7th Annual Meeting of the Harmonized Cognitive Assessment Protocol (HCAP) International Network

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Acronym List

AD	Alzheimer's disease
ADAMS	Aging, Demographics, and Memory Study
AD/ADRD	Alzheimer's disease and Alzheimer's disease-related dementias
AI	artificial intelligence
AL-SEHA	A Longitudinal Study of the Egypt Healthy Aging Initiative
AUC	area under the curve
CADAS	Caribbean American Dementia and Aging Study
CDR	Clinical Dementia Rating
CES-D	Center for Epidemiologic Studies Depression Scale
CFA	confirmatory factor analysis
CHARLS	China Health and Retirement Longitudinal Study
CIHA	Côte d'Ivoire Health and Aging Project
COSA	Colombian Study of Aging
COSMIC	Cohort Studies of Memory in an International Consortium
CRELES	Costa Rican Longevity and Healthy Aging Study
CRP	C-reactive protein
CSID	Community Screening Instrument for Dementia
CVFS-SCAN	Chitwan Valley Family Study-Study of Cognition and Aging in Nepal
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ELEGUA	Estudio Longitudinal de Envejecimiento en Guatemala (Longitudinal Study of Aging in Guatemala)
ELSA	English Longitudinal Study of Ageing
ELSI-Brasil	Estudo Longitudinal da Saúde dos Idosos Brasileiros (Brazilian Longitudinal Study of Aging)
EPS	Encuesta de Protección Social (Chilean Social Protection Survey)
EV-miRNA	Extracellular vesicle microRNA
GECC	Gateway Exposome Coordinating Center
GFAP	glial fibrillary acidic protein
GPS	global positioning system
HAALSA	Health and Aging in Africa: Longitudinal Studies in South Africa
HAALSI	Health and Aging in Africa: Longitudinal Study of an INDEPTH Community in South Africa
HARPS	Health, Aging & Retirement Panel Study
HbA1c	hemoglobin A1c
HCAP	Harmonized Cognitive Assessment Protocol
HCAP-XC	HCAP Cross National Training
HEALS	Health Effects of Arsenic Longitudinal Study (Bangladesh)
HIV	human immunodeficiency virus
HRS	Health and Retirement Study
hs-CRP	high-sensitivity C-reactive protein

IADL	Instrumental Activities of Daily Living
ICDT	Institutional Career Development and Training
INDEPTH	International Network for the Demographic Evaluation of Populations and Their Health
INTB	International Neurobehavioral Test Battery
IQCODE	Informant Questionnaire on Cognitive Decline in the Elderly
ISR	Institute for Social Research
KLoSA	Korean Longitudinal Study of Aging
KLPS	Kenya Life Panel Survey
KLPS-5	Kenyan Life Panel Survey Wave 5
KLPS-6	Kenya Life Panel Survey Wave 6
LASI	Longitudinal Aging Study in India
LASI-DAD	Longitudinal Aging Study in India Diagnostic Assessment of Dementia
LOSHAK	Longitudinal Study of Health and Aging in Kenya
LSAHA	Lebanon Study on Aging and Health
MCI	mild cognitive impairment
Mex-Cog	Mexican Cognitive Aging Ancillary Study
MHAS	Mexican Health and Aging Study
MLSFH	Malawi Longitudinal Study of Families and Health
MMSE	Mini-Mental State Examination
MPI	multiple Principal Investigator
MRI	magnetic resonance imaging
N-HCAP	Nepal Harmonized Cognitive Assessment Protocol
NDI	National Death Index
NfL	neurofilament light chain
NIA	National Institute on Aging
NIA-AA	National Institute on Aging–Alzheimer's Association
NICOLA	Northern Ireland Cohort for the Longitudinal Study of Ageing
NIH	National Institutes of Health
NOFO	Notice of Funding Opportunity
PHQ-9	Patient Health Questionnaire-9
PI	Principal Investigator
PM2.5	fine particulate matter
RAISE-Botswana	Research on Aging, AD/ADRD, and Their Social Determinants in Botswana
SES	socioeconomic status
SHARE	Survey of Health, Ageing and Retirement in Europe
TICS	Telephone Interview for Cognitive Status
TILDA	The Irish Longitudinal Study on Ageing
VHAS	Vietnam Health and Aging Study
Z-CHAD	Zambian Cohort of Healthy Aging and Dementia

Meeting Summary

Welcome

Kenneth Langa and Lindsay Kobayashi

On September 9 and 10, 2026, the Harmonized Cognitive Assessment Protocol (HCAP) International Network convened in Bethesda, MD, for its seventh annual meeting to review (a) updates on ongoing and recently funded HCAP studies, pilot studies, and other network activities; (b) a comparison of mild cognitive impairment (MCI) and dementia incidence in the United States and India; (c) the HCAP Toolbox; (d) updates on the Cohort Studies of Memory in an International Consortium (COSMIC) and the Gateway Exposome Coordinating Center (GECC); (e) funding challenges, strategies, and opportunities for continued international collaborations; and (f) lessons from the first HCAP Scholar Exchanges. Results from applying the Health and Retirement Study (HRS)-HCAP algorithm to other populations demonstrate the feasibility of using HCAP to generate harmonized population estimates that can be compared internationally. Together, these studies are generating a more comprehensive understanding of dementia risk and resilience.

University of Michigan multiple principal investigators (mPIs) Kenneth Langa and Lindsay Kobayashi welcomed attendees to the meeting and expressed their gratitude to the National Institute on Aging (NIA) for continuing to support globally harmonized research on aging populations and for guiding so many of the Network's participating study PIs. The meeting was the largest HCAP Network gathering with the largest number of countries represented to date. Participating study PIs credited the HRS HCAP team for their support in developing the instruments and promoting productive collaboration across the network, as well as NIA staff for their commitment to the field.

NIA Welcome

Richard Hodes, Kenneth Santora, Minki Chatterji, and Jonathan King

NIA staff commended the HCAP Network for its considerable accomplishments over the past seven years and emphasized the National Institutes of Health (NIH)'s commitment to cross-national comparative research that studies Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD) across multiple populations, communities, and geographies. Global research initiatives and foreign collaborations are essential for understanding AD/ADRD incidence and determinants.

A new NIH activity code, PF5, exists for foreign collaborations. Through this mechanism, NIH funds separate, linked awards for U.S. researchers and their foreign collaborators. Staff emphasized that applicants should be clear and succinct when justifying the need to conduct research in a different country and the research's applicability to U.S.-based populations.

Santora shared several recent NIH-wide efforts to streamline the grant application process and to support early-stage investigators. NIA is on track to spend all of its available funding this

year, including NIH's overall support of at least 1,200 early-stage investigators. Investigators should be aware that career awards (i.e., K-awards) will be consolidated into four overarching categories and will no longer provide support for clinical trials. However, K-awards may cover investigators' training related to a clinical trial. NIH has updated its data sharing policy to reflect the new FORMS J with a checklist of yes/no questions. Final approval will be just in time.

HCAP Network Updates

Overview of Meeting Agenda and HCAP U24 Network Updates
Kenneth Langa and Lindsay Kobayashi

The HCAP Network continues to expand, especially across Southeast Asia and Africa. It remains highly productive, with ongoing data collection, scientific publications (162 cumulative through August 2026), new study applications, and training opportunities. The Network funded two scholars, Sara Moustafa, Ph.D., and Valentine Ucheagwu, Ph.D., through its scholar exchange program, and held three NIA-funded R25 HCAP short courses over the past year. Kobayashi and Sarah Kwiatek are leading the development of the HCAP Toolbox, which will house (a) a written protocol outlining the basic principles of an HCAP study, (b) a centralized repository that contains extensive information about item use and adaptation throughout the Network, and (c) a directory of Network studies. In addition to the annual meetings, special purpose or regional meetings have been convened for studies in Africa (2024, 2025, 2026), Latin America (2025, 2026), and the United States. A meeting focused on the Caribbean is scheduled for February 2027 in Kingston, Jamaica.

Data Collection Across the HCAP International Network
Kobayashi outlined the status of data collection across 20 studies in the HCAP Network (**Table 1**). Studies in 16 countries have completed data collection. Ten of those countries have publicly released their Wave 1 data, five of which have also publicly released their Wave 2 data. In addition to the full studies listed in Table 1, the Network includes pilot studies funded and completed in Botswana, Brazil, Cameroon, Colombia, Ghana, Guatemala, Malawi, Pakistan, and Zambia. The Network is also advising and supporting research teams preparing applications for pilot or full studies in Afghanistan, Belgium, Croatia, Indonesia, Jamaica, Japan, Malaysia, Nigeria, Philippines, Scotland, Senegal, Spain, Sri Lanka, Sweden, Uganda, and Vietnam.

Study Funding
Over the past year, the network awarded funding for three new U24 network pilot grants, and several African HCAP studies are adapting and refining protocols in close collaboration (Botswana, Cameroon, and Côte d'Ivoire). Two studies received R01s to administer HCAP sub-studies: the Health Effects of Arsenic Longitudinal Study (HEALS) in Bangladesh and the Vietnam Health and Aging Study (VHAS). In addition, the Network has submitted PF5 applications for the Survey of Health, Ageing and Retirement in Europe-HCAP (SHARE-HCAP), the Lebanon Study on Aging and Health (LSAHA), and Afghanistan. More applications are in development.

Table 1: HCAP International Network Study Status							
Country	**Study**	**Funded (21)**	**Begun (20)**	**Completed (16)**	**Wave 1 Data Released (10)**	**Wave 2 Data Released (5)**	**Wave 3 (4)**
USA	HRS	✓	✓	✓	✓	✓	
Mexico	MHAS	✓	✓	✓	✓	✓	In progress
England	ELSA	✓	✓	✓	✓	✓	Planned for 2028
South Africa	HAALSI*	✓	✓	✓	✓	✓	Completed
India	LASI-DAD	✓	✓	✓	✓	✓	Planned for 2027
China	CHARLS	✓	✓	✓	✓		
Chile	EPS	✓	✓	✓	✓		
Europe**	SHARE	✓	✓	✓	✓		
Ireland	TILDA	✓	✓	✓	✓		
N. Ireland	NICOLA	✓	✓	✓	✓		
S. Korea	KLoSA	✓	✓	✓			
Caribbean	CADAS	✓	✓	✓			
Lebanon	LSAHA	✓	✓	✓			
Kenya	KLPS	✓	✓	✓			
Nepal	CVFS-SCAN	✓	✓	✓			
Egypt	AL-SEHA	✓	✓	✓			
Kenya	LOSHAK	✓	✓				
Côte d'Ivoire	CIHA	✓	✓				
Costa Rica	CRELES	✓	✓				
Bangladesh	HEALS	✓	✓				
Vietnam	VHAS	✓					

* National pilot is in progress

**Czechia, Denmark, France, Germany, and Italy; SHARE-HCAP-2 is pending NIA funding

HCAP Study Updates

Mexico | MHAS Cognitive Aging Ancillary Study (Mex-Cog)
Rebeca Wong

The Mexican Health and Aging Study (MHAS) began in 2001 with 15,186 interviews of individuals born in 1951 or earlier, followed by six successive waves of data collection in 2003, 2012, 2015, 2018, 2021, and 2024. A next wave is slated for 2027. Refresher samples were added in 2012, 2018, and 2024 of individuals born in 1952–1962, 1963–1968, and 1969–1974,

respectively. The Mexican Cognitive Aging Ancillary Study (Mex-Cog) conducted two studies of individuals drawn from the larger MHAS sample in 2016 (2,265 interviews) and 2021 (4,073 interviews) and is currently conducting a third wave, with field work scheduled for October through November 2026 (est. 5,000 interviews).

