Rapid Response Brief

Date: March 2026

What can research evidence tell us about: Tools that have been adapted for screening for cognitive impairment among the elderly at the community level in Africa

Key messages

- Cognitive impairment can range from mild to severe, and its burden is largely attributed to Alzheimer's disease, related dementias, and mild cognitive impairment.
- Regarding dementia, the Ascertain Dementia 8-item questionnaire (AD8) can accurately identify 91% of the cases, while the Identification of Dementia in Elderly Africans cognitive screen (IDEA) can identify 90%.
- For mild cognitive impairment, the Community Screening Instrument for Dementia (CSI-D) can accurately identify 92% of the cases, while the Montreal Cognitive Assessment (MoCA) can identify 90%.
- The AD8 questionnaire is also useful for screening for mild cognitive impairment, with the ability to accurately detect 80% of the cases.
- Other tools that have not yet been adapted to low-income settings but can accurately identify over 85% of people with cognitive impairment include the Brain Health Assessment (BHA) tests and Memory Alteration Test (M@T) for MCI, and the Memory Impairment Screen (MIS) and Addenbrooke's Cognitive Examination Revised (ACE-R) for dementia.low-resource

Where did this Rapid Response come from?

This document was created in response to a specific question from a policymaker in Uganda.

It was prepared by the Center for Rapid Evidence Synthesis (ACRES), at the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative

✚ Included:

- **Key findings** from research
- **Considerations about the relevance** of this research for policy decisions in Uganda

✖ Not included:

- Recommendations
- Detailed descriptions

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Short summary

Background:

In Uganda, 7.2% to 20% of individuals above the age of 60 are living with dementia. In Mukono, one of the districts in Uganda, the District Health Team (DHT) reportedly observed an increase in the number of elderly people in communities showing signs of cognitive impairment (CI). These individuals need to be identified and managed early, before their condition progresses to more severe stages. However, the team is uncertain about what screening tools are available for cognitive impairment screening in low-income settings. Therefore, they are interested in tools that have been used among the elderly people in such communities.

Rapid response question: What tools have been adapted for screening for cognitive impairment among the elderly at the community level in Africa?

Findings:

The common tools adapted to screen for MCI in low-income communities include the Montreal Cognitive Assessment (MoCA) in Uganda and Tanzania; the Ascertain Dementia 8-item questionnaire (AD8) in Uganda; the Alzheimer's Disease Assessment Scale (ADAS-Cog) in Tanzania; and the Community Screening Instrument for Dementia (CSI-D) in Uganda, Tanzania, and the Central African Republic. Those adapted for dementia include the Identification of Dementia in Elderly Africans (IDEA) cognitive screen in Tanzania, and the Ascertain Dementia 8-item questionnaire (AD8) in Uganda. Adaptations to some of these tools were supported by the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) 10-word list. Other highly reliable tests for MCI are the Memory Alteration Test and the Brain Health Assessment, while those for dementia include the Memory Impairment Screen and Addenbrooke's Cognitive Examination Revised.

Conclusion:

Screening for cognitive impairment is important for raising public awareness of the conditions underlying their occurrence and enabling policymakers and health managers to plan and provide appropriate services. Cognitive impairment screening tools adapted for African settings have been modified to reflect cultural contexts and accommodate low literacy levels. Many of them demonstrate high reliability in identifying individuals with mild cognitive impairment or dementia in low-resource settings. However, their effectiveness for the management of cognitive impairment conditions requires a functional referral system for definitive diagnosis.

Background

Cognitive impairment (CI) is a decline in mental abilities, including memory, reasoning, learning, decision-making, following instructions, and problem-solving[1,2]. It can range from mild to severe[1], with the burden is largely attributed to Alzheimer's disease, related dementias, and mild cognitive impairment (MCI)[3]. Alzheimer's disease mainly affects an individual's recall ability and is associated with both dementia and MCI[4]. Dementia refers to a significant decline in cognitive abilities, with disruption to one's functional ability[5], while MCI only constitutes a decline in cognitive abilities, without affecting the ability to perform daily activities [6-8].

