

MEMORY ACROSS THE OCEAN

Alzheimer's disease and all dementias in American Samoa

Population, caregiving, clinical capacity and policy outlook | 2000–2050



“American Samoa is not yet an old society. It is becoming an older society at the same moment it is becoming a smaller one.”

Prepared for Jerry Perone | August 2026

Research report • evidence review • demographic forecast • service-capacity analysis

A clear line between what is known and what is modeled

American Samoa does not yet have a completed, representative, territory-wide estimate of diagnosed Alzheimer's disease or all-cause dementia. That absence is itself a major finding. This report therefore keeps four evidence types visibly separate:

A**Observed**

Counts or percentages measured by the U.S. Census or a named survey. These describe the population or a study sample; they are not forecasts.

B**Published screening signal**

A positive cognitive screen in a research sample. It identifies possible impairment, not a clinical diagnosis and not territory-wide prevalence.

C**Planning benchmark**

An age-structure model built for this report. It estimates planning need if U.S. age-specific Alzheimer's rates apply and Alzheimer's represents 60%–70% of all dementia.

D**Projection**

A future scenario from the UN, Hawai'i DBEDT or U.S. Census. Projection is not destiny; migration, mortality, prevention, diagnosis and treatment can change the path.

THE SINGLE MOST IMPORTANT CAVEAT

The report answers "how many?" with a transparent benchmark because no defensible official count exists. It never treats a screening result, diagnosis count, claims record or demographic model as interchangeable.

Reading map

Section	Theme	Question answered
01	Executive finding	What decision-makers need to know now
02	The demographic turn	Age 65+, population contraction and life expectancy
03	How many people?	Measured evidence, screening signal and planning benchmark
04	Care inside the aiga	What family care looks like and where strain hides
05	Risk and prevention	Cardiometabolic burden and protective community assets
06	Services and diagnosis	Testing, primary care, specialists and long-term supports
07	2030 and 2050	What the trajectory means for households and institutions
08	A practical response	An American Samoa memory pathway and implementation roadmap
09	Methods and sources	Model assumptions, limitations and reference list

Language note. “Dementia” is an umbrella syndrome involving decline in memory, thinking, behavior or function. Alzheimer’s disease is the most common cause, but vascular, Lewy body, frontotemporal and mixed dementias also matter. Alzheimer’s is not a normal part of aging.^[13, 33]

Four safeguards against misreading

- A positive screen identifies a person who needs assessment; it does not establish a dementia diagnosis.
- A population projection is a planning scenario, not a count of residents who have already been observed.
- A missing provider or program record means access was not publicly verified; it is not proof that no visiting or informal service occurs.
- Global caregiver averages provide context, but this report does not present them as a local American Samoa time-use estimate.

01 / EXECUTIVE FINDING

Dementia is present, but the system cannot yet see it clearly

A younger territory is aging rapidly, while care remains mostly private, unpaid and family-based.

9.1%

Age 65+ in 2026

UN medium projection; 6.3% in the 2020 Census

~552

All dementias in 2026

Age-profile midpoint; plausible range 513–598

17.4%

Positive research screen

40 of 230 adults age 50+; possible dementia, not diagnosis

5.45%

Primary-care need met

HRSA shortage calculation; 17 additional PCPs needed

American Samoa's dementia challenge is not simply that more residents will grow old. It is that the number of older adults will rise while the total population falls, the clinical workforce remains thin, and most care is absorbed by households. In 2000, 1,901 residents were age 65 or older. By 2020, there were 3,147. The UN medium projection reaches roughly 7,065 by 2050—more than triple the 2000 count—while the total population falls to about 37,500.^[1, 2, 3, 5]

The territory is also living with a data paradox. A 2025 study found 40 of 230 participating adults age 50 and older screened positive for possible dementia, yet the sample was non-random and much younger than a conventional dementia cohort. The ongoing Puipui Malu Manatu study is designed to build the first culturally grounded population evidence, including clinical evaluations and biomarkers. Until those results are complete, any confident single prevalence number is more precision than the evidence supports.^[15, 16, 17]

For service planning, this report's age-only benchmark suggests about 359 people living with Alzheimer's disease in 2026—0.79% of the total population—and roughly 513 to 598 people living with all dementias, or 1.13% to 1.32% of the population. The midpoint is about 552 people, 1.22% of the territory. The benchmark rises to about 660 people with all dementias in 2030 and 1,266 in 2050.^[5, 13, 14]

THREE TRUTHS

1) The family is already the long-term-care system. 2) Primary care must become the front door to dementia care because resident specialists are effectively absent. 3) American Samoa does not need to wait for a perfect prevalence study to build a culturally safe, measurable care pathway.

The decision agenda

- 1

Name a territorial dementia lead
Give one office responsibility for the pathway, annual data report and cross-agency accountability.
- 2

Build a primary-care memory pathway
Use a Samoan/English history, informant interview, culturally validated screen, cognitive lab panel, imaging criteria and a shared referral protocol.
- 3

Make specialist care travel digitally
Establish scheduled tele-neurology and tele-geriatrics case conferences, backed by periodic visiting clinics and clear off-island escalation.
- 4

Treat caregivers as part of the care unit
Identify the lead caregiver, measure strain, teach hands-on skills, create respite options and connect families to nutrition, transport and benefits.
- 5

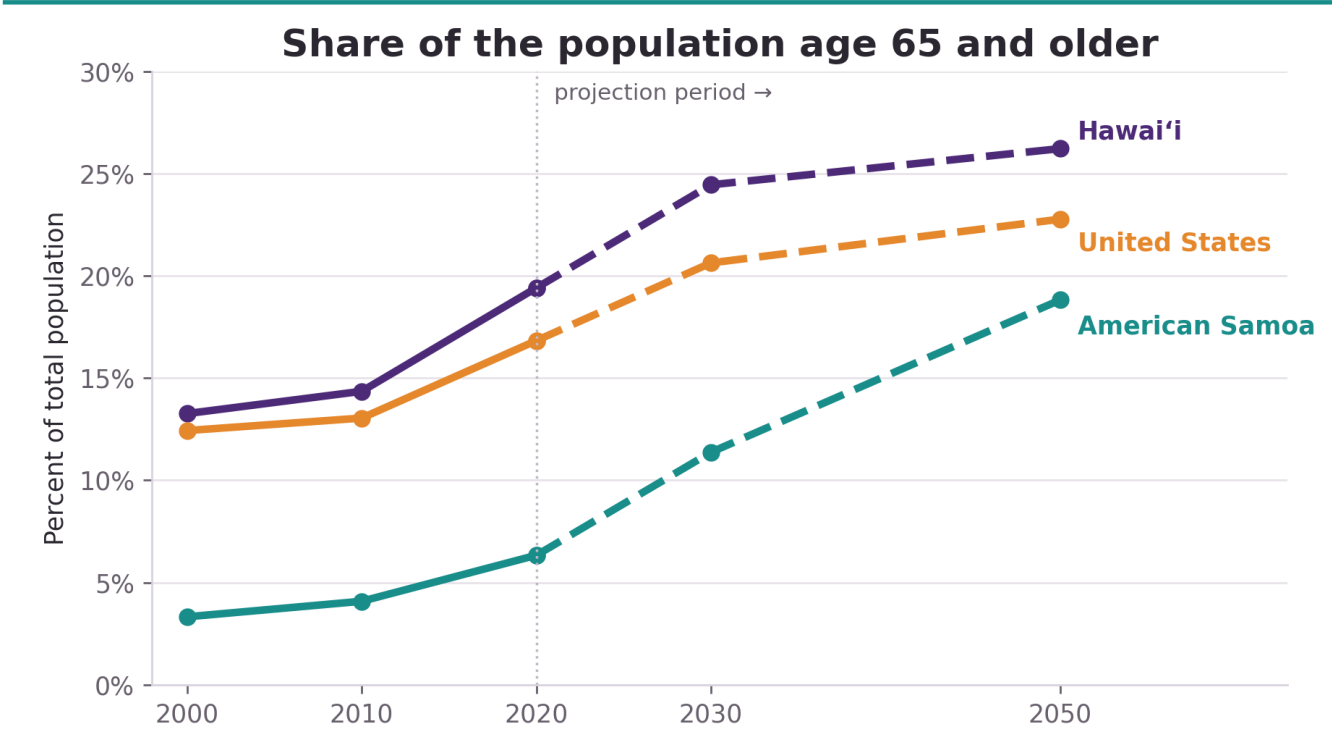
Turn research infrastructure into care infrastructure
Translate Puipui Malu Manatu instruments, trust and partnerships into a durable clinical registry, not a program that ends with a grant.

