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PERSPECTIVE

Scientific knowledge about dementia: From the Global South to the world

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Abstract

Most people with dementia live in low- and middle-income countries (LMICs), but scientific knowledge about dementia is dominated by Global North perspectives. This interdisciplinary article combines expertise from Latin America, India, and Europe, using a mixed-methodology approach that incorporates expert discussions, a narrative review, and five illustrative case studies. The review on dementia in the Global South yielded 82 results, highlighting the themes of challenges in diagnosis and assessment, socioeconomic and systemic barriers to cognitive health and care pathways, and the need for local capacity building. Those themes were then used to interpret case studies on functionality assessment, genetic heterogeneity, bilingualism, structural inequalities, and North–South collaborations. These cases highlight the misalignment between

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Northern frameworks on dementia and the realities of LMICs, and illustrate the potential for locally generated knowledge to enrich global understanding. Through several rounds of expert discussion, we identified priorities for Global South perspectives for dementia research and policy.

KEYWORDS
capacity building, dementia, diagnosis, Global South, scientific knowledge, social determinants

Highlights

- Knowledge from the Global South is crucial to understanding dementia and reducing its global burden.
- The scientific understanding of dementia has been dominated by perspectives from high-income countries.
- We call for a re-conceptualization of research priorities that includes action against social determinants, equitable access to diagnostics, and more equitable collaborative research.

1 | INTRODUCTION: PERSPECTIVES ON DEMENTIA

Pathological, age-related cognitive decline has long been a part of popular world culture and folklore traditions. In Gabriel García Márquez's literary epic *One Hundred Years of Solitude*, the inhabitants of the fictional city of Macondo lose their memory to the "quicksand of forgetfulness."[1] Alongside popular and literary understanding of these phenomena, scientific understanding of dementia has also developed more recently. For instance, García Márquez's compatriot, the late Colombian neurologist Francisco Lopera, discovered the Paisa mutation responsible for aggressive cases of what we now call autosomal dominant Alzheimer's disease.

In the traditional Indian system of Medicine "Ayurveda" (literally meaning "the knowledge of life") that dates back to 1500 B.C. the loss of *Medha* (intellect) is considered a natural phenomenon of aging.[2,3] Ayurvedic medicinal plants, formulations, and ancient practices of meditation and yoga that were described to enhance health, memory, and cognition, are being investigated in modern times as therapeutic interventions for mild cognitive impairment and dementia.[4–6]

Due to an aging global population, dementia is becoming an increasingly global phenomenon for science and society. Over the last few decades, the high-income Global North has collectively invested billions of dollars in efforts to find a cure for this elusive condition. Thus, the understanding of dementia in society and science continues to evolve across space and time. Through an examination of existing knowledge, this article will propose the need for a complementary approach to a comprehensive, scientifically informed, and global understanding of dementia.

Although dementia has been recognized in the South, as alluded to above, the evolution of scientific knowledge on dementia tends to exclusively reflect the shifting societal and scientific perspectives on aging and cognitive impairment associated with brain disorders in Europe, the United States, and Canada, with its focus on Alzheimer's disease (AD).[7] Dementia is generally understood as an umbrella term referring to a clinical syndrome defined by the coexistence of acquired cognitive impairment, associated with behavioral and psychological symptoms leading to functional impairment. It includes several diseases that cause dementia, AD being the paradigmatic and most prevalent form of neurodegenerative dementia, though there are other causes due to different diseases and injuries. Although memory dysfunction is widely recognized as a hallmark feature of dementia, considerable variability exists in the types of cognitive impairments and neuropsychiatric symptoms observed.

