Dementia Academy®

Education with impact:

Dementia care in faith communities across Africa, Asia and beyond

Workplace projects from the Anna Trust Dementia Academy programme impact report 2025–26

Neurology Academy®

NEUROLOGY ACADEMY: EDUCATION WITH IMPACT

THE ANNA TRUST
CATHOLIC SISTERS' ELDER CARE FUND

Index

Acknowledgements

Every project in this report is the work of a dedicated healthcare professional — a nurse, physician, chaplain, midwife, counsellor or clinician — who chose to look beyond the walls of their own service and ask: how can we do this better? Our sincere thanks go to each of the fifteen delegates whose workplace projects are captured here.

This programme would not exist without the vision and generosity of the Anna Trust, whose support has made it possible for clinicians and carers from eleven congregations across nine countries to access Dementia Academy education. Our thanks also go to the Faculty and speakers who contributed their expertise to this international cohort, and to the congregational leaders and superiors who championed this work within their communities.

Foreword

The ANNA TRUST collaboration with the Academy of Neurology has been a mutual enriching experience. Our shared commitment to best practice and the values of care and compassion for all whom we serve has offered an opportunity to continue to grow and learn together as a global community. The diversity of the lives and professional experiences of the sisters who have participated in the MasterClass in Dementia Care Programme has broadened our understanding of the needs of sisters caring for their members who are living with cognitive impairment in resource poor situations and how they respond to these challenges. The programme has been enriched by the cultural richness of religious life and sisters have said that it has deepened their commitment to their vocation as religious sisters who have been called to serve all entrusted to their care.

The excellent, up to date research-based learning has deepened participants understanding of the dementia syndrome and empowered them to care with greater skill and confidence. It has encouraged them to share their learning and to continue to develop their professional practice.

Sister Siobhán O'Keeffe

THE ANNA TRUST
CATHOLIC SISTERS' ELDER CARE FUND

Sister Siobhán O'Keeffe, SSHJM

Cognitive Impairment Program Director

Rome, Italy

Executive summary

The Anna Trust Dementia Academy programme (2025–26) brought together clinicians, nurses, chaplains, and community health practitioners from eight countries across Africa, Asia and Europe to address the urgent and growing challenge of dementia within Catholic religious congregations and wider faith-based communities. With two-thirds of the world's population living with dementia residing in low- and middle-income countries, and with limited specialist training available in these regions, the programme set out to deliver education with impact — combining expert-led teaching with mandatory workplace projects implemented in real clinical and community settings.

Fifteen projects were completed across Kenya, Zimbabwe, Zambia, Uganda, Nigeria, Indonesia, Malawi and Ireland. Each project translated learning into practical action, addressing one of four core themes: raising awareness, early identification, therapeutic and non-pharmacological interventions, and caregiver support.

Across the cohort, several patterns emerged:

- Awareness and understanding remain low, with dementia often misattributed to ageing, spiritual causes or mental illness. Projects in Kenya and Zambia demonstrated the transformative role of congregations as trusted platforms for health education.
- Early identification is inconsistent, with many elderly sisters and community members living with undiagnosed cognitive decline. Pilot studies in Zimbabwe and Kenya revealed significant unmet need and highlighted the value of structured screening pathways.
- Non-pharmacological interventions are central in resource-limited settings. Projects in Ireland, Indonesia and Malawi showed measurable improvements in emotional expression, daily functioning and engagement — including a rise in meaningful activity participation from 5.6% to 94.4% in one nursing home.
- Caregiver burden is high, often unrecognised and unsupported. Innovative models such as the Memory Support Hub in Nigeria and validated caregiver assessments in Uganda demonstrated sustainable, community-led approaches to strengthening resilience and improving care quality.

Collectively, these projects demonstrate that Dementia Academy's model of education-with-impact — expert-led learning combined with a mandatory workplace project — works not only in the United Kingdom but in low- and middle-income settings across the world. The Anna Trust partnership has made this possible. They show that religious communities function as critical health systems for their ageing members. They also demonstrate that sustainable change is most effective when built on peer capacity, culturally grounded approaches, and real data. The programme's outcomes confirm that education — when paired with practical application — can drive meaningful improvements in dementia care, even in the most resource-constrained environments.

Delegate feedback also demonstrated a growing depth of clinical engagement, with participants identifying increasingly complex questions around differential diagnosis, pharmacological management, caregiver support and end-of-life care — providing a clear case for continued, longitudinal education.

Introduction

Dementia is a global challenge, but its burden falls unevenly. Two-thirds of the world's people living with dementia reside in low- and middle-income countries — the very places where services are least resourced, access to specialist training is most limited, and health literacy around the condition is still developing. In these settings, dementia is frequently misattributed to normal ageing, spiritual causes, or personal failing, leading to delayed diagnosis, stigma, and preventable suffering for patients and carers alike.