A proposed 2030 service promise

5 days Navigator contact From receipt of a memory concern	30 days Primary-care memory visit Unless urgency requires faster care
100% Named caregiver or contact With consent and preferred language recorded	1 / year Public dementia dashboard Waits, completion, safety and caregiver outcomes

American Samoa is aging fast from a young starting point

The senior share remains below Hawai'i and the nation—but the pace and context create a sharper local shock.



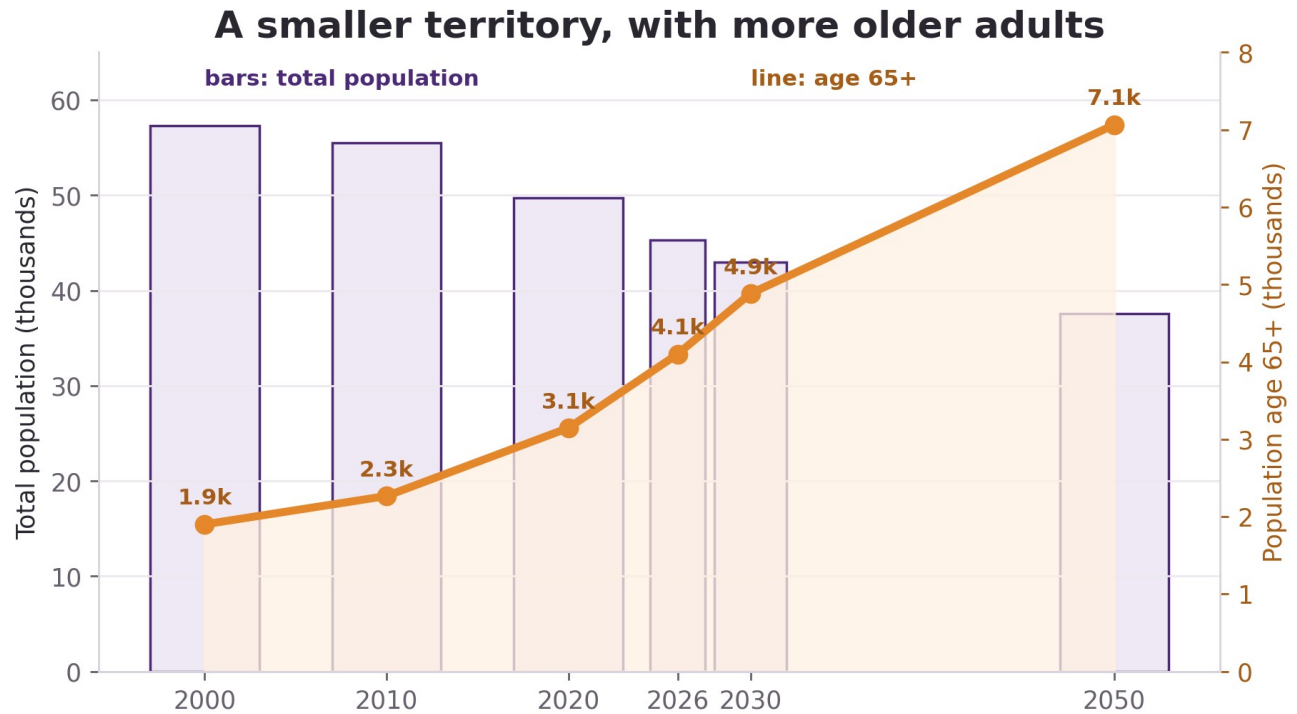
Observed: 2000–2020 decennial censuses. Projected: American Samoa, UN WPP 2024 medium variant; Hawai'i, DBEDT 2024; United States, Census 2023 main series. Projection methods differ and should be read as planning trajectories, not precise point predictions. Sources [1–8].

Year	American Samoa	Hawai'i	United States	Evidence
2000	3.3%	13.3%	12.4%	Census observed
2010	4.1%	14.3%	13.0%	Census observed
2020	6.3%	19.4%	16.8%	Census observed
2026	9.1%	22.6%*	18.9%*	AS projection; *latest QuickFacts periods
2030	11.4%	24.4%	20.6%	Projection
2050	18.8%	26.2%	22.8%	Projection

The 2020 apples-to-apples comparison is the cleanest: 6.3% of American Samoa was age 65 or older, compared with 19.4% in Hawai'i and 16.8% nationally. American Samoa's lower share does not mean low need. The territory's absolute 65+ population increased 65% from 2000 to 2020, and the next three decades shift the oldest age groups most sharply.^[1, 2, 3, 6]

Hawai'i remains the older society throughout the forecast. Yet American Samoa's senior share is projected to approach today's U.S. level by 2050 while operating with a far smaller workforce and service base. In 2050, roughly one in five American Samoa residents is projected to be 65 or older.^[5, 7, 8]

The compression problem



Census counts are used for 2000, 2010 and 2020; UN WPP 2024 medium-variant totals and age structures are used for 2026, 2030 and 2050. Bars and line use separate axes. Sources [1–5].