Mex-Cog Wave 3 Planning Update

Mex-Cog Wave 3 will include 3,286 Mex-Cog Wave 1 and 2 participants and a new sample of 2,000 individuals. The latter sample is drawn from participants with a direct interview or proxy interview due to health reasons in the MHAS 2024. This new sample includes individuals from all 32 states of Mexico and across rural and urban areas. The new participants were aged 54–63 in 2024; 50% live in single households, and 50% live in couple households. Wave 3 also includes an oversample of individuals with moderate or severe cognitive impairment based on the MHAS 2024 assessment.

To develop the Wave 3 instruments and protocols, the Mex-Cog team conferred extensively with NIA and the HRS and HCAP teams. The Mex-Cog Wave 3 interview protocol consists of a cognitive evaluation and assessments of self-reported memory and depressive symptoms (about 60 minutes). The protocol also includes a 15-minute informant interview regarding the participant's cognitive and functional decline and caring needs. To improve the cognitive assessments for individuals with low literacy, the Mex-Cog study team made several adjustments to the Wave 3 cognitive assessment questionnaire: (a) removed the serial 7s task from the executive function assessment, (b) added letter fluency and 3 naming figures to the language and fluency assessment, and (c) removed the CSID 2-step instructions, CSID elbow, and instruction to store tasks from the language and fluency assessment. The study team also added several items from the main MHAS interview to the informant interview, including 6 of the 16 Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) items and the Instrumental Activities of Daily Living (IADL) battery. The evaluation of deterioration and mental and behavioral disturbance were removed from the informant interview.

Nepal | Progress Update for CVFS-SCAN

Emily Briceño

Chitwan Valley Family Study—Study on Cognition and Aging in Nepal (CVFS-SCAN), currently in its fifth year of funding from NIA, aims to establish the infrastructure for population-based AD/ADRD research in Nepal and to understand the prevalence and determinants of AD/ADRD within the Nepalese context. The study team plans to collect data from each participant during two visits. The first visit will include the HCAP respondent interview. The second will include a blood sample, the comprehensive survey, health assessment, the informant interview, and data on the neighborhood context.

A multidisciplinary team of experts from Nepal and the United States translated and adapted the Longitudinal Aging Study in India Diagnostic Assessment of Dementia (LASI-DAD) to the Nepal context using an iterative mixed methods approach. The team conducted focus groups and cognitive interviews with community-dwelling Nepali elders to determine item clarity, cultural appropriateness, and linguistic accessibility. Based on this feedback, the team made

several modifications and added some novel measures to ensure the assessment's appropriateness for the community. The resulting modified, 90-minute N-HCAP version was then pilot tested among 150 individuals who were representative of the Chitwan Valley region.

The study team collected baseline data from February to December 2025. Of the 3,342 eligible surviving cohort members from the Chitwan Valley cohort sample, 3,051 completed the N-HCAP, 2,938 completed the physical assessment, and 2,473 provided a blood sample. Informant interviews were completed with 3,116. The average age of the N-HCAP sample was 64, and the sample represented a range of ethnicities/castes and education levels.

Psychometric Evaluation of the N-HCAP Data

To assess the validity of the N-HCAP, the study team used confirmatory factor analysis (CFA) to create N-HCAP domain scores, drawing on prior HCAP work. All CFA models showed a good fit across all domains despite extensive adaptation of the HCAP to Nepal. Reliability was high for the memory and executive domains and lower for the language, visuospatial, and orientation domains. However, the reliability for all domains was acceptable for the range of ability in which cognitive impairment classification occurs, that is, 1.5 standard deviations below the mean. Moreover, preliminary validation work showed that N-HCAP domain scores were lower for respondents with informant-reported cognitive decline.

Estimation of MCI and Dementia Rates

To develop its algorithm for classifying dementia, the study team defined the CVFS-SCAN normative sample in collaboration with the Nepali clinician expert team. Because of the health care infrastructure in Nepal, the study had limited access to health care–based diagnoses, which may impact the sensitivity of the normative data and thus lead to relatively conservative estimates of cognitive impairment and dementia prevalence.

Overall, preliminary estimates of dementia prevalence led to a low estimated rate of dementia (4%) and a higher rate of MCI (14%). The low dementia rate might be due to the relatively young sample (aged 50+) compared to other studies, norms that lead to conservative impairment estimates, and the pending classification of participants who did not engage in cognitive testing. As expected, dementia rates were higher with higher age and lower with increasing levels of education.

The study team anticipates beginning Wave 2 data collection in February 2027. In parallel with preparations for Wave 2, the team is refining the normative sample and algorithm and clinically validating the cognitive screening test embedded in the N-HCAP.

Caribbean Islands | Caribbean American Dementia and Aging Study

William H. Dow

According to the American Community Survey, an estimated 30% of U.S. Hispanic immigrant adults aged 60 and older are from the Caribbean. These immigrants tend to have higher levels of education and are more likely to live alone than are immigrants from Mexico. They also have

higher rates of household-reported cognitive difficulties, for reasons that are poorly understood.

Background on the Caribbean American Dementia and Aging Study

The Caribbean American Dementia and Aging Study (CADAS) seeks to understands the life course determinants and social consequences of aging in the Hispanic Caribbean (Dominican Republic and Puerto Rico). A sister study, the Cuban Aging and Cognition Study, is being conducted in Cuba, the largest island in the Caribbean, using the same instruments, but is not funded by the U.S. government. The CADAS study team recruited representative samples of 1,500 individuals aged 65 and older in each region. The Cuban sample is being drawn only from urban and rural clusters in the western part of the island, because there is no fuel to travel to the eastern part of the island.

The CADAS surveys were cross-harmonized with the HRS global sister study cores. Assessments also included a new physical exam, Gateway exposome linkages, the HCAP cognitive and informant interviews, and items from the 10/66 Dementia Research Group Protocol (10/66). The study team published its protocol in *BMC Geriatrics* in 2025.[1] Preliminary data are now available via the Harvard Dataverse. The sensitive exposome data are being prepared for release and will be available through the Gateway enclave. Cuba data can be requested from the PI (Juan Llibre).

For clinical validation of the HCAP algorithm, the study team adapted the online clinical dementia consensus protocols from LASI-DAD and Health and Aging in Africa: A Longitudinal Study in South Africa (HAALSI) to obtain clinical expert diagnoses based on CADAS data for 900 subjects; separately, the team conducted in-person clinical evaluations to obtain Clinical Dementia Rating (CDR) scores for 300 participants from Cuba and 100 participants from the Dominican Republic. Thus far, the clinical data are exhibiting some discrepancies from the dementia 1066 algorithms; the latter have very large education and socioeconomic gradients, which could be either real or artifactual.

Costa Rica | Successful Aging in Costa Rica? Learning from the Costa Rican Longevity and Healthy Aging Study (CRELES)

William H. Dow

Launched in 2005, the Costa Rican Longevity and Healthy Aging Study (CRELES) aims to understand why life expectancy in Costa Rica converged so rapidly with life expectancy in high-income countries over the course of the 20th century. For example, prior work had shown the life expectancy at age 80 for Costa Rican men to be the highest in the world. Health and longevity are even better in the Nicoya "blue zone" region of Costa Rica. While prior survey waves found that Nicoya residents exhibit less cognitive decline than other regions, the Nicoya longevity advantage no longer exists in younger cohorts. Although Costa Rica has lower

[1] Liu MM, Llibre-Guerra J, Soria C, et al. The Caribbean American Dementia and Aging Study: protocol for a population-based study of older adult health and dementia in Cuba, the Dominican Republic, and Puerto Rico. *BMC Geriatr*. 2025;25(1):669. Published 2025 Aug 29. doi:10.1186/s12877-025-06131-0

socioeconomic gradients in health than many other countries, perhaps because of the strong safety net, inequality is increasing in the country.

CRELES Initial Waves

CRELES consists of two national birth cohorts of approximately 2,800 individuals each. The cohort born before 1945 was surveyed in 2005, 2007, and 2009. The cohort born between 1945 and 1955 was surveyed in 2010 and 2012. The surveys assessed income, wealth, work, activities, household composition, health care usage and spending, self-reported health, anthropometry, and blood pressure. Venous blood was collected and tested for cholesterol, hemoglobin A1c (HbA1c), and C-reactive protein (CRP). The team also collected genetic data, including genotypes, telomere length, and methylation data. The initial waves do not contain cognitive data apart from a mini-mental exam. The team tracks mortality in these cohorts using the national death index.

CRELES 2026-2027 Wave

With funding from NIA, the study team is collecting an additional wave of data from the CRELES participants to determine (a) how dementia rates vary by socioeconomic status (SES) across the country, (b) how incidence and determinants in Costa Rica compare to other countries, and (c) whether rising inequalities and fragmenting of community bonds is diminishing Costa Rica's "healthy aging" exceptionalism.

The study team will attempt to re-interview all living CRELES respondents, now aged 70 years and older, as well as their spouses, and anticipates completing approximately 2,100 interviews. The team is also adding a new sample from Nicoya. The interviews will include the CRELES longitudinal questionnaires, mortality tracking, blood samples for cardiovascular disease and AD biomarkers and genetics, and an HCAP that follows the CADAS protocol. The interviewers will ask a series of follow-up questions regarding participant cognition if the informant assessment differs from their cognitive assessment.

Research on the 10/66 Dementia Algorithm

The team plans to estimate dementia incidence using the 10/66 algorithm, which was developed to be less sensitive to education differentials. Dow recently examined the performance of the 10/66 algorithm in the U.S.-based Aging, Demographics, and Memory Study (ADAMS). The algorithm exhibited high specificity, sensitivity, and overall accuracy relative to the clinical gold standard, but still overestimated education gradients. In CADAS, individuals with lower levels of education had lower scores for the animal naming, delayed recall, and the Telephone Interview for Cognitive Status-27 (TICS-27). Hearing loss, hypertension, depression, vision loss, and diabetes could explain some of these effects.

To further probe cross-cultural variation in dementia diagnosis, Chris Soria, Dow, and colleagues conducted a study to examine how clinicians from five different countries (Dominican Republic, India, Mexico, Puerto Rico, and the United States) evaluated the same data from the Caribbean. Disagreement with the international consensus was lowest among clinicians from the United States (2%) and highest among clinicians from India (10%), who were less likely to conclude that cognitive difficulties interfered with daily life.

Discussion
Dow clarified that CADAS used almost the full set of 10/66 items, except for its depression questions. The study team used the Center for Epidemiologic Studies Depression Scale (CES-D) instead.

India | Updates on LASI-DAD: Progress, Innovations, and Planning
Jinkook Lee

Launched in 2015, LASI-DAD is the first and only nationally representative study of late-life cognition and dementia in India. The data from LASI-DAD enables national-level inferences regarding dementia incidence and determinants, assessment of the societal impacts of dementia, and new insights through research innovations.

Recent Activities
The study team released the final harmonized Wave 2 data in April 2026, including AD biomarker, language fluency, diet, magnetic resonance imaging (MRI), and indoor exposome data.

