A scientific guide and a proposed framework

Alzheimer's Disease in Older Persons

Understanding symptoms, diagnosis, care and risk reduction

and towards an Emirati model of care for patients and their families

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Introduction

Concern in a family often begins with a question asked over and over, a forgotten appointment, or unusual difficulty managing household affairs. Yet not all forgetfulness is Alzheimer's disease, and Alzheimer's is not an inevitable part of ageing. This guide explains what medicine currently knows about the disease and what families can do, without alarm or unproven promises of cure. Its second part proposes an Emirati framework for the care of people living with the disease and their families, built on dignity, integration and scientific evaluation.

Part One of this guide draws on the medical sources listed in the references and is no substitute for consulting a specialist. Part Two is the author's main contribution. It proposes a framework for supporting people living with Alzheimer's and their families, grounded in the rights to dignity and autonomy.

Part One:
A Simplified Scientific Guide for Families

1. What is Alzheimer's disease, and how does it relate to dementia?

Alzheimer's is a neurodegenerative disease that causes gradual changes in brain cells and their connections, and it is the most common cause of dementia. Dementia, by contrast, is a clinical description of cognitive decline that affects everyday independence; it is not a synonym for Alzheimer's. Other forms exist, such as vascular dementia and dementia with Lewy bodies, and several causes may coexist in the same person.[1]

The disease process of Alzheimer's is associated with deposits of beta-amyloid protein, abnormalities of tau protein and loss of neural connections. This knowledge alone is not enough to diagnose an individual; diagnosis requires linking symptoms, clinical examination and appropriate tests.[2]

2. The scale of the problem worldwide

The World Health Organization estimates that around 57 million people were living with dementia worldwide in 2021, that new cases approach ten million a year, and that Alzheimer's disease may contribute to 60–70% of dementia cases.[1]

> **How should these figures be read?**
>
> These are global estimates for dementia as a whole, not all of which is Alzheimer's, and the reference year is 2021. They should not be presented as national figures for the United Arab Emirates without an independent local source.

3. How do symptoms appear and progress?

Early on, the person may forget recent events or repeat the same question, and find it hard to plan or to find words; changes in initiative or mood may also appear. Some people first show difficulties with organisation or orientation before obvious memory loss.

In the middle stage, the need for help grows: difficulty managing money and medication, confusion about place and time, disturbed sleep, or wandering without knowing the way. In advanced stages, speech, walking and swallowing may be affected, and continuous daily support becomes necessary. The course varies; not every case follows a fixed timetable.[1]

4. Age-related forgetfulness or a sign of disease?

- A healthy person may be slow to recall a name and remember it later; repeatedly forgetting recent conversations, with declining daily function, warrants assessment.
- Anyone may miss an occasional appointment; getting lost in a familiar place or growing unable to do a routine task is a sign that needs attention.
- Memory changes are not always Alzheimer's: depression, poor sleep, some medicines, vitamin B12 deficiency and thyroid disorders can contribute to symptoms, and some of these are treatable.

Ten warning signs that warrant assessment[3]

- Memory loss of recent information that disrupts daily life.
- Difficulty planning or keeping track of familiar bills or recipes.
- Increasing difficulty completing tasks the person used to do.
- Recurrent confusion about time or place.
- New trouble judging distance or understanding visual images and spatial relationships.
- New problems with words in speaking or writing.
- Misplacing things in unusual places and losing the ability to retrace steps.
- Poor judgement or unusual financial decisions.
- Withdrawal from work, hobbies and social activities.
- Clear changes in mood, personality or trust in others.

These are warning signs, not a diagnostic test, and none of them proves the disease on its own; but they call for a medical review if they recur or worsen and affect daily life.

> **When is it urgent?**
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> Confusion that starts suddenly over hours or days, or that comes with sudden weakness in a limb or acute speech disturbance, is not a typical onset of Alzheimer's and needs urgent medical assessment.

5. Risk factors: what is fixed and what can change?

Age is the strongest known risk factor. Genes and family history may affect susceptibility, but having an affected relative does not make the disease inevitable.

The 2024 report of the Lancet Commission identified fourteen modifiable risk factors across the life course, including high blood pressure, diabetes, high LDL cholesterol, smoking, physical inactivity,

obesity, untreated hearing loss and vision loss, social isolation, depression, head injury, air pollution, excessive alcohol use and lower levels of education. High cholesterol and vision loss were new additions in that report.[4]

What does the 45% figure mean?

