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WHO Collaborating Centre for the FIC in The Netherlands

WHO Family of International Classifications (FIC)

NEWSLETTER

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A new concept of health
And its relation with ICF

In 2009 an invitational conference of international health experts was held in the Netherlands to discuss an adaptation of the 1948 WHO definition of health. The conference resulted in an article in the British Medical Journal (Huber et al., 2011) in which a new, dynamic concept of health was introduced: '*Health as the ability to adapt and to self-manage, in the face of social, physical and emotional challenges.*'

Operationalizing the new concept of health
To date, a report by Huber and others is at the verge of publication in which results are presented of a follow-up study to operationalize this general concept 'bottom-up', so based on what people say about indicators of health. Stakeholders in different domains of health care (patients with chronic conditions, health care providers, policy makers, insurers, public health actors, citizens and researchers) were approached both qualitatively (50 interviews, focus groups and working groups with altogether 140 persons) as well as quantitatively (questionnaires to people approached by panels and networks; with a total number of participants of 1938).

The qualitative study yielded 556 observations about health indicators, and in a consensus process with another research institute (NIVEL) these were categorized into six dimensions of health: 1) bodily functions, 2) mental functions and perceptions, 3) spiritual dimension, 4) quality of life, 5) social and societal participation, and 6) daily functioning. The six dimensions were specified in 32 different aspects. The dimensions and aspects were then included in the questionnaire to study their importance for the different groups of stakeholders. In the process of categorizing, ICF literature was taken into account, but leading was working 'bottom-up' with the expressions and intentions of the persons who were interviewed.

Overlap with ICF
Having accomplished this, looking at the dimensions and aspects from an ICF-perspective, it is interesting to see how they overlap with ICF domains and classes. To study this overlap the aspects were linked to the most appropriate ICF-categories by the first author (YH), using the linking rules of Cieza et al. (2005; using 'meaningful concepts'). The results were discussed with the second author (MH). Based on a more detailed explanation of what is meant with the different aspects - sometimes going back to the observations used for the categorization - the linking was enhanced. However, some of the aspects need to be studied in further detail to capture their true meaning, so the codes given are temporary.

The linking process made clear that there are many aspects which can be seen as a personal factor. At present, 46 meaningful concepts are derived from the 32 aspects of which 18 are coded as a personal factor. *(This article continues on page 2)*

Editorial

This newsletter includes a few personal messages. One sad message about Howard Meltzer, who passed away last February. A more pleasant one about Björn Smedby who was awarded by the WHO-FIC Lifetime Achievement Award.

The front page article in this newsletter is a challenging one concerning the concept of health and the relation with ICF. We are curious about the reactions of our readers.

We did not manage to get papers regarding the ICD (10 or 11), but we are grateful for the paper on mapping of SNOMED to WHO-FIC members. As always we got several contributions concerning the ICF and its use in several areas.

Time is our limiting factor nowadays. Several colleagues expressed their willingness to prepare a contribution for our newsletter, but finally by lack of time it did not seem to be possible. We regret that, but we understand the situation completely. That is why we created a new heading in the newsletter: latest news. It is our intention to collect facts which are worthwhile to be mentioned including a website or e-mail address in order to find the relevant details. We invite all interested readers to send us their news in a few lines or a longer contribution (500 – 1000 words).We hope to receive an overwhelming amount of longer or short contribution for our newsletter autumn 2013!

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A new concept of health

And its relation with ICF *(continued from page 1)*

This high percentage of concepts coded as a personal factor is for the Dutch WHO FIC Collaborating Centre another argument to make a plea in favor of a list of personal factors to be added to the ICF (Heerkens et al., 2012). This is confirmed by the quantitative study of Huber et al. (in preparation) indicating that for all stakeholders involved the aspects coded as personal factors are important, although not all dimensions are equally important for all stakeholders.

Recommendations
One of the recommendations of the report of Huber et al. (2013) is to develop a visualization in the form of a benchmark, with the six dimensions as axes, and to link this benchmark to objective measurement instruments. At this moment much effort is put into linking items from existing measurement instruments to ICF-categories. The group of Huber et al. can learn from these efforts and they can probably use the instruments that can measure ICF-classes that are linked to their aspects, while people involved in the update and revision of the ICF can learn from the research of Huber et al. about the importance of the different concepts and about items that can be included in a future list of personal factors.