Recent LASI-DAD Publications

Over the past year, more than 30 publications reported findings from LASI-DAD, including multiple papers on risk factors for cognitive decline. Most risk factors, particularly demographic and cardiovascular characteristics, were associated with steeper cognitive decline in expected directions. For example, a history of high cholesterol or a heart attack was comparable to the effect of an additional 8 to 10 years of age on cognitive decline. Another publication investigated the association between education and cognitive decline, examining whether practice effects, differential mortality, or other sources of bias could explain findings that those with higher education had steeper cognitive decline. Additionally, research showed that while people who were multilingual had lower cognitive functioning, these benefits were generally limited to participants with a high SES or high levels of educational attainment. In terms of biomarkers, the data show significant association between elevated levels of glial fibrillary acidic protein (GFAP) and neurofilament light chain (NfL) and worse cognition, both cross-sectionally and longitudinally. Higher exposures to fine particulate matter (PM2.5) were also associated with steeper cognitive decline. In terms of mortality, dementia and cardiometabolic conditions were the strongest risk factors.

Wave 3 Preparations

The study team has received ethical clearance for Wave 3 and has completed its sampling strategy and project protocol. In preparation for Wave 3, the study team conducted three pilot studies on picture naming and descriptions, digital biomarkers collected via audio and actigraphy, and a life history questionnaire. Wave 3 will recruit 7,000 LASI participants: 3,000 LASI-DAD Wave 1 and 2 participants, 1,500 newly age-eligible LASI participants aged 55–65, and a refresher sample of 2,500 individuals aged 65 and older. Data collection for Wave 3 focuses primarily on cognitive assessment and adds environmental data (e.g., indoor air pollution and

temperature data), measures of social isolation and social interaction, biomarkers (speech and actigraphy data), and -omics. Fieldwork will begin in February 2027.

Proteomics Analyses

In parallel with Wave 3 preparations, the proteomics team is analyzing the data from its proteomics assays of Wave 1 and Wave 2 data. The proteomics team partnered with Henrik Zetterberg's laboratory for cross-cohort harmonization and plans to run a quarter of its sample (N = ~1,500) using the Olink Explore HT Platform next year. The team has started to conduct differential abundance analyses as well as examining associations with the MRI data.

Retinal Imaging

To enable retina-based tools for risk stratification and clinical decision support, the study team has been collecting data and establishing the analytic pipeline for its retinal imaging substudy. The analytic pipeline will include quality control, feature extraction, building of machine learning/artificial intelligence (AI) models to identify patterns, and rigorous validation procedures. To date, retinal images have been collected from 1,000 participants. Retinal imaging offers a unique noninvasive window into brain and vascular health, which may provide insights into cognition beyond what is accounted for by demographic factors. In preliminary data analyses, retinal data explained an additional 5.5% of the variance in cognition beyond the 40% accounted for by demographic factors.

England | ELSA-HCAP
Paola Zaninotto

Embedded within the English Longitudinal Study of Aging (ELSA), ELSA-HCAP launched its first wave of data collection in 2018 (N = 1,273), followed by a second wave in 2022 (N = 2,022). The 2023 cohort included all living participants from the 2018 cohort (n = 547), an ethnic minority sample (~307), and a randomly selected sample of ELSA participants aged 65 and older (~1,168). The 2023 study included 1,814 informant interviews and 173 end-of-life interviews with family members or carers of 2018 HCAP participants who have died (response rate of 44%). Data from these studies are available through the United Kingdom data service. A third ELSA-HCAP study is planned for 2028, with data release expected in 2029. The study will recruit approximately 2,000 individuals from 2018 and 2023 HCAP participants as well as a refresher sample that includes oversampling of underrepresented groups.

Recent Publications
Several papers have been published using ELSA-HCAP data. Zaninotto highlighted several papers recently submitted for publication that examined (a) the relationship between severe infections and vulnerability across cognitive domains, (b) ethnic differences in multidomain cognitive performance among older adults, and (c) patterns and characteristics of attrition in ELSA-HCAP. She also highlighted a recently published paper that developed a study evaluation framework for measuring cognition based on the ELSA, HRS, The Irish Longitudinal Study on Ageing (TILDA), and Northern Ireland Cohort for the Longitudinal Study of Aging (NICOLA)

protocols.[2] The framework identifies ways to improve data quality and support cross-national comparisons.

Northern Ireland | NICOLA-HCAP Update
Bernadette McGuinness

NICOLA, a study of approximately 8,500 community dwelling adults aged 50 and older, is the only large-scale longitudinal study of aging in Northern Ireland. Embedded in NICOLA, NICOLA-HCAP1 collected data from a random sample of 1,037 NICOLA Wave 2 participants aged 65 and older to generate robust estimates of dementia and MCI in Northern Ireland. Assessments included 19 neurocognitive tests and informant interviews completed for 862 individuals. Application of the HRS-HCAP diagnostic algorithm to the NICOLA-HCAP sample yielded estimates of the prevalence of dementia (6.2%) and MCI (15.8%) among community-dwelling older adults in Northern Ireland.

Associations Between Ultra-Processed Food and Cognitive Function
The NICOLA team recently conducted two studies examining the associations of ultra-processed food intake and sensory impairments with cognitive decline using NICOLA-HCAP1 data. Higher ultra-processed food intake was associated with lower levels of education and greater area-level deprivation. Unexpectedly, higher levels of ultra-processed food intake were significantly associated with better executive function. After controlling for demographic factors, this association remained significant, and ultra-processed food intake was also significantly associated with better memory and language-fluency. Secondary analyses showed that a better nutritional profile within ultra-processed food was associated with better cognitive health. In the second study, having dual visual and hearing loss was associated with a doubling of the covariate-adjusted risk for cognitive impairment.

The team also conducted an HCAP clinical validation study with 120 community-dwelling adults aged 65 and older to determine whether the HCAP interview and algorithm-derived classifications correlate with clinician diagnoses. Missingness was significantly associated with worse cognition and lower MMSE scores. HCAP-derived dementia and normal classifications corresponded well with clinical diagnoses, but substantially less well for MCI.

NICOLA-HCAP2 will collect data via face-to-face and informant interviews for 1,000+ adults aged 65 and older who participated in NICOLA-HCAP1. Data collection will occur approximately four years after NICOLA-HCAP1 and will include novel components: blood biomarkers of neurodegeneration, multi-omics data, environmental exposure data, including GPS tracking and activity and sleep monitoring data, and linked open-source environmental data.

[2] Hayat S, Assaad S, Ahmed N, et al. A study evaluation framework for measuring cognition: lessons learned in cross-national contexts from four English-speaking aging cohorts. *Eur J Epidemiol* 2026;41:637–650. https://doi.org/10.1007/s10654-026-01375-5

Europe | Share-HCAP: HCAP-1 Uptake and the Next European Wave
David Richter

Richter reviewed the status of HCAP-1 data and plans for SHARE-HCAP-2 The full SHARE HCAP-1 data have been publicly released and downloaded 1,137 times. SHARE-HCAP-1 collected data from residents of five European countries: The Czech Republic, Denmark, France, Germany, and Italy. SHARE-HCAP 2 is awaiting NIA funding decisions and proposes to collect data from residents of Belgium, Croatia, Spain, and Sweden in addition to the original five European countries. SHARE-HCAP-2 will include approximately 1,000 interviews per country and 1,250 longitudinal follow-ups of SHARE-HCAP-1 participants and will use an HRS-HCAP aligned protocol. The study team anticipates collecting data in 2029, with full data released within 24 months. The newly added countries have some important national characteristics. For example, Croatia has a recent history of violence, Spain has a very high dementia prevalence, and Sweden has considerable high-quality data on its population. HCAP-2 will produce open, reproducible deliverables, including public-use data, codebooks, imputation code, and replication scripts.

The study team hopes to use the HCAP-1 and HCAP-2 data to examine dementia prevalence in the nine countries, as well as the impacts of different policy environments, retirement plans, and education systems on the prevalence and determinants of dementia throughout Europe, by imputing MCI and dementia status for all SHARE participants (N = ~80,000 in 28 countries).

Kenya | Kenya Life Panel Survey (KLPS) Project Updates
Edward Miguel and Michael Walker

Kenya Life Panel Survey (KLPS) and the related Primary School Deworming Project have been gathering data on approximately 6,500 individuals since 1998, when they were schoolchildren. All respondents were initially recruited from the Busia region, and they have been tracked over successive KLPS rounds with a greater than 80% effective tracking rate, even for participants who moved outside of Kenya.

KLPS-5 Data Collection
During the Round 5 (KLPS-5) data collection, KLPS participants were in their late 30s and early 40s, so the assessments focused on establishing a midlife baseline.

KLPS-5 data were collected via three separate visits. The first visit included the adapted HCAP battery and exposome assessments (2023-24); the second visit included health measures, demographics, anthropometrics, dried blood spots, and assessments of children for work funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (2024-25); and the third visit included measures of earnings, labor, consumption, expenditures, elder caregiving, pension/retirement, expectations, and AI usage (2025-26). All three visits collected data on all of the Lancet Commission's modifiable risk factors for AD/ADRD. The resulting data have several notable features for aging research: (a) a link to a childhood health experiment shown to boost human capital and earnings; (b) survey data with broad relevance to a range of disciplines; (c) data from childhood to age 30; (d) low survey

attrition; and (e) intergenerational data. The data, surveys, and code are publicly available: https://dataverse.harvard.edu/dataverse/KLPS.

Recent Publications

Recent publications using KLPS data have examined (a) the validity of the KLPS HCAP, (b) an outline of data-driven priorities for economic research and policy related to the aging of African populations, (c) a profile of the KLPS cohort, and (d) the impacts of contemporaneous air pollution on cognitive performance in Kenya. Contemporaneous air pollution was associated with modest declines in cognitive performance over relatively short periods. Survey-based in situ measurements were more accurate than satellite-based measurements of air pollution; the latter attenuated toward zero.

Several papers in preparation focus on the gender wage gap in Kenya, the economic benefits of height, the transmission of cognitive skills across generations, the impact of secondary school education two decades later, and AD/ADRD risk factors and midlife cognitive ability. Height may be linked with higher earnings because it reflects better nutrition and health. Better cognition appears to account for approximately half of the height premium.

KLPS-6

The study team has submitted an R01 renewal application for an additional round of data collection (KLPS-6) for 2027-31, when KLPS participants will be aged 38–48. KLPS-6 will include an HCAP battery to collect data on midlife cognitive changes, as well as assessments of vision and hearing, menopause, air pollution exposure, and estimate levels and trends for the Lancet Commission's modifiable risk factors. The study will examine whether improved early-life health and education has causal impacts on AD/ADRD risk factors, midlife cognition, and rate of cognitive decline using the randomized deworming intervention and the quasi-experimental discontinuity in secondary school attainment.

South Africa | Cognition and Dementia in the Health and Aging in Africa Longitudinal Study of an INDEPTH Community in South Africa (HAALSI-HCAP)

Lisa F. Berkman

Due to the pause in federal funding from April to October 2025, some Health and Aging in Africa Longitudinal Study of an International Network for the Demographic Evaluation of Populations and Their Health (INDEPTH) Community in South Africa (HAALSI) Year 3 project activities have not yet been completed, including the Agincourt MRI and echocardiography sub-studies and the Health, Aging & Retirement Panel Study HCAP (HARPS-HCAP) pilot and main data collection. Despite these delays, the study team has completed data collection for Agincourt HAALSI Wave 4 and HAALSI-HCAP Wave 3, and Waves 1 and 2 respondent, informant, and neurological data are now available on the Harvard Dataverse. HAALSI-HCAP activities have resumed, with ongoing MRI and echocardiography data collection, biomarker shipment and analyses, and preparations for the public release of HCAP Wave 3 data. Year 3 activities for HARPS-HCAP have also resumed and will extend into Year 4; these include ethics review, sample selection, questionnaire translations into the 11 official South African languages, and setting up servers and establishing data protocols. Given the delays, the study team anticipates

launching the HARPS-HCAP pilot in July 2027 and embarking on Wave 1 data collection in October 2027. The national study team is currently defining and selecting HCAP measures, establishing a multidisciplinary team for local expert review, translating and adapting measure items, and preparing for a pretest followed by additional refinement of measures and procedures.

