



WORLD HEALTH ORGANIZATION MEETING ON THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS,
DISABILITIES, AND HANDICAPS (ICIDH)

Voorburg, Netherlands, 14-17 November, 1994

Executive Summary

In its capacity as World Health Organization Collaborating Centre for the Classification of Diseases and Health-related Classifications, Statistics Netherlands, Voorburg, the Netherlands, hosted a meeting co-sponsored by WHO on revising the International Classification of Impairments, Disabilities, and Handicaps (ICIDH), November 14-17, 1994. This was part of a series of international meetings held as part of the ICIDH revision. Nearly 50 experts in disability classification and statistics from 8 countries considered proposals for revising the ICIDH, with special emphasis on applications to children and the elderly.

Agreement was reached on:

- | | |
|-----------------------|---|
| Field trials | The International Task Force on Mental Health - Behavioural Cognitive Developmental (MH/BCD) was asked to prepare a preliminary plan for field testing, which could serve not only for MCH/BCD but for various aspects of the ICIDH with appropriate consultations. This draft plan should be available by February 1995. |
| Environment | A list of environmental factors will be made available for the 1995 meeting. |
| Handicap definition | Consultation will be undertaken about the proposed revision, in order to facilitate formal agreement on the definition. |
| Handicap-disability | The WHO Collaborating Centre in North America will develop an initial set of criteria to facilitate partitioning between D and H. These criteria may be applied on an empirical basis in order to reach an acceptable distribution of items within D and H. |
| Solo/compound | The Disability Task Force will continue to work along the lines it has proposed, paying attention to positive and negative measures of disability; comments from participants due to task force by the end of 1994. |
| Structure vs function | The Dutch CC will describe the structure of anatomical in the I classification and indicate the level of detail needed within the various subdivisions. |

The participants noted that it is essential to the success of the revision process that WHO Secretariat continue to provide direction and coordination to the Collaborating Centres and other organizations, thus ensuring international participation, and agreed to inform appropriate officials in their nations of the role of the WHO Secretariat, and to encourage continued support of WHO's work.

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Les opinions exprimées dans les documents par des auteurs cités nommément n'engagent que lesdits auteurs.

Opening ceremony (Item 1)

In welcoming the participants and observers on behalf of Statistics Netherlands, Dr J.T.P. Bonte Adjunct Director of Division of Public Sector and Welfare, outlined the substantial contribution of Statistics Netherlands and of the WHO Collaborating Centre for the ICIDH in the use, promotion and further development of the ICIDH. He stressed the need for co-operation between the different types of users of the ICIDH.

Prof. Dr P.F. de Vries Robbé, Director, WCC Dutch Classification and Terminology Committee for Health, welcomed participants and observers on behalf of the WCC; he asked the meeting to keep in mind the multipurpose use of the classifications and terminologies and the necessity to join the activities of statistics and informatics.

Dr H.R. Hapsara, Director, Division of Epidemiological Surveillance and Health Situation and Trend Assessment, touched on the increasing importance of the long-term consequences of diseases and trauma in the health of the population, and of an appreciation that the concept of health is a dynamic one, which includes the person in the physical and social environment. The revision of the ICIDH will proceed with participation of people with disabilities and countries from all regions of WHO (ESS/ICIDH/Backg/94.23)

Election of officers, Adoption of agenda, Introduction of participants (Items 2-4)

Dr W. Hirs, as host, asked for a few moments of silence in remembrance of the contributions and life of Dr Pierre Minaire. Dr Hirs was appointed chairman of the meeting, and proposed Drs A. Deveau and G. Hendershot as co-chairs. Dr E. Badley, Mrs J. Davis, and Dr W. Brandsma were appointed rapporteurs. The agenda was approved with the modification that the meeting should break into working groups for Item 15, reporting back in the plenary session, before the scheduled breaks (ESS/ICIDH/C94.01 - Annex I). All participants were asked to introduce themselves with reference to their connection to the ICIDH revision process (ESS/ICIDH/C/94.02 - Annex II).

Conclusions of the 1993 revision meeting (Item 5)

(Dr W. Hirs)

The executive summary from the revision meeting held in Washington D.C., USA, in December 1993 (ESS/ICIDH/93.35 - Annex VIII) was presented. Further to this meeting the WHO secretariat has contacted non-governmental organizations in official relations with WHO which deal with matters of concern to the ICIDH. The ICIDH had also been discussed at a recent meeting in Caracas of Centre Heads for the ICD, where it was agreed that the ICIDH should be a permanent agenda item for the foreseeable future, and that the centres should become more involved with ICIDH within their terms of responsibility. The Australian Collaborating Centre has already initiated such an action.