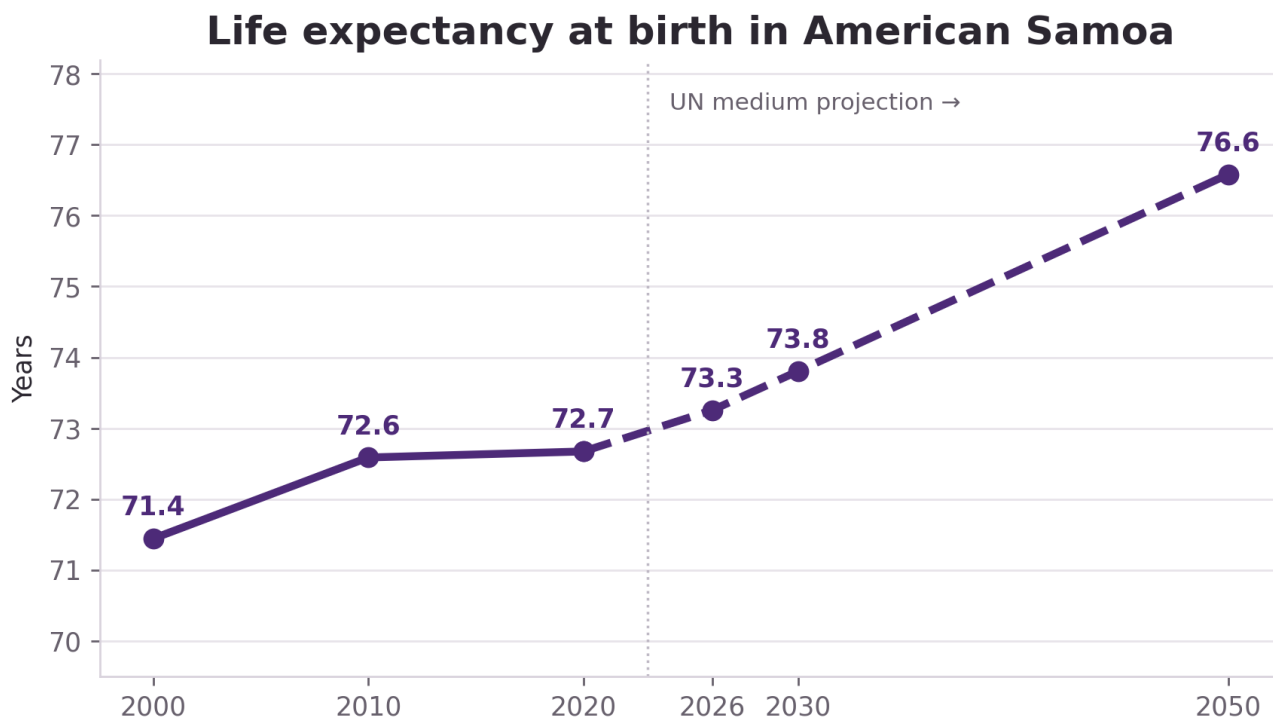
From the 2020 Census to the 2050 UN projection, the total population declines by about 24%, while the number age 65 and older increases about 124%. This is the fiscal and caregiving core of the problem: fewer residents overall, more elders, and a rapidly increasing 85+ group—from 145 people in 2020 to about 745 by 2050.^[3, 5]

HOUSEHOLD CONTEXT

American Samoa's average household was 6.05 people in 2000. In 2020, 26.6% of family households were multigenerational, only 9.7% of households were one-person households, and 96.7% of people age 5+ spoke a language other than English at home. These are strengths for connection—and design requirements for communication, consent and care coordination.^[1, 3]

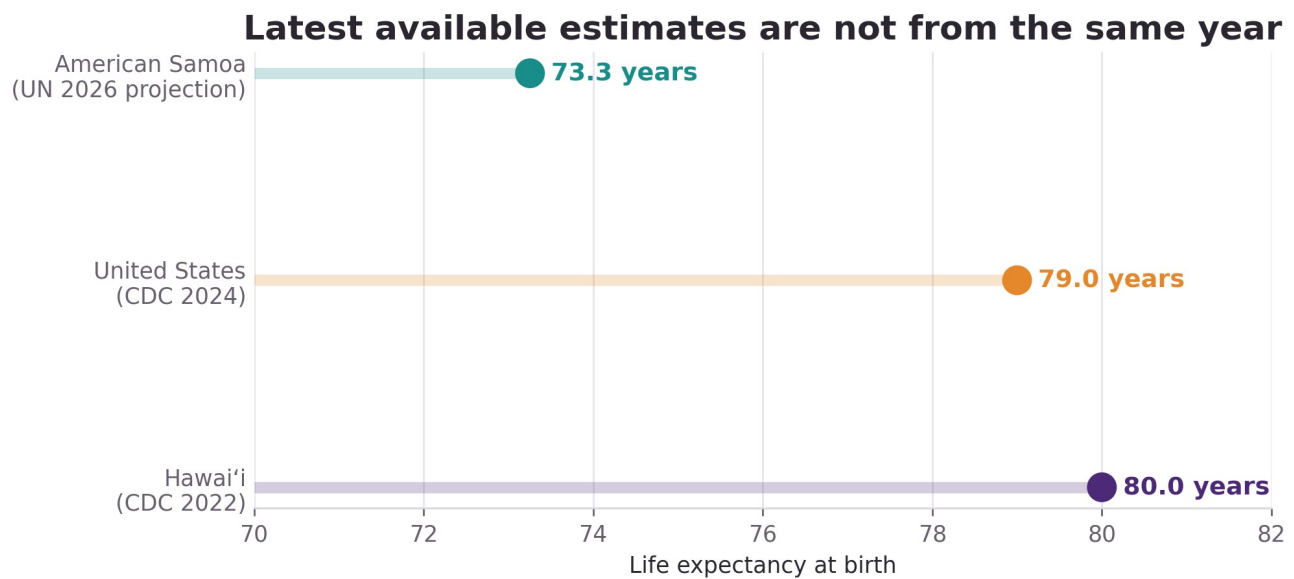
Life is getting longer—but American Samoa remains years behind

Life expectancy tells two stories: improvement over time and a persistent gap in the conditions that protect brain and vascular health.



American Samoa life expectancy at birth, both sexes. 2000–2023 are UN WPP estimates; 2024 onward is the medium projection. Source [5].

Life expectancy at birth rises from 71.4 years in 2000 to a projected 73.3 in 2026, 73.8 in 2030 and 76.6 in 2050. The gain is real but slow. A person who reaches age 65 in 2026 is projected to live another 15.5 years on average—long enough for chronic illness, disability and dementia to require sustained family and clinical support.^[5]



Latest available published values are labeled by year. American Samoa: UN WPP 2026 projection. Hawai'i: CDC 2022 state life table. United States: CDC 2024 national life table. Sources [5, 11, 12].

On the latest available figures, American Samoa trails Hawai'i by about 6.7 years and the United States by about 5.7 years. Because those estimates are not from the same year, a same-year check is useful: in 2022 the UN estimated American Samoa at 72.8 years, compared with CDC values of 80.0 in Hawai'i and 77.5 nationally. Either comparison shows a substantial longevity gap.^[5, 11, 12]

WHY LIFE EXPECTANCY MATTERS FOR DEMENTIA

Longer life increases exposure to dementia risk simply because age is the strongest risk factor. But lower life expectancy is not protective: it can reflect the same hypertension, diabetes, obesity and access barriers that raise vascular and mixed-dementia risk earlier in life.^[14, 21, 22]

A measured gap, a strong signal and a defensible planning range

The right answer is not one number. It is a ladder of evidence that improves as local research matures.