1.1 | Historical perspectives on dementia and the Global North

The history of dementia clarifies how AD came to dominate contemporary understandings. Age-related memory decline was noted as early as ancient Egypt, but it was not until the Hellenistic period that physicians distinguished between reversible "delirium" and irreversible "dementia." By the nineteenth century, the term "senile dementia" was applied to cognitive decline associated with old age. In the early twentieth century, AD was identified in Central Europe as a distinct disorder, differentiated from senile dementia and typically observed in midlife cases marked by amnesia, aphasia, and behavioral changes.[8] *Post mortem* studies revealed a characteristic neuropathology of amyloid beta (Aβ) plaques and neurofibrillary tangles, establishing AD as a key model for dementia research. From its initial framing as a rare midlife condition distinct from late-life decline, by the 1970s and 1980s,

evidence converged on the clinico-pathological similarity of rare "AD" and common "senile dementia." This led to AD becoming almost synonymous with dementia in English-speaking Global North countries at a time when patient associations like the US Alzheimer's Association were born in the 1980s. The "Alzheimer's movement" established a unique diagnostic entity framed as both a major public health threat in aging societies and a crisis demanding aggressive funding.[9]

Despite accumulating evidence that the most prevalent type of dementia varies according to geographic location and ethnic background,[10] the "Alzheimerization of dementia" became increasingly consolidated during the 1990s.[11] A pivotal moment occurred in 1992, when Hardy and Higgins, building on the description of a mutation in the *APP* gene linked to early-onset AD, proposed the amyloid cascade hypothesis (ACH). This hypothesis posits that Aβ deposition triggers a downstream cascade leading to tau pathology and neurodegeneration. Since then, the ACH has remained the dominant framework for understanding the pathogenesis of AD.[12,13]

1.2 | Contemporary dementia research and developments

Research efforts and the worldwide cost of dementia remain highly skewed toward high-income countries (HICs) across several dimensions, including priority setting, diagnostic infrastructure, and treatment options.[14] Accordingly, in recent years, research on dementia in the Global North has simultaneously progressed in various directions, particularly in diagnostics and epidemiology. The emergence of in vivo biomarkers of the amyloid cascade in the Global North since the late 2000s has led to an increasingly biological definition of AD.[15] However, whether AD should be defined as a disease solely on the basis of biomarker evidence remains contentious and has generated substantial debate within the neurology community.[16] Recently, Arboleda-Velasquez et al. reported the case of Aliria, a woman from Medellín who carried the dominant Paisa amyloid mutation but did not develop AD, an outcome attributed to a further mutation, the protective Christchurch mutation. This case illustrates that the clinical expression of pathogenic amyloid variants can be modified by additional genetic factors.[17] Moreover, the importance of sociocultural and ethnic factors in biomarker research has been overlooked, and factors such as access and cost limit their use in the Global South population.[18,19]

Alongside biomarker development, meta-analyses have revealed that in rich countries, while the burden of dementia is increasing in an aging society, the age-related prevalence of dementia is actually decreasing.[20] These have motivated action against nonspecific modifiable risk factors for dementia, including low education attainment; poor physical, mental, and social health; and air pollution. Fourteen modifiable risk factors are associated with 45% of cases worldwide, and in many low- and middle-income countries (LMICs), the population attributable fraction of modifiable risk is even higher than this number.[21] However, most efforts at prevention have been framed in terms of individual choice and lifestyle,[22]

TABLE 1 Challenges and priorities related to Northern perspectives on dementia.[15,16,21,24]

Dimensions of dementia	Challenges for the Global South	Priorities for the Global South
Clinical diagnosis of dementia (Lancet Commission)	Assessing functional ability in diverse contexts Equitable prevention	Ambitious action against social and structural determinants of brain health
Clinical–biological diagnosis of Alzheimer's disease (International Working Group)	Differences in the affordability and availability of biomarkers	Use diverse biomarkers (e.g., cerebrospinal fluid and plasma) in clinical practice
Biological definition of Alzheimer's disease (Alzheimer's Association)	Relevance of amyloid and tau biomarkers in diverse populations	Validate biomarkers before prescribing biomarker-lowering therapies
Layperson's understanding of age-related cognitive decline (broader society)	Stigma and misunderstanding	De-mystifying dementia

which is a very limited model that overlooks structural and social factors that affect health behaviors.[23] Given the problems of transposing Northern models of dementia to the Global South (Table 1), it remains critical to consider the unique challenges and contexts of LMICs.