Over 60% of the global dementia burden is borne by low- and middle-income countries[9,10]. In addition to this, 18.9% of people in Africa are reported to have MCI[11]. However, despite these statistics, many CI screening tools are still not applicable to communities in Africa, as they have been validated and adapted for high-income countries[12,13]. The application of such tools to low-income settings results in mismanagement of CI because they are not culturally appropriate and sensitive to low-literacy communities. Additionally, the use of some of them requires specialists, who are not readily available in low-resource settings[14].

In Uganda, 7.2% to 20% of individuals above the age of 60 are living with dementia[15,16]. The District Health Team (DHT) in Mukono, which is one of the districts in Uganda, reportedly observed an increase in the number of elderly people in communities showing signs of cognitive impairment. These individuals need to be identified and managed early, before their condition progresses to more severe stages. However, the team is uncertain about which tools are available for detecting cognitive impairment in low-income settings and is therefore interested in those that have been used among the elderly people in such communities.

Rapid Response question: What tools have been adapted for screening for cognitive impairment among the elderly at the community level in Africa?

How this Rapid Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research.

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Summary of findings

Common screening tools for cognitive impairment

Mild cognitive impairment conditions include neurodegenerative diseases such as early stages of Alzheimer's Disease (AD), while severe cognitive impairment may include advanced stages of AD or dementia. The common tools used to screen for MCI are the Montreal Cognitive Assessment (MoCA)[6,7] and the St. Louis University Mental Status test (SLUMS)[17]. SLUMS is used for distinguishing between individuals with MCI and those without[18], while MoCA is a 30-point, 10-minute tool that examines visuospatial reasoning, short-term memory, delayed recall, naming, attention, abstraction, language, and orientation[6,7]. When adjusted for lower levels of education, SLUMS can detect 92% of people with MCI and 81% of those without MCI[18]. MoCA is also highly reliable, with the ability to detect over 90% of individuals with MCI[7,19].

The tools commonly used to screen for dementia include the Mini-Mental State Examination (MMSE), the Mini-Cognitive Assessment Instrument (Mini-Cog)[20], the Rapid Cognitive Screen (RCS)[21] and the Ascertain Dementia 8-item questionnaire (AD8)[8,22], with MMSE being the most widely used[7,23]. MMSE assesses orientation, recall, language, and attention[24]. It shows high reliability in the identification of people with dementia, with a sensitivity of 87%% and a specificity of 82%. When adjusted for education, it can detect up to 97% of people with dementia and 70% of those without[23].

The Mini-Cog is a brief screening tool that consists of a delayed 3-word recall task and a clock drawing test[25]. The RCS is an abbreviated form of the SLUMS assessment and includes 3 items: clock drawing, memory, and story[21]. AD8 is a brief tool consisting of eight yes/no questions that assess memory, function, judgement, and orientation[26]. The RCS can detect up to 89% of individuals with dementia[21], the Mini-Cog can detect 76% of people with dementia[25], while AD8 can detect 80% of individuals with MCI and 91% of those with dementia[26].

Cognitive Impairment screening tools adapted to low-income countries

1. Community Screening Instrument for Dementia (CSID)

CSID is the most widely adopted screening tool for dementia across many low-income countries. It is composed of two sections: one for the participant suspected of having dementia and the other for a caregiver or close relative. CSID has a long version and a short version. The long version comprises 32 items for the participant and 26 items for the caregiver, while the short version comprises 7 items for the participant and 6 items for the informant[27]. The brief CSID can be used by primary health care workers with minimal training[27]. The participant section is scored from 0 to 9, with higher scores indicating better cognitive performance, while the caregiver section is scored out of 6, with higher scores indicating worse performance[28].