Catholic religious congregations across Sub-Saharan Africa, East Africa, Asia and beyond face this challenge acutely. With growing numbers of ageing sisters in frail-care homes and mission hospitals operating without dementia-specific training, and communities of faithful people whose understanding of the condition is shaped more by cultural and spiritual frameworks than clinical evidence, the need for high-quality, contextually sensitive education has never been greater.

Methodology

In partnership with the Anna Trust, the Dementia Academy operates as a dedicated arm of Neurology Academy, extended its proven model of education-with-impact to this international cohort. Drawing on the same principles that have underpinned Dementia Academy's work across the UK, Bangladesh, India and beyond, the programme combined expert-led learning with a mandatory workplace project: every delegate was required to apply their learning directly to a real service, community or care setting.

The result is fifteen workplace projects spanning Kenya, Zimbabwe, Zambia, Uganda, Nigeria, Indonesia, Tanzania, Malawi and the United Kingdom — each a practical, locally-grounded step towards better dementia care. Together they address awareness, screening, therapeutic intervention, and caregiver support. Collectively they demonstrate that education, wherever it is delivered and whoever receives it, can be — in the truest sense — education with impact.

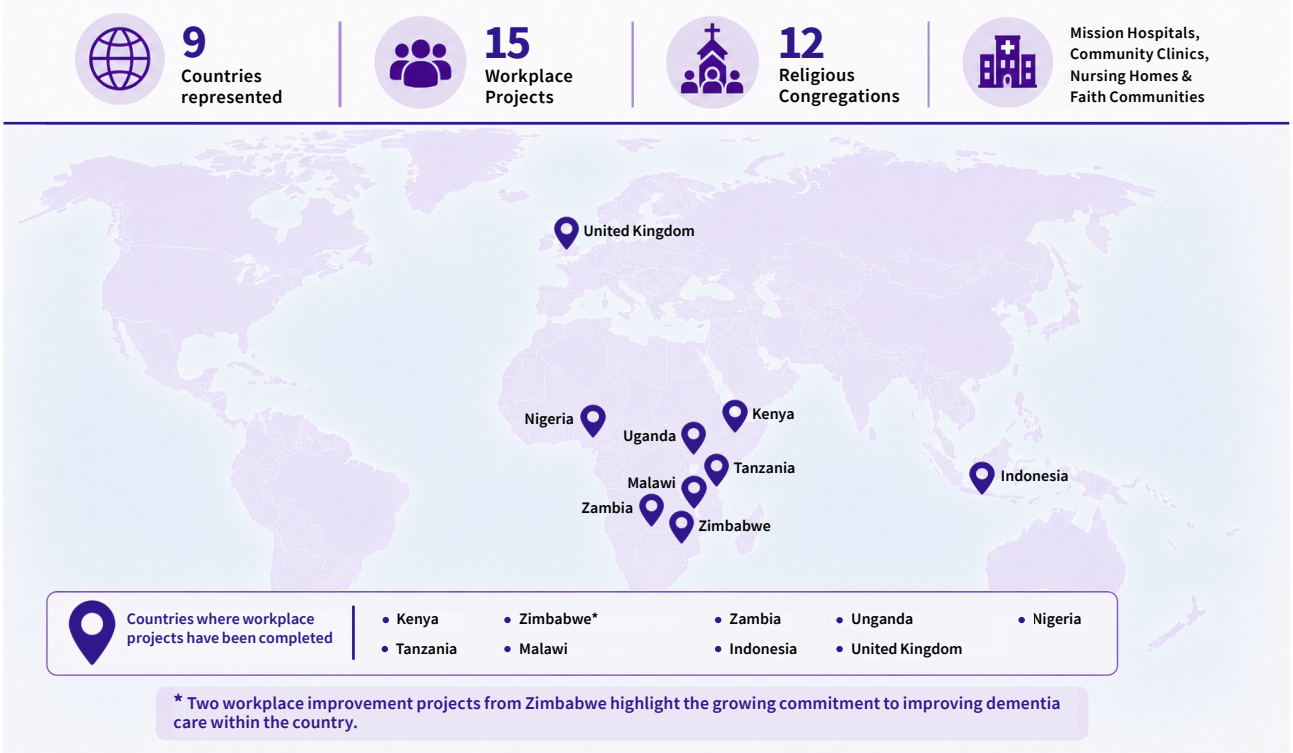
> *"Without the Academy structure and support, this work would not have been carried out. These projects demonstrate how education can have a real impact on individuals with dementia and the people who care for them — not just in the UK, but wherever this disease touches lives."*
>
> **Prof Iracema Leroi, Academic director, Dementia Academy**

The cohort participants

Figure 1

A Global Dementia Academy Community

15 workplace projects delivered across 9 countries, spanning Africa, Asia and Europe.