The Commission estimated that about 45% of dementia cases at population level are associated with these factors combined. This is a modelled estimate based on epidemiological assumptions. It does not mean that an individual can prevent the disease by 45%, nor that all cases are preventable. A statistical association also does not mean a direct causal effect of every factor in every person; some features, such as depression or social withdrawal, may sometimes be early signs of the disease rather than its cause.[4]

6. How is it diagnosed?

Assessment begins with a description of the symptoms, their duration and course, a neurological and functional examination, and a review of medicines and other conditions. The doctor may use standardised cognitive tests, blood tests to look for treatable causes, and brain imaging with MRI or CT where needed. In specialist centres, biomarkers in cerebrospinal fluid, imaging or validated blood tests may be used within a defined clinical context.[2]

New blood tests — Alzheimer's Association guideline (2025)

The 2025 guideline supports using blood tests in specialist memory clinics for patients with objectively confirmed cognitive impairment. Tests with at least 90% sensitivity and at least 75% specificity may be used for initial triage. Tests that reach at least 90% on both measures may substitute for amyloid PET imaging or cerebrospinal fluid testing for Alzheimer's biomarkers. These recommendations apply to patients with cognitive impairment after a comprehensive clinical evaluation.[5]

Early diagnosis gives an opportunity to organise care, assess safety around driving, medication and finances, and involve the person in decisions while they are still able to make them. It also allows treatment of coexisting problems that can improve, and discussion of treatment options with a specialist.

7. What about new treatments?

There is still no treatment that guarantees a cure. Some symptomatic medicines may ease symptoms for certain patients. Anti-amyloid therapies have emerged for some cases of confirmed early Alzheimer's disease, most notably lecanemab and donanemab:

- **Lecanemab — the CLARITY AD trial (2023):** 1,795 participants; it showed a moderate slowing of clinical decline over 18 months compared with placebo. This was not a cure, nor a recovery of lost memory.[6]
- **Donanemab — the TRAILBLAZER-ALZ 2 trial (2023):** 1,736 participants with early Alzheimer's selected by biomarkers; it showed slower decline over 76 weeks.[7]

Risks: amyloid-related imaging abnormalities (ARIA)

These therapies can cause brain swelling or micro-bleeds detected on MRI. In a secondary analysis of 3,030 participants in donanemab trials, oedema (ARIA-E) occurred in 24.4% of treated participants in the placebo-controlled trials versus 1.9% on placebo; most cases were mild or moderate, but some were serious. Treatment therefore requires careful patient selection and regular MRI monitoring.[8]

Availability of these therapies differs from country to country, and decisions about them are a matter for careful specialist judgement after weighing benefits and risks. Families should not start supplements or folk remedies, or stop prescribed medicines, on the basis of content circulating on social media.

8. Reducing risk: what does the evidence support?

Growing evidence supports attention to heart, brain and sensory health and to social connection, but trial results are more nuanced than is often claimed:

- **The FINGER trial (Finland, 2015):** 1,260 people aged 60 to 77; a two-year intervention combining diet, physical activity, cognitive training and vascular risk monitoring. It showed a relative improvement in measured cognitive performance, but did not show prevention of Alzheimer's.[9]
- **The US POINTER trial (United States, 2025):** 2,111 people at risk of cognitive decline; it compared a structured programme with a self-guided one over two years. Cognition improved in both groups, slightly more in the structured group (0.029 standard deviations per year), without demonstrating prevention of dementia.[10]
- **The ACHIEVE trial (2023):** 977 older adults with untreated hearing loss. There was no significant reduction in cognitive decline in the whole sample over three years, but a pre-specified

analysis showed benefit in a higher-risk group. Treating hearing loss is worthwhile for its proven health and communication benefits, without promising that it prevents dementia.[11]

- **The SPRINT MIND trial (original report 2019, follow-up 2025):** intensive blood pressure control reduced the occurrence of mild cognitive impairment; the reduction in probable dementia alone did not reach statistical significance in the original report. A follow-up of about seven years confirmed a continued reduction in mild cognitive impairment and in the combined outcome (mild cognitive impairment or probable dementia). The blood pressure target remains an individual medical decision, depending on the person's condition, fall risk and side effects.[12,13]

World Health Organization guidelines (second edition, July 2026)

