to implement this Plan of Action;
 - f) facilitate the dissemination of information and exchange of experiences and good practices, in addition to promoting technical cooperation between Member States;
 - g) facilitate technical collaboration with the committees, bodies, and rapporteurs of United Nations and Inter-American entities; and promote partnerships with other international and regional entities and with scientific, technical, and

educational institutions, organized civil society, the private sector, and others, to promote the protection of and respect for older persons with dementias.

Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

1. Agenda item: 4.5 - Strategy and Plan of Action on Dementias in Older Persons

2. Linkage to Program and Budget 2014-2015:

Category: 3. Determinants of health and health promotion throughout the life course.

Program Area: 3.2. Aging and health.

Outcome: 3.2. Increased access to interventions for older adults to maintain an independent life.

Category: 2. Noncommunicable diseases and risk factors.

Program Area: 2.2. Mental health and psychoactive substance use disorders.

Outcome: Increased service coverage for mental health and psychoactive substance use disorders.

Category: 2. Noncommunicable diseases and risk factors.

Program Area: 2.4. Disabilities and rehabilitation.

Outcome: 2.4. Increased access to social and health services for people with disabilities, including prevention.

3. Financial implications:

a) Total estimated cost for implementation over the life course of the resolution (including staff and activities):

To implement the Plan of Action it will be necessary to forge partnerships and identify external donors who will support the initiative. It is calculated that the cost of implementing the Plan of Action for the five-year period (2015-2019) will be:

Staffing: US\$ 8,100,000 (87%) (includes personnel currently working in aging and health, mental health, and disabilities).

Operating expenses/cost of activities: US\$ 1,200,000 (13%).

Total: US\$ 9,300,000.

b) Estimated cost for the 2016-2017 biennium (including staff and activities):

Staffing: US\$ 2,700,000 [permanent staff of the following units: Family, Gender and Life Course/Healthy Life Course (FGL/HL); Noncommunicable Diseases and Mental Health/Mental Health and Substance Use (NMH/MH); Noncommunicable Diseases and Mental Health/Noncommunicable Diseases and Disabilities (NMH/ND)] (87%).

Operating expenses/cost of activities: US\$ 400,000 (13%).

Total: US\$ 3,100,000.

c) Of the estimated cost noted in b), what can be subsumed under existing programmed activities?

The current permanent staff of the Healthy Life Course, Mental Health, and Disability units is sufficient to cover the implementation of the Plan of Action in this biennium and the next one. The funding gap essentially involves temporary contracting that will be necessary for expert support in specific activities, as well as operating expenses for technical cooperation.

Staffing: US\$ 2,400,000 (92%)

Operating expenses/cost of activities: US\$ 200,000 (8%)

Total: US\$ 2,600,000

Annual gap: US\$ 500,000

4. Administrative implications:

a) Indicate the levels of the Organization at which the work will be undertaken:

The planned work is focused on the needs of the Member States. Special importance is given to the priority countries, which have less developed programs, services, and long-term care for older persons with dementias. Population groups in conditions of vulnerability or with special needs should also be a focus of attention.

The Plan will be implemented at three levels:

- Regional: resource mobilization, advocacy, and preparation and dissemination of technical, methodological, and training documents; technical cooperation is offered to the countries for the implementation of national policies, plans, and legislation.
- Subregional: coordination with subregional integration agencies such as CARICOM, SICA, MERCOSUR, UNASUR, and the Hipólito Unanue Agreement; facilitation of cooperation among countries, discussion of shared problems, and sharing of experiences.
- National: formulation and implementation of policies, plans, and legislation under the direction of the ministries of health, with the participation of other sectors and institutions; involves support for and supervision of local levels; PASB will provide technical cooperation to the countries based on jointly identified needs.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):

The Plan can be implemented with the support of the PASB's regional advisors on healthy aging, mental health, and disabilities and rehabilitation; and the work can be coordinated through a network established with the collaborating centers and reference centers; support will also be provided by the Bureau's different focal points in the country offices, with linkage to other interprogrammatic and intersectoral activities. However, it would be advisable to hire a professional with experience in public health and neurology, at the regional level, in order to work specifically on this Plan of Action.