What is actually measured

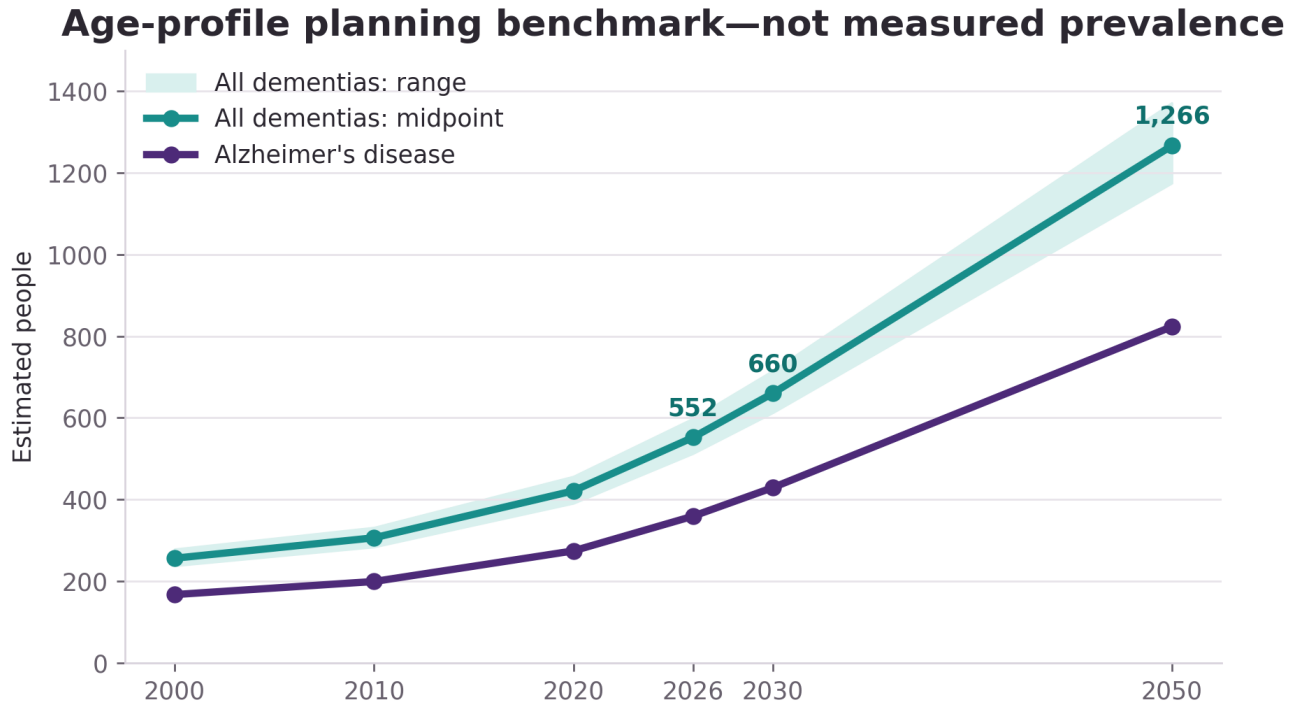
No completed, representative population survey has yet published territory-wide clinical prevalence for Alzheimer's disease or all-cause dementia in American Samoa. Administrative diagnoses would also miss people who never present, are not recognized, or are coded under another condition. Public health planning should therefore report "unknown" for official measured prevalence rather than promote a modeled value as fact.^[15, 16]

PUBLISHED SCREENING SIGNAL

In the 2021 INSPIRE study, 40 of 230 participants age 50–91 (17.4%) scored at or below the KICA threshold for possible dementia. The sample was recruited through respondent-driven methods, 86% were younger than 66, and the screen is not a diagnosis. The finding is important as a warning signal—not a population prevalence estimate.^[15]

The ongoing Puipui Malu Manatu study is the most important bridge from signal to measurement. Its registered design targets approximately 1,098 adults of Samoan ancestry age 50 and older, uses culturally adapted questionnaires and cognitive measures, and adds clinical evaluations, genetic and plasma biomarkers. By early 2025, community reporting indicated more than 400 participants had enrolled. Final representative estimates should supersede the benchmark in this report when published.^[16, 17, 18, 37]

The 2026 planning benchmark

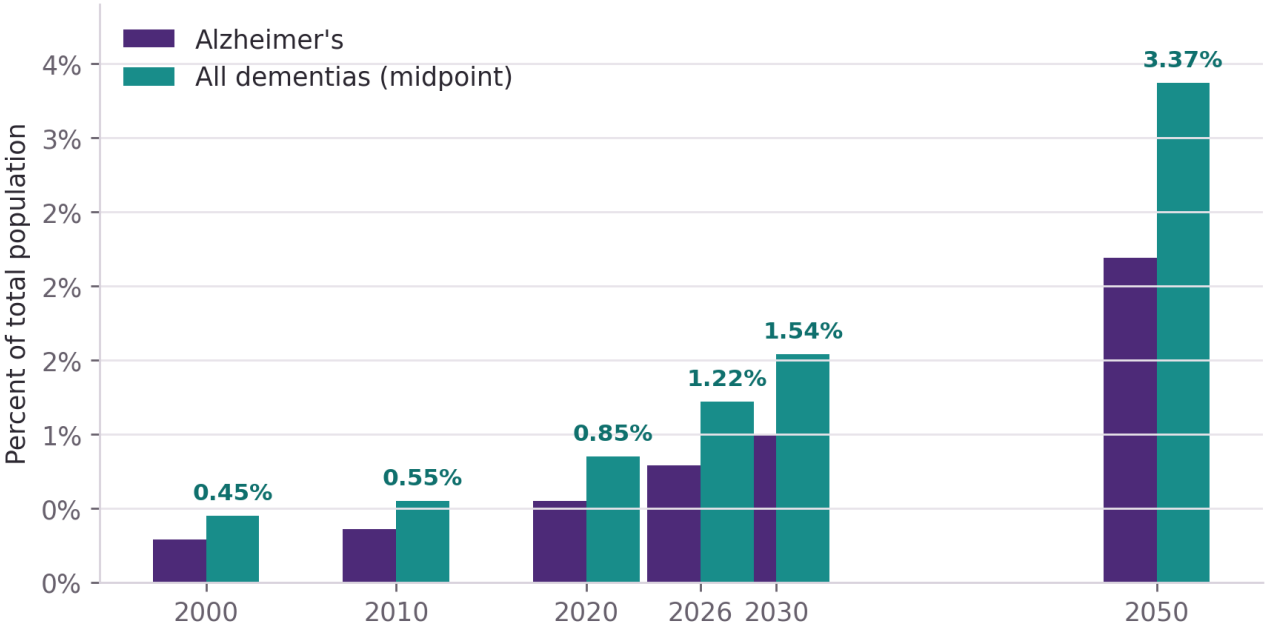


Model uses 2026 U.S. clinical Alzheimer's prevalence by age—5.2% at 65–74, 13.8% at 75–84 and 35.8% at 85+—applied to American Samoa's age bands. All-dementia range assumes Alzheimer's accounts for 60%–70% of dementia; midpoint uses 65%. Sources [5, 13, 14].