This article explicitly adopts a Global South perspective. Early definitions of the Global North and South focused on economic dominance and dependency, were region based, or metaphorical. Here, we have a specific focus on knowledge about dementia to question certain assumptions inherent in knowledge production dominated by the Global North. Traditionally, "knowledge production" has referred to the way in which academic structures autonomously produce data and information that is relevant to, and evaluated by, a certain scholarly discipline.[25] However, scientific knowledge is becoming increasingly scrutinized, heterogeneous, and transdisciplinary, and evidence generated across diverse research contexts has become a key dimension in strengthening the construction of consensual scientific knowledge.[26] A Global South perspective can challenge the assumption that dementia research is universal, timeless, or context- and value-independent. We emphasize the bias inherent in treating knowledge produced in the Global North as the "default case."[27]

Critical perspectives on the globalization of dementia are emerging.[28,29] Nonetheless, most existing knowledge on dementia continues to be situated within Global North contexts and shaped by Northern values.[29,30] Here, we define the Global South as the perspectives on dementia from countries where the majority of people face heightened vulnerability to factors affecting brain health, and that are generally resource poor, economically dependent on wealthier nations, and still experiencing the legacy of colonialism.

2 | METHODOLOGICAL APPROACH: EXPERT DISCUSSION, NARRATIVE REVIEW, HYPOTHETICAL CASE STUDIES

This article makes an original contribution to the field of dementia research by analyzing how knowledge about neurocognitive disorders is produced in the Global South and how Southern perspectives can broaden, enrich, and equally challenge prevailing understandings. An international group of experts from India, Europe, and Latin America—representing neurology, geriatrics, psychology, ethics, and the social sciences—met virtually between January and October 2024 to discuss the specific challenges associated with dementia in their respective contexts. Through these deliberations, the group reached a consensus to focus on dementia knowledge emerging from the Global South, using a mixed-methods design that integrated expert discussions, a PubMed review, and five illustrative case studies addressing key aspects of dementia knowledge, that is, prevention, genetics, and diagnosis. This mixed-methodology approach generated insights that informed a broader discussion and the formulation of key recommendations for research and policy.

3 | NARRATIVE REVIEW ON DEMENTIA AND THE GLOBAL SOUTH

A bibliometric search was conducted in PubMed on April 1, 2025, to identify publications from 2010 to 2024 using the keyword pairings "LMIC" and "dementia," and "Global South" and "dementia," which together yielded 82 unique results. The term "developing countries" was not included, following the points made by Jimba et al.[31] Three authors (P.V., I.L.B., T.D.) independently reviewed all retrieved publications for validity and relevance, with inclusion criteria focusing on studies addressing diagnosis, epidemiology, treatment, prevention, or public perceptions of dementia in LMIC and/or Global South contexts. Eleven studies were excluded due to thematic irrelevance or an exclusive focus on caregiver-only interventions, leaving 68 articles for analysis. Notably, publications explicitly using the term "Global South" in relation to dementia only began appearing after 2018, suggesting a recent shift in the framing of research in this area.

Thus, between 2010 and 2024, with particularly sharp growth between 2015 and 2020, a total of 68 articles were included in the review. The majority of these (63.2%) were empirical studies, followed by reviews (25%) and commentaries or perspectives (10%). In terms of focus areas, diagnosis and assessment—for example, cognitive testing and biomarkers—emerged as the most prominent theme, accounting for 23.5% ($n = 16$) of the literature. Studies primarily highlighted persistent challenges, such as underdiagnosis, low awareness, and limited cultural adaptation of cognitive tools (see Table S1 in supporting information). Several works emphasized the lack of locally validated tests, such as culturally adapted versions of the Montreal Cognitive Assessment, as well as restricted access to advanced biomarkers. Other notable areas included caregiver support (11.8%, $n = 8$), prevention (8.8%, $n = 6$), non-pharmacological interventions (8.8%, $n = 6$), and social determinants of brain health (7.4%, $n = 5$), alongside additional contributions to health systems integration, stigma, and bilingualism. Collectively, this distribution reflects a broad spectrum of concerns, ranging from biomedical to public health and sociocultural dimensions, with diagnosis remaining a central preoccupation in literature. Geographically, the research was concentrated in Asia—particularly India—along with significant contributions from Latin America (notably Brazil, Mexico, and Cuba) and Africa (especially Nigeria and South Africa), while several studies adopted a global or multinational perspective.