HAALSI-HCAP Wave 3

The HAALSI team was able to complete HAALSI Wave 4 and HAALSI-HCAP Wave 3 before the temporary NIH funding suspension at Harvard University halted Year 3 project activities. The response rate for HAALSI-HCAP Wave 3 was 93% (765 of 825 potential participants approached), with 60% of participants drawn from past HAALSI-HCAP waves. Of the longitudinal participants contacted, 44 had died, 5 had migrated, 10 were lost to follow-up, and 1 refused. Sub-study data collection is ongoing, with the MRI data collected in Wave 1 (N = 99) and Wave 2 (N = 200) fully processed and MRI data for 375 Wave 3 participants collected thus far. The team has also prepared the plasma samples from HAALSI-HCAP Wave 3 for shipment to the University of Gothenburg, Sweden, where they will be analyzed for NfL, phosphorylated tau (p-tau), β-amyloid (Aβ), and GFAP.

HAALSA-HCAP Agincourt Consensus

Teams of reviewers from the United States and South Africa have completed their consensus diagnoses for HAALSI-HCAP Agincourt Waves 1 (N = 635) and 2 (N = 683). The study team is now preparing to collect consensus diagnoses for Wave 3 (N = 765). Analyses of Wave 1 and 2 diagnoses have revealed some reversions from MCI to normal.

In February 23–27, 2026, a HAALSA-HCAP National meeting was held in Cape Town, South Africa. HAALSI-HCAP activities originally scheduled for Year 3 have restarted and will now continue into Year 4.

Measurement of Cognition Among Older Individuals in Côte d'Ivoire: The Côte d'Ivoire Health and Aging Project (CIHA)

Philip Anglewicz

Prior colonization by France has had lingering effects on the numerous countries in West Africa, including Côte d'Ivoire. Compared to British colonies, Francophone colonies in West Africa had greater direct rule and disenfranchisement and provided little to no systemic access to economic gains through development. The Francophone approach focused on assimilation and was highly centralized, with strict government control over the education system.

Côte d'Ivoire has a large and growing population of older adults; a projected 10–20% of the population will be aged 60 and older by 2050. The country's life expectancy at age 60 (10.8 years) is among the lowest of African countries. Forty-five percent of the population is urban, and 3% is living with HIV. The country continues to grapple with the impacts of two civil wars in 2002–2007 and 2010–2011 and has a rudimentary but expanding pension system. A trip to Côte d'Ivoire is planned for November 2026 to coincide with the training of interviewers, continued technical training for École Nationale Supérieure de Statistique et d'Économie Appliquée

d'Abidjan (ENSEA), and establishment of data collection infrastructure. Data collection is planned for December 2026 for 400 rural and urban respondents.

In UG3 phase 1, the Côte d'Ivoire Health and Aging Project (CIHA) will establish data collection and research protocols for collecting data on the older population in Côte d'Ivoire (age 40+) and will develop a network of stakeholders involved in aging-related policies and programs within the country. The CIHA team has created materials for data analysis, data collection and management, and training in AD/ADRD, and has created an external advisory board to provide technical input (e.g., survey review) as well as connections to policymakers and program managers. The team is currently adapting the French SHARE-HCAP to the Côte d'Ivoire context, and plans to pilot test the adapted instrument with 400 participants in December 2026. The instrument will contain modules on trauma exposure, social net usage, caregiving, economic status and security, and household structure.

In UH3 phase 2, CIHA will collect data on dementia from a nationally representative sample of approximately 4,500 adults aged 40 and older and will conduct research on risk factors for AD/ADRD within the country.

Zambia | (Z-CHAD) Zambian Cohort of Healthy Aging & Dementia
Melissa Elafros

2023–2025 Pilot Study
From 2023 to 2025, the Zambian Cohort of Healthy Aging & Dementia Study (Z-CHAD) them conducted a population-based household survey of cognitive impairment (using the Community Screening Instrument for Dementia [CSID]) among 734 adults aged 55 and older. The team then validated these community-based findings via neuropsychological testing with the International Neurobehavioral Test Battery [INTB]) among a subset of participants (N = 555), only 412 of whom had normative data. The team also collected 734 informant interviews and gathered information on medical and societal dementia knowledge and attitudes via provider and informant interviews.

Pilot Study Results
The pilot study demonstrated that community administration of the CSID in Zambia was feasible; however, participants and community health workers frequently switched between languages during interviews. Confirmatory factor analyses of the cognitive data showed that the orientation measures had ceiling effects while executive functioning scores were quite low overall. The team then applied the DSM algorithm to the neuropsychological data for the 412 participants with normative data, yielding dementia prevalence estimate of 11% and a high rate of test results consistent with possible MCI (N = 237). The latter, however, likely suggests the need for further test validation in Zambia.

Previous studies on caregivers in Zambia have focused on support for people living with HIV. The caregiver interviews in the pilot study found that 72% provided care assistance occasionally or most of the time. Of those, 29% had mild or greater burden, as assessed by the Zarit Burden Inventory, and 12% met the criteria for moderate or greater depression, as assessed by the

Patient Health Questionnaire-9 (PHQ-9). Qualitative interviews with a subset of caregivers (N = 16) found that they had limited knowledge of dementia and its difference from normal aging or witchcraft.

Current Activities
The Z-CHAD team is conducting a Fogarty International Center–funded (R21) study to estimate the prevalence of dementia and MCI in an urban (Lusaka) and a rural (Mazabuka) region of Zambia, using the CSID, INTB, and HCAP, and to quantify the prevalence of modifiable risk factors. The team will conduct laboratory testing for diabetes, HIV viral load, syphilis, cholesterol, vitamin B12 deficiency, and systemic inflammation (hs-CRP).

With support from the University of Michigan, the team is also conducting a pilot study (Kukalamba Ndi Ulemu) that tests the use of HCAP to assess cognition among urban adults aged 18 and older with no education and to estimate dementia prevalence among adults older than age 40 and adults older than age 55. The pilot study will quantify the prevalence of modifiable risk factors among these participants and will develop more nuanced measures of caregiver burden, health, and quality of life for caregivers aged 40 and older. To assess these risk factors, the team will collect blood samples, physical exams, and an audiology assessment. The team is piloting the use of wearable technologies and methods for explaining these technologies to participants and will create a participant registry for longitudinal tracking. Finally, the team plans to submit a PF5 application for a national study of cognition and risk factors among adults aged 55 and older across all 10 Zambian provinces and the seven official languages.

Brazil | ELSI-Brasil
Laiss Bertola

The Estudo Longitudinal da Saúde dos Idosos Brasileiros (ELSI-Brasil) team is conducting a pilot study to ensure the methodological rigor and validity of HCAP in a Brazilian context. The pilot will focus on culturally and linguistically adapting HCAP for use primarily in ELSI-Brasil (the Brazilian HRS partner study) and secondarily as a standardized framework for other major Brazilian aging cohort studies. The pilot team will recruit a clinical sample of patients with MCI or depression and a community-based sample of healthy adults (total N = 72) from outpatient clinics at Escola Paulista de Medicina and from the Casa do Idosa Senior Community Center in São José dos Campos, respectively. All participants will be aged 60 or older. The study aims to assess the feasibility of administering HCAP and participant comprehension. The pilot team is selecting specific HCAP tests to mirror the HRS-HCAP core cognitive domains and to ensure harmonization with the central HCAP framework and comparability with other studies in low- and middle-income countries.

Botswana | RAISE-Botswana
Lillian Okui

The Research on Aging, Alzheimer's Disease, and Alzheimer's Disease-Related Dementia and Their Social Determinants in Botswana (RAISE-Botswana) is a two-year pilot project (funded by an NIA R03 grant, 2025-27) to assess the feasibility of conducting a population-based HCAP

study among adults aged 50 and older—a group that currently comprises 15% of Botswana's population. Botswana lacks population-based estimates of AD/ADRD and does not have a national cohort to aid in cognitive health planning. The country has high illiteracy rates among adults aged 50 and older as well as a large number of people living with HIV, who, with the advent of antiretroviral therapy, are living longer but with vascular and cognitive comorbidity risks. A national study would assess the impact of HIV and other social determinants (e.g., gender, education, care access) on dementia risk.

The pilot has three aims: (a) leveraging the 2022 Botswana Census to develop the sampling frame and study design for population-based aging and AD/ADRD research, (b) adapting and translating the HCAP respondent and informant protocols for the Botswana context, and (c) assessing the acceptability and feasibility of population-based aging and AD/ADRD surveys in an urban (Gaborone) and a rural (GoodHope) district. The pilot team spent the past year developing study materials (e.g., sampling frame, protocols) and has adapted and translated HCAP instruments into Setswana and Ikalanga. In November 2026, the pilot team plans to pretest the household survey, which includes HIV testing, biometrics, and an HCAP battery. Starting in March 2027, the pilot team will field the pilot survey and collect additional qualitative data on perceptions of aging, memory, care, stigma, cognitive decline, and health-seeking.

Bangladesh (HEALS) | Enhancing Research Capacity for Addressing AD/ADRD and Metal-Induced Cognitive Decline in an Aging Cohort in Bangladesh
Faruque Parvez

Initiated in 2000, the Health Effects of Arsenic Longitudinal Study (HEALS) has collected more than 20 years of longitudinal data on metal exposures, clinical history, and lifestyle factors on 35,000 individuals living in Bangladesh, including more than 10,000 adults aged 60 and older. The 2027 wave will focus on gathering data on cognitive decline in Bangladesh to understand how metals exposures affect risk for cognitive decline and AD/ADRD.

Accumulating evidence links toxic metals (e.g., arsenic, cadmium, and lead) to cognitive decline and dementia. Some essential metals (e.g., manganese, copper, selenium, zinc) may be beneficial at normal levels of exposure but are potentially toxic at high levels or in combination with exposures to other metals. However, little is known about how metal exposure affects cognitive trajectories over time or about the molecular pathways that link metal exposure to neurodegeneration.

The 2027 wave will collect data on cognition (via a harmonized LASI-DAD HCAP), AD/ADRD biomarkers, and microRNAs packages inside of extracellular vesicles (EV-miRNAs) among 1,000 HEALS participants aged 65 and older. The HEALS team will use these data to examine (a) the impacts of metals exposure on cognitive decline, neuron-derived EV-miRNAs, and AD/ADRD biomarkers; (b) the links between EV-miRNA and cognitive decline; and (c) potential EV-miRNA signatures of metal-related cognitive decline. The project also aims to build sustainable AD/ADRD research capacity in Bangladesh.