The updated guidelines recommend physical activity, stopping tobacco use, reducing alcohol, a healthy diet, managing blood pressure, diabetes and cholesterol, cognitive training and stimulation, social participation, the possible offer of hearing aids, and reducing exposure to air pollution. They do not recommend vitamin B or E, omega-3 or multivitamin supplements to prevent cognitive decline in the absence of a diagnosed deficiency. These steps do not guarantee prevention of Alzheimer's in any individual, but they support brain and body health.[14]

Summary of the evidence: what the studies show and what they do not

Study	Type of evidence	What it found	What it does not mean
Lancet Commission[4]	Expert report based on systematic reviews	14 modifiable risk factors, linked to about 45% of cases at population level	That an individual can prevent the disease by 45%
FINGER[9]	Randomised controlled trial	Relative improvement in cognition over two years	Prevention of Alzheimer's
US POINTER[10]	Randomised controlled trial	Slightly greater improvement with the structured programme	A reduction in dementia incidence
ACHIEVE[11]	Randomised controlled trial	Benefit in a higher-risk group only	That hearing aids prevent dementia for everyone
SPRINT MIND[12,13]	Study within a randomised trial	Fewer cases of mild cognitive impairment and of the combined outcome	A single blood pressure target for all older people

Study	Type of evidence	What it found	What it does not mean
CLARITY AD and TRAILBLAZER-ALZ 2[6,7]	Randomised controlled trials	Slower decline in selected early-stage patients	A cure, or suitability for every patient
Blood test guideline[5]	Clinical guideline based on a systematic review	Conditional use in specialist clinics	Diagnosing healthy people or skipping clinical assessment

Three levels should therefore be kept apart: risk factors observed in population studies, interventions that improved cognitive performance in trials, and therapies that may slow decline in selected patients. None of them amounts to a guarantee of prevention or cure. The practical priorities for families are early assessment, control of chronic conditions, treatment of hearing and vision problems, suitable activity, and family support.

9. A family guide to daily care

Communication by stage

- **Early stage:** speak to the person directly, give enough time to respond, ask what kind of help they prefer, and do not assume they have lost the ability to decide.
- **Middle stage:** reduce noise, ask one question at a time, offer two clear choices, and use visual cues. Do not turn conversation into a memory test or argue about details.
- **Advanced stage:** introduce yourself calmly, use facial expression, gesture and a reassuring voice, respect their preference about touch, and watch for non-verbal signs of pain.

Routine and activities

Keep regular times for sleep, meals and activity, and use a clear clock and calendar. Encourage walking, hobbies, conversation, family photographs and suitable social participation without exhaustion.

Bathing and personal care

Prepare everything before starting, check the water temperature, and use grab bars and non-slip floors. Explain the next step simply, offer limited choices, and protect privacy and modesty. If the person refuses to bathe, look for the cause of their discomfort and try again later; avoid force.

Eating, drinking and swallowing

Serve food in a calm setting with suitable utensils, and watch for changes in weight and appetite. Repeated coughing while eating, a changed voice after swallowing, or choking are signs that call for as-

sessment by a doctor or swallowing specialist; the texture of food or drinks should not be changed without professional advice.

Wandering and leaving the home

Prepare a plan in advance that includes a recent photograph, an emergency contact method, places the person may head for, and an assessment of nearby roads and water. Door sensors or location devices may be considered, with attention to consent and privacy. Locks that prevent exit during a fire or that confine the person should not be used. If the person goes missing, start searching immediately and ask the competent local authorities for help.[15]

Challenging behaviour and evening confusion

New agitation, suspicion or hallucinations may point to pain, hunger, dehydration, constipation, infection, a medication effect or a change in surroundings and routine; look for the cause before treating the behaviour as deliberate. Confusion may increase in the evening for some people, and comfortable lighting, calm activities and a regular routine help. Sudden or severe onset needs medical assessment, and sedatives should not be used without specialist supervision.

A practical family checklist

- ☐ Record symptoms, when they began, how they have changed, and the medicines used.
- ☐ Name one clear coordinator with the medical team, involving the person as far as possible.
- ☐ Review safety in the bathroom and kitchen, lighting and fall risks.
- ☐ Prepare a plan for wandering and emergencies without disproportionate restriction of freedom.
- ☐ Share care tasks and schedule regular breaks for carers.
- ☐ Review nutrition, weight, swallowing, sleep and behaviour during follow-up.