The review revealed that the study of dementia in the Global South remains limited in scope, but over the last decade, the body of literature has expanded in both thematic and methodological breadth. The synthesis resulted in three significant areas. To begin with, the challenges of diagnosis and assessment persist, marked by underdiagnosis and delayed diagnosis, as well as the limited availability of culturally validated cognitive tools and biomarkers tailored to local contexts. Second, out-of-pocket spending, fragmented health systems, and the overall dominance of social factors, such as education, literacy, and migration, present socioeconomic and systemic barriers that still limit timely access to care and equitable outcomes. Third, there is an increasing body of literature on intervention and

capacity-building initiatives, including culturally grounded non-pharmacological interventions, frameworks for caregiver training, and equitable North–South research partnerships.

Building on these emergent themes of challenges in diagnosis and assessment, socioeconomic and systemic barriers to cognitive health and care pathways, and the need for local capacity building, we have constructed the analytical basis for the five hypothetical cases analyzed below.

4 | HYPOTHETICAL CASE STUDIES

Hypothetical case studies are used to illustrate relevant dimensions and are presented in the following boxes: functional ability as a diagnostic axis (Box 1), genetic heterogeneity (Box 2), bilingualism (Box 3), structural inequalities in dementia prevention (Box 4), and North–South collaboration (Box 5).

4.1 | Functional ability as a diagnostic axis (see Box 1)

BOX 1 Case report 1—challenges in functional assessment

V.B. is a 66-year-old right-handed Chilean woman. She is widowed and attended a clinical evaluation in Santiago with her daughter. She was born in Corral, southern Chile, and moved to the capital 2 years ago to live with her daughter's family. She completed part of primary school and spent her life in domestic and caregiving roles, first for her mother and later for her daughter and grandchildren.

Over the past year, she has reported memory difficulties that worry her. In a previous consultation, she was told her symptoms reflected normal aging. However, their persistence, along with her family history of dementia, led her daughter to seek a second opinion. Her daughter noted her frequent forgetfulness, repetitive questioning, and occasional trouble finding words. She has not seen any signs of disorientation or loss of valuable items.

During the interview, V.B. was cooperative but appeared mildly anxious. She mentioned feeling "slower" and less useful since she stopped doing household tasks that had once shaped her daily routine. She now lives with her daughter, who handles most domestic responsibilities. Still, V.B. continues to engage in certain meaningful activities, such as making desserts for her grandchildren and caring for plants. She manages her medications on her own but needs reminders for medical appointments. She no longer goes out alone because she fears getting lost in an unfamiliar city.

Laboratory tests and a brain computed tomography scan showed no issues. Neuropsychological assessment indicated her performance was within the expected range for her age and education, with no signs of major cognitive impairment.

However, a detailed evaluation of activities of daily living revealed a slight reduction in independence when facing new or complex situations. This limitation appeared to be more closely related to contextual and emotional factors than to a decline in neurocognitive functioning.

Taken together, the cognitive and functional findings support the hypothesis that a functional limitation is associated with recent relocation, bereavement, and changing family roles, rather than a deficit primarily driven by cognitive impairment. Accordingly, V.B. was classified as cognitively unimpaired but presenting with context-related functional limitations.

4.2 | Genetic heterogeneity (see Box 2)

BOX 2 Genetic variants from the global south

Brain health and dementia are impacted by a multitude of heterogeneous factors that may not be universally applicable across all diverse contexts. Because the Global South comprises most of the world's population, it also bears most of the burden of diseases, the world's poor, and the socially disadvantaged. As a result, the Global South, compared to the Global North, is least able to cope with the increasing advances in health care due to the aging population, urbanization, and increasing prevalence of chronic diseases like dementia, which are accompanied by increasing reliance on costly medical technologies for diagnosis and treatment. This high prevalence is associated with health and socioeconomic disparities.[32] Furthermore, dementia genetic risk factors, such as the apolipoprotein E $\varepsilon 4$ allele, a significant factor for Alzheimer's disease (AD), differ across populations. It is more frequently observed among individuals with African ancestry but has an attenuated association with AD risk compared to individuals with European ancestry.[33] These genetic differences are further evident among variants of frontotemporal dementia (FTD), a highly heritable form of dementia. The most common variants observed in FTD populations of the Global North include those in the *MAPT*, *GRN*, and *C9orf72* genes. However, these variants have not been frequently reported from the Global South.[34] Instead, novel variants of uncertain significance have been reported from many countries in the Global South.[35,36] The reasons for this disparity are not completely understood but may include factors such as complex genetic ancestry in regions like South Asia, as well as limited funding for genetic studies in populations from the Global South. This highlights the interactions between heterogeneous social determinants of health, sociocultural diversity, and the role of unique ancestry complicated by complex genotypes of the Global South compared to the Global North.[18]