A CSID cognitive score of less than 5 indicates probable dementia, 5 to 6 indicates possible dementia, and a score greater than 6 indicates that dementia is unlikely. For individuals scoring 5 or 6, the caregiver is

interviewed to enhance the validity of the results. The CSID informant score is then subtracted from the CSID cognitive score to yield an overall score ranging from -6 to 9. Similarly, a score less than 5 suggests possible dementia[28]. CSID is well-suited to populations with low levels of education and has been validated in many settings[28,29]. The tool can accurately identify up to 92% of individuals with MCI and 90.3% of those without[30]. It has been adapted in Uganda[28], Tanzania[31], and the Central African Republic[32] for people aged 60 years and above.

2. **Montreal Cognitive Assessment (MoCA)**

MoCA examines visuospatial reasoning, short-term memory, delayed recall, naming, attention, abstraction, language, and orientation[6,7]. Visuospatial reasoning is examined using a clock-drawing test and trail-making task, while attention and short-term memory are tested using a sustained attention exercise, a subtraction test, and repeating numbers in the same order and reverse order[6]. It can detect over 90% of people with MCI and has been validated for use in individuals aged 55 to 85 years in countries such as Tanzania[29].

Despite being a highly sensitive tool, it is affected by socio-demographic factors like education[29]. Therefore, the developers introduced a single-point adjustment for individuals with less than 13 years of education[19]. In Uganda, the tool has not yet been formally validated, and therefore, its linguistic adaptation was informed by the validated Swahili version (K-MoCA)[29].

Table 1: Adaptation of MoCA

Country	Item	Modification
Uganda[29]	All items	The tool was linguistically adapted into Luganda using a forward–backward translation process.
Tanzania[33]	All items	The original MoCA was modified into K-MoCA, the Kiswahili version, through forward-backward translation.

3. Ascertain Dementia 8-item questionnaire/ Alzheimer's Disease scale 8 (AD8)

The AD8 is a brief 8-item informant interview used to identify individuals with or without dementia by detecting changes in thinking and memory, regardless of the cause and of the person being assessed[34]. The 8 questions assess memory, judgement, orientation, and function[35,36], with scores of 0 to 1 indicating normal cognition, and scores of 2 and above suggesting cognitive impairment[37]. While AD8 can detect over 80% of individuals with MCI and 91% of those with dementia[26], the tool has not yet been formally validated in Uganda. Nevertheless, it has been adapted for use by community health workers to screen for cognitive impairment among the elderly in Wakiso, Uganda[38].

4. Alzheimer's Disease Assessment Scale (ADAS-Cog)[13]

ADAS-Cog is a tool that uses three main subscales: language, memory and new learning, and praxis, to screen for CI. It contains 11 items, which are assessed out of 70, with lower scores indicating less impairment. Spoken language, word finding, and comprehension are assessed through an open-ended discussion on neutral

topics. Comprehension is also examined by asking the individual to follow five increasingly complex commands. Naming ability is assessed by asking the individual to name objects and body parts. Ideational praxis is examined by the individual's ability to fold a letter properly, place it in an envelope, seal and address it, and attach a stamp, while constructional praxis is assessed by asking the person to correctly copy four simple shapes. Memory is examined using orientation tests, the ability to learn a familiar word list with strong images, the ability to recognize a visually presented word list, and the extent to which reminders are needed during the word recognition task.

Although ADAS-Cog is commonly used for measuring mild to moderate AD, it shows low sensitivity, mainly because many of its items being affected by floor or ceiling effects at different stages of AD. Specificity. Nevertheless, it has been used in many countries, and where adaptation was required (e.g., choice of words for recall, ordering of questions, and choice of objects), the adaptation was discussed by an expert panel[13].