The fifteen delegates who completed workplace projects represent a remarkable breadth of experience, profession and geography. They include doctors, nurses, midwives, a counsellor, a clinician, a hospital director, a hospital matron, and a chaplain-psychotherapist. They work in mission hospitals, frail-care homes, community health centres, a nursing home and private practice. They come from eleven congregations across nine countries **(Table 1).**

Delegate Characteristics and locations

Table 1

NAME	ROLE	WORKPLACE	CONGREGATION	COUNTRY
Agnes Chipo Tererai	Doctor	Domhealth - Palliative Care Centre, Harare	Dominican Missionary Sisters of the Sacred Heart of Jesus	Zimbabwe
Sr Ann C. O'Sullivan	Chaplain / psychotherapist	Methodist Organisation / Private Practice	Sisters of Christian Instruction - St Gildas	UK
Cecilia Nyaga	Counsellor	Mikindani Catholic, Mombasa	Sisters of St Joseph of Tarbes	Kenya
Sr Emily Jebiwott	Lead nurse	Mombasa Catholic CBHC Services	Sisters of St Joseph of Tarbes	Kenya
Rev. David Opondo	Clinician	Mbungoni Health Centre, Mombas	Servants of the Sick - Camillians	Kenya
Sr Vaidah Simubali	Nurse	Chikuni Mission Hospital	Religious Sisters of the Holy Spirit, Monze Diocese	Zambia
Lucy Nyaga	Nursing officer in charge	Mombasa Catholic CBHC Services - Mikindani	Sisters of St Joseph of Tarbes	Kenya
Sr Irene Mwende	Staff nurse	Health Centre, Njoro	Sisters of St Joseph of Tarbes	Kenya
Rev. Sr Kyogabirwe Fulgensia	Registered midwife	Uganda Martyrs Ibanda Hospital, Ibanda District	African Sisters of Our Lady of Good Counsel, Archdiocese of Mbarara	Uganda
Nkeiruka Attracta Njoku	Hospital Matron / community nurse	St Anthony's Hospital Mgbowo & Bishop Shanahan Retirement Home, Enugu	Missionary Sisters of the Holy Rosary	Nigeria
Sr Dr Luisa Nunuhitu,	Medical doctor / Hospital director	Stella Maris Makassar Hospital, South Sulawesi	Sisters of Jesus Mary Joseph (SJMJ)	Indonesia
Theodora Mwasu	Medical doctor	St Gemma Hospital, Dodoma region	St Gemma Galgani Sisters	Tanzania
Nobuhle Ngazimbi	Bursar general	Malindela Community, Bulawayo	Servants of Mary the Queen	Zimbabwe
Felicia Ndawala	Nurse / advanced geriatric care coordinator	Maryview Nursing Home, Limbe	Servants of the Blessed Virgin Mary (SBVM)	Malawi
Mary Z. Bere	Nurse in charge	St Andrews Mission Hospital	Handmaids of Our Lady of Mt Carmel	Zimbabwe

Project summaries - raising awareness in faith and community settings

In many of the communities represented in this cohort, dementia is not understood as a medical condition. It may be attributed to supernatural causes, dismissed as normal ageing, or hidden by families who fear stigma. Before screening, before treatment, before caregiver training — understanding must come first. Five delegates addressed this foundational challenge directly.

Rev. David Opondo

Clinician • Servants of the Sick – Camillians • Mbungoni Health Centre, Mombasa, Kenya

Fr Opondo observed that dementia is frequently misunderstood within religious communities in the Archdiocese of Mombasa — sometimes associated with superstitious beliefs in ways that delay medical attention and compound stigma. His project identified seven clear objectives: creating community awareness, establishing baseline knowledge, reducing stigma and misconception, enhancing early medical help-seeking, reducing rejection of those living with dementia, understanding community attitudes, and identifying knowledge gaps. His findings confirm widespread ignorance of dementia's cause, symptoms and treatment. The Church — a trusted presence in the daily lives of elderly people across the Archdiocese — emerges from his work as one of the most powerful platforms for health education available.

Sr Vaidah Simubali

Nurse • Religious Sisters of the Holy Spirit, Monze Diocese • Chikuni Mission Hospital, Zambia

As the sister responsible for sick and elderly members of her congregation, Sr Vaidah was acutely aware of the knowledge gaps that placed vulnerable sisters at risk. Her project — the most substantial in the cohort at twelve pages — assessed the scope and nature of dementia awareness within her congregation. Her findings confirmed significant misconceptions: symptoms were frequently attributed to normal ageing or mental illness, leading to stigma and delayed help-seeking. The project provides an evidence base for a targeted congregation-wide education programme and a framework other congregations in Zambia could replicate.