4.3 | Bilingualism (see Box 3)

BOX 3 Bilingualism and dementia

As of 2023, >7000 languages are spoken by different communities worldwide, and contact between linguistically diverse societies has led to widespread multilingualism. More than 60% of the world, especially in the Global South, speaks more than one language. However, dementia practice and research have largely assumed monolingualism as the norm. Bilingualism impacts multiple aspects of dementia, including diagnosis, management, and prevention. Multilingual and multicultural societies in the Global South offer a valuable opportunity to develop a deeper understanding of the relationship between life-course experiences, such as bilingual experience, and dementia.

India is linguistically diverse, with 122 major languages, 22 official languages, and 1599 other languages spoken. Approximately 33% of Indians are multilingual. Because most neuropsychological tests have been developed for educated, predominantly English-speaking Western populations, a need to develop equivalent and appropriate tests in Indian languages was recognized, and a harmonized and culturally appropriate cognitive test battery was developed and validated in Hindi, Telugu, Kannada, Malayalam, Urdu, Tamil, Bengali, and Indian English for dementia diagnosis across the country.[37,38] Standards for neuropsychological testing of bilinguals were also developed,[39] and these recommendations provide a reference framework for addressing similar situations in large bilingual populations in other societies.

Life course factors impact risk and resilience to dementia, and emerging research indicates a potentially protective role for bilingualism. However, confounding factors such as education, immigration, socioeconomic status, and differences in language use resulted in heterogeneity in reported effects of bilingualism.[40] India, with the extensive practice of normative and neighborhood bilingualism, provides a unique setting to explore this relationship. The mechanistic effects of bilingualism on a range of pathologies, including Alzheimer's disease, frontotemporal dementia, and stroke, are being actively studied. Significantly, a delay of nearly 5 years in the onset of dementia and a reduced prevalence of dementia among bilinguals has been demonstrated, free from the confounding effects of immigration, literacy, and socioeconomic status,[41,42] and the neural mechanisms underlying this association have also been elucidated.[43] More recently, bilingual research has brought together culturally diverse populations, including Spanish–English immigrants and Chinese in the United States, as well as bilingual communities in Bangalore, India.[44] Bilingualism research from the Global South thus offers a framework for dementia research that is inherently diverse, more collaborative, and more relevant to a larger number of people in need.

4.4 | Structural inequalities and dementia prevention (see Box 4)

BOX 4 Structural inequalities and dementia risk

Prevention strategies require that choices be made about risk-reduction strategies. Approaches based on population-level strategies that address broader determinants of health (e.g., poverty, education, and health-care infrastructure) have been generally overlooked in favor of promoting individual lifestyle changes (e.g., diet, exercise).[45]

There is compelling evidence, particularly from Latin America, demonstrating that structural factors significantly increase the aging burden from healthy aging to accelerated brain aging. Exposures to environmental contamination (e.g., pollution), social determinants (socioeconomic status, inequalities, migration), and psychosocial stressors (democratic instability) exhibit cumulative, non-additive effects that accelerate aging across global populations.[46]

We now understand that social determinants of health, such as socioeconomic inequality, air pollution, and health disparities, are influential predictors of accelerated brain aging, particularly in Latin America and the Caribbean.[47] This divide complicates the adoption of prevention frameworks, such as those proposed by the Lancet Commission, which have generally focused on individual behaviors rather than addressing the social determinants of health. However, the Commission is slowly shifting toward a public health approach.[21]