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Latest News

The ***website of the WHO-FIC Education and Implementation Committee (EIC)*** contains a lot of interesting information regarding ICD and ICF: WHO-FIC Information Sheets (ICD and ICF), WHO-FIC implementation database, Training and Certification Program for ICD, ICF Training. Go and see: http://www.cdc.gov/nchs/nacc-education-committee.htm

Posters and plenary presentations of the ***Annual WHO-FIC Network Meeting 2012*** are to be found at http://apps.who.int/classifications/network/meeting2012/en/index.html

The ***International Classification of Traditional Medicine* (*ICTM*)** is planned to be created as a separate chapter (24) of the ICD-11 and not as a separate WHO-FIC member.

ICD-11 functioning properties: the fTAG is connecting the ICD-11 and the ICF by finding ICF core sets for every ICD-chapter, mirror coding between ICD and ICF and inclusion of the ICF list of environmental factors in the Z-list of the ICD. For information: Cille Kennedy, co-chair of the fTAG: cille.kennedy@hhs.gov

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International Organizations

Washington Group on Disability Statistics

Summary of the 12th Annual Meeting (Bangkok) and Objectives for the 13th (Amman)

The main objective of the Washington Group on Disability Statistics (WG) is the promotion and co-ordination of international co-operation in health statistics focusing on disability measures suitable for censuses and national surveys. The WG has developed a short set of disability measures, suitable for use in censuses, sample-based national surveys, or other statistical formats, for the primary purpose of informing policy on equalization of opportunities. The WG is also developing extended sets of survey items to be used as components of population surveys or as supplements to specialty surveys. The World Health Organization (WHO) International Classification of Functioning, Disability, and Health (ICF) has been used as the basic framework for the development of the sets. All disability measures recommended by the group are accompanied by descriptions of their technical properties and guidance on implementation is provided. A complete overview of the WG including reports from past meetings as well as products and documentation is available at: http://www.cdc.gov/nchs/washington_group.htm
Below are key issues covered during the 12th meeting of the WG, 23-25 October 2012 in Bangkok, Thailand.

Use of the WG Short Set
The WG continues to monitor the collection of disability data internationally, and annually requests detailed information from representatives from National Statistical Offices covering survey periodicity, sample size and frame, mode of data collection, language(s) used, exact question wording along with response options and finally prevalence estimates.

The data received from 34 countries in response to the WG's request was supplemented with information provided by countries participating in a disability seminar sponsored by the Arab Institute for Training and Research in Statistics (AITRS) in December 2010. Also, data were received from two countries (Zambia and South Africa) independent of the WG's annual request.

While countries continue to report disparate disability prevalence rates, with few exceptions, those that use the WG as intended (Israel [census/2008]; Aruba [census/2010]; Zambia [survey/2006]; and Maldives [survey/2009]) have reported disability prevalence rates that are comparable. Further analyses of these data are pending.

WG Extended Set on Functioning
The extended set of disability questions on functioning (ES-F) were added to the US National Health Interview Survey (NHIS) beginning in 2010. The ES-F items were examined by domain, individually, and by various socio-demographic categories. Coding choices in each domain and cut points for definitions of disability prevalence were discussed. It was agreed that more in depth analysis would be useful and that a formal workgroup, led by the representatives from the US National Center for Health Statistics (NCHS), would be established. The workgroup will develop an analytic plan and continue analysis of the ES-F data collected on the 2011 NHIS.

The session also included a discussion on analytic guidelines and strategies for data collected using the ES-F. Representatives from NCHS provided a presentation focusing on the use of a mixed-method approach to assess validity and cross-subgroup comparability using results from the 2010 NHIS and focusing on the pain domain within the ES-F questions.

Methodological Issues Concerning Surveys
The workgroup investigating environmental factors and participation, chaired by the NCHS, presented their work consisting of a conceptual framework and related questions sets. The presentation was followed by a discussion on the challenges related to developing a question set and the next steps for the workgroup. It was agreed that the workgroup should continue to move forward with the development of a question set, reducing the scope to focus to one service area or basic activity.