Cecilia Nyaga

Counsellor • Sisters of St Joseph of Tarbes • Mikindani Catholic, Mombasa, Kenya

Cecilia's motivation for joining this programme was deeply personal: her older brother had been diagnosed with dementia at a stage beyond treatment, and in her rural community, conditions like his are often attributed to witchcraft rather than medical illness. Her project set five time-bound, measurable objectives for Chaani Catholic CBHC Services — covering screening, staff training, community awareness meetings, caregiver support groups and formal referral pathways — all targeted for completion by late 2026. In its comprehensiveness, it offers a replicable service development template for CBHC settings across East Africa.

Sr Irene Mwende

Staff nurse • Sisters of St Joseph of Tarbes • Health Centre, Njoro, Kenya

Sr Irene's project addressed the foundational clinical knowledge required for any care setting to function effectively. Covering types of dementia, causes, and the critical distinction between dementia and normal ageing, her work reflects a reality that is easy to overlook: in many congregation settings, even basic clinical literacy around dementia is absent. Establishing this foundation is a prerequisite for everything else.

Theodora Mwasu

Medical doctor • St Gemma Galgani Sisters • St Gemma Hospital, Dodoma region, Tanzania

Working at St Gemma Hospital in Tanzania, Theodora designed a community programme to promote awareness of ageing and its health challenges — including cognitive decline — among sisters and the wider community. Her project's photographs, showing engaged groups of community members, testify to the reach this work achieves beyond the hospital walls.

Key outcomes from this section

- Seven clear objectives established for dementia awareness across the Archdiocese of Mombasa, using the Church as a primary platform for health education — Rev. David Opondo, Servants of the Sick–Camillians, Kenya.
- Comprehensive 12-page assessment of dementia knowledge gaps within a congregation in Zambia, providing an evidence base for a targeted education programme replicable across other congregations — Sr Vaidah Simubali, Religious Sisters of the Holy Spirit, Zambia.
- Five time-bound SMART objectives set for Chaani Catholic CBHC Services, Mombasa — covering screening, staff training, community awareness meetings, caregiver support groups and formal referral pathways, all targeted for 2026 — Cecilia Nyaga, Sisters of St Joseph of Tarbes, Kenya.
- Foundation clinical education on dementia types, causes and differential diagnosis from normal ageing delivered in a congregational health centre setting — Sr Irene Mwende, Sisters of St Joseph of Tarbes, Kenya.
- Community-wide ageing and dementia awareness programme delivered at St Gemma Hospital, with photographic evidence of community engagement across multiple groups — Theodora Mwasu, St Gemma Galgani Sisters, Tanzania.

Screening and early identification

Without early identification, families are unprepared, individuals miss the window for timely support, and healthcare systems encounter people only at the point of crisis. Four delegates made early detection their focus — each responding to a different gap in a different setting.

Agnes Chipo Tererai

Doctor • Dominican Missionary Sisters of the Sacred Heart of Jesus • Domhealth – Palliative Care Centre, Harare, Zimbabwe

A physician currently undertaking PhD research in palliative care, Agnes produced the most methodologically rigorous project in the cohort. Her mixed-method pilot study at a frail-care home for Catholic sisters in Harare found that nearly one-third (32.1%) of the home's 28 residents showed cognitive decline or confirmed dementia — yet only three had received a formal diagnosis by a physician, and none were receiving dementia medication. The sister-nurse in charge had been managing all of this without specialist support or clinical guidance. Agnes's recommendations — clinical assessment using validated screening tools, basic caregiver training, and a national situational analysis of Catholic frail-care homes across Zimbabwe — provide a clear and urgent roadmap.

> *"The pilot study revealed an urgent and critical need for empowering caregivers regarding dementia and cognitive decline management. Providing care without specific training or medical support strategies places a heavy burden on staff and limits the optimisation of patient quality of life."*
>
> **Agnes Chipo Tererai, Dominican Missionary Sisters of the Sacred Heart of Jesus, Harare, Zimbabwe**

Sr Emily Jebiwott

Lead nurse • Sisters of St Joseph of Tarbes • Mombasa Catholic CBHC Services, Kenya

Sr Emily, who also oversees administration, HIV/AIDS client care, ARV prescribing and home visits at her facility, addressed the absence of any systematic dementia screening at the Little Sisters of the Poor Elderly Home. Her project stands out for its intellectual balance: rather than simply advocating for screening, she carefully weighs its benefits against its ethical limitations — including the risk of false-positive anxiety, stigma, and healthcare costs. Her nuanced analysis reflects a clinician who has moved beyond the basics of dementia knowledge towards genuine service-design thinking.

