A.L.M.A
25º Aniversario
1989-2014

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Asociación Lucha contra el Mal de Alzheimer y Alteraciones Semejantes de la República Argentina

RAdA
Red Alzheimer de Argentina (2013)
Previous actions contributed to boosting the request for a National Plan

2011
The training programme support participants with the development and implementation of an advocacy plan and look at how to work with various stakeholders to achieve the advocacy goals.

September   Chile - COPRAD Submitted a request for a National Plan to President Sebastián Piñera, signed by Coporacion Alzheimer de Chile.

2012
June   A.L.M.A. Convened its Scientific Comitee and started drafting a Supporting Document to accompany the request for a National Plan submitted to government authorities.

December   A.L.M.A. revised and approved the Document. It considered different submission alternatives to ensure an adequate reception of the request.
2013

March: The Secretary General of Institutional Coordination and Monitoring of the Ministry of Social Development granted the first audience to A.L.M.A. He met Ana Baldoni and MD Fernando Taragano, who submitted the Request for a National plan for Alzheimer’s and other diseases causing dementia.

August: The Secretary General summoned A.L.M.A. Notified the ministry’s decision to sponsor a National Alzheimer Program (PNAz), which was a first stage for a national plan.

- Conditions: A university institution in charge -CEMIC -
- Coordination with Community Intervention Centers (CIC) of the Ministry of Social Development and
- Coordination with the Community Doctor Training Program (PMC) of the Health Ministry.

September: PNAz started conducting tasks with a team of professionals under the responsibility of M.D. Taragano in CEMIC’s headquarters.

October: ADI’s Director of Development, Johan Vos, visited CEMIC at request of A.L.M.A. and authorities of PNAz, who provided him with details of the recently launched program.
A.L.M.A. presentó un Petitorio por un Plan Nacional de Alzheimer y otras enfermedades causantes de demencia

El 11 de marzo de 2013 fue entregado el Petitorio por un Plan Nacional de Alzheimer y otras enfermedades causantes de demencia, con un Documento Respaldatario elaborado por A.L.M.A., a las autoridades del Ministerio de Desarrollo Social de la Nación.

En audiencia concedida a la presidenta de A.L.M.A., Ana M. Bujálo de Balthoni, y al representante del Comité Científico de la asociación, Dr. Fernando Taragano, el Cthdr. Carlos D. Castagneto, Secretario de Coordinación y Monitoreo Institucional del Ministerio de Desarrollo Social, escuchó con atenta deferencia las razones y fundamentos de la presentación y al mismo tiempo recibió para ser considerados el Petitorio y la documentación respaldatoria.

A.L.M.A. impulsó y acompaña voluntades reunidas para instar a las autoridades nacionales a iniciar, cuanto antes, acciones que conduzcan a la realización de un Plan Nacional para el Alzheimer y otras enfermedades causantes de demencia.
Programa Nacional de Alzheimer
PNAz
A.L.M.A. Annual Plan 2014

(13) Advocacy...

.....Monitoring the PNAz
National Alzheimer Plan
-PNAz-

Resolution MDS No. 13789-2013 SC y MI
Background
National programs and plans

Australia
Bolivia
Denmark
France
Germany
Japan
Netherlands
Norway
Peru
South Korea
United Kingdom
United States
Sweden
PNAz Objectives

1. Immediate action
   To strengthen, in the vulnerable population, social-healthcare promotion and prevention actions in the national territory (CIC)

2. Mediate action
   To address strategies that may intervene in the social and healthcare needs which are not immediately expressed (PMC)

3. Long-term action
   To research which actions may decrease the problem (Plan testigo, CIC).
• The PNAz is divided into 4 stages

- a. Design stage dedicated to developing and planning instruments

- b. Stage I: Screening. Using the instrument makes it possible to detect patients with potential dementia and to identify the associated risk factors.

- c. Stage II: Developing a control case study that makes it possible to check the validity of the instrument developed and to identify cases of Alzheimer’s disease.