Previews of Newly Funded Pilot Studies

Benchmarking Dementia Diagnostic Frameworks in the Caribbean American Dementia and Aging Study
Jorge Llibre-Guerra

This pilot study aims to develop a validated diagnostic algorithm for CADAS to deliver rigorous, comparable dementia surveillance across the Caribbean and the wider HCAP Network. CADAS's cognitive assessment is harmonized with the HCAP and 10/66 protocols and assesses five cognitive domains (memory, executive function, language, orientation, and visuospatial abilities). A structured informant interview provides information on functional decline. The pilot study applied the Manly-Jones HCAP framework to construct a rule-based diagnostic algorithm that uses harmonized cognitive domains and informant-reported functional decline to classify cases as normal, MCI, or dementia, based on the following criteria:

- unimpaired: at most one impaired domain and no significant subjective or informant-reported complaints
- dementia: two or more impaired domains and corroborated functional or cognitive decline
- MCI: no significant functional impairment but with one of three subtypes: (a) multi-domain objective impairment without subjective or informant decline, (b) single-domain impairment with informant or subjective concern, or (c) no objective impairment but converging subjective and informant concerns

Algorithm Development and 10/66 Proof of Concept Study
To develop the harmonized algorithm, the pilot team plans to use the 10/66 study to construct the normative core sample. As part of a proof-of-concept study using 10/66 data, the team tested three levels of stringency for excluding individuals from the initial 10/66 sample (N = 10,834 adults aged 65+): low (N = 7,653), moderate (N = 3,813), and high (N = 2,421). The level of stringency had little effect on estimated dementia prevalence, changing the estimates only from 9.6% to 10.7%.

To test the harmonized algorithm, the team examined its performance with the 10/66 study. When compared against CDRs, which were available for 242 10/66 participants, the algorithm exhibited high specificities for discriminating between normal and dementia cases (area under the curve [AUC] = 0.971) and between MCI and dementia cases (AUC = .819), and performed slightly less well, but acceptably, at discriminating between normal and MCI cases (AUC = 0.764). Notably, the harmonized algorithm, with its expanded MCI definition, more accurately detected MCI than the original 10/66 algorithm.

Next Steps
The pilot study team will benchmark the harmonized algorithm results against online clinical consensus for 900 CADAS participants from the Dominican Republic and Cuba. The

classifications will then be validated against face-to-face clinician diagnoses and CDR-staging for 300 CADAS participants. Blood-based biomarker data will be compared to the clinician and algorithmic classifications.

Discussion

Llibre-Guerra confirmed that the 10/66 study contains longitudinal information on its participants' cognitive status, enabling removal of individuals who later develop cognitive impairment from the normative sample. Because of societal changes in education and other factors, overall performance on cognitive tests might have improved during the 10 years between the 10/66 study and CADAS. The pilot team may consider examining whether cognitive performance among unimpaired individuals changed during that time. Attendees also suggested that cognitive performance may vary across countries, which would make within-country normative samples preferable to a region-wide normative sample, if sufficient sample sizes are available.

HCAP Pilot Study: Validity, Psychometric Analysis, and Instrument Adaptations of the Malawi HCAP

Helen Purcell

The Malawi Longitudinal Study of Families & Health (MLSFH) began in 1998 to study fertility decisions. In 2012, it added a Mature Adults Cohort and collected integrated cognitive data on participants aged 45 and older, with a focus on aging, cognitive decline, and AD/ADRD risk. Participants live in a rural, agrarian society, and have high levels of exposure to very adverse conditions, including sustained poverty (living on less than $1 a day), repeated disease epidemics, and a high rate of infant and childhood mortality.

In 2025, MLSFH expanded its cognitive assessment to align with HCAP, by adding items to assess five cognitive domains (memory, executive functioning, orientation, visuospatial abilities, and language). These new items included new language and orientation questions, meaningful statements about themselves, paper folding, interlocking pentagons, story recall, matchsticks, CSID, symbol cancellation, lost child, and serial 3s. MLSFH participants scored highly on the orientation domain tasks and exhibited increased performance with increasing educational attainment and declines with increasing age.

The HCAP pilot study aims to conduct the psychometric evaluations and harmonization work required to integrate the 2025 cognitive data into the HCAP Network. The psychometric evaluations will include test-retest reliability across MLSFH waves, assessments of convergent and discriminant validity, inter-item reliability, evidence-based item reduction, and item response theory modeling to determine item difficulty and discrimination. The harmonization work will benchmark the MLSFH against harmonized factor scores; classify each MLSFH item as either a direct equivalent, partial equivalent, or context-specific adaptation of the HRS gold standard; and confirm that the administration and scoring procedures match those of the broader HCAP network. The pilot study team is already mapping cross-HCAP items and examining comparability; in a few months, it will advance to synthesis (including harmonization), documentation, and production of deliverables (manuscripts, submissions to

HCAP network). In addition, MLSFH now has epigenetic clock and exposome data, which will enable the team to examine links between biological aging and the HCAP-harmonized cognitive data.

Discussion
Purcell clarified that MLSFH also has an extensive caregiver survey for a subset of participants.

Cross-national Comparison of MCI and Dementia Incidence

United States (HRS-HCAP)
Lindsay Kobayashi

Using two waves of data from HRS-HCAP, the HRS-HCAP study team has estimated the national incidence of MCI and dementia from 2016/17 to 2022/23 among U.S. adults aged 65 and older, and by age, sex, race, ethnic, and educational subgroups.

Death and attrition present a considerable challenge for estimating incidence of MCI and dementia in HRS-HCAP and more generally in longitudinal studies of aging, because both death and attrition are related to cognitive status. Deriving estimates based solely on continuing participation is therefore subject to selection bias.

Because HRS-HCAP is embedded within HRS, intervening HRS core wave data and linked National Death Index (NDI) records can be used to help determine cognitive outcomes for HRS-HCAP 2016/17 participants who died or attritted prior to the 2022/23 HCAP. Of the 3,121 participants without dementia who completed the 2016/17 HRS-HCAP, 51.4% were re-interviewed for the 2022/23 HRS-HCAP, 20.5% attritted but completed one or more intervening HRS core waves, 26.7% died but had intervening HRS core data or NDI data available, and 1.3% (41 individuals) attritted with no intervening core or NDI data. Dementia was listed on 321 of 834 death certificates of participants who had died. Final cognitive outcomes for deceased participants were assigned based on NDI data, if available; otherwise, their most recent core data were used. For re-interviewees and attritors, the study team applied the Manly-Jones algorithm to classify reinterviewees by cognitive status in the 2022/2023 HCAP or the most recent intervening HRS core interviews for drop-outs. For attritors, their final observed cognitive status in core data was considered definitive. Estimates were produced using the 2016 HCAP sampling weights.

The overall incidence of MCI was 32 cases per 1,000 person-years, which translates to 5,254,568 cases in the population. The overall incidence of dementia was 21.7 cases per 1,000 person-years, which translates to 4,775,631 cases in the population. Dementia and MCI incidence decreased with increasing educational attainment. MCI incidence was lowest among Blacks. Importantly, dementia incidence among attritors and deceased participants was two to three times higher than among re-interviewees. While the age gradient was steeper among re-interviewees, the absolute rates were higher for attritors and deceased in every age group.

The study had several limitations. Although higher incidence among deaths and attritors is expected, the increased incidence could also be a methodological artifact of applying the Manly Jones algorithm to HRS core data, which lacks several inputs available in the HCAP. Differences between subgroups could reflect differences in measurement as well as true differences in incidence. For some subgroups (e.g., non-Hispanic Other), sample sizes were small, lowering the reliability of estimates for those groups. In addition, the study team has not yet incorporated Medicare claims data and exit interviews, which could supplement the available cognitive data.

Future analytic steps include calculating the lifetime risk of MCI and dementia using life table methods, modeling the reversion from MCI and dementia, and conducting sensitivity analyses using the Manly-Jones algorithm in HRS core data only for re-interviewees.

India (LASI-DAD)
Emma Nichols

The LASI-DAD team compared three different dementia classification schemes: CDR online consensus (with clinicians blinded to Wave 1 classifications), CDR online consensus (not blinded to Wave 1 classifications), and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) algorithm. For the CDR online consensus classifications, three clinicians independently rate each case using data that would be available in a clinical context, and a consensus conference adjudicates any disagreements. The DSM-5 algorithm relies on informant-rated cognitive decline, objective cognitive decline, functional decline in everyday activities, and exclusionary conditions to assign classifications.

The normative sample included 23% of Wave 1 (N = 955) and 40% of Wave 2 (N = 1,868) respondents. Participants were excluded from the normative sample if they did not return for Wave 2 or had a history of stroke, a LASI proxy interview, a self-reported learning or intellectual disability, a self-reported IADL difficulty in LASI, or informant-reported slow and steady onset of memory problems.

Although a small number of people were classified as having dementia in Wave 1 but not in Wave 2, most people who had dementia in Wave 1 were not re-interviewed in Wave 2. Notably, both measurement error and changes to medical conditions can affect dementia diagnoses, including clinician-based diagnosis, according to a recent study conducted at the University of California, San Francisco.[3]

The three classification schemes were compared to in-person diagnoses. These in-person diagnoses were completed after Wave 2 based on semi-structured interviews with participants and informants and used the same CDR rating protocol as the online consensus process. The CDR unblinded resulted in 0.9% more severe ratings and 6.2% less severe ratings than the in-

[3] Miramontes S, Khan U, Zimmerman S, et al. Diagnostic reversion in dementia care: a real-world analysis of mild cognitive impairment diagnoses following dementia in a large electronic medical record system. Preprint. medRxiv. 2025;2025.07.16.25331678. Published 2025 Jul 17. doi:10.1101/2025.07.16.25331678

person diagnosis; the CDR blinded resulted in 3.4% more severe and 3.9% less severe; and the DSM-5 resulted in 7.7% more severe and 2.7% less severe.

Incidence Estimation

Of the Wave 1 sample, 5.5% were lost to follow-up, 23.9% died, and 7.9% refused to participate. Thus, to estimate prevalence using the CDR, the study team used sampling weights and inverse probability weights for attrition, imputed CDR statuses that were missing for Phase 1 of Wave 1, and imputed dementia status prior to death using end-of-life data. The team assigned dementia based on a random draw of plausible times between when they were observed at Waves 1 and 2 (an approach that gives similar results to using the midpoint).

The CDR unblinded classification scheme yielded an incidence of 11.5 per 1,000 person-years, CDR blinded yielded an incidence of 23.8 cases per 1,000 person-years, and DSM-5 yielded an incidence of 30.0 cases per 1,000 person-years. Incidence was notably higher among those who died between waves than among re-interviewees, and among women, the less educated, and older individuals. No strong rural versus urban differences were observed.

Status Reversions

The study team found high rates of reversion from MCI to normal from Wave 1 to Wave 2, with reversion rates of 29% for CDR unblinded, 43% for CDR blinded, and 59% for DSM-5. Individuals with other risk factors for dementia were less likely to revert (e.g., older adults), whereas those with higher grip strength and relatively high cognitive performance were more likely to revert. Thus, differences in case ascertainment (even subtle) can lead to differences in estimates of absolute incidence. Some reversion from dementia between waves is unavoidable, but the percentage may have been inflated by the high mortality between waves among participants with dementia. Reversion from MCI is more common in participants with otherwise less "risky" profiles, in line with MCI as a risk state.

Next steps include examining the factors driving incidence calculations (e.g., rater confidence, uncertainty) and considering approaches to reduce the reliance on MCI cases that clinicians considered questionable (i.e., with CDR scores of 0.5), such as adopting the National Institute on Aging—Alzheimer's Association (NIA-AA) Research Framework used by CADAS. For Wave 3, the study team may expand the use of in-person and telemedicine calls (for a random or targeted subsample) to enable estimation of the incidence rate based on imputed in-person diagnoses.

Discussion

Dementia diagnoses involve assigning a risk-based classification that by nature is probabilistic and may fluctuate. Performance between assessments may improve for a variety of reasons, including the context in which performance is assessed (e.g., sleep quality, illness, medication, depression). Classification reversals are unlikely to be the result of a reversal in the underlying pathology.