Lucy Nyaga

Nursing officer in charge • Sisters of St Joseph of Tarbes • Mombasa Catholic CBHC Services–Mikindani, Kenya

Like her colleague Cecilia, Lucy has a family member living with dementia — a brother — providing personal as well as professional motivation for this work. Her project is the most data-rich in the cohort. She identified a high-risk cohort of 290 elderly clients in the facility, 250 of whom were HIV-positive and aged 60 or over — a group in which local research has found a 24% rate of cognitive decline. She implemented routine dementia screening and collected real data: of 47 clients screened across HIV and NCD clinics, one positive case was identified (2.1%). This is the beginning of an evidence base that, built upon, will make the case for system-wide change.

Nobuhle Ngazimbi

Bursar general • Servants of Mary the Queen • Malindela Community, Bulawayo, Zimbabwe

Nobuhle brings an unusual perspective to this cohort as a Bursar General rather than a clinical professional — demonstrating that the need to understand and respond to dementia extends well beyond the clinical team. Her quality improvement project used a structured step-by-step framework to address the root cause of poor dementia outcomes in her congregation setting: inadequate initial assessment and diagnosis. Her approach — mapping the problem, identifying resources, formulating care plans, and establishing referral pathways — offers a replicable QI model for congregational settings.

Key outcomes from this section

- 32.1% of residents at a Catholic frail-care home in Harare found to have cognitive decline or confirmed dementia — none receiving dementia medication — with clear recommendations for validated screening, caregiver training and a national situational analysis of Zimbabwe's Catholic frail-care homes — Agnes Chipo Tererai, Dominican Missionary Sisters, Zimbabwe.
- Balanced ethical and clinical analysis of early dementia screening in an elderly care setting, weighing benefits against risks of false positives, stigma and cost — establishing a framework for evidence-based service design — Sr Emily Jebiwott, Sisters of St Joseph of Tarbes, Kenya.
- 47 clients screened across HIV and NCD clinics at Mombasa Catholic CBHC Services; 290-strong high-risk cohort of HIV-positive elderly clients identified (local research indicating 24% cognitive decline rate); baseline screening data established for system-wide expansion — Lucy Nyaga, Sisters of St Joseph of Tarbes, Kenya.
- Structured QI framework applied to dementia assessment and diagnosis in a congregational setting, with care plans, resource mapping and referral pathways formulated — demonstrating that non-clinical staff can lead meaningful service improvement — Nobuhle Ngazimbi, Servants of Mary the Queen, Zimbabwe.

Therapeutic and non-pharmacological interventions

In settings where pharmacological options are limited or inaccessible, non-pharmacological approaches are not supplementary — they are the primary therapeutic toolkit. Three projects explored what good non-pharmacological care looks like in practice, producing results that deserve a much wider audience.

Sr Ann C. O'Sullivan

Chaplain / psychotherapist • Sisters of Christian Instruction – St Gildas • Methodist Organisation / Private Practice, UK

Over six years working in a specialist dementia unit, Ann — who combines her role as a chaplain with a private psychotherapy practice and is now considering doctoral research in dementia — observed residents with mild to moderate dementia becoming increasingly withdrawn and isolated. Her response was sand play: a symbolic, non-verbal therapeutic medium that requires no words and no cognitive performance. Over eight sessions, she worked with selected residents, gathering qualitative data on eight themes — security, connection, playfulness, expression, identity, memories, autonomy and increased stimulation. Her findings document something clinically important: that even as verbal communication becomes impossible, the capacity for inner life, creativity and connection remains — and can be reached through the right medium. This project sits at the intersection of occupational therapy, psychotherapy and spiritual care, and breaks new ground.

> *"Sand play offers a symbolic form of communication that requires no words. It offers the opportunity to touch and be with the sand, imagination and support if needed from a trained facilitator — enhancing emotional expression, stimulating memory, reducing anxiety, and fostering a sense of autonomy and safety."*
>
> **Sr Ann C. O'Sullivan, Sisters of Christian Instruction – St Gildas, UK**

Sr Dr Luisa Nunuhitu, SJMJ

Medical doctor / Hospital director • Sisters of Jesus Mary Joseph (SJMJ) • Stella Maris Makassar Hospital, South Sulawesi, Indonesia

As Director of Stella Maris Makassar Hospital — an institution preparing to become a leading educational hospital in neurology — Sr Dr Luisa brings both clinical depth and institutional authority to her project. Following assessment of fifteen elderly sisters for cognitive decline, three were enrolled in a structured one-month psychosocial and non-pharmacological intervention programme. The results, captured in a before-and-after outcomes table, showed reductions in agitation and anxiety, and improvements in daily activity participation, caregiver confidence, and quality of life. A clear assessment and intervention pathway diagram adds clinical rigour. This is the most structured clinical intervention in the cohort, and demonstrates what is achievable even with small numbers when the methodology is sound.