10. The right to dignity and autonomy

A diagnosis does not mean an immediate loss of capacity to make every decision; capacity varies with the type of decision and the stage of the disease. The older person should therefore be addressed directly, options explained in understandable language, privacy respected, and the person involved in care decisions as far as possible, with capacity assessed when needed in accordance with applicable law and procedures.

The legal basis in the United Arab Emirates

Federal Law No. (9) of 2019 on the Rights of Senior Citizens guarantees rights including autonomy, privacy, protection from abuse, health and social care, and confidentiality of information, and applies to Emirati citizens aged sixty and over.[16] Questions of powers of attorney and legal capacity require specialised Emirati legal advice according to the case and the provisions in force, and should not rely on foreign templates.

Discussing future health and financial arrangements early can help, while the person is still able to express their wishes.

11. Supporting the carer

Long-term caregiving can cause exhaustion, anxiety and disturbed sleep. It is important to share roles among family members, ask for help when needed, set aside time for rest, and use support groups and community services. Seeking support is not a failure; it protects both the person with dementia and the carer.[1]

The World Health Organization's iSupport programme offers training and self-help for carers, covering understanding dementia, self-care, everyday care and dealing with changes in behaviour.[17]

12. The Emirati family context, and when to seek help

Family ties and the majlis (the traditional family sitting room where relatives and neighbours gather) offer valuable opportunities for participation and connection with senior citizens, provided that visits, conversation and activities are adapted to the person's abilities and comfort. Preserving their social presence without embarrassment, easing their access to specialised services, and educating sons and daughters are practical elements of more humane care. To learn about available services, families are advised to consult the competent health authority in their emirate or their family doctor.

- **Book a medical assessment** when there is repeated and increasing forgetfulness, difficulty managing daily tasks, or noticeable changes in language, orientation or behaviour.
- **Seek urgent help** for sudden confusion, weakness in a limb, acute speech disturbance, or unusually rapid deterioration.
- **Prepare for the appointment** with a list of symptoms and when they started, medicines and supplements, chronic conditions, and specific examples from daily life.

Part Two:
Towards an Emirati Model of Care for People Living with Alzheimer's — A Proposed Framework

Overview

This part proposes moving from general awareness to a connected service model that places the older person living with dementia, and their family, at the centre of decision-making. The initiatives presented here are original development proposals by the author, not existing official programmes, and before implementation they require feasibility studies, partnerships and regulatory approvals. The model takes account of the country's cultural and linguistic diversity and of differences in patients' abilities and stages of the disease.

First: Foundations of the model

- **Dignity and autonomy:** respecting the person's wishes and changing decision-making capacity, with support rather than exclusion.
- **Health and social integration:** linking primary care, memory clinics, home services and community centres through a clear referral pathway.
- **The family as a partner, not a substitute for the professional:** training and psychologically supporting family members and giving them respite, without loading them with medical responsibilities that do not suit them.
- **Cultural fit:** using the majlis, stories, heritage images and the Arabic language in optional activities that respect individual comfort.
- **Scientific evaluation:** starting with small pilots and comparing indicators before and after, without claiming effectiveness before it is shown.
- **Privacy and equity:** protecting health data, and making programmes accessible to different groups and to areas with less access to services.

Second: The twelve initiatives

Initiative 1: Our Memory Is a Trust (Thakiratuna Amana)

Aim	Raise awareness of early signs and of the difference between ordinary forgetfulness and cognitive disorders.
Target group	Families, senior citizens and community service workers.
Implementation	Short awareness sessions in majlis and centres, simple Arabic leaflets, and a clear pathway to book a medical assessment, without mass screening.
Indicators	Number of participants, knowledge gains on pre- and post-tests, and the share of referrals that reached assessment.

Initiative 2: The Emirati Memory Majlis

Aim	Strengthen social connection and belonging through familiar activities.
Target group	People at suitable stages of the disease and their families.
Implementation	Small gatherings led by a trained facilitator: old photographs, Emirati stories and familiar activities according to personal preference, avoiding embarrassing memory tests.
Indicators	Regular attendance, satisfaction of participants and families, and observed comfort during sessions.

Initiative 3: Family Support (Sanad Al Usra)

Aim	Build carers' skills and reduce unsupported burden.
Target group	Sons, daughters and non-professional carers.
Implementation	Workshops on communication, behaviour, sleep, safety, emergencies and hearing checks, drawing on the iSupport programme, with a referral route to a specialist when care becomes difficult.
Indicators	Knowledge gained, confidence in care tasks, and validated carer-burden scales.