Most dementia incidence estimates come from studies with relatively short re-assessment intervals, and without an intervening global pandemic. A shorter time between waves might be

a better design for understanding incidence of dementia, given the impacts of mortality and attrition. However, including more than one HCAP data collection in a five-year project would be extremely time-intensive and costly. Braudt noted that NIA funds a number of studies with shorter intervals between cognitive assessments, which could be a valuable resource for exploring different intervals. Together, these two studies underscore the importance of good follow-up and the use of ancillary data for tracking participant outcomes.

Attendees discussed ways to gather additional data on cognitive status between waves. Studies could conduct in-person to telephone calibration followed by yearly telephone follow-ups. While end-of-life interview data were critical for estimating incidence, the data quality could be improved by shortening the interval between death to the interview. The HRS team might consider ways to supplement the Core data to facilitate improved imputation of cognitive status. Currently only a limited number of measures in the Core are harmonized with HCAP.

Impact of Blinding for LASI-DAD

The five-year interval is quite long for clinical follow-up, so the unblinded clinicians were more conservative to switches and thus more influenced by the prior CDR status, especially when they were uncertain about the current classification. This phenomenon could explain why the blinded CDR was a better approximation to the in-person diagnosis.

Updates from Previously Funded Pilot Studies

Colombian Study of Aging (COSA)
Jennifer Ailshire

The aims of the COSA-Cog Pilot were to (a) administer the HCAP in a subsample of 200 participants aged 50+ and their informants drawn from the COSA pilot study, (b) evaluate the psychometric properties of the HCAP protocol in the Colombian context, and (3) compare cognitive performance in Colombia with HRS-HCAP and Mex-Cog.

To develop the HCAP battery, the study team translated items from HRS-HCAP and used Mex-Cog items, adapting as needed to the Colombian context. Some words and concepts were changed to reflect idiomatic Spanish in Colombia. Study procedures were also based on those of HRS-HCAP and Mex-Cog.

Participants were recruited from the COSA-Cog sample frame. All participants were aged 50 and older and Spanish speaking. They were selected to reflect urban, rural, and remote areas and a range of education levels, with oversampling of those with impaired cognition to address a high rate of attrition and refusals among those with dementia. All interviews were conducted in person between July and August 2026.

Based on the pilot study, tablets did not present issues for participants, and the team received few complaints about survey duration. Colombia's public mortality data base is easily accessible. Citizens have a national identification number which makes tracking easy; however, immigrants do not. The team also tested the use of AI to assist with field work (e.g., WhatsApp

scheduling and AI voice calls) and to simulate 1,000 interviews to identify potential skip pattern mistakes before going into the field.

Next steps include determining whether AI can assist with quality control to augment human review, conducting psychometric evaluations, and comparing cognitive performance in the pilot with HRS-HCAP and Mex-Cog. The team is piloting several AI-assisted approaches to improve survey operations, including for participant engagement, questionnaire flow checks, and quality control review.

Longitudinal Study of Aging in Guatemala (ELEGUA)
David Flood

Estudio Longitudinal de Envejecimiento en Guatemala (ELEGUA) is an HRS-HCAP-aligned study under development in Guatemala that aims to advance understanding of aging phenomena by leveraging the unique populations, exposures, and resources in Guatemala, and of healthy aging among people of Central American origin living in the United States.

Guatemala is a country of 18 million people with a large indigenous population of Mayan and Mayan American people. Guatemalans speak 22 different languages, and 35% speak one or more Mayan languages. Guatemala's safety net is very weak, even compared to its regional peers, characterized by high poverty rates (40% or higher), low pension coverage (17% of those aged 65 and older), no national health insurance, and limited health care spending. Remittances in Guatemala are extraordinary, currently at $100 million daily.

In 2025, the study team received an NIH grant (R21) plus HCAP funding to conduct a full pilot of the HCAP battery, including in Mayan languages. The pilot focused on adapting the HCAP battery to Guatemala, which was first translated by Mex-Cog to Guatemalan Spanish and then to the most common Mayan language spoken close to the capital. Mayan languages present translation challenges because they are unique, with a very different verb structure and vocabulary from most languages, non-written, and use a base-20 counting system. In Guatemala, bilingualism exists on a spectrum (many people speak using both Spanish and Mayan words and switching rapidly between the two), with considerable dialectical variation. To address these challenges, the pilot team focused on linguistic flexibility while preserving meaning and participant understanding (i.e., not being dogmatic about a particular phrasing or wording), excluding or modifying written tests, emphasizing practical applications, and carefully comparing Spanish and Mayan vocabulary.

Pilot fieldwork for ELEGUA will conclude in November 2026. The study team plans to submit a PF5 application in 2027, with the goal of launching ELEGUA in 2028/29, with HCAP and core longitudinal follow-ups every 4-5 years.

Validation of the Manly-Jones Algorithm in the Aging, Demographics and Memory Study (ADAMS): Results and extensions
Zach Kunicki and Emma Nichols

HCAP used an actuarial algorithm and robust neuropsychological norms to assign dementia, MCI, and no impairment classifications. A small (N = 50) validation sample using online consensus diagnosis showed that the algorithm was generally consistent with clinical diagnoses (weighted kappa = 0.75). ADAMS provides the opportunity to conduct a larger, second validation of the HCAP algorithm and to compare the algorithm with the 10/66 predictive algorithm that was previously developed in ADAMS.

To apply the Manly-Jones HCAP algorithm to ADAMS data, the pilot study team first developed summary scores for the five cognitive domains. Memory, executive functioning, and language/fluency domains in ADAMS represented the same constructs but included small changes from models previously estimated in HCAP given differences in the cognitive batteries. The team then (a) imputed the algorithm components, (b) identified a robust normative sample (using clinical consensus diagnoses), (c) estimated demographically adjusted impairment thresholds, and (d) classified respondents based on impairment in cognitive domains, physical functioning, and self-reported memory.

When validated against clinical diagnoses in ADAMS (N = 308), the HCAP algorithm had high specificity, but slightly lower sensitivity than the 10/66 algorithm. The 10/66 algorithm yielded an higher estimate for overall prevalence of dementia (16%) than the HCAP algorithm (12%), and clinician diagnoses (14%). While the overall agreement between the HCAP algorithm and clinician diagnoses was strong (weighted kappa = .79), and the two rarely differed for unimpaired and dementia classifications, they were more discordant for MCI and normal cases.

Discordances between the HCAP algorithm and clinician diagnoses were highest for MCI in the presence of other comorbidities (e.g., substance abuse, psychiatric conditions), for non-AD/ADRD dementia, among Black Americans, and for those in the oldest age groups.

The pilot study team plans to re-estimate performance using the same definition of dementia as the Manly-Jones and use a multiverse analysis to evaluate the effect of investigator decisions (e.g., normative group criteria, cognitive domains, cognitive thresholds, functional limitations) on model estimates of dementia prevalence and algorithmic performance compared to clinician diagnoses.

Introduction to the HCAP Toolbox

Lindsay Kobayashi

The HCAP Toolbox aims to provide resources for researchers who intend to initiate new HCAP studies. This effort is particularly important because the Network continues to expand rapidly. Standardized materials promote harmonization and documentation and reduce reliance on ad hoc consultations and connections to obtain study materials. The HCAP Toolbox will house all of

the items used in HCAP, alongside documentation on their implementation and adaption across Network studies and licensing and copyrighting considerations.

With support by Kobayashi and Emily Briceño, Sarah Kwiatek and TC Cho have catalogued cognitive test items from HRS HCAP, Mex-Cog, HAALSI Dementia Study, LASI-DAD, the Chile Cognitive Aging Study, SHARE-HCAP, KLPS, and the Longitudinal Study of Health and Aging in Kenya (LOSHAK) pilot. In 2025–2026, a Network team held workshops to review the compiled materials, provide feedback, suggest additional materials for inclusion, and draft standardized written protocol. The Network team, NIA program officials, and study representatives continue to iteratively review materials for the Toolbox. This living shared resource will be updated over time with new measures, measure adaptations, and experiences with existing measures.

The Toolbox is accessible through this link. The content is currently password protected. Individuals interested in accessing the Toolbox should contact Kwiatek (sarahkwi@umich.edu).

Discussion

Attendees discussed whether the Toolbox should be made available to potential grantees or only funded grantees and whether password protection was required. Kobayashi explained that the team currently wants to keep the Toolbox internal to the network to encourage sharing across the Network and to address potential copyright issues. Although the Toolbox cannot replace direct consultation with Network members when applying for HCAP study funding, the Network could inform researchers that the Toolbox will be available once funding is secured. Another possibility is to offer consultation services to researchers through the Toolbox.

Currently, the Toolbox does not include information about clinician-based diagnoses being used throughout the Network; however, adding that information would be valuable.

Unlocking Global Cognitive Aging Data: Connecting COSMIC and HCAP

Susanne Röhr

The Cohort Studies of Memory in an International Consortium (COSMIC) was established in 2012 by Perminder Sachdev, who serves as the co-director of the Center for Healthy Brain Ageing (CHeBA) at UNSW Sydney, Australia, and the principal investigator of COSMIC. COSMIC currently brings together 62 studies from 38 countries across six continents, representing more than 220,000 participants. COSMIC only supports longitudinal, population-based cohort studies with at least 500 participants, cognitive outcomes, and at least two assessments. Exceptions to these criteria have been made to increase regional representation. COSMIC data can be requested through Dementias Platform Australia. Data custodianship rests with each research group.

Unlike HCAP, COSMIC uses retrospective data harmonization to transform conceptually similar but structurally different variables. COSMIC has harmonized diagnostic cognitive outcomes, including subjective cognitive decline, MCI, and dementia, and has published on the feasibility

of retrospective harmonization.[4] However, efforts to harmonize cognition are challenged by the range of measures used in the Network. Until now, COSMIC analyses have relied heavily on harmonized diagnostic categories or individual cognitive tests that happen to be shared across studies, with the result that much of the cognitive information available within COSMIC remains underused.

The COSMIC-HCAP Project

The COSMIC-HCAP project aims to develop a set of harmonized cognitive domain and global scores across the COSMIC and HCAP networks. As a first step, the project team has documented what cognitive measures were administered in COSMIC studies and how they overlap with HCAP cognitive measures. The project team must then agree on the mappings, complete data intake, evaluate anchor and latent score methods, and validate scores and release reusable code.

The COSMIC-HCAP project sits within the COSMIC Harmonization Working Group, which is developing a common data schema across COSMIC studies, in collaboration with the AD Data Initiative. The working group is also exploring FORGE AI-assisted metadata discovery and data curation. Its broader goal is to move from harmonizing specific datasets to developing a governed and extensible pipeline through which harmonized variables, metadata, decisions, and analytic tools are maintained and can be reused across projects.

Gateway / Gateway Exposome Coordinating Center (GECC) Updates

Alden Gross and Jinkook Lee

Gateway to Global Aging Data (Gateway) aims to provide a high-quality, user-friendly data and information hub for aging research that stimulates rigorous, reproducible research on aging. Since October 2025, Gateway has released 13 newly harmonized datasets, including linked exposome and environmental data, and has maintained its extensive reach throughout the scientific community by publishing multiple papers and hosting webinars, workshops, and symposia at national and international conferences. David Knapp has been leading an effort to build a historical policy database that covers education, retirement, and long-term care policy. Within the Gateway Exposome Coordinating Center (GECC), Sara Adar has been gathering environmental exposome data and linking these data to survey participants using geocoded residential histories.