The workgroup on the development of an extended set for measuring disability among children and youth (ES-C) presented the work accomplished in the previous year as part of its collaboration with the United Nations Children's Fund (UNICEF). Representatives from the children's workgroup, chaired by members from the Italian National Institute for Statistics (ISTAT), provided a review of the conceptual framework for question development and a proposed set of questions. An update on the Multiple Indicator Cluster Surveys (MICS) was presented on behalf of UNICEF, as well as, a presentation by a representative from ADAPT (formerly the Spastics Society of India) on the cognitive testing of the module on child functioning and disability in India. It was agreed that the workgroup will continue to collaborate with UNICEF and present the proposed final set of questions at the next meeting.
Post WG-12 and as of spring 2013 it can be noted that cognitive testing has been completed in the USA and Belize, is planned for Oman during April 2013 and Montenegro during May of 2013. An additional francophone West African country is also being considered. It is anticipated that cognitive testing will be completed by summer 2013 and field testing of the module will begin shortly thereafter.

Updates on other WG and collaborative activities
A representative from UN ESCAP's Social Development Division provided an overview of the Incheon Strategy, a

framework designed to guide action on disability in the Asian-Pacific region over the next decade.
A representative from the World Health Organization (WHO) provided an overview of the World Report on Disability, launched in June 2011, and the Model Disability Survey scheduled to be launched in 2013. Both projects were joint collaborations between WHO and the World Bank.

Plans for the thirteenth meeting
The 13th meeting is scheduled to take place in Amman, Jordan; 29-31 October, 2013. Objectives for this 13th WG meeting:

- To review and approve analyses of results of country data collection using the Washington Group Short Question Set (WG SS)
- To review and approve guidelines for analyzing data obtained from the Washington Group Expended Question Set on Functioning (WS ES-F)
- To adopt the Extended Set of Questions on Child Disability (WG ES-C)
- To review progress in developing the Washington Group Extended Set of Questions on Environmental Factors and Participation (WG ES-E/P)
- To review recent international activities in disability statistics.

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International Health Terminology Standards Development Organisation

Mapping IHTSDO's SNOMED CT to WHO's Family of International Classifications

Summary
A collaboration between the International Health Terminology Standards Development Organisation (IHTSDO®) and the World Health Organization (WHO) has resulted in a map of priority set of SNOMED CT® 21,819 concepts to ICD-10® to support the epidemiological, statistical and administrative reporting needs of the IHTSDO member countries, WHO Collaborating Centres, and other interested parties. This international cross map is the first of many mapping projects planned between IHTSDO and WHO.

IHTSDO and WHO Collaboration
The IHTSDO and WHO signed a harmonization agreement in 2010. This agreement resulted in the establishment of a Joint Coordination Group (JCG) responsible for agreeing to an annual strategic joint work plan and the Joint Advisory Group (JAG) whose focus is operational. One or more Joint Working Groups (JWG) may be created under the umbrella of the JAG to address specific issues.

The JAG is accountable for proposing to the JCG via an annual work plan key work areas and project plans. The current projects include:

- SNOMED CT Foundation/ontological layer of ICD-11
- SNOMED CT to ICD-10 mapping methodology and validation
- SNOMED CT and ICF harmonisation work

In 2012, a JWG was launched to advance the SNOMED CT and ICF harmonisation work.

SNOMED CT to ICD-10 Map Project
Within the IHTSDO two groups, the Mapping Special Interest Group and the IHTSDO Mapping SNOMED CT to ICD-10 Project Group, oversaw the development of the preview publication in September 2011 followed by the SNOMED CT to ICD-10 Technology Preview Map in August 2012. IHTSDO contractors and volunteers completed these two work products and the supporting documentation, which included scope, audience, purpose, and heuristics. Mapping tools utilized by the team comprised of stand-alone mapping and workflow tools along with ICD-10 and CliniClue SNOMED CT Browsers.

As part of the mapping process, twenty-nine concepts were identified as needing review by the consensus panel. This panel consists of an IHTSDO and WHO representative along with a third consensus manager. In addition, the American Health Information Management Association with IHTSDO and WHO participation conducted an independent content validation of the Technology Preview.

Mapping Service Team
In order to advance the initial work in May 2012, the IHTSDO established the Mapping Service Team (MST). The team consists of one part time mapping lead, one member who splits her time between mapping lead and mapping specialist, and two full-time mapping specialists.