Felicia Ndawala

Nurse / advanced geriatric care coordinator • Servants of the Blessed Virgin Mary (SBVM) • Maryview Nursing Home, Limbe, Malawi

Felicia's project produced the most striking quantitative result in the entire cohort. A trained nurse and midwife who holds an Advanced Geriatric Care certificate from the Avila Institute of Gerontology in the United States, she identified that only 5.6% of residents were participating in meaningful engagement activities. Over twelve weeks, she designed and implemented a programme of structured, person-centred activities — sewing, knitting, charcoal making and rosary making — chosen to be culturally grounded and practically achievable. The SMART objective was not only set but fully achieved, the data was rigorously collected, and the activities were rooted in the daily lives and traditions of the residents themselves.

Key outcomes from this section

- Participation in meaningful activity: from 5.6% to 94.4% in 12 weeks — Felicia Ndawala, SBVM, Maryview Nursing Home, Malawi.
- Agitation reduced, anxiety reduced, daily activity participation improved after one month of structured intervention — Sr Dr Luisa Nunuhitu, SJMJ, Stella Maris Hospital, Indonesia.
- Eight themes of inner life reached through sand play — including identity, memories and autonomy — among residents with mild to moderate dementia — Sr Ann C. O'Sullivan, Sisters of Christian Instruction, UK.

Supporting caregivers and building community capacity

Behind every person living with dementia is a caregiver — often untrained, frequently unsupported, and at increasing risk of burnout and crisis. In the congregation settings represented in this cohort, caregivers are often fellow sisters or community members with no clinical background and no specialist support. Two projects recognised that sustainable change requires building capacity within communities, not importing it from outside.

Rev. Sr Kyogabirwe Fulgensia

Registered midwife • African Sisters of Our Lady of Good Counsel, Archdiocese of Mbarara • Uganda Martyrs Ibanda Hospital, Ibanda District, Uganda

Sr Fulgensia, who cares for elderly and sick sisters of her congregation at Uganda Martyrs Ibanda Hospital, identified caregiver burnout as the critical — and largely invisible — threat to dementia care quality in her setting. She used the Zarit Burden Interview (ZBI), a validated clinical tool, to assess stress levels and coping strategies among fifteen primary caregivers. This methodological choice is significant: by using a validated scale, she transforms a subjective perception into measurable evidence. Her findings reflect the global picture — up to 40% of dementia caregivers experience depression or anxiety — while highlighting a particularly acute local reality: Uganda has no national policy on managing burnout among dementia caregivers. Her project lays the groundwork for targeted caregiver-level interventions that could protect both the wellbeing of carers and the quality of care received by those living with dementia.

> *"High levels of burnout lead to poor caregiver health and reduced quality of care for patients. Despite rising dementia prevalence, Uganda has no national policy on the management of burnout among dementia caregivers. Caregiver-level interventions are urgently needed."*
>
> **Rev. Sr Kyogabirwe Fulgensia, African Sisters of Our Lady of Good Counsel, Uganda Martyrs Ibanda Hospital, Uganda**

Sister Mary Bere

Religious Sister • Carmelite Religious Sisters • St Andrews Mission Hospital, Zimbabwe

Working within the Carmelite Religious Sisters community in Zimbabwe, Sister Mary recognised that cognitive decline among older sisters was frequently overlooked or accepted as a normal part of ageing. Her project developed a structured framework to support earlier recognition of dementia while ensuring that sisters living with cognitive impairment continue to experience dignity, belonging and compassionate, person-centred care within their own community.

Rather than focusing solely on diagnosis, Sister Mary's project addressed the wider systems needed to support dementia care. She developed a practical implementation pathway incorporating awareness raising, observation and documentation, referral for clinical assessment, individualised care planning, caregiver education and environmental adaptations. The project also places strong emphasis on preserving each sister's spiritual identity and sense of purpose, recognising that dementia care within religious communities extends beyond clinical management to maintaining participation in community and faith life.

Although submitted after the formal project review process had concluded, the project demonstrated excellent service-design thinking and provides a practical model that could be readily adapted by other religious congregations caring for ageing members. As implementation progresses, evaluation of caregiver confidence, referral rates and quality-of-life outcomes will provide valuable evidence to support wider adoption of this approach.

Nkeiruka Attracta Njoku

Hospital Matron / community nurse • Missionary Sisters of the Holy Rosary • St Anthony's Hospital Mgbowo & Bishop Shanahan Retirement Home, Enugu, Nigeria

Nkeiruka brings a uniquely international perspective to this programme, having worked as a caregiver in homes and hospitals in Ireland as part of her Bachelor in Nursing and Midwifery studies — an experience that fundamentally shifted her understanding of dementia. Returning to Nigeria, where she works with a 1:5 nurse-to-resident ratio at the Retirement House of the Missionary Sisters of the Holy Rosary, she created the Memory Support Hub: a model that embeds dementia support into the everyday life of the community rather than grafting on an external service. The Hub's two centrepieces are the Dementia Link Sisters — five community members trained as peer experts — and the Resource Corner, a permanent physical space providing accessible information and materials. Both are designed for sustainability: they do not depend on outside professionals, ongoing funding, or institutional memory. When the project ends, the capacity remains.