Year	Alzheimer's	% total pop.	All dementias: range	Midpoint	% total pop. midpoint
2000	167	0.29%	238–278	256	0.45%
2010	199	0.36%	284–331	306	0.55%
2020	274	0.55%	391–456	421	0.85%
2026	359	0.79%	513–598	552	1.22%
2030	429	1.00%	613–715	660	1.54%
2050	823	2.19%	1,175–1,371	1,266	3.37%

The benchmark is deliberately conservative in one way and uncertain in another. It excludes younger-onset dementia and holds age-specific rates constant. It also cannot adjust for American Samoa's unusually high cardiometabolic risk, different survival, education, language, diagnostic access or protective social factors. The range around all dementia only reflects uncertainty in Alzheimer's share—not all model uncertainty.^[13, 14, 21]

Planning prevalence as a share of the total population



Modeled planning prevalence as a percentage of the entire population. All-dementia bars use the midpoint. These are not observed or diagnosed rates. Sources and method as above.

Why the two headline percentages are not contradictory

Number	Denominator	Meaning	Use
17.4%	230 research participants age 50+	Positive screen for possible dementia	Signal; informs better research and clinical follow-up
1.22%	Entire projected 2026 population	All-dementia age-profile midpoint	Capacity planning only
~13.5%	Projected population age 65+	Same all-dementia midpoint among older adults	Shows concentration of need in older ages

The screening study uses a selected 50+ sample and a threshold; the model uses the entire territory and age-specific clinical prevalence. Different denominator, different method, different question.

The family is the care system—and its strength can hide its burden

Care is relational, home-centered and culturally meaningful. It is also time-intensive, financially exposed and only lightly supported by formal services.

There is no probability-based time-use survey that defines an “average American Samoan dementia caregiver.” The most defensible representation is a synthesis of local caregiver research, household structure, clinician interviews and program experience. It describes a common pattern, not every family.

74%

Home-only care belief

Caregivers agreed elders with Alzheimer’s should be cared for solely at home

26.6%

Multigenerational families

Share of family households in the 2020 Census

76%

Female informants

INSPIRE study informants; median age 32

125

Caregivers trained

Tausi Feagaiga participants, 2016–2020

The 2021 caregiver study found a powerful blend of duty and misunderstanding: half of surveyed caregivers viewed Alzheimer’s as normal aging, 83% viewed it as mental illness, and 74% believed affected elders should be cared for only at home. Qualitative themes included respect for elders, shame surrounding difficult behaviors, disagreement over terminology and the need for culturally safe language.^[19]

The Tausi Feagaiga initiative turned those values into skills. The partnership trained 125 family and formal caregivers through classroom teaching and supervised practice at Hope House; self-rated confidence and geriatric competence improved significantly. Its framing—care as covenant, respect and service—offers a stronger foundation than importing a mainland caregiver curriculum unchanged.^[20]

A composite day of care

Time	What the family often does	Where strain accumulates
Morning	Wake, cue, bathe, toilet, dress, prepare food, give medicines; assess pain, balance and mood.	A caregiver's workday begins before paid work; intimate care can be physically demanding.
Day	Coordinate handoffs across relatives; prevent wandering; shop, manage money and paperwork; arrange TAOA meals, clinic visits and transport.	Sparse formal respite means missed work, fragmented care and transportation costs.
Evening	Meals, church or village connection, medications, bathing; respond to repetition, agitation or "sundowning."	Behavior is sometimes interpreted as stubbornness, mental illness or normal aging, delaying help.
Night	Monitor toileting, falls, exits and sleep; reassure the elder and protect others in the household.	Interrupted sleep creates a second patient: the exhausted caregiver.

Families may divide tasks among daughters, daughters-in-law, grandchildren and other relatives; the lead coordinator may be a younger woman living with the elder, but migration and paid employment can thin the roster. In the INSPIRE study, informants were mostly women, had a median age of 32, and usually lived with the participant in households with a median of six people.^[15]

WHAT "FAMILY CARE" SHOULD NEVER MEAN

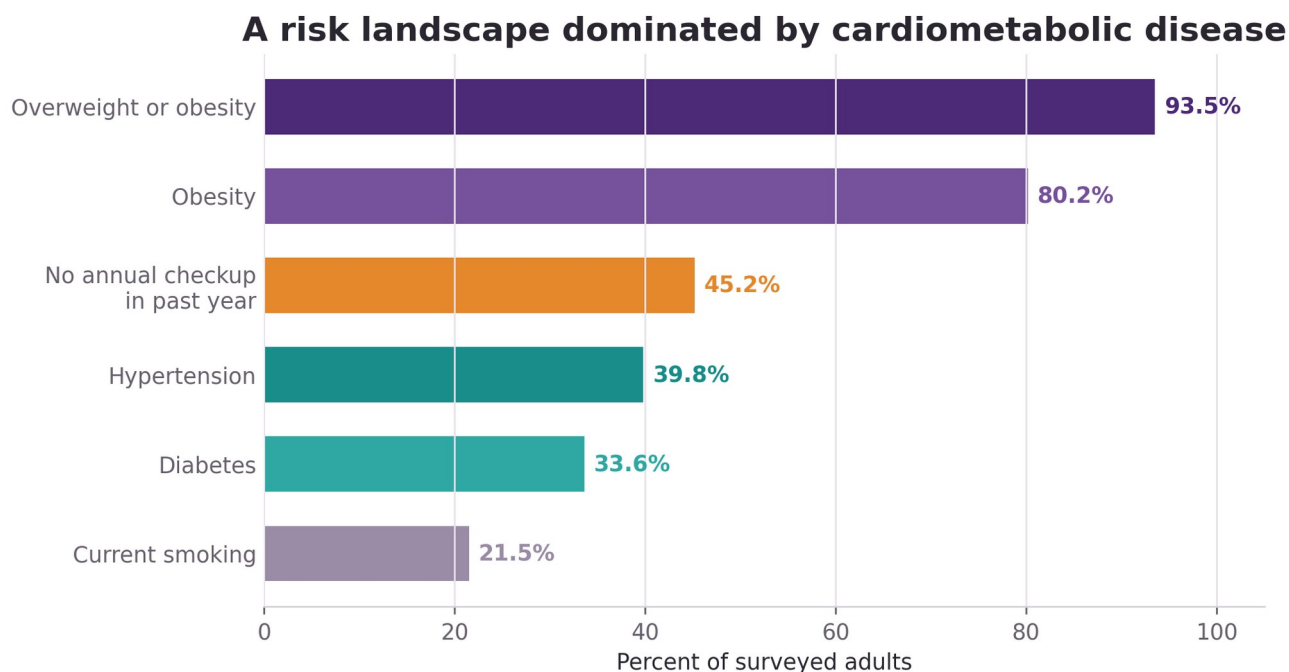
Respecting fa'a Samoa does not justify leaving families alone. A culturally congruent system adds coaching, respite, transport, nutrition, safety equipment, benefits support and clinical backup around the aiga; it does not replace the aiga.

Protective assets already present

- Dense family, village and faith networks that can spread knowledge and monitor isolated elders.^[3, 21]
- Strong norms of respect, service and reciprocity that support caregiving identity.^[19, 20]
- High smartphone access—86.6% of occupied households in 2020—which can support tele-consults and caregiver education when broadband and digital literacy permit.^[3]
- A research partnership with culturally adapted instruments and community trust that can become a clinical bridge.^[16, 17]

The territory's dementia strategy must also be an NCD strategy

The most actionable dementia risks in American Samoa are the same conditions already burdening primary care.



American Samoa Adult Hybrid Survey, 2018, n=1,005 adults. Percentages are survey estimates and should not be treated as 2026 prevalence. Source [21].