Since the formation of the MST, a SNOMED CT to ICD-10 Candidate Baseline Map has been released. This Candidate Baseline brings the previously released Technology Preview map in line with the July 2012 SNOMED CT International Release and ICD-10 2010. The Candidate Baseline may be downloaded by any IHTSDO Member organization, affiliate or interested party who is registered through the SNOMED CT Affiliate License Service Application (SALSA; • IHTSDO and WHO SNOMED CT to ICD-10 cross maps releases, 2013). This team will also undertake other mappings from SNOMED CT to classifications as required by IHTSDO Member countries.

Next Steps
The next release of the SNOMED CT to ICD-10 Map will occur July 2013 and future updates will follow the regular International Release timetable of every six months. The

next update will be aligned with the July 2013 International Release of SNOMED CT and include:

- Updates to the Candidate Baseline Map
- Additional ICD-10 maps for SNOMED CT concepts related to General and Family Practice being utilized in the development of the SNOMED CT to International Classification of Primary Care, Version 2 (ICPC-2) Map
- Additional ICD-10 maps from priority lists including frequently used diagnoses from an international perspective

In addition to the regular maintenance of the SNOMED CT to ICD-10 Map, the IHTSDO MST is engaged in:

- Collaborating with the IHTSDO project responsible for the map between a reference set of SNOMED CT concepts and ICPC-2
- Establishing a collaborative working relationship with coding systems developers, external advisors and reviewers
- Providing expert advice on mapping methodology and implementation of mapping derivatives to IHTSDO Member Countries and the community of practice
- Creating additional supporting documentation such as the Mapping Personnel Handbook and Implementation Guide
- Transitioning from a stand-alone mapping and workflow tools to an integrated tooling solution to support mapping activity in the international workbench

The JWG will be submitting a SNOMED CT and ICF harmonisation report to the JAG in August 2013. The report will include the findings of the group's gap analysis and recommendations for the next phase of the work.

Reference

- IHTSDO and WHO SNOMED CT to ICD-10 cross maps releases. Available from https://www.ihtsdoregistration.nss.cfh.nhs.uk/salsa/user/guest/group/1/pack/4.

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International Council of Nurses

Launch of 2013 release of ICNP

At ICN Congress in Melbourne, Australia

The International Council of Nurses (ICN) launched the 2013 release of ICNP®, a terminology for nursing that supports improved quality of care and standardized nursing documentation worldwide. The documentation data can be re-used for multiple purposes, including clinical and administrative decision-support, generating evidence for practice, nursing education, and policy development. The formal foundation of ICNP makes it capable of harmonizing other nursing and multi-disciplinary terminologies in order to optimize care documentation and analysis of health interventions related to outcomes for patients, groups or communities. ICNP is available at http://www.icn.ch/pillarsprograms/ehealth/.

To date, ICNP has been translated from English into 14 languages. Several of ICN's translation partners used the 2013 pre-release of ICNP (available to translators and vendors) to complete an updated translation for their countries concurrent with the formal release date.
The 2013 release of ICNP reflects the intense focus on development of subsets of the terminology that can meet nurses' information needs in hospitals, in ambulatory care settings and in the community. These subsets, published as ICNP Catalogues in print or on the ICN website, are comprised of pre-coordinated statements of nursing diagnoses, nursing interventions and nursing sensitive outcomes for documentation in electronic health records.

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World Health Organization

WHO–FIC Network Meeting 2013: 12 - 18 October

Universal Health Coverage: Information and Innovation

The 2013 annual meeting of the WHO Network of Collaborating Centres for the Family of International Classifications will be held in Beijing, China, from 12 to 18 October 2013, at the Empark Grand Hotel. The meeting will be hosted by the Chinese WHO Collaborating Centre for the Family of International Classifications. Please find contact information, information about Beijing accommodations and social events at http://www.whofic2013.org.

The theme for WHO-FIC 2013 is 'Universal Health Coverage: Information and Innovation'. This topic reflects how to form an innovation, so that providers, policy makers and people can enhance the use of medical classification and coding in an accurate and complete way to better health information systems development by all means of innovation in the context of universal coverage.

A provisional timetable and meeting agenda is available at http://www.whofic2013.org. Other meeting documents, such as papers, posters, and meeting reports will become available on this website as well. During the first five days of the meeting the Committee & Reference Groups convene. On Thursday October 17th the meeting will be opened officially.