During the next project period, Gateway plans to (a) conduct psychometric evaluations of informant-based measures and crosswalk these measures across studies (e.g., IQCODE vs CSI-D measures); (b) develop a publicly available item repository that documents item differences across HCAP studies; (c) support efforts to probe how different algorithmic decisions affect cognitive impairment and dementia estimates across studies; and (d) co-calibrate cognition

[4] Lipnicki DM, Lam BCP, Mewton L, Crawford JD, Sachdev PS. Harmonizing Ethno-regionally diverse datasets to advance the global epidemiology of dementia. C*lin Geriatr Med*. 2023;39(1):177-190. doi:10.1016/j.cger.2022.07.009

across longitudinal HRS International Network of Surveys by harmonizing a general cognitive factor across waves and cohorts using latent variable methods.

Gateway Data Enclave
The Gateway Data Enclave provides a secure, remote access environment on NIA's LINKAGE for U.S.-based researchers. The Gateway Data enclave team is partnering with the AD Data Initiative, a Gates Venture funded enclave environment, to provide non-U.S.-based researchers with access to the Enclave.

Gateway Exposome Coordinating Center
GECC aims to foster collaboration and consensus-building to break down research silos, generate science-ready data and guidance for research, and advance the science on links between life-course environmental exposures and health. It studies the external exposome to identify potentially modifiable drivers of aging across six domains: extreme weather, policy environment, physical environment, social environment, community services environment, and life experiences.

Recent GECC activities include (a) sharing findings about the state of knowledge and research priorities; (b) building consensus and developing guidance for core exposome measures; (c) developing resources, including novel measures and data; and (d) disseminating information and forming partnerships. GECC has published 10 papers in a special issue of *Alzheimer's & Dementia* and a report on a 2025 workshop in *Nature Aging*, and has a consensus statement in press, also at *Nature Aging*. The GECC Dataverse now houses a publicly available heat metric dataset. In addition, GECC has developed guidance on greenspace measures, a playlist that provides guidance on handling measurement error, and a GECC Data Explorer.

Over the coming year, GECC will host a joint GECC and Demography & Economics of Aging Coordinating Center seminar series and a fall 2026 town hall series; conduct the 2027 GECC Pilot Project Call; and, in partnership with the National Alzheimer's Coordinating Center, oversee a pilot competition and host a 2027 Summer Institute.

NIH PF5 International Collaboration Mechanism

NIA Introduction to the PF5 Mechanism
Minki Chatterji, Jonathan King, and Delany Torres

NIH has created the Collaborative International Research Project (PF5) mechanism to replace the traditional foreign grant subawards andconsortium structures. The PF5 consists of multiple components, including a new component for foreign work ("International Project"). This component is not a subaward of the PF5, but rather a separate, directly funded, but linked single RF2 award. PF5 applications will be reviewed by special emphasis panels in the appropriate scientific area.

PF5 Notice of Funding Opportunity

On January 20, 2026, NIH posted the first Notice of Funding Opportunity (NOFO) using the PF5 activity code, the PA-26-002 NIA Collaborative International Research Project (Parent PF5 Clinical Trial Optional). This NOFO is designed to support funded international collaborations between a U.S.-based prime organization and foreign organizations. It uses the Multi-component (M) Application Guide and Package, does not have an explicit budget cap, does not require approval if direct costs exceed $500,000, and offers more flexibility in application size and structure than other multi-component NOFOs. NIH international projects in a PF5 application should not be used for foreign consultants, purchasing equipment or supplies from foreign vendors, foreign collaborations that do not involve NIH funding, or any other foreign component that would not previously have resulted in a foreign subaward.

PF5 Application Structure

The PF5 application structure contains five components: Overall, Research Project(s), International Project(s), Core, and Institutional Career Development and Training (ICDT). The Overall component provides a high-level overview of the project, goals, and collaborative approach, and is scored. The Core component is optional, not scored, and proposes a U.S.-based core (like the cores in a P30 or P01) for domestic institutions only. At least one Research Project and at least one International Project component is required. The Research Project(s) component describes the scientific and technical approach and the budget for the U.S. institution and is scored. The International Project(s) component covers the components previously funded through foreign subawards and describes the scope and role of the international institution. Although not scored, this component is vital because the reviewers' comments will influence whether each international project is included in the PF5; a weak International Project will unlikely be awarded as an RF2.

The Institutional Career Development and Training (ICDT) component is an optional application section that describes professional development opportunitiesfor cohorts of scholars or trainees in connection with the research activities described in the Overall, Research Project and International Project components. Activities such as domestic scholars engaging in training activities with international partners or domestic training activities that are hosted at domestic institutions, which international partners may attend should be supported through the overall or research projects. Any activities through collaborating foreign institutions should be supported through the International Project component. The ICDT is scored based on five criteria: (a) institutional career development and training program environment (e.g., rationale, timelines, content, institutional environment), (b) career development and training program director(s), (c) mentors, (d) international scholars/trainees, and (e) training record.

Several NIH programs have issued NOFOs that do not use the PF5 activity code but indicate that international collaborations may be relevant. For these NOFOs, applicants proposing foreign collaborations can leverage the application forms and structure of the PF5 Parent Announcement. This application process is only available for the NOFOs listed. The PF5 Activity Code website provides instructions on how to leverage the PF5 for these applications.

Discussion: From the Applicant Perspective
*Lindsay Kobayashi, David Richter, Carlos Mendes de Leon, *Martine El Bajjani, Jean Francois Trani, *Ganesh Babulal*

SHARE-HCAP
The SHARE-HCAP application used an MPI structure, included 12 international projects, and was 928 pages in length. A separate PI was named for each SHARE country study. The Overall component described the aims that spanned the components, and the International Project components described each project's more detailed sub-aims. The SHARE-HCAP team developed templates to help the international teams write their components. Two aspects of the application process were particularly challenging: (a) determining what information belonged in the Overall component versus the Research Project component, and (b) capturing all relevant scientific and technical information for both domestic and international work in the Research Project component. Because the PF5 application is new, some application requirements may evolve after the first round of reviews.

LSAHA
The PF5 application process for LSAHA was less complex because it has only one International Project component. The team struggled with determining the level of detail needed in the Research Project to avoid the perception that the project was merely collecting data in Lebanon for analysis in the United States. King noted that some international projects should instead apply for a foreign R01 with a subaward for the domestic component; however, these projects cannot issue subawards to other international institutions.

Afghanistan
This application proposed an MPI structure, with two U.S.-based PIs, and one International Project component to test the HCAP in Kabul. The project team intended to examine the impact of conflict, lack of access to services and health care, and isolation, and then apply the findings to better understand dementia risk among vulnerable populations in the United States. The most challenging aspect of application preparation was developing the three interconnected aims across the Overall, Research Project, and International Project components.

Open Group Discussion
NIA staff clarified that separate Overall and Research Project components for each International Project component are not required in PF5 applications. Typically, each country has one International Project component, but some may have more than one. Importantly, because the International Components do not allow for subawards, all survey agencies are contracted through the University of Michigan. The Overall component covers the overall specific aims, research strategy, and rationale for the international collaboration, without providing specific technical or scientific details. It also contains a dispute resolution plan.

The Research Project component is the element most comparable to an R01 application, because it provides the scientific and technical details for both the domestic and international work as a unified project. NIA staff also clarified that the ICDT component is intended to fund either domestic training activities that international trainees can attend or international

activities that domestic trainees can attend. However, international activities for trainees must be proposed through the International Project component, but other activities can be proposed in the Overall or a Research Project component. The PF5 data sharing policy is the same as those of other funding mechanisms. Notably, researchers can access HCAP Network data through the Gateway Data Enclave, which is part of the NIA LINKAGE program, and the partnership with AD Workbench, which enables mirrored access to the Gateway Data Enclave for international researchers.

Chatterji and King emphasized the importance of contacting NIA early in the application process to resolve issues related to contracting and collaboration structures. Chatterji suggested that applicants should share drafts of the Overall, Research Project, and International components, as well as the budget, before meeting with NIA staff. International teams seeking to partner with a U.S.-based PI can contact NIA or the HCAP Network for suggestions. NIA staff will have more information about the recommended degree of domestic involvement once the initial round of PF5 applications have been reviewed. In response to an attendee's question, NIA stated that they would consider providing sample PF5 applications or detailed descriptions of each component.

Flash Session: Lessons from HCAP Scholar Exchanges

It's All About Networking and Collaborations: Lessons from the 2026 HCAP Scholar Exchange Program
Valentine Ucheagwu

Ucheagwu shared that attending the 2026 HCAP Cross National Training (HCAP-XC) at the Institute for Social Research (ISR) increased his comfort level with advanced psychometric concepts, computer programming, and statistical techniques (e.g., item response theory, measurement invariance, confirmatory factor analysis), as well as his confidence in his team's ability to conduct an HCAP study in Nigeria. In addition, he met with numerous experts in dementia and survey research and attended events such as the Michigan Sensory Health and Aging Research Collaborative workshop. Building on these experiences, he and his team are drafting two research applications for submission in 2026 and 2027.

Three Weeks in Ann Arbor: Reflections from the HCAP Network Scholars Exchange
Sara Moustafa

The HCAP Network Scholars Exchange supports extended research visits between HCAP study sites, with a focus on supporting early-stage investigators working in low- and middle-income countries. Through this program, ISR hosted Moustafa for three weeks during which she worked closely with Briceño on A Longitudinal Study of the Egypt Healthy Aging Initiative (AL-SEHA) to advance the cross-cultural adaptation, validation, and harmonization of cognitive assessments of older Egyptians. She also conferred with numerous survey and dementia experts and attended the HCAP-XC, where she learned about methods, harmonization, dementia classification algorithms, and sampling considerations.

Group Discussion and Next Steps

HCAP Network Announcements
Lindsay Koboyashi

Kobayashi highlighted several upcoming HCAP activities. In June 2027, Kobayashi and Jones will lead the 2027 HCAP Cross National Training at Brown University in Providence, Rhode Island. In March 2027, Wong, Mejia-Arango, and Saenz will hold the next short course at the University de las Americas in Puebla, Mexico; the topic will be advancing cross-national research on aging and cognitive function using the MHAS and HRS/HCAP studies. The HCAP team will send save-the-date notifications for the workshop, short course, and the 2026-2027 Virtual Seminar Series, which will be held bimonthly on Fridays from 10 to 11 a.m. Eastern Standard Time on Zoom. Individuals interested in the seminar series can sign up on the HCAP website. The pilot competition, which aims to support analyses of existing data to improve harmonization across the Network, will accept applications from November 30, 2026 to January 22, 2027. Awardees may request up to $40,000 in direct costs for 1-year. Unfortunately, the competition is not open to foreign pilot projects. Kobayashi encouraged early-stage investigators and foreign investigators to apply to the scholar exchange program, which supports visits to a range of Network sites, including outside the United States, by funding up to $10,000 in travel and housing costs.

Future Priorities and Directions from the NIA Perspective
Minki Chatterji, Jon King, and Delany Torres

Explanatory Variables in Standalone HCAP Studies
Chatterji noted that many standalone HCAP studies within the Network are not part of a larger HRS study. Thus, Network investigators should ensure that these studies incorporate the explanatory variables needed for cross-national examinations of the factors driving cognitive trajectories.

Next HCAP Conference
King encouraged Network members to continue promoting the Network with additional investigators to foster its ongoing expansion. He noted that the Network conference in 2027 might feature a special session on the funded PF5s, as well as discipline-specific work (e.g., epidemiological, biomarker-related) being conducted throughout the Network.