In the 2018 Adult Hybrid Survey, 93.5% of adults were overweight or obese, 80.2% had obesity, 33.6% had diabetes and 39.8% had hypertension. Nearly half reported no annual checkup in the past year. Among adults 65 and older, hypertension reached 58.4%. Almost half of adults with diabetes and more than half with hypertension were undiagnosed in the survey.^[21]

These are not proof of dementia. They are a prevention mandate. Hypertension, diabetes, obesity, tobacco exposure and physical inactivity are associated with higher risk of cognitive decline or dementia, especially vascular and mixed disease. The territory can reduce future burden even before a dementia registry is complete by detecting and controlling these conditions earlier.^[22]

Risk or protection target	Practical dementia-linked action	Where it fits
Blood pressure	Opportunistic screening, home cuffs, medication access, follow-up registry and control target.	ASDOH clinics, LBJ, village outreach
Diabetes	Find undiagnosed disease; simplify medication and nutrition plans; monitor hypoglycemia in cognitively impaired adults.	NCD program + primary care
Movement and weight	Culturally acceptable group movement, walking and strength programs; avoid stigmatizing messages.	TAOA, churches, villages
Hearing and vision	Add low-cost sensory checks to memory evaluation; correct reversible communication barriers.	Primary care + visiting specialty
Smoking	Brief treatment and quit support, with special attention before midlife risk accumulates.	Primary care + public health
Social connection	Protect village, faith and intergenerational participation; adapt activities as function changes.	Aiga + community partners

THE PREVENTION MESSAGE

“Brain health” should not become another disease silo. Pair memory awareness with blood-pressure checks, diabetes control, movement, hearing and vision—services residents already recognize and need.

A front door exists; the specialist corridor is narrow

Primary care, family and research carry most of the load. Imaging is improving, but a complete diagnostic and treatment pathway is not yet publicly documented.

What is available now

Capability	Current availability	Assessment
Primary care	LBJ Tropical Medical Center plus public/community health clinics; HRSA lists two primary-care shortage designations.	Available, severely capacity-constrained
Dementia screening	Can be performed in primary care; culturally adapted tools are used in Puipui Malu Manatu research. No public territory-wide screening protocol found.	Possible, not standardized
Laboratory workup	LBJ laboratory and referral pathways can support reversible-cause evaluation; detailed current test menu is not public.	Basic workup likely; verify locally
CT imaging	Two functioning CT scanners at LBJ as of May 2026.	Locally available
MRI	A first MRI device was introduced by 2026 after a 2024 grant. Public sources do not yet establish routine scheduling, sequences or dementia capacity.	New capability; operational details unclear
Neurology	Study registry reported no neurologists at launch; current NPPES-linked directory scan found no American Samoa business-address listing.	No verified resident service
Geriatric medicine	No individual geriatric-medicine listing found; one organization NPI record exists, without evidence of appointment capacity.	Extremely limited / unverified
Neuropsychology	Research cognitive testing is available through PMM; no dedicated clinical neuropsychology service found publicly.	Research-access, not routine
Amyloid / tau biomarkers	Genetic and plasma biomarkers are part of research. No routine PET, CSF or FDA-cleared blood-test pathway found publicly.	Research or off-island
Caregiver training	Tausi Feagaiga demonstrated a culturally grounded model; Alzheimer's Association Hawai'i serves American Samoa remotely.	Promising, not yet universal
Long-term support	Hope House is the territory's only facility of its type and became a Medicaid personal-care / LTSS provider. TAOA offers senior supports and meals.	Very limited formal capacity

Public-source absence is not proof that a service never occurs. Visiting clinicians, informal tele-consults and ad hoc referrals may exist. The operational finding is that families and referring clinicians cannot see a reliable public directory, wait-time standard or dementia-specific pathway.^[16, 20, 23, 24, 27, 28, 29, 30, 31, 38, 39]

Primary care: the essential bottleneck

HRSA's June 30, 2026 shortage report lists two primary-care HPSA designations covering an administrative population of 55,009, only 5.45% of need met, and 17 additional primary-care physicians required to remove the

designations. The denominator differs from the UN's current population projection, but the shortage signal is unmistakable.^[24]

GAO's 2021 review found one hospital and four federally qualified health centers at the time, difficulty recruiting both primary and specialty clinicians, and markedly lower Medicare outpatient evaluation-and-management use than Hawai'i or the nation. Access cannot be inferred from the existence of a clinic alone; appointment supply, continuity, transport, language and affordability determine whether memory concerns become diagnoses.^[23]

BOTTOM LINE ON PHYSICIANS

Primary care physicians: present but severely undersupplied. Neurologists: no verified resident provider in the public records reviewed. Geriatricians: no verified individual provider; one organization record does not demonstrate access. Gerontologists: no complete professional registry exists, so availability cannot be quantified defensibly.^[24, 30, 31]

Testing: what a complete pathway requires

1

Concern and context

Private conversation with the person and an informant; timeline, daily function, medicines, mood, sleep, alcohol, safety, hearing and vision.

2

Culturally and linguistically safe assessment

A brief validated cognitive and functional screen in Samoan or English, interpreted in light of education and culture. A screen is not a diagnosis.

3

Medical evaluation

Physical and neurologic exam plus a cognitive laboratory panel to look for reversible or contributing conditions.

4

Structural imaging

CT or MRI when indicated to identify stroke, tumor, hydrocephalus or other structural disease and support subtype assessment.

5

Specialist escalation

Tele-neurology, geriatrics, psychiatry or neuropsychology for unusual onset, rapid progression, complex behavior, uncertain subtype or treatment eligibility.

6

Biomarkers only when useful

Amyloid PET, CSF or an FDA-cleared blood test can support Alzheimer biology in appropriate symptomatic patients; none is a stand-alone population screen.

7

Disclosure and plan

Explain findings in the preferred language, document the lead caregiver, address driving/wandering/falls/medicines, connect services and schedule follow-up.

Modern anti-amyloid treatments add urgency but also infrastructure requirements. They are intended for mild cognitive impairment or mild dementia due to Alzheimer’s, require evidence of amyloid pathology, infusion capacity and repeated MRI safety monitoring. A new MRI is progress; it does not by itself create treatment readiness.^[32, 33, 34, 40]

Imaging has improved—but access history matters

In 2023, 77 American Samoa patients were approved for off-island MRI examinations. LBJ supported travel for 34, other programs supported 22, and 21 did not travel because they could not afford the associated costs. A 2024 philanthropic grant funded the territory’s first MRI, and 2026 sources report the device’s introduction. LBJ also reported two functioning CT scanners in May 2026. These are material gains; staffing, maintenance, interpretation, scheduling and dementia protocols will determine their impact.^[27, 28, 39]

06B / THE LIVED PATHWAY

What happens when a family notices memory change

Today’s pathway often starts at home, pauses in uncertainty and reaches care late. A redesigned pathway can preserve dignity without demanding a specialist on every island.