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WHO-FIC Lifetime Achievement Award for Björn Smedby

At the Brasilia WHO-FIC Network Meeting October 2013 Björn Smedby was awarded by the WHO-FIC Lifetime Achievement Award. Unfortunately he could not attend the meeting. But an interview with Björn was held in Sweden some days before the meeting. This interview - and some pictures and the Powerpoint presentation - is available at: http://www.nordclass.se/BjornAwardWHOFIC2012.htm After the meeting, Lars Berg, brought the Award to Sweden and delivered it to Björn, in Uppsala, Sweden.

Speech of the nestor of WHO-FIC network, Ruy Laurenti, addressed at WHO-FIC Brasilia Meeting

It is a pleasure to receive all of you for this "WHO FIC-Network 2012Meeting" in Brasilia. This is the 4th meeting organized by the Brazilian Center. The others occurred twice in São Paulo (1978 and 1985) and once in Rio de Janeiro (2000). Till some years ago these meetings were called "Center's Heads Meeting" and currently it is known as the "WHO FIC-Network Meeting".

History of the Brazilian Center
The Brazilian Center was created in 1976 soon after its approval by the World Health Assembly, on May 1976. In that occasion there were only five Centers: Paris, London, Moscow and Caracas (for the Spanish speaking countries); the North American Center (Washington) was established a few months before the Brazilian Center.

The official name was "WHO Collaborating Center for the ICD in Portuguese" for the Portuguese speaking countries (Brazil, Portugal and African Portuguese speaking countries). Recently the name was changed to "WHO Collaborating Center for the Family of International Classification in Portuguese".

In the first "Center's Heads Meeting" organized by the Brazilian Center, in 1978, and in the second, in 1985, the number of participants was around 25. In the 2000 meeting (Rio de Janeiro) the number of participants was around 40, the biggest number of participants till that year. In this 2012 meeting the number of participants is around 200! In those previous meetings, with a small number of persons, we sat around a table and had good and great discussions/comments. To tell you the truth I am not sure if we are very good friends or in reality a family. Now it's curious to note that it was changed to a "family of classifications…"

Participants
I remember very well the names of some participants: M. Alderson (London), G. Cerkovnyi (Moscow), R.A. Israel (Washington), P. Maguin (Paris), J.M.Avilan-Rovira (Caracas), B. Smedby (Nordic Centers), Feng Chuan-Yi (Beijing), S.Meads (Washington), C.Percy (Washington), K.Kupka (WHO, Geneve), G. Brämer (WHO, Geneve).

Before it became a big meeting, in each meeting the first presentation was the "Center's Activities in the Last Year", presented by the Center's Head. There were always many questions and comments about the presentation. Following this first presentation, the WHO staff members presented topics to be discussed, such as, the discussion/approval of the code for the infection and disease due to HIV in the future ICD-10. The topic of homosexuality in the new classification was very well discussed. Each Center presented one or more "papers" directly or indirectly linked to the use, structure, and other aspects of the ICD; the same with the WHO staff members.

Social events
Due to the small number of participants, cultural activities were common at the Center's Heads Meeting such as theater, ballet, orchestras, among other activities. When the meeting was set in the city were the Center was located, it was not uncommon for the Center's director to host dinner at his house.

A lot has changed during the last 35-40 years for our annual meetings, changing from small meetings, to our current situation that is close to a mini congress.

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FIC around the World

Italy

Considering the role of environmental factors in body functions and structures when describing functioning and disability

Rationale
The ICF red book is not clear about the full adoption of the descriptive model provided by ICF when describing body impairments. In ICF, impairments are defined as "problems in body function or structure as a significant deviation or loss" (p. 12), but it is also stated that "environmental factors interact with the components of Body Functions and Structures and Activities and Participation" (p. 17) (WHO, 2001). It follows that when dealing with problems of body functions and structures we should also take into consideration environmental factors (EF).

However, the interrelationship between body impairments and environmental factors is not emphasized enough, and a "medical" understanding of body impairments seems to prevail. But, what about the role of drugs on mental functions or on cardiovascular or breathing functions? What about the role of products and technologies in restoring an arrhythmia? What about the role of health services, systems and policies in assuring the right to health?

Similarly to the performance qualifier for Activity and Participation (A&P), the first qualifier of Body Functions (BF) and Structures (BS) should describe the interaction between an individual with a health condition and his/her contextual factors. In this contribution, presented at the 2012 WHO-FIC Annual meeting (Frattura et al., 2012), the author shows the preliminary results of a field trial where EF for each BF and BS category were also coded. The aim was to verify if this way of coding is useful to describe "cared/treated" body versus "ill/impaired" body.