- d. Stage III: Addressing the etiological diagnosis of dementia.
1/3 agrees to conduct surveys
5,300 people

CSI-D
Survey of Associated Factors

16,200 households visited

1060 cases
With cognitive impairment

4,240 checkups
Without cognitive impairment

495 cases
S-EFA

495 checkups
S-EFA

a. Design Stage

b. Stage I
Screening and consistence with stage II

c. Stage II
Case control and severity -EFA

d. Stage III
Clinical attribution and metabolism

b. Stage I
Screening and consistence with stage II

1/3 agrees to conduct surveys
5,300 people

CSI-D
Survey of Associated Factors

16,200 households visited

1060 cases
With cognitive impairment

4,240 checkups
Without cognitive impairment

495 cases
S-EFA

495 checkups
S-EFA

Cognitive severity checkup
C/MMSE

Clinical diagnosis
Etiological attribution

100
With cognitive impairment

20 PET
Conclusions regarding the PNAz

1. Controlling the multiple intervening factors through social and healthcare action will make it possible to decrease and delay the cases of dementia.

2. will make it possible to decrease and delay the cases of dementia.

3. and to reduce disparities among vulnerable and geographic groups.
- Direct education about Alzheimer’s disease and other types of dementia for community and healthcare agents, as well as primary healthcare professionals.

- To validate an accessible cognitive impairment detection instrument to be used by community and healthcare agents, as well as primary healthcare professionals.

- To determine the regional distribution of associated factors and their impact on the clinical expression of Alzheimer’s disease.

- Cognitive impairment prevalence data in the vulnerable population.
• M.D. Fernando Taragano

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Estructura por edad y sexo de la población.
Total del país. Año 2010

Gráfico nº1. Población por grandes grupos de edades.
Total del país. Años 1869 a 2040. Total del país.
Censos nacionales de población; INDEC.
Gráfico n°1 bis

Indice de envejecimiento femenino
(mujeres de $\geq 65$ años por cada cien $\leq 14$)

mujeres de $\leq 14$ años valor controlado en 100.
The main value for the elderly is their autonomy
Clinical diagnosis accuracy + amnestic cognition + biomarkers

(before 4; now 20)

And now?
Background
National programs and plans

Dementia: a public health priority
World Health Organization, 2012
WHO, April, 2012
Dementia: a public health priority.
Recommendations

1. Training people
2. Reducing isolation
3. Empowering people
4. Acknowledging the rights of people with dementia and their caregivers
5. Engaging people in their local communities
6. Supporting and training informal caregivers and hired professionals
7. Improving the quality of the treatment provided both at home and in institutions
8. Improving the training of primary healthcare physicians
9. Urging the governments to create national plans and/or programs
10. Furthering research on alternatives to approach the problem
Alzheimer, a complex health problem

- Chronic disease
- Multi-factorial
- Time-dependent
- Related to vulnerability conditions
- Expanding
What does a complex health problem mean?

– Social-healthcare problem affecting a community

– Where the disease is manifested
Why is an early diagnosis useful?

To control the epidemiological expansion

= 

To delay cases of dementia
(without having administered any specific medication)
Why is an early diagnosis useful?

1. To prescribe the correct medication

1. To address the control of:
   - The multiple intervening factors
   - The vulnerability conditions
Individual clinical expression

Intervening variables

EC = Age x SCV x DBT x HBP x A x βLoad x Comorb. x TBI x Gen

And do we know what the community clinical expression depends on?
Which are the main determining factors of the community clinical expression?

1. Social stratification?
2. Differential exposure to risk factors?
3. Differential vulnerability due to the association of risk factors?
4. Differential impact due to the consequences that the problem has on the affected social group?
Nobody knows which of the multiple factors may be controlled
Or alternatively, nobody knows if the problem is immune to social and healthcare factors

There is little research aiming at identifying the modifiable risk factors of dementia.

WHO, Descriptive note No.362, April, 2012

http://www.who.int/mediacentre/factsheets/fs362/es/

Last accessed on 9/9/13
Conditioning factors of chronic diseases:

• Social isolation
• Vulnerability (biological-psychological-social)
• Lack of knowledge
• Inaccessibility to the system
Now that the problem can be detected early (before it becomes dementia)

• We can attempt to control the intervening factors

• Developing a social and healthcare strengthening strategy in the territory.

Then, a plan and subsequent legislation will follow.
Guidelines.

1. Intervention shall be carried out by unifying resources.

2. Territorial and regional approach ("bottom up").

3. To strengthen existing spaces, with models of the local reality.

4. To promote knowledge, resorting to the regional culture.

5. The approach includes the family group, as all the group suffers the consequences of a chronic and adverse problem.
National Alzheimer Program