Step	Common pattern	What it means
1	Family notices change	Repeated questions, lost steps in familiar tasks, money or medicine errors, behavior change, getting lost.
2	The aiga absorbs it	Relatives compensate, supervise and protect the elder. Symptoms may be normalized as aging or framed as mental illness.
3	Clinic contact	Care is sought when function, behavior, falls, wandering or another medical problem creates urgency.
4	Partial workup	Primary care can take history, screen, order labs and use CT/MRI, but continuity and specialist interpretation may be limited.
5	Escalation gap	A complex case may need visiting, telehealth or off-island expertise; cost and logistics can end the pathway.
6	Family resumes care	Diagnosis or no diagnosis, the household provides most supervision and hands-on support.

This is a synthesis, not a measured average pathway. Its value is operational: every point where the pathway pauses can be redesigned with a named next step, a responsible person and a time standard.^[19, 20, 23]

The service ecosystem

Layer	Existing asset	Missing dementia function to add
Aiga / village / church	Daily care, trust, cultural interpretation, early observation	Training, respite, safety planning, caregiver strain screening

Layer	Existing asset	Missing dementia function to add
TAOA / community programs	Senior meals, activities, social connection and outreach	Dementia-capable staff, homebound outreach, caregiver groups
ASDOH clinics / ASCHC	Accessible primary-care and prevention front door	Shared memory screen, registry, lab bundle and referral algorithm
LBJ	Hospital, laboratory, two CT scanners, newly introduced MRI	Memory clinic session, diagnostic disclosure, treatment and imaging protocol
ASCCC / PMM	Trusted research, culturally adapted instruments, data and biomarkers	Transition plan from study findings to routine clinical care
Hawai'i / academic partners	Alzheimer's Association chapter, dementia specialists and memory-system experience	Scheduled tele-clinic, case conference, rotations and referral agreements

The Alzheimer's Association Hawai'i Chapter explicitly includes American Samoa in its service area and offers a 24/7 helpline. That is useful remote support, but it is not a substitute for a local navigator who knows LBJ, clinics, TAOA, Hope House, Medicaid and village resources.^[29]

07 / 2030 AND 2050

Two horizons, one narrowing window

2030 is the build deadline. 2050 is the capacity consequence.

Indicator	2020 observed	2026 planning	2030 projection	2050 projection
Total population	49,710	45,322	42,960	37,548
Age 65+	3,147	4,102	4,883	7,065
Share age 65+	6.3%	9.1%	11.4%	18.8%
Age 85+	145	188	217	745
Alzheimer's planning estimate	274	359	429	823
All-dementia midpoint	421	552	660	1,266
All dementia, % total	0.85%	1.22%	1.54%	3.37%
Life expectancy at birth	72.7	73.3	73.8	76.6

By 2030, the modeled number of people with all dementias is about 20% higher than in 2026. That is close enough to affect today's workforce, budgets, clinic workflows and caregiver training. A clinician trained in 2027, an MRI protocol established in 2028 and a respite pilot funded in 2029 can all be operating before the need peaks.^[5, 7, 8]

By 2050, the midpoint reaches about 1,266 people—more than double 2026—and the 85+ population nearly quadruples from 2026. Advanced dementia, frailty, falls, incontinence, swallowing problems, pressure injuries and end-of-life needs will increase disproportionately because the oldest group grows fastest.^[5, 13, 14]

CAPACITY CONSEQUENCE

If each person with dementia has only one lead family caregiver, the 2050 midpoint implies roughly 1,266 lead caregivers in active roles at one time—before counting relatives who share tasks. This is an illustrative translation, not a caregiver prevalence estimate.

Forecast risks that can move the line

Could raise need	Could lower or delay need	Could improve visibility without changing disease
Poor hypertension/diabetes control; obesity; smoking; limited hearing/vision care; survival after stroke	Better vascular prevention; physical activity; education and cognitive engagement; sensory care; reduced tobacco exposure	Routine screening of symptomatic adults; culturally safe language; tele-specialists; accessible biomarkers; better coding and registry
Outmigration of working-age caregivers; clinician shortages; delayed diagnosis	Earlier diagnosis and care planning; caregiver training; respite; medication safety	Research findings translated into practice and a public annual dementia dashboard

A rising diagnosis count after pathway reform may be good news: it can mean hidden cases are finally recognized earlier. Success should be judged by time to evaluation, care plans, safety, caregiver strain and avoidable crises—not by trying to make diagnosis counts fall.

08 / A PRACTICAL RESPONSE

Build an American Samoa Memory Pathway

A small, connected system can outperform a fragmented large one—if every resident has a clear route from concern to care.

The attached Hawai'i HANAI Memory Network infographic offers a nearby design reference: dementia care specialists, memory clinics, early detection, referral and long-term care connected as a network. American Samoa should adapt the architecture to its own scale, language, workforce and geography rather than copy a Hawai'i budget or staffing pattern.^[36]

DESIGN PRINCIPLE

One front door, one shared assessment pathway, one named navigator and many community entry points.

The minimum viable pathway

1

Memory concern enters anywhere

A family, church, TAOA site, clinic, hospital or helpline can start the same referral using a one-page form.

2

Navigator calls within five business days

Clarify urgency, language, transport, informant and safety; book a primary-care memory visit.

3

Primary-care memory visit within 30 days

Cognitive-functional assessment, medicine review, exam, lab panel and imaging decision.

4

Weekly virtual case huddle

Local clinician, navigator and remote neurologist/geriatrician review complex or abnormal cases.

5

Disclosure in the preferred language

Explain what is known, what remains uncertain, and what the family should do next.

6

Care plan reaches the home

Named caregiver, safety plan, medical follow-up, benefits, TAOA/Hope House/community supports and crisis contacts.

7

Registry and 6-month follow-up

Track diagnosis, function, caregiver strain, service use and unresolved referrals.

Workforce design for a small territory

Role	Start with	Function
Territorial dementia lead	0.5–1.0 FTE program authority	Policy, data, funding, agreements and accountability
Memory navigator	1 nurse, social worker or experienced CHW	Intake, family education, referrals, follow-up and registry
Clinic dementia champions	One trained clinician per clinic/site	Standardized evaluation and local coaching
Remote specialist panel	Neurology + geriatrics + psychiatry/neuropsychology	Case review, consultation, education and treatment readiness
Caregiver trainers	Tausi Feagaiga graduates and community partners	Hands-on skills, behavior, safety and respite planning
Data steward	Shared analyst support	Annual prevalence, pathway and equity dashboard

This design does not pretend American Samoa can recruit a full specialty department immediately. It reserves scarce specialist time for cases that need it, while giving primary care and families reliable support. Visiting clinics can add examination and relationship-building; telehealth supplies continuity between visits.

08B / ROADMAP

Move from research signal to reliable care by 2030

The steps are sequenced so that each year leaves behind durable capacity.