Methods
In 2011, under the FABER Project, the Italian WHO-FIC Collaborating Centre coordinated the first field trial in the Friuli Venezia Giulia Region to put in use a new ICF-based functioning/disability assessment protocol (VILMA / FABER-FVG) (Frattura et al, 2011a; Frattura et al., 2011b). The protocol included a paper form, a web application, an informed consent form, and a workflow. The protocol was divided into two parts: 1) collection of personal, socio-demographic, and treatment information and mapping to ICF EF through the web application; and 2) ICF-based evaluation on all the three components (BF, BS, A&P). The multidisciplinary evaluation teams were free to code different BF and BS categories, whereas A&P categories were fixed. EF were coded for each BS, BF and A&P category.

Results
213 outpatients were enrolled (mean age 34, range 1-92): 41.8% females, 18.8% less than 14 years old, 12.2% living alone, 82.6% not occupied and only 8% married. Most patients were certified as disabled according to Italian laws, and in everyday life activities they generally declared they needed some help (patients requiring no help to dress up, to move, and to eat were 7%, 5.6%, and 9.8%, respectively). The coded BF categories were 354 in the whole sample, 191 in the subsample of patients younger than 18 years, 156 in the subsample of patients cared for by community mental health services. The most frequently coded BF category was b122 in the whole sample, b140 in the younger patient subsample, and b130 in the mental health services patient subsample.

The EF identified in relation to BF, BS, and A&P categories were 102. The most frequent EF were: e310 (immediate family), e355 (health care professionals), e110 (products or substances for personal consumption), e575 (general social support services, systems and policies), and e580 (health care services, systems and policies). EF over the 3rd quartile on the EF distribution were 25 in the A&P categories, 15 in the BF categories, and 6 in the BS categories. The analysis of the role of EF in the extent of BF impairments was performed comparing the distribution of the qualifier values (0, 1, 2, 3, 4) and the presence/absence of coded EF.

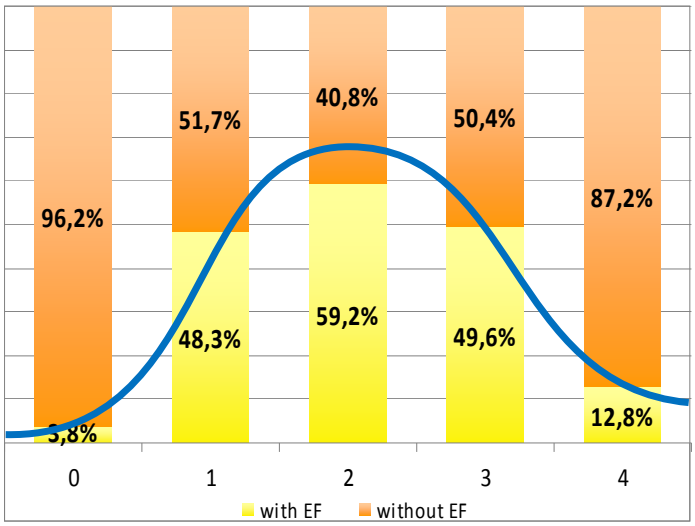

Figure 1: Distribution of BF categories by qualifier value and EF presence (N= 213)

Among BF categories with no impairment (.0), the presence of EF was reported in only 3.8% of cases, while this

percentage increased among BF categories with mild impairment (48.3%), moderate impairment (59.15%), and severe impairment (49.6%). BF categories coded .4, indicating total limitation, reported the presence of EF in 12.8% of cases (Figure 1). This trend in the EF coding across qualifier values could be found in all coded BF categories. The e1 and e3 categories were considered as barriers in only 7% and 5% of BF categories, respectively; e2 categories were coded as barriers in58% and e4 categories in 49% of BF categories.

Conclusions

The role of EF on functioning is one of the novelties of the evaluation based on ICF. Nevertheless, at body level, the role of EF seems to be neglected.