Secondary Data Usage
The Network should explore strategies to expand collaboration with external researchers conducting certain secondary data analyses of publicly available HCAP data, without serving as gatekeepers. Kobayashi suggested that the HCAP website encourage data users to contact the Network to consult with Network experts and receive guidance on study design and best practices. Attendees also emphasized the need for pooled and comparative analyses across studies and the use of linked data to expand the scope of the research undertaken by the Network.

Secondary data usage increases the likelihood that researchers' aims overlap in applications. Notably, NIA cannot share information about unfunded applications to help researchers avoid this issue. However, given the wealth of available biomarker data, many researchers outside of the Network may submit applications without possessing the same familiarity with HCAP and its processes. Network members may consider using their connections to learn more about efforts to use the secondary data.

Appendix A: Agenda

Rev. September 10, 2026

*Virtual Participant

Wednesday, September 9

8:30 AM **Morning Refreshments**

9:00 **Welcome and Introductions**
Kenneth Langa, Lindsay Kobayashi

NIA Welcome
Richard Hodes, Director
Kenneth Santora, Acting Deputy Director; Director, Division of Extramural Activities
Minki Chatterji, Program Official
Jonathan King, Program Scientist

9:15 **Overview of Meeting Agenda & HCAP U24 Network Updates**
Kenneth Langa, Lindsay Kobayashi

9:30 **Updates from HCAP Studies (10 mins per study)**
Mexico (Mex-Cog) | **Rebeca Wong*
Nepal (CVFS-SCAN) | *Emily Briceño*
Caribbean (CADAS) | *William Dow*
Costa Rica (CRELES) | *William Dow*
India (LASI-DAD) | *Jinkook Lee*
*England (ELSA-HCAP) | *Paola Zaninotto*
Northern Ireland (NICOLA-HCAP) | *Bernadette McGuinness*
Europe (SHARE-HCAP) | *David Richter*
Kenya (KLPS) | **Edward (Ted) Miguel and *Michael Walker*

11:00 **Break**

11:30 **Previews of Newly Funded Pilot Studies (15 min each)**
The CADAS dementia classification algorithm | *Jorge Llibre-Guerra*
Psychometric performance of the Malawi HCAP |*Helene Purcell*

12:30 **LUNCH | Commonwealth Indian**

1:30 **Cross-national comparison of MCI and Dementia incidence (60 min)**
Alden Gross, Tsai-Chin Cho, Emma Nichols

2:30 **Updates from Previously Funded Pilot Studies (20 min each)**

Colombian Study of Aging (COSA) | *Jennifer Ailshire*
Longitudinal Study of Aging in Guatemala (ELEGUA) | **David Flood*
Development and validation of the Manly-Jones algorithm in the HRS-ADAMS | *Zachary Kunicki & Emma Nichols*

3:30 **Break**

4:00 **Introduction to the HCAP Toolbox**
Lindsay Kobayashi

4:20 **Cosmic Consortium**
Susanne Röhr

4:40 **Gateway / Gateway Exposome Coordinating Center (GECC) updates**
Alden Gross and Jinkook Lee

5:00 **ADJOURN**

6:00 **GROUP DINNER | Fogo de Chao**

Thursday, September 10

8:30 AM **Morning Refreshments**

9:00 **Updates from HCAP Studies, Continued (10 min each)**
South Africa (HAALSA) | *Lisa Berkman*
Côte d'Ivoire (CIHA) | *Philip Anglewicz*
Zambia (Z-CHAD) | *Melissa Elafros*
Brazil (ELSI-Brasil) | **Laiss Bertola*
Botswana (RAISE-Botswana) | **Lillian Okui*
Bangladesh (HEALS) | **Faruque Parvez*

10:15 **NIH PF5 International Collaboration Mechanism (60 minutes)**
NIA introduction to the PF5 mechanism | *Minki Chatterji, Jonathan King, Delany Torres*
Discussion: examples from the applicant perspective | *Lindsay Kobayashi, David Richter, Carlos Mendes de Leon, *Martine El Bajjani, Jean Francois Trani, *Ganesh Babulal*
Open group discussion: opportunities and strategies for leveraging the PF5 mechanism across the HCAP Network
Discussant: Kenneth Langa

11:30 **BREAK**

11:50 **Flash Session: Lessons from HCAP Scholar Exchanges (10 minutes each)**
**Valentine Ucheagwu*
**Sara Moustafa*

12:10 **Group Discussion and Next Steps**
HCAP Network Announcements
Future priorities and directions from NIA's perspective | *Minki Chatterji, Jon King*

12:30 **ADJOURN**

Appendix B: Meeting Participants

Rev. September 10, 2026

*virtual attendee

USA ***HCAP Network and Health and Retirement Study (HRS) Team***

Kenneth Langa, MPI and Diagnosis and Validation Core Co-Leader, HCAP Network; MPI, Co-Director, HRS; Co-I, LSAHA; University of Michigan (UM)

Lindsay Kobayashi, MPI, HCAP Network; Co-I, HRS; Director, HRS-HCAP; Collaborator, LASI-DAD; Co-I, Gateway to Global Aging Data; Collaborator, HAALSI; Co-I, LOSHAK; UM

Jennifer Ailshire, Co-I, HRS; PI, Colombian Survey of Aging (COSA) Biomarker Pilot (2022-2023); PI, 2025 HCAP Network Pilot; Collaborator, LASI-DAD; Co-I, Gateway to Global Aging Data; University of Southern California (USC)

***Richard Jones**, Co-I and Statistical Harmonization Core Leader, HCAP Network; Co-I, HRS-HCAP; Co-I, HRS; Collaborator, Gateway to Global Aging Data; Brown University

Jennifer Manly, Co-I and Diagnosis and Validation Core Co-Leader, HCAP Network; Co-I, HRS-HCAP; Co-I, HRS; Columbia University

Lindsay Ryan, Co-I and Protocol Content and Administration Core Leader, HCAP Network; Co-I, HRS-HCAP; Collaborator, HRS; UM

***Amanda Sonnega**, Co-I and Outreach and Dissemination Core Leader, HCAP Network; Collaborator, HRS; UM

***Miguel Arce Rentería**, Collaborator, HCAP Network; Co-I, Mex-Cog and MHAS; Collaborator, LASI-DAD; Collaborator, Gateway to Global Aging Data; Columbia University

Emily Briceño, Collaborator, HCAP Network; MPI, 2025 HCAP Network Pilot; Co-I, BASIC-Cog; Co-I, CVFS-SCAN; Co-I, AGUA/ELEGUA; Co-I, Gateway to Global Aging Data; UM

***Tsai-Chin Cho**, Collaborator, HCAP Network, UM

***Muqi Guo**, Collaborator, HCAP Network; UM

Sarah Kwiatek, Project Manager, HCAP Network; Project Manager, HRS-HCAP; Research Support Staff, Midlife Health Inequities in the Rural South; UM

***Ryan McCammon**, Collaborator, HRS-HCAP; UM

USA ***Brain Attack Surveillance in Corpus Christi (BASIC-Cog)***

Emily Briceño, Co-I; Co-I, CVFS-SCAN; Co-I, AGUA/ELEGUA; Co-I, 2025 HCAP Network Pilot; Co-I, Gateway to Global Aging Data; Collaborator, HCAP Network; UM

BOTSWANA ***Research on Aging, AD/ADRD, and Its Social Determinants in Botswana (RAISE-Botswana)***

***Lillian Okui**, PI; Botswana University of Maryland School of Medicine Health Initiative (BUMMHI)
***Kaizer Ikgopoleng**, Team Member; BUMMHI
***Selebaleng Vinoliah Mokonopi**, Team Member; BUMMHI
***Mpho Zwinila**, Team Member; BUMMHI

BRAZIL ***Brazilian Longitudinal Study of Health, Ageing & Well Being (ELSI-Brazil)***

***Laiss Bertola**, Team Member; Universidade Federal de São Paulo
***Cleusa Pinheiro Ferri**, Team Member; Universidad Federal de São Paulo

CARIBBEAN ***Caribbean American Dementia and Aging Study (CADAS)***

William Dow, Co-PI; Co-PI, CRELES; Collaborator, Gateway to Global Aging Data; University of California, Berkeley
***Ivonne Z. Jimenez-Velazquez**, Co-PI; Universidad de Puerto Rico Escuela de Medicina
Jorge Llibre-Guerra, Co-I; PI of 2022 HCAP Pilot Award; Washington University School of Medicine
***Juan J. Llibre-Rodriguez**, Co-I; Study PI, 10/66, MHAS harmonization advisors (Cuba/USA); Medical University of Havana
***Chris Soria**, Team Member; University of California, Berkeley

CHILE ***Chilean Social Protection Survey (EPS) and Cognitive Aging Study (Chile-Cog)***

***Irma Elo**, Co-PI; Collaborator, Gateway to Global Aging Data; University of Pennsylvania
***Catalina Bravo**, Team Member; University of Pennsylvania
***Magdalena Delaporte**, Team Member; University of Pennsylvania
***Sneha Sarah Mani**, Team Member; Johns Hopkins Center on Aging & Health

COSTA RICA ***Costa Rican Longevity and Healthy Aging Study (CRELES)***

William Dow, Co-PI; Co-PI, CADAS; Collaborator, Gateway to Global Aging Data; University of California, Berkeley

CÔTE D'IVOIRE ***Côte d'Ivoire Health and Aging Study (CIHA)***

Philip Anglewicz, Co-PI; Johns Hopkins University
Alden Gross, Co-I; Co-I, LASI-DAD; MPI, Gateway to Global Aging Data; Johns Hopkins Bloomberg School of Public Health
***Rosine Addy Mosso**, Co-PI; École Nationale Supérieure de Statistique et d'Économie Appliquée (ENSEA)
***Gwladys Aby**, Team Member; ENSEA
***Jean Gueu**, Team Member; ENSEA
***Franck Alexandre Houffoue**, Team Member; ENSEA
Jean Ikanga, Team Member; Co-I, LOSHAK; Co-I, KLPS-5A; Emory University

EGYPT ***A Longitudinal Study of Egyptian Healthy Aging (AL-SEHA)***

***Sara A. Moustafa**, Postdoctoral Fellow; 2025 HCAP Scholar Exchange; The American University in Cairo

ENGLAND ***English Longitudinal Study of Ageing (ELSA)***

***Andrew Steptoe**, PI; Collaborator, Gateway to Global Aging Data; University College London

***Paola Zaninotto**, Co-I; Deputy Director, ELSA; University College London

***Yaqing Gao**, Team Member; University College London

EUROPE ***Survey of Health, Aging and Retirement in Europe (SHARE)***

David Richter, PI and Managing Director, SHARE-ERIC; Director, SHARE Infrastructure, SHARE Berlin Institute

***Agnieszka Burzynska**, Research Coordinator, SHARE Berlin Institute

***Salima Douhou**, Coordinator; Max Planck Institute (SHARE-HCAP Wave 1)

***Marcela Otero**, Senior Research Scientist; Munich Research Institute for the Economics of Aging; Max-Planck-Institute for Social Law and Social Policy (SHARE-HCAP Wave 1)

***Beatrice Baaba Tawiah**, Research Scientist; Munich Research Institute for the Economics of Aging and SHARE Analyses (SHARE-HCAP Wave 1)

GUATEMALA ***The Longitudinal Study of Aging in GUAtemala/Estudio Longitudinal de Envejecimiento en GUAtemala (ELEGUA)***

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