Key outcomes from this section

- Zarit Burden Interview used to quantify caregiver stress in 15 primary caregivers — rigorous baseline established for future intervention — Sr Fulgensia, Uganda.
- Memory Support Hub created with five trained Dementia Link Sisters and a permanent Resource Corner — Sr Njoku, Nigeria.
- Sustainability built into the model from the outset: capacity remains in the community when the project ends — Sr Njoku, Nigeria.
- A structured dementia-friendly care framework developed for a religious congregation, incorporating caregiver education, early recognition, referral pathways, person-centred care planning and environmental adaptations to improve support for older sisters living with dementia — Sr Mary Bere, Zimbabwe.

Themes emerging from the cohort

The religious community as a health system.

- In many settings here, the congregation is the primary — sometimes only — healthcare provider for its elderly members. Investing in dementia capability within these communities is not supplementary to health system strengthening; it is health system strengthening.
- Sustainability through peer capacity.
- The most durable projects build their sustainability from the start. The Memory Support Hub in Nigeria does not depend on external experts or ongoing funding. It creates local leaders — and the learning stays when the programme ends.
- Data makes the case.
- Where delegates collected real data — Agnes's 32.1% prevalence finding, Lucy's screening results, Felicia's participation rates — the impact is irrefutable and the case for further investment becomes undeniable.
- Personal motivation drives exceptional work.
- Multiple delegates in this cohort have family members living with dementia. That lived experience, channelled into professional practice, produces work of unusual depth and commitment.
- Culture is a resource, not a barrier.
- The most effective projects work with their communities' cultural and spiritual frameworks. The Church is not an obstacle to health education — as Fr Opondo recognised, it is one of the most powerful platforms for it.

Recognition and personal relevance

For many delegates, the programme's true power lay in the moment academic evidence intersected with the daily reality of those in their care. This was more than a transfer of information; it enabled participants to identify cognitive decline already manifest within their own congregations and equipped them with the professional confidence to act.

> *"The symptoms of dementia discussed — I see them in my sisters who are old. I am happy I have learnt how to manage people with dementia."*
>
> **Rev. Sr Kyogabirwe Fulgensia, African Sisters of Our Lady of Good Counsel, Uganda Martyrs Ibanda Hospital, Uganda**

This translation of learning into practice was echoed across the cohort. Delegates described moving beyond the basic dementia knowledge previously available to them and developing a greater understanding of early diagnosis, ageing and neurodegenerative disease.

Theodora Mwasu, a medical doctor working with the St Gemma Galgani Sisters in Tanzania, described the programme as addressing a gap she had long felt in clinical practice — the gap between what is taught in medical training and what clinicians actually encounter in the field:

> *"We normally learn some basics only. That is why it is difficult to diagnose the disease at an early stage for clinicians in our countries. Through this education I have gained a lot. I can now help my fellow sisters in our communities and create awareness across different ages — especially those between 40 and 65 years — and prepare for a better ending of life, as we do in religious and other societies."*
>
> **Theodora Mwasu, St Gemma Galgani Sisters, Tanzania**

Depth of clinical engagement

The questions delegates raised in their feedback are striking not only for their breadth, but for their clinical specificity. These are not the questions of practitioners who have received a surface-level overview; they are the questions of professionals thinking critically about real cases, diagnostic complexity, therapeutic risk and the limitations of the services available to them. The questions delegates raised in their feedback are striking not for their breadth but for their specificity. These are not the questions of clinicians who have received a surface-level overview — they are the questions of practitioners thinking carefully about the cases, diagnostic complexity, and therapeutic risk.

Questions raised by delegates — a reflection of clinical depth

Sr Irene Mwende, Kenya: Can lifestyle and life experiences expose a person to early-onset dementia? Can dementia subtypes stand alone as conditions rather than being subsumed into psychiatric categories — given the documented risks of misdiagnosis and inappropriate antipsychotic prescribing?

Nkeiruka Attracta Njoku, Nigeria: Further information is required for the diagnostic criteria for Semantic Variant Primary Progressive Aphasia.

Maximilla Nasirumbi, Kenya: When exactly should end-of-life care begin for a patient with dementia? What are the pharmacodynamics and pharmacokinetics of cholinesterase inhibitors? How are the roles of psychologist and psychiatrist distinguished in dementia care?

Sr Luisa Nunuhitu, SJMJ, Indonesia: How do we distinguish older adults with severe dementia from those with advanced Alzheimer's disease in daily clinical practice? What non-pharmacological and psychosocial management strategies are most appropriate?

Concepta Masoni, Kenya: Can teenagers present with dementia? How do we manage patients with dementia who are HIV-positive?