This contribution provides a first exploratory analysis of the effort to also consider EF when dealing with BF and BS categories. This novelty allows an in-depth analysis of the role of EF in the BF and BS describing the individual's health condition. Our results show that the presence of EF was heterogeneous across the qualifier values describing the severity of impairments, with a lower number of EF where no BF/BS impairment (qualifier 0) was registered. Moreover, the e1, e3, and e5 categories were generally facilitators in relation to BF and BS categories, while the e4 category more frequently represented a barrier.

To facilitate the coherent application of the ICF descriptive model in all components, it should be clearly explained that the model offer the opportunity to describe individual-context interactions also at body level. In other words, in an ideal flow chart, the evaluation based on the ICF as a descriptive model and as a standard language comes after the "diagnostic phase", in which the "ill" body is described. The functioning profile does not correspond to the translation into ICF of the signs and symptoms of a disease, but it allows to describe, for the first time, the interaction between a person with a health condition (coded with the ICD) and contextual factors: the "treated/undertreated/not even treated" ill body instead of the ill/impaired body solely. Similarly, it would be useful to reformulate the meaning of the first qualifier for BF, BS, and A&P, clarifying that it describes the "problems of an interaction", not the "problems of an individual". Consequently, the "same generic scale" proposed by ICF to describe problems in all three components (p. 22) could be explicitly used to assess the problems of the interaction between an individual and his/her contextual factors. This clarification would encourage people to abandon a mixed approach in favour of a fully coherent ecological approach to the use of the ICF.

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Kenya

Building ICF expertise in Africa

The large gap in access to information between low and high income countries is well known. In an effort to address this gap with regard to functioning and disability, a two day workshop introducing the ICF and its application was held for delegates to the World Confederation for Physical Therapy Africa Region Congress held in Nairobi, Kenya. The workshop facilitators were Catherine Sykes (World Confederation for Physical Therapy) and Jennifer Jelsma (University of Cape Town). The host representative was Jessica Shiraku (Kenyan Society of Physiotherapy).

Participants

There were 65 participants from Benin, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Uganda and Zambia. Nigeria and Kenya had large contingents, whereas other countries had only single delegates.

Program

The program included an introduction to the ICF and its role in health information and data collection systems. Interactive sessions allowed the participants to locate their existing practice in the ICF framework and language and consider how introducing the ICF might change practice. The ICF curriculum modules were considered in the design of the program. The content of the workshop enabled the participants to consider their own practice and potential changes to practice consequent on the knowledge gained in the workshop.

Materials

Workshop materials included: the program outline, case studies and coding exercises and the ICF checklist (though some copies were incomplete). Additional materials including the ICF overview, a brief guide on finding, collecting and using data, academic papers and copies of the slides which were provided by the Local Organizing Committee on a compact disc. Thirty copies each of the short version of ICF and the WHO DAS manual were provided by the World Health Organization. The participants acknowledged the generosity of WHO with acclamation. The books arrived during the second morning

and representatives of each country present received at least one copy of each book.

Teaching methods included presentation using power point slides, question and answer, small group discussions, case studies and problem solving tasks.

Workshop evaluation
Evaluation of the workshop indicated that the participants considered that the workshop had provided them with information with which to evaluate and make changes to their practice and that the materials and methods used were locally appropriate. During the course of the workshop, the participants enthusiastically identified ways in which the ICF principles could be applied within their own contexts.

Suggestions for improvement of the workshop can be divided into three categories, those pertaining to the materials and content, recommendations for extension of ICF education across countries and professions and the need for liaison with health administrations for support in the implementation of the classification.

There were requests for more and more readily available resources to support ICF education and for inclusion of education about the ICF in physical therapy curricula. There were several requests to extend the duration of the workshop and indications of need for time to assimilate information. Participants recognized the importance of ICF in improving their ability to provide and report on quality physical therapy services and the outcomes for people with disabilities.

Conclusions
A clear need emerged for the region to improve the approach to gathering information relating to functioning and disability. This was evident in that the workshop was the most popular of the pre-congress offerings, drawing participants from across the continent, many of whom held influential positions in clinical, academic and administrative settings.

It is apparent that there is enthusiasm and will within the African physical therapy community to implement both the framework of the ICF and to initiate some system of collection of data on functioning. However, the capacity and resources are limited in this geographic area and it is suggested that WHO HQ and regional staff and members of the WHO-FIC network actively engage in supporting and encouraging these fledgling initiatives.