4.5 | North–South collaboration (see Box 5)

BOX 5 World-wide fingers as a model for north–south collaboration

The World-Wide FINGERS (WW-FINGERS) initiative[48] exemplifies equitable North–South collaboration in dementia prevention research. Originating from the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER),[49] this global network was established to test the generalizability of a multidomain lifestyle intervention across diverse sociocultural, economic, and health-care system contexts, including > 60 studies worldwide. LatAm-FINGERS[50] constitutes the first large-scale adaptation of the FINGER model in Latin America, illustrating how knowledge generated in the Global North can be meaningfully translated, adapted, and enriched through South-led research. Rather than a simple replication, LatAm-FINGERS involved a rigorous two-step harmonization process: external harmonization with the original FINGER trial and other WW-FINGERS studies, and internal harmonization across

12 Latin American countries to ensure feasibility, cultural relevance, and data comparability. This process required consensus building among multidisciplinary teams and careful adaptation of eligibility criteria, outcomes, and interventions to local realities, including linguistic diversity, educational heterogeneity, and differing cardiovascular risk profiles.

Importantly, LatAm-FINGERS was designed and led by Latin American investigators, with local management of data, biobanks, and implementation strategies. Capacity building was a central component of the collaboration, encompassing technology transfer, training in neuroimaging and biomarker collection, as well as the strengthening of research infrastructure across participating centers. This approach moves beyond extractive research models, positioning the Global South as an active producer of scientific knowledge rather than a passive recipient.

The collaboration with other WW-FINGERS studies, particularly U.S. POINTER,[51] further demonstrates the partnership's bidirectional nature. Harmonized outcomes and aligned protocols create the opportunity for pooled analyses across continents, enabling comparative research that includes ethnically and socioeconomically diverse populations traditionally underrepresented in dementia prevention trials. In this sense, LatAm-FINGERS not only tests the applicability of the FINGER intervention in Latin America but also contributes novel insights that can refine prevention strategies globally.

5 | DISCUSSION

The experience, recognition, and management of dementia in the Global South are strongly shaped by historical and sociocultural contextual factors. A deeper study of these perspectives could enrich a field that has, until now, been predominantly shaped by contributions from the Global North.

Neither the historical development of the concept of dementia nor the scientific components traditionally regarded as their defining pillars represent universal truths. Sociocultural contexts shape how cognitive decline is understood and distinguished from healthy aging, and they further modulate both the factors associated with dementia risk and the complex relationships between biological markers and clinical manifestations. Building on these insights, we propose three key challenges to scientific knowledge and to the capacity to address dementia in the Global South.

5.1 | Challenges in diagnosis and assessment

The diagnosis of dementia in the Global South often occurs at a more advanced stage due to low societal awareness and stigma compared to the Global North.[52] This low awareness is also observed among health professionals, adding further to the delay in the diagnosis of dementia.

V.B.'s case illustrates key diagnostic challenges in neurocognitive disorders. Although she and her daughter reported memory difficulties and reduced daily functioning, the mismatch between V.B.'s intact cognitive performance and her functional difficulties argues against a diagnosis of dementia, as neither functional impairment (FI) without cognitive deficits nor isolated cognitive decline without functional impact is sufficient for diagnosis. Importantly, diagnostic accuracy depends on incorporating contextual and cultural factors into assessments.[53] Although these factors have been widely examined in cognitive evaluations, they have received far less attention in functional assessments, despite the central role of FI in distinguishing cognitively unimpaired aging, mild cognitive impairment, and dementia. Functional assessment provides a critical lens for understanding how diagnostic categories are operationalized across cultures as it requires evaluating an individual's capacity to perform activities of daily living (ADLs), which entails determining the degree of impairment that qualifies as FI—the "how much" question—and identifying which ADLs are essential for independent living—the "what" question.[54] Cultural and gender factors shape perceptions of independence, necessitating functional assessments tailored to specific sociocultural contexts.[55] To ensure accurate diagnosis, these assessments must be culturally competent, recognizing that essential ADLs vary based on gender roles, environmental factors (e.g., rural vs. urban settings), and other contextual elements.

