

Cognitive Function and Disability in Late Life: Cultural Considerations for Research in Low and Middle Income Countries

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Introduction

Neurocognitive disorders are a major cause of disability and mortality in late life and are associated with high costs for health systems and society [1-3]. The Global Burden of Disease report identifies neurocognitive disorders as one of the main causes of disability and this has a disproportionate impact on capacity for independent living in later life. Comorbidity with cardio metabolic disorders is common and interacts in complex ways to create disability, and dependence [4]. Therefore, it is important to understand the contribution of cognitive disorders, relative to that of other chronic diseases, to disability and dependence.

In the developed world empirical evidence progressed with providing newer insights and evidence that have not just helped better understanding of the disease models but also informed development of population based interventions for dementia like disorders. However in low and middle income a country (LMICs), with highest burden of late life neurocognitive disorders, very little has been achieved outside the semantic work carried out by the 10/66 dementia research group [5]. In LMICs with poor resources and lower levels of literacy, there is an urgent need to develop and validate culturally appropriate instruments that are not only acceptable and feasible, but also are education fair, to evaluate the disease, its progress and impact, instead of borrowing western models which are not contextually appropriate and applicable.

Progress in this regard in dementia research in LMICs like India is not keeping pace to international culturally sensitive considerations. This is paramount as population based studies in India report 7.5% and 10.6% prevalence for dementia in those aged above 60 yrs in urban and rural areas respectively [3,5]. Crucially, this is expected to increase two-fold by 2030 because of the steady growth in the older population

and stable increments in life expectancy [3]. Although neurocognitive disorders are the second highest source of burden after tropical diseases, research in India remains minimal [6].

The need for studies in LMICs is required to better consider the cultural and contextual adaptations. This will then open possibilities for cross cultural comparisons to be mutually progressed. However, such studies must be subject to rigorous scientific validation and further examined for ecological validation. What then follows is that they must have clear real world applications to establish if they work or not in clinical practice. Some may comment that this is nothing new, but should then consider why this not occurring transculturally on a sufficient scale. Clinical Guidelines and policy should then encompass the evidence base, and this could then facilitate improving levels of health and social care for a marginalised societal group.

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