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Sweden

A Swedish Classification of Interventions using the ICF structure

A Nordic procedure classification (NOMESCO Classification of Surgical Procedures – NCSP) was developed in 1996, and national versions of the NCSP are used for statistics and DRG in the Nordic countries and in Estonia. National non-surgical procedure classifications are used in the Nordic countries, with different categorical structures and hierarchies. The codes from the national surgical and non-surgical classifications are collected for DRG use in a cross-map called NCSP Plus. The non-surgical procedure classification in Sweden lacked items to describe interventions relevant for rehabilitation and nursing care, as well as procedures suitable for occupational therapists, physiotherapists and nurses. Within a national project, resources were allocated to develop a national, multi-professional classification of interventions using the ICF structure.

Methods and materials
Multi-professional focus-groups with experts with knowledge about ICF and methods for classifications contributed to the work. Practical tests performed during 2006, together with reviews from clinical professionals, contributed to the final version.

Results
The result was a national, multi-professional classification of 314 interventions using the ICF structure at two levels (1st and 2nd) and the ICF components Body Functions, Activities and Participation and Environmental Factors. Of these, 31 were more general interventions at the 1st level, e.g., investigation of mental functions, investigation of personal care, treatment of sensory functions and pain, support and training in domestic life.

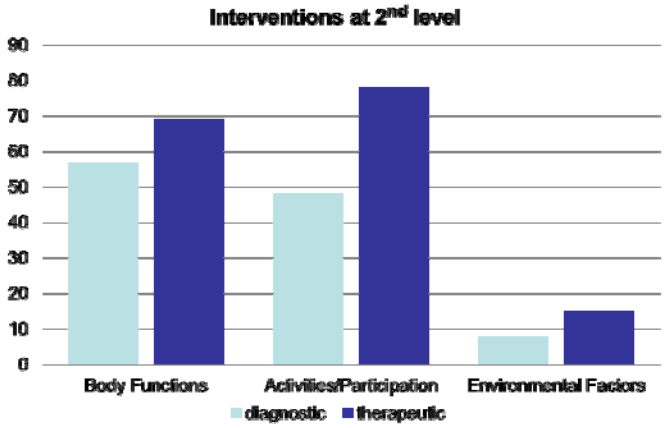

Figure 1. Number of diagnostic and therapeutic interventions in the components.

There were 132 interventions for diagnostic procedures and 182 for therapeutic actions. Each intervention had a textual unambiguous clinical description. For 126 of the interventions the target, at the 2nd level, was Body Functions

and for 126 of the interventions the target was Activities/Participation (Figure 1). Most of the diagnostic interventions were related to mental functions (e.g. assessment of memory functions). The therapeutic interventions were related to functions of the digestive, metabolic and endocrine systems (e.g. support for weight loss). Most of the diagnostic interventions related to Activities/Participation were found in the chapter Mobility (e.g. assessment of fine motor skills), and the therapeutic interventions were found in the chapter Self-care (e.g. training in oral care).

In January 2008, the interventions, using the ICF structure, were included as a specific part of the Swedish non-surgical procedure classification. According to a Swedish national register, two thirds of these interventions were used in in-patient care in 2009. In a mapping exercise, one third of the concepts could not be found in SNOMED CT.

Mapping to ICHI

The WHO has an ongoing project focused at the development of the International Classification of Health Interventions (ICHI), which has a structure of three axes: Target, Actions and Means. During 2012, the interventions from the Swedish procedure classification were mapped to the three axes of ICHI (Alpha version), to investigate the usefulness of the structure of ICHI, and also to contribute to the development of the classification.
The results from the mapping to ICHI showed that the targets of the interventions in the Swedish procedure classification could be mapped to the chapters and second level of the ICF-components (Body functions, Activities/Participation and Environmental factors) in ICHI. The actions of the interventions were not as specified as in ICHI.

Conclusion

ICF could be used as a framework for a multi-professional classification of interventions. The targets of the interventions are assigned to the components Activities and Participation, Body functions and Environmental factors, which support the integration of these components in the WHO International Classification of Health Intervention (ICHI). The targets need to have a hierarchical structure in ICHI, similar to the one in ICF. The actions of ICHI can contribute to more specified actions than the Swedish national classification. The axes of ICHI, especially Targets to Activities/Participation and Environmental factors and Actions also contribute to the current development of a Swedish national classification of interventions used in social care.

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