Importantly, early functional decline, particularly in instrumental ADLs (IADLs), may remain clinically silent due to multilevel mechanisms such as intergenerational living, informal caregiving, and community support. The absence of overt FI should therefore not be interpreted as absence of disease impact, but rather as compensation and redistribution of cognitively demanding tasks within the household. Because IADLs such as financial management, shopping, and medication management are often assumed early by family members, standard functional instruments may underestimate emerging decline when sociocultural context and informant input are not adequately considered, underscoring the need for culturally adapted assessments.[56] In Latin American contexts, in which care relies predominantly on family networks, these compensatory dynamics may delay clinical recognition of functional change while increasing caregiver burden and leaving psychosocial needs unmet.[57] Consistent with the "how much" dimension of person-centered functional assessment models, the interaction between individual capacity and environmental demands may allow structural living conditions to mask early FI despite underlying cognitive decline.[54] Clinicians should avoid uncritical reliance on cultural norms and remain alert to ageist assumptions, as resilience-related compensation may paradoxically impede timely detection of AD and related dementias in majority-world populations.[58]

Box 2 suggests the necessity of diverse biomarkers for accurate diagnosis and their potential in the diverse Global South; however, a significant gap in biomarkers remains. Blood-based biomarkers are likely to enhance access to diagnosis confirmation, which may

otherwise rely on invasive spinal taps or inaccessible brain scans, but they do not replace clinical judgment.[59] These diagnoses are further complicated by a lack of resources and trained professionals, exacerbating the challenge of early diagnosis, particularly in primary care settings in which general practitioners may have limited dementia-related training.[60] Thus, reducing AD to a biomarker-based system without considering these constraints risks both under- and overdiagnosis, leading to ineffective dementia management in the Global South.

Taken together, Boxes 1 and 2 prompt us to reflect on the challenges in diagnosis and assessment. When we examine Northern definitions, they all have their limitations when applied to the Global South. The biological definition of AD, which heavily relies on biomarkers such as amyloid and tau, assumes widespread access to sophisticated diagnostic technologies. However, in many LMICs, the health-care infrastructure lacks the capacity to offer advanced imaging techniques, such as positron emission tomography scans or even cerebrospinal fluid biomarker analysis. A survey of professionals in LMICs found that clinicians saw more patients, had less time for evaluations, used formal screening and tools less frequently, and had less access to biomarkers.[61] Even though efforts are now being made to provide advanced diagnostic tools, there are few comparative studies within the Global South and between the Global North and South.[18] These considerations highlight the need for interdisciplinary research in the Global South that integrates scientific constructs of dementia with the cultural and social realities of local communities,[58,62] ultimately enhancing diagnostic accuracy and relevance.

5.2 | Structural determinants of cognitive health and care pathways

The Global South bears a disproportionate share of the global dementia burden: ≈ 60% of people living with dementia reside in LMICs, a proportion projected to increase to nearly 71% by 2050.[63,64] In parallel, the burden of young-onset dementia is increasing globally, with some studies reporting younger ages at onset in certain LMIC settings, despite the scarcity of epidemiological studies from the Global South.[65,66] In this context, earlier dementia onset in Global South populations is unlikely to be explained by genetic risk alone and instead reflects strong gene–environment interactions operating across the life course.[66] While genetic susceptibility contributes to individual vulnerability, its phenotypic expression is substantially modulated by environmental exposures that shape biological embedding and systemic aging trajectories.[67] Consequently, earlier dementia onset in these populations may be partially driven by accelerated biological aging resulting from cumulative exposomic and systemic influences.