Table 2: Adaptation of ADAS-Cog

Country	Subscale	Modification
Tanzania [13]	Language	The primary/preferred language was clarified, and the sections were completed in Swahili where appropriate. Because individual names for fingers do not exist in Swahili, the naming of fingers of the dominant hand was replaced by naming five body parts (neck, knee, shoulder, thumb, fingernails). High-, medium-, and low-frequency items for the naming task were changed if they were likely to be unfamiliar to older adults who did not travel. Real objects were presented rather than photographs or line drawings.
	Praxis	This task was replaced by the stick design test, a similar four-item construction task validated in low-literacy settings, where individuals are asked to copy four simple shapes constructed from matchsticks.
	Memory and new learning	Other adaptations have included a variety of words for the word list, based on published word-frequency lists when available in the language. No frequency list exists in Swahili; therefore, the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) 10-word list is used.

5. Identification of Dementia in Elderly Africans (IDEA) cognitive screen

The IDEA cognitive screen consists of 6 items from available cognitive assessments, used in developing countries (Community Screening Instrument for Dementia (CSI-D) and Consortium to Establish a Registry for Alzheimer's Disease (CERAD))[39]. The 4 items from CSI-D include the ability to name a bridge from a description of its function, knowledge of the day of the week, knowledge of the village chief's name or a relevant alternative, and the ability to name as many animals as possible in 60 seconds[40]. The 5th item is taken from CERAD's 10-word recall test and assesses the ability to remember 10 common words, after a 5-minute

delay[41]. The 6th item measures praxis and involves the correct placement of matchsticks. IDEA is scored 0 to 15, with a higher score indicating better cognitive function.

To minimise potential educational bias, the test does not involve reading, writing, drawing, or calculation[42]. IDEA has been able to detect over 90% of individuals with dementia in different African settings[42]. In these settings, the tool was developed using data from a low-literacy setting and tested on communities with a high prevalence of CI[42]. Whereas IDEA was validated for use in a hospital setting, it can also be applied in community settings.

Table 3: Adaptation of IDEA

Country	Item	Modification
Tanzania[42]	Language	The test is administered in Swahili or Chagga for Tanzania. The words from the CERAD 10-word list are translated into the local meaning or equivalent.

6. Consortium to Establish a Registry for Alzheimer's Disease neuropsychological battery (CERAD-nb)

CERAD-nb is designed to detect early signs of cognitive impairment related to Alzheimer's disease. It consists of 9 subsets: verbal fluency, naming test, Mini-Mental State Examination (MMSE), wordlist learning, constructional praxis, wordlist delayed recall, wordlist recognition, delayed constructional praxis savings, and clock drawing[43]. The CERAD-nb element commonly integrated into screening tests adapted to the African setting, is the word list[13,39]. It consists of 10 high-frequency words that are read three times, with the person screened and asked to list all words immediately recalled across three trials.

Cognitive Impairment screening tools are not adapted for communities in Africa

Other instruments for cognitive impairment screening exist but have been used primarily in high- and middle-income countries. Tools used for MCI include the Memory Alteration Test and the Brain Health Assessment. Tools used for dementia include the General Practitioner Assessment of Cognition, Memory Impairment Screen, Short Portable Mental Status Questionnaire, Clock Drawing Test, Blessed Orientation-Memory-Concentration test, Persian Test of Elderly for Assessment of Cognition and Executive Function, and Addenbrooke's Cognitive Examination Revised.

Table 4: Tools for MCI screening not adapted to the community level in low-income countries

Tool	Description	Performance
Memory Alteration Test (M@T)[44,45].	M@T is used to identify persons with amnestic MCI at the community level and assesses 5 skills: free recall, cued recall, semantic memory, encoding, and orientation. It is scored out of 50 and consists of 33 to 45 questions based on free recall success. Despite being validated in Spain, it has been translated into English with changes made to the original questions applied to	In the United Kingdom and Peru, where it has been used, M@T has demonstrated the ability to identify over 96% of

	communities in the UK[45]. It is a good test for discriminating early AD cases and people with amnestic MCI[44]. It can also be used for communities with low education levels[44].	people with amnestic MCI[44,45].
Brain Health Assessment (BHA) tests	BHA is a screening tool that includes subsets of visuospatial skills, memory, executive functions, and speed[46]. It is a subset of tools from the Tablet-based Cognitive Assessment Tool (Tab CAT), known to be sensitive to cognitive impairment[47]. These include favorites, match, animal fluency, motor quick tap, and line orientation and line length. In countries like Nigeria, where it was used, most of the tests were found to be culturally appropriate[46]	BHA can detect 84% of individuals with MCI and up to 100% of those with dementia[46].