Initiative 4: My Home Remembers Me

Aim	Improve home safety and preserve remaining independence.
Target group	Families living with a person with dementia.
Implementation	An optional home assessment by a specialist, improving lighting, visual signage, medication organisation and removing fall hazards, without confinement, with reassessment when the condition changes.
Indicators	Hazards identified and addressed, reported incidents, and family satisfaction.

Initiative 5: The Smart Memory Companion

Aim	Ease daily routine and family communication without replacing the doctor.
Target group	People able to use technology and their families.
Implementation	A prototype for reminders of appointments, activities and familiar names in Arabic and local dialect, with clear permissions, informed consent and easy switch-off; it does not diagnose disease.
Indicators	Usability, technical errors, user satisfaction, and data-protection reviews.

Initiative 6: Grandchildren Who Keep the Story

Aim	Strengthen bonds between generations and preserve family narratives.
Target group	Grandparents, grandchildren and interested families.
Implementation	Voluntary sessions to record selected stories and photographs with the person's consent, with the right not to be recorded or to request deletion at any time.
Indicators	Number of sessions, quality of interaction, and the share of documented informed consents.

Initiative 7: A Day of Respite for the Carer

Aim	Relieve the strain of continuous caregiving.
Target group	Primary carers.
Implementation	A pilot respite service at home or in a licensed centre with trained staff, with an assessment of the person's needs and a safe handover plan.
Indicators	Hours of respite, family satisfaction, safety incidents, and changes in exhaustion measures.

Initiative 8: A Memory-Friendly Community

Aim	Improve how public facilities deal with people living with dementia.
Target group	Staff in shopping centres, transport and service providers.
Implementation	Short training in communication and responding to disorientation and confusion, easy-to-understand signage, and clear procedures for asking for help without stigma.
Indicators	Number of staff trained, practical assessment results, and service users' experience.

Initiative 9: Brain Health Starts Today

Aim	Reduce modifiable risk factors at community level.
Target group	Adults and older people, according to health assessment.
Implementation	A follow-up pathway for physical activity, blood pressure, diabetes, hearing, vision, smoking and social participation under health-team supervision, based on the results of FINGER and US POINTER and the WHO guidelines.
Indicators	Health indicators and adherence to the plan; a fall in Alzheimer's cases is not used as a short-term indicator.

Initiative 10: Rights That Memory Does Not Forget

Aim	Strengthen the legal and ethical protection of the person living with the disease.
Target group	Families and health and social care workers.
Implementation	A simplified rights guide explaining privacy, informed consent, supported decision-making and protection from exploitation, legally reviewed under UAE legislation.
Indicators	Improved rights awareness, endorsement of the guide by specialists, and monitoring of complaints and referrals.

Initiative 11: The Nearest Memory Clinic

Aim	Reduce barriers to specialist follow-up.
Target group	Families who live far away or have limited mobility.
Implementation	Remote follow-up consultations under licensing and privacy rules, with triage of cases that need an in-person examination, and without becoming a self-diagnosis service.
Indicators	Time to appointment, follow-up completion rate, and satisfaction of patients and families.

Initiative 12: The Emirati Observatory on Quality of Life with Alzheimer's

Aim	Produce local knowledge that supports policy and service improvement.
Target group	Service providers, researchers, decision-makers and families.
Implementation	A multi-agency research project collecting anonymised indicators on needs, services and quality of life, after ethical and regulatory approvals.
Indicators	Data quality, number of approved reports, and adoption of measurable recommendations.

Third: Linking evidence to initiatives

Scientific evidence	Related initiative	Limits of inference
Lancet Commission 2024 and WHO guidelines 2026	Brain Health Starts Today	Justifies reducing risk factors at community level; does not prove that a particular local initiative prevents the disease.
FINGER and US POINTER	Brain Health Starts Today	Justifies testing programmes that combine activity, diet, health follow-up and cognitive activity, adapted and evaluated locally.
ACHIEVE	Family Support; A Memory-Friendly Community	Results differ by group, so it cannot be claimed that hearing aids prevent dementia for all users.
Blood test guideline 2025	The Nearest Memory Clinic	Justifies appropriate referral pathways, not a self-diagnosis service.
Evidence on carer support and the iSupport programme	Family Support; Day of Respite; Memory Majlis	Justifies designing testable services, not prior proof of their effectiveness in the UAE.