Consistent with this framework,[67,68] evidence from Latin America demonstrates that dementia risk and severity are closely linked to structural and social determinants of health, alongside a high prevalence of modifiable risk factors—such as obesity, physical inactivity, and depression—supporting a life-course accumulation model and earlier onset in Global South settings. Importantly, the apparent influence of ancestry attenuates when accounting for these contextual and modifiable factors.[58,69,70] At the same time, gene–environment interactions, direct genetic contributions, and epigenetic mechanisms remain largely understudied in the Global South, representing a unique and largely untapped opportunity for scientific discovery. As discussed in Box 3, research on bilingualism has reshaped our understanding of its role as a potential protective factor against dementia. This example illustrates how multilingualism, common in many regions of the Global South and yet underrepresented in dementia models largely developed in the Global North,[71] may constitute an additional, overlooked source of cognitive resilience within the cultural and linguistic contexts of the global majority.[72] These observations underscore the need for deeper, context-sensitive understanding of how protective and risk factors for dementia interact. In this regard, a syndemic approach[62] could help to clarify the contribution of genetic–exposome interaction across dementia subtypes. Noticeably, as discussed in Box 4, social determinants of dementia have a dual impact on dementia in the Global South: increasing exposure to environmental factors of unhealthy brain aging, and reducing access to health care to access diagnosis and care. Even among Organisation for Economic Co-operation and Development countries with dementia plans that acknowledge social determinants of health, only one third include tangible strategies to address them.[73]

5.3 | Local capacity building

We have discussed how knowledge from the Global South is crucial for reducing the global burden of dementia and developing a more comprehensive understanding of the condition. The examples of work on social exposomes and multilingualism demonstrate how the Global South is taking a leading role in these understudied aspects of dementia. Latin America in particular provides an example of successful collaboration in the Global South.[19]

Moreover, the example of WW-FINGERS in Box 5 provides a model of North–South collaboration, highlighting the value of shared scientific frameworks combined with local adaptation, mutual learning, and respect for regional expertise. Such collaborations are crucial for reducing global inequities in dementia research and for developing prevention strategies that are both globally informed and meaningful at a local level.

6 | CONCLUSION: PRIORITIES FOR DEMENTIA IN THE GLOBAL SOUTH AND BEYOND

Northern models of dementia fail to capture the social, linguistic, and cultural diversity found in most of the world. The challenge is not just to add the Global South as a perspective within existing frameworks. We must also recognize it as a valid source of ideas, questions, and ways of knowing that can reshape our understanding of dementia in both science and society. The current fragmentation of scientific knowledge risks leaving us with only partial perspectives, echoing the metaphor of the blind men describing different parts of an elephant. Northern research traditions, with their overall focus on precision, illuminate

certain aspects. Southern approaches, with a focus on diversity, highlight others; through their integration, a more comprehensive picture of dementia can be achieved. As Naomi Oreskes[26] argues in *Why Trust Science?*, pluralism is essential for producing robust and transferable scientific knowledge that can inform effective public policy.[74]

In this sense, the integration of perspectives from both the Global North and the Global South deepens our scientific understanding of dementia and increases the likelihood of developing more effective, equitable, and globally relevant strategies to address its impact. Knowledge production on dementia from the Global South is steadily increasing, demonstrating that high-quality, novel contributions can emerge from this region. This and future research have the potential to broaden our understanding of cognitive disorders and to open new conceptual avenues. Building connections between the North and South involves fostering collaborations founded on mutual respect, humility, and shared benefits. A diverse and inclusive science of dementia that listens to the languages, histories, and lived experiences of the South will generate fairer knowledge and produce more relevant insights for everyone. The coming century should focus on gaining an understanding that embraces diversity, acknowledges inequality, and aims for a science that serves all minds, everywhere.

We propose three major actionable priorities for systems, diagnosis, and capacity:

1. Ambitious action against structural and social determinants of brain health.
2. Large-scale implementation of culturally and contextually appropriate tools for timely diagnosis and care.
3. Research and policy initiatives that align with international action plans such as World Health Organization initiatives,[75] while remaining responsive to local realities.

Addressing these priorities offers a timely opportunity to strengthen global efforts toward more equitable dementia prevention, diagnosis, and care.

AUTHOR CONTRIBUTIONS

A.S., T.D., S.A., I.L.-B., and P.V. conceived and designed the study and developed the principal conceptual framework. T.D., I.L.-B., and P.V. conducted the review. A.S., T.D., S.A., I.L.-B., and P.V. prepared the initial draft of the manuscript. All remaining authors contributed to the preparation of the boxes. All authors participated in the critical revision of the manuscript and approved the final version for submission.

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CONFLICT OF INTEREST STATEMENT

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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