Table 5: Tools for screening for dementia not adapted at the community level in low-income countries

Tool	Description	Performance
General Practitioner Assessment of Cognition (GPCOG)[48,49]	A screening tool consisting of 2 parts, one for the patient (scored out of 9), and the other for the informant (scored out of 6). The patient examination assesses time orientation, clock drawing, recall of a recent news event, and recall of a name and address, while the informant interview involves asking a caregiver about changes in the patient's cognition and functionality[49]	GPCOG can detect 82% of individuals with dementia[49]
Memory Impairment Screen (MIS)[50,51]	MIS uses controlled learning to screen for AD through a 4-item delayed free recall and cued recall memory test[50,51]. It is used to assess for dementia among the elderly and can reliably discriminate between AD and dementia[51].	In New York, MIS showed that it can correctly identify 86% of individuals with AD[50]
Short Portable Mental Status Questionnaire (SPMSQ)[52]	SPMSQ is a 10-item test used to assess memory, intellectual functioning, and orientation. It adjusts for education level, allowing it to be used among lower-literate populations[53]	It can identify over 87% of dementia cases among the less educated[53].
Clock Drawing Test (CDT)[54]	CDT is a test in which individuals are asked to draw a large clock face with numbers and clock hands, indicating times as instructed by the examiner[54]. However, considering that few people in low-resource settings use clocks or even wristwatches, CDT may be highly affected by the level of education.	CDT can identify an estimated 77% of persons with CI when adjusted for education level[55]
Blessed Orientation-Memory-Concentration test (BOMC)[56]	BOMC is a 5-minute tool comprising 6 items, arranged in order of increasing difficulty. Respondents answer questions on year, month, and time. They are also asked to repeat a phrase, count from 20 to 1,	BOMC can identify 69% to 100% of people with dementia, depending on the population[57]

	and say the months in reverse order[56]. However, it is reported to misclassify more black people as cognitively impaired[57].	
Persian Test of Elderly for Assessment of Cognition and Executive Function (PEACE)[58]	PEACE was developed to detect cognitive impairment in elderly people regardless of literacy level. It comprises 14 items: language, memory, attention and concentration, animal naming, orientation, abstract thinking, attention and calculation, praxis, gnosis, planning, judgement, problem solving, similarity, and general information[58]	PEACE can identify over 75% of individuals with AD[58]
Addenbrooke's Cognitive Examination Revised (ACE-R)[59]	ACE-R is a brief test assessing 5 aspects: language, attention/ orientation, verbal fluency, memory, and visuospatial abilities[59].	ACRE-R can correctly identify over 91% of people with dementia[60]

Conclusion

Screening for cognitive impairment is important for raising public awareness of the condition and enabling policymakers and health managers to plan and provide appropriate services. The cognitive impairment screening tools adapted for African communities have been modified to reflect cultural contexts and accommodate low literacy levels, so as to identify as many people as possible with such conditions. These adaptations include translation of the psychometric properties into local languages, making changes to some terminologies, and replacing less familiar items with those that the individuals in those communities are more familiar with. Some adaptations have also been supported by the Consortium to Establish a Registry for Alzheimer's Disease (CERAD) 10-word list. Overall, most of the tools demonstrate high reliability in identifying individuals with mild cognitive impairment or dementia. However, their effectiveness for the management of these conditions requires a functional referral system for definitive diagnosis.

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Conflicts of interest

None known.

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Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing systems, and strategies for implementing changes.

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Glossary

of terms used in this report: 01 sure rapid response guides 2011 11.pdf (cochrane.org)