Fourth: Governance and implementation plan

A multidisciplinary coordination team is proposed, including specialists in health care, geriatric medicine and neurology, social services, universities and data protection, together with representatives of families and of people living with the disease who are able to take part. The bodies mentioned are possible categories of partnership, not existing commitments. The team would begin by mapping existing services to avoid duplication, then select two or three initiatives to pilot before any expansion.

Phase	Main tasks
One: first three months	Needs assessment, review of existing programmes, identification of partners and target groups, and preparation of an ethics guide and data governance.
Two: months four to six	Designing Arabic materials, training teams, and piloting the Memory Majlis, Family Support and My Home Remembers Me on a limited scale, with baseline data collection.
Three: months seven to twelve	Evaluating safety, acceptability, cost and outcomes, and adjusting the design before adding digital initiatives or expanding the service.

Phase	Main tasks
Four: after the first year	Considering phased expansion according to funding, results and regulatory approvals, and publishing a transparent evaluation report.

Fifth: Impact evaluation method

Each initiative would have a "logic model" linking resources, activities, outputs and expected outcomes, with a baseline, follow-up indicators and a timetable, distinguishing implementation indicators (such as number of sessions) from outcome indicators (such as change in carer burden or home safety). Proposed indicators include:

- The share of families completing training, and knowledge gains before and after training.
- Satisfaction of people living with the disease and their families with communication, respect and involvement in decisions.
- The rate of appropriate referrals to medical assessment, and waiting times.
- Change in carers' psychological burden, using a culturally validated tool.
- Reported falls or wandering incidents, interpreted cautiously given small samples.
- Cost per beneficiary, based on real local prices, and equity of access across groups.

Independent evaluation with a comparison group is preferable where feasible and ethical. Improvements in satisfaction, attendance or knowledge alone cannot be taken as evidence of slower progression of Alzheimer's or a lower incidence.

Sixth: Ethical safeguards and protection of rights

- Obtaining ethical approvals and informed consent, assessing capacity to consent for the specific decision, and providing decision-making support.
- Not publishing photographs, stories or health data without valid explicit consent, respecting the right to withdraw, and minimising data collection.
- Preventing financial exploitation, regulating the use of digital tracking, and handling wandering safely without excessive surveillance.
- Avoiding any description of a digital application as diagnosing the disease or guaranteeing the person's safety.
- Setting referral protocols for acute cases, and providing accessible complaint channels.
- Taking account of differences in language, education, income and digital access, and not turning proposals into obligations on families.

Final legal wording should be reviewed by specialists in UAE law and the relevant health authorities, and numerical indicators should never replace listening to the person and their family.

Seventh: A proposed research agenda

A mixed-methods study is proposed to understand the journey of Emirati families from noticing the first sign through diagnosis to long-term care, without assuming that families' circumstances are alike, and examining differences in housing, available support, health awareness and place of residence.

- **Research questions:** What signs prompt a family to seek assessment? What practical, linguistic and psychological barriers exist? How are responsibilities shared among sons, daughters and carers? How can the older person's presence in majlis and family occasions be preserved without embarrassment or exhaustion?
- **Method:** semi-structured interviews with carers and professionals, an optional needs survey, and small focus groups, after ethical approval and with protection of data confidentiality.
- **Gaps worth testing:** ease of access to memory clinics, availability of culturally suitable Arabic training, the time, financial and psychological burden on families, and access to respite care and legal education.
- **Expected outputs:** a map of the family journey, a practical Arabic guide for the different stages, and recommendations for referral and respite services.

> **Limits of this framework**
>
> The twelve initiatives and the Emirati model are original proposals in this work, not existing government services or programmes of proven effectiveness, and the gaps listed are hypotheses for research rather than findings of a field survey. The core value of the initiatives lies in their feasibility, measurability and improvement, not in their number or the appeal of their names.

Conclusion

Alzheimer's changes a person's abilities, but it does not diminish their worth. Accurate knowledge, appropriate diagnosis and calm care help families face the disease with realism and compassion, while safeguarding the dignity of the older person and their right to take part as far as possible. The Emirati model proposed here is an invitation to care in which family, community and institutions work together, grounded in evidence and honestly measured.

Medical notice

This content is educational, not a diagnosis or a treatment prescription. If you notice new or worsening symptoms, consult a neurologist, a geriatrician or a memory clinic; for sudden neurological symptoms, seek urgent care.

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