The question from Sr Irene Mwende — about the risks of subsuming dementia into psychiatric categories — is particularly significant. It reflects a clinical reality across many of the settings in this cohort: where psychiatric services are the default pathway for any cognitive or behavioural presentation, people with dementia are frequently misdiagnosed and treated with antipsychotics at significant risk to their health. That a nurse in a Kenyan health centre is asking this question, and framing it in terms of patient safety, is exactly the kind of critical thinking this programme is designed to generate.

Importantly, greater knowledge did not simply answer questions. It enabled delegates to identify areas of uncertainty within their own services and practice. This ability to recognise clinical gaps, question established pathways and seek further specialist knowledge is itself an important educational outcome.

A call for continuity

Several delegates used their feedback not only to reflect on what they had learned, but to identify what they need next: greater clinical depth, practical skills development, updated education and continued access to specialist expertise. This is not dissatisfaction with the programme. Rather, it demonstrates that the education has increased awareness of the complexity of dementia care and enabled participants to recognise gaps within their own knowledge, practice and local services.

> *"I would like to say thank you for this programme. God bless you. For further use of the course, if possible you can maintain and provide an update every year, support materially and financially — it will lead us to keep on learning, on-the-job training, and educating religious communities\as many as possible."*
>
> **Theodora Mwasu, St Gemma Galgani Sisters, Tanzania**

> *"I have learnt a lot and been challenged in many practical aspects. I would like further information on Module 3, with particular focus on the diagnostic criteria of Semantic Variant PPA."*
>
> **Nkeiruka Attracta Njoku, Missionary Sisters of the Holy Rosary, Enugu, Nigeria**

Sr Luisa Nunuhitu went further, connecting the programme directly to the future direction of her institution — Stella Maris Makassar Hospital, which is preparing to become a leading educational hospital in the field of neurology:

> *"I would like to express our sincere appreciation for this valuable and enriching learning experience. I am particularly interested in further exploring the assessment and management of patients with dementia, especially psychosocial interventions and palliative care approaches, which are highly relevant to our service. We would greatly appreciate guidance on appropriate assessment methods as well as non-pharmacological management strategies for distinguishing severe dementia from advanced Alzheimer's disease."*
>
> **Sr Dr Luisa Nunuhitu, SJMJ, Sisters of Jesus Mary Joseph, Stella Maris Makassar Hospital, Indonesia**

Taken together, this feedback provides a clear direction for future educational development. Delegates are asking for further education in dementia screening and cognitive assessment, differential diagnosis, behavioural and psychiatric symptoms, psychosocial and non-pharmacological interventions, cognitive stimulation therapy, caregiver support, pharmacological management and palliative and end-of-life care.

The delegates who completed this programme did not simply receive information. They returned to their communities better able to recognise dementia, question existing practice and identify the next clinical and service gaps that need to be addressed. This provides a compelling case for a longitudinal Academy model: one that continues to build knowledge, develop practical skills and support participants as they translate education into sustainable change within their communities.

Conclusion

What emerges from this collection of projects is not simply a set of individual initiatives. It is a portrait of a global community of practice — doctors, nurses, midwives, counsellors, chaplains and clinicians, from Harare to Mombasa, from Bulawayo to Ibanda, from Enugu to Makassar, from Limbe to the United Kingdom — who have chosen to apply what they have learned to the real and urgent needs of the people in their care.

The breadth of ambition is striking. In one setting, the challenge is persuading a community that dementia is a medical condition at all. In another, it is implementing validated clinical tools in a frail-care home operating without specialist support. In another still, it is raising participation in meaningful activity from 5.6% to 94.4% in twelve weeks. These are not small achievements. They reflect genuine clinical leadership, genuine service transformation, and a genuine commitment to better outcomes for some of the most vulnerable people in the world.

> *"Every year, I'm inspired by the passion and innovation shown by our delegates — and this programme is no exception. The work featured in this report reflects exactly what Neurology Academy stands for: education that drives meaningful, measurable change in clinical practice.*
>
> *My heartfelt congratulations to all fifteengraduates — your commitment to improving dementia care is clear, and your impact will be felt long after the course has ended."*
>
> **Sarah Gillett, Managing director, Neurology Academy**

Find out more about Dementia Academy: *www.neurologyacademy.org/dementia-academy*

Neurology Academy: education with impact

Dementia Academy operates as a dedicated arm of Neurology Academy.

Neurology Academy is an innovative educational provider for healthcare professionals including consultants, specialist nurses, pharmacists, therapists and other allied health professionals. Our courses are developed by practising specialists who combine their experience and expertise into case-based learning designed to create specialists in their field with confidence in effecting change.

We specialise in education, networking and mentorship, encourage the sharing of good practice, and promote clinical leadership across a range of conditions. Each condition or healthcare theme is an integral component of Neurology Academy.

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