Horizon	Priority actions	Proof of progress
0–6 months	Appoint lead; convene LBJ, ASDOH/ASCHC, ASCCC, TAOA, Hope House, Medicaid, village/faith and Hawai'i partners; publish service map; select common tools.	Named authority; signed charter; public directory; baseline dashboard
6–18 months	Train clinic champions; launch navigator; run weekly case huddle; standardize labs/imaging; begin caregiver course and strain screening.	Median intake time; completed evaluations; caregiver plans; referral completion
18–36 months	Establish recurring memory-clinic sessions; formalize specialist and off-island agreements; launch respite/transport pilot; integrate PMM findings.	Diagnosis by subtype; wait times; avoided crises; respite use; equity by village/language
By 2030	Fund routine pathway; maintain workforce pipeline; expand dementia-capable TAOA and home/community support; publish annual report.	Territory-wide coverage, stable financing and transparent outcomes
2030–2050	Scale respite, palliative care and LTSS; maintain imaging/treatment readiness; refresh projections and prevention priorities every 3–5 years.	Capacity rises with 75+/85+ need; caregiver burden and preventable hospitalization fall

Ten measures that make the pathway real

- 1. Days from concern to navigator contact
- 2. Days from referral to primary-care memory visit
- 3. Percent with an informant and preferred language documented
- 4. Percent with cognitive-functional assessment and medicine review
- 5. Percent with indicated laboratory and imaging workup completed
- 6. Days to specialist review for complex cases
- 7. Percent with diagnosis or documented diagnostic uncertainty disclosed
- 8. Percent with a named caregiver, safety plan and follow-up date
- 9. Caregiver strain and respite/skills support received
- 10. Avoidable emergency visits, hospitalizations and off-island failures

ACCOUNTABILITY RULE

Publish the dashboard even when the numbers are uncomfortable. Missing data, long waits and incomplete referrals should be visible problems, not invisible family burdens.

Immediate policy choices

Choice	Why now	Guardrail
Fund a navigator before a building	Coordination is the first gap families experience and can begin with existing sites.	Do not make the role grant-dependent without a transition plan.

Choice	Why now	Guardrail
Contract scheduled specialist time	A standing clinic is more reliable than ad hoc calls and cheaper than waiting for resident recruitment.	Include response times, teaching, documentation and local handoff.
Standardize a culturally safe evaluation	Inconsistent language and tools can create false positives, missed cases and distrust.	Validate locally; never use a test score alone.
Fund caregiver relief	Home-centered care is a policy asset only if households can sustain it.	Measure who receives respite by village, income and severity.
Protect the PMM legacy	Research has built trust, instruments and data infrastructure that routine care lacks.	Consent and governance must clearly separate research from clinical care.

08C / CONCLUSION

The opportunity is to make memory care visible before crisis makes it unavoidable

American Samoa’s dementia future is not predetermined by the forecast. The territory cannot change the fact that its population is aging, but it can change whether memory loss is recognized early, whether families receive skills and relief, whether primary care has a next step, and whether a resident must cross an ocean to obtain every specialist opinion.

The evidence supports urgency without alarmism. The senior share is rising rapidly. Cardiometabolic risk is high. A local screening study signals unmet need. The clinical workforce is constrained. Yet American Samoa also has assets many larger systems struggle to build: multigenerational connection, cultural traditions of service, community-based research trust, a caregiver-training model, improving imaging and partners in Hawai’i and the continental United States.

The practical task is to connect those assets. By 2030, every family should know where to start, every clinic should use the same pathway, every complex case should have access to scheduled specialist review, and every diagnosis should produce a care plan that reaches the home. That is what turns a forecast into readiness—and family devotion into supported care.

THE REPORT IN ONE SENTENCE

American Samoa should build a primary-care-led, family-supported and specialist-connected memory pathway now, while ongoing research turns uncertainty into local evidence.

Useful entry points

Resource	Role	Public contact
Alzheimer's Association Hawai'i	Education, support and 24/7 helpline; service area includes American Samoa	800-272-3900
Puipui Malu Manatu / ASCCC	American Samoa brain-health research and culturally adapted assessment	asccancercoalition.org/puipui-malu-manatu
Territorial Administration on Aging	Senior programs and community supports	699-2531 (publicly listed)
LBJ Tropical Medical Center / local clinics	Clinical evaluation, laboratory and imaging front door	Use current local directory / emergency services as appropriate

Before a memory appointment

- Bring a relative or friend who knows the person well and can describe changes over time.
- Bring every medicine, supplement or an up-to-date list—including sleep and allergy products.
- Write down two or three specific examples: a missed bill, getting lost, medicine errors, changed behavior or lost ability in a familiar task.
- Bring glasses and hearing aids; ask for the conversation and written plan in the person's preferred language.
- Ask what has been ruled out, what remains uncertain, who will call next and when follow-up should occur.

DO NOT WAIT FOR A ROUTINE MEMORY VISIT

Sudden confusion, new weakness, severe headache, loss of consciousness or abrupt behavior change can be a medical emergency. Seek urgent clinical help rather than assuming the change is dementia.

This report is informational and is not medical advice.

How the estimates and comparisons were built

Population and age 65+

American Samoa observed population and age bands come from the 2000, 2010 and 2020 decennial censuses. The American Community Survey is not conducted in the Island Areas, so there is no annual ACS series. The 2026, 2030 and 2050 American Samoa values come from the UN World Population Prospects 2024 medium variant, using July population and five-year age groups. Hawai'i observed values come from the decennial Census and projections from the State of Hawai'i DBEDT 2024 series. U.S. projections come from the Census Bureau's 2023 main series.^[1, 2, 3, 5, 6, 7, 8]

Life expectancy

American Samoa's life expectancy series comes from UN WPP 2024; 2000–2023 are estimates and 2024 onward is the medium projection. Hawai'i uses the latest published CDC state life table (2022) and the U.S. uses the CDC 2024 national estimate. Year labels are shown because latest-available values are asynchronous.^[5, 11, 12]

Alzheimer's and all-dementia benchmark

For each year, the report groups American Samoa residents into ages 65–74, 75–84 and 85+. It applies 2026 U.S. clinical Alzheimer's prevalence of 5.2%, 13.8% and 35.8% respectively. Alzheimer's estimates are the sum of age-band population × rate. To approximate all dementia, the Alzheimer's estimate is divided by 0.70 and 0.60 to form a range; the midpoint divides by 0.65. This follows WHO's statement that Alzheimer's may contribute to 60%–70% of dementia cases.^[13, 14]

The benchmark is not calibrated to American Samoa morbidity, education, survival, migration, diagnosis, genetics or protection. Holding rates constant isolates the demographic effect. Counts are rounded to whole people. Percentages use the total territory population, not only people age 65+. Younger-onset cases are excluded.

Service-capacity review

The review triangulated federal shortage and utilization reports, Medicaid sources, clinical trial records, provider-directory records, hospital and funder announcements, peer-reviewed caregiver research, and public program pages current through August 12, 2026. A missing public record is reported as “not verified” or “not publicly documented,” never as definitive proof that informal, visiting or unlisted care does not occur.^[16, 20, 23, 24, 25, 27, 28, 30, 31]

Key limitations

- No completed representative clinical dementia prevalence study for the territory was available at the report date.
- The local 17.4% finding is a screening result from a non-random sample, not a diagnosed prevalence estimate.
- Projection series use different base populations and methods; cross-place future comparisons are directional.
- UN life expectancy for American Samoa is model-based, reflecting limited local vital-statistics depth.
- Provider registries can lag, omit visiting clinicians or list organizations that do not offer current appointments.
- The service scan cannot measure wait times, affordability, quality, actual referral completion or family satisfaction without local operational data.

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MEMORY CARE SHOULD NOT REQUIRE A FAMILY TO NAVIGATE ALONE.

A primary-care-led, family-supported and specialist-connected pathway can begin now.

American Samoa | 2000-2050