- c) **Time frames (indicate broad time frames for the implementation and evaluation):**
2015: approval of the Plan of Action by the Directing Council.
2016: initial implementation of the Plan of Action.
2016 and 2019: biennial evaluations for the Bureau's Executive Management.
2020: final evaluation and presentation to the Governing Bodies.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.5 - Strategy and Plan of Action on Dementias in Older Persons

2. Responsible unit:

Family, Gender and Life Cycle/Healthy Life Course (FGL/HL)

Noncommunicable Diseases and Mental Health / Mental Health and Substance Use (NMH/MH)

Noncommunicable Diseases and Mental Health/Noncommunicable Diseases and Disabilities (NMH/ND)

3. Preparing officer: Dr. Enrique Vega García (FGL/HL); Dr. Dévora Kestel (NMH/MH);
Dr. Armando Vásquez Barrios (MNH/ND)

4. Link between Agenda item and Health Agenda for the Americas 2008-2017:

The following links are especially significant:

- Statement of intent: paragraphs 2, 3, 5, and 7.
- Principles and values: paragraphs 9, 10, 11, and 12.
- Situation analysis and health trends in the Americas: paragraphs 15, 16, 17, 20, 22, 26, 28, 30, 31, 32, and 33.

Areas of action: paragraphs *a, b, c, d, f, g, and h.*

5. Link between Agenda item and the amended PAHO Strategic Plan 2014-2019:

- The fundamental link is with Category 3 (Determinants of Health and Promoting Health throughout the Life Course). Program area 3.2 (Aging and Health): Outcome 3.2, Indicator 3.2.1.
- It is also linked to Category 2 (Noncommunicable Diseases and Risk Factors). Program area 2.2 (Mental Health and Psychoactive Substance Use Disorders): Outcome 2.2, Indicator 2.2.1.
- It is also linked to Category 2 (Noncommunicable Diseases and Risk Factors). Program area 2.4 (Disabilities and Rehabilitation): Outcome 2.4, Indicators 2.4.1.
- In the PAHO Program and Budget 2014-2015, the links are to the outputs 2.2.1, 2.2.2, 2.2.3, 2.4.1, 3.2.1, and 3.2.2.
- The Healthy Life Course area will carry out effective interprogrammatic work with the other categories and programs related to this subject.

6. List of collaborating centers and national institutions linked to this Agenda item:

- Instituto Nacional de Servicios Sociales para Jubilados y Pensionados (PAMI), Argentina.
- Hospital Nacional de Geriátría y Gerontología (el Hospital Blanco Cervantes), Costa Rica.
- Centro de Investigaciones sobre Longevidad, Envejecimiento y Salud (CITED), Cuba.
- Alzheimer Disease International.
- AARP.
- Department of Family Medicine and Geriatrics. McGill University, Montreal, Canada.
- Administration for Community Living. Department of Health and Human Services, United States.
- Instituto Nacional de Geriátría. Institutos Nacionales de Salud, Mexico.
- Instituto de Envejecimiento. Universidad Javeriana, Colombia.
- Centro de Investigación del Envejecimiento, Universidad San Martín de Porras, Peru.
- Instituto Nacional de Rehabilitación de México. PAHO/WHO Collaborating Center for Medical Research and Rehabilitation, Mexico.
- Instituto Nacional de Rehabilitación Adriana Rebas Flores, Lima, Peru.
- Servicio Nacional de la Discapacidad, Santiago, Chile.

7. Best practices in this area and examples from countries within the Region of the Americas:

The following countries have demonstrated best practices and successful experiences. The ministries of health and the legislative systems of these countries have designed public policies aimed at establishing minimum standards of care for people living with Alzheimer's disease and other mental disorders. Countries such as Bolivia, Costa Rica, Mexico, Peru, and the United States have approved national action plans on Alzheimer disease and other dementias:

- a) Bolivia: Law 4034 on the Creation of Support Centers for Patients with Alzheimer Disease and Other Dementias.
- b) Costa Rica: National Plan for Alzheimer's Disease and Related Dementias.
- c) The United States: National Plan to Address Alzheimer's Disease, 2014.
- d) Mexico: Plan of Action on Alzheimer's and Other Dementias, 2014.
- e) Peru: National Plan for the Prevention and Treatment of Alzheimer's and Other Dementias.

Furthermore, countries such as Argentina, Brazil, Canada, Chile, Uruguay, and Venezuela are working toward national action plans and clinical protocols for diagnosis, treatment, and protection of patients who suffer from Alzheimer's disease and other dementias.

- a) Argentina: The National Alzheimer's Plan is advancing and has been approved by the congressional commission on Social Action and Public Health.
- b) Brazil: Clinical protocol for therapeutic guidelines on Alzheimer's disease.
- c) Canada: Development of dementia plans at national and subnational levels.
- d) Chile: Proposal for a national plan for Alzheimer's disease and other dementias.
- e) Venezuela: National action plan for Alzheimer's disease in public policies.

Finally, several countries of the Region have carried out interventions to improve the quality of life of older persons who suffer from Alzheimer's disease and other dementias, including Argentina, Canada, Chile, Cuba, the Dominican Republic, the United States, and Venezuela, among others.

8. Financial implications of this Agenda item:

Successful implementation of this Plan of Action will have the financial implications detailed in Annex B.

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