Progress reports (Item 6)

Progress reports were presented from working groups and task forces as indicated below. In all cases, presenters summarized highlights from the prepared reports. General themes of the ensuing discussions included:

- the interdependence of the revision process for the various parts of the Classification, and the impact of the revision of the I, D and H classifications on the work of the cross-cutting groups;
- the need for a mechanism by which the different working groups could work together, and be informed of each others' progress;
- the revised classifications should, insofar as is possible, fit within the current framework classifications (e.g. with regard to the nine digit categories available);
- although it was recognized that the concepts of the ICIDH should remain unchanged, some changes were proposed to the wording of the definitions, in order to clarify and better define the scope of the I, D and H classifications;
- the potential value of rewording the classifications in terms of positive as well as negative functioning was stressed.

a) MOVEMENT
(Dr D. van Ravensberg)

A progress report on movement (ESS/ICIDH/C/94.04 and Backg/94.22) included a draft re-classification scheme of the relevant sections of the impairment code, and a suggested re-wording of the definitions. The proposed scheme is presented as more adequate to classify impairments and disabilities of children, the elderly and persons with problems of neurological origin.

b) SENSORY, PERCEPTION AND COMMUNICATION
(Dr P. Roussel)

This was a general progress report (ESS/ICIDH/C/94.05 and 0.6) on the outcome of deliberations of French experts in three working groups for ocular, aural and language impairments. Although needing some changes of the ocular and aural classifications, the general structure is generally satisfactory. The report on language and communication was not yet available. The discussion clarified that impairments of the senses of taste and smell should fall into the "sensory" aspects, and thus in the remit of the CTNERHI; the latter would identify contributors for these areas with the help of other collaborating centres.

c) MENTAL HEALTH/BEHAVIOUR-COGNITIVE AND DEVELOPMENT ASPECTS
(Drs S. Basset and B. Üstün)

The International Task Force on Mental Health/Behavioral-Cognitive-Developmental (MH/BCD) aspects of ICIDH (ESS/ICIDH/C/94.07) oversees the areas both of the consequences of mental and behavioural, cognitive and developmental disorders and of mental health aspects for I, D and H in general. During 1994, the Task force has completed a revision of the I classification as related to the area of mental health, using the taxonomic guidelines already established. This proposal reflects continuity with the current version of the ICIDH and accounts for current criticisms; it also incorporates observable/measurable concepts/performances, and harmonizes with current work on the ICD-10. A worldwide review of legislation which relates to the consequences of mental disorders is being conducted through WHO. An abstracted bibliography has also been compiled focusing on classification methods and assessment. Two meetings held in the United States focused on the utility and practical applications of the ICIDH.

Activities for the forthcoming year include: a current practice/needs assessment survey covering potential users of ICIDH, a critical review of the literature, the development of an I/D/H item pool and the subsequent refinement of the I/D/H categories and items. Later prospects include the development of a WHO/NIH joint project on the assessment and classification of mental disablements, in collaboration with the NIMH Children and Adolescent Survey "UNOCAP". WHO's Division of Mental Health is working with the UN for a Global Programme on Mental Health in order to attract attention to mental health matters. The disablement construct and hence the ICIDH, will play a major part in this endeavour since it adds an extra dimension to the understanding of phenomena related to disorders and their consequences.

In summary, the task force outlined the following important issues:

- development of close relationships to other groups (e.g. Movement and Sensory Groups/Psychological reaction to disablements);
- construction of descriptions (glossary, lexicon) and operational definitions for various categories;
- field trials with multi-professional participation (and integration of this into the revision process).

In the course of discussion, the meeting welcomed the proposal for a global programme of mental health in 1996-2005, trusting that special attention will be paid to avoiding terms such as "burden", which may erroneously imply that persons with mental problems are of lesser worth.

d) CROSS-CUTTING CONCERNS: ICD/ICIDH OVERLAP
(Dr A.C. Nilsson)

A draft report (ESS/ICIDH/C/94.08 and Annex) comparing the content of the ICIDH with that of the ICD showed that there are many overlaps, and this raises the question of the correspondences between the ICIDH and the ICD. Three options can be considered:

- overlaps are a normal occurrence and things should remain as they are;
- the Impairment classification is superfluous - ICD-10 covers what is needed;
- the ICIDH specifically covers manifestations and symptoms as consequences of disease, whereas the ICD deals essentially with disease itself. Attention must be paid in future to harmonization between the contents of the I code in the ICIDH and the contents of the ICD symptom chapter (and symptom codes in the organ chapters).

Both "congenital" and "acquired" deformity are terms coded in the ICD. Since the ICIDH is not concerned with the underlying cause, the same term "deficiency" could be used for both in the ICIDH. Problems of translation should be taken into consideration in this regard.

e) IMPAIRMENT
(Dr P. Roussel)

There is concern about the large number of items in the I code, and the fact that these items are unevenly distributed between the chapters. The possibility of a reduction in numbers of codes could be envisaged (ESS/ICIDH/C/94.24 & 25 - Annexes IV and V). This is a difference in approach to that of the Dutch group on movement, which had proposed an expansion of the current classification.

The issue was raised of where the focus of the I code should be as regards impairments in structure vs. impairments in function. It was suggested that, wherever possible, the I code should deal with function, since anatomical abnormalities (which caused the lack of function) are more a concern of the ICD.

f) DISABILITY
(Dr Y. Heerkens)

A new sub-division of the classification of disability along a range of complexity for basic disabilities to more complex disabilities was presented (ESS/ICIDH/C/94.09R and ESS/ICIDH/Backg/94.20). This was introduced as a possible response to earlier criticisms of the ICIDH.

g) HANDICAP/ENVIRONMENT
(Ms A. Furrie, Dr P. Fougeyrollas)

Proposals for the revision of the handicap classification (ESS/ICIDH/C/94.10) drew attention to the operating principles for the handicap classification, taking into account input from persons with disabilities and persons with different cultural backgrounds. This will include ethical guidelines which are currently being developed by the North American Collaborating Centre (NACC). The focus of the handicap classification being developed by the NACC will be presented at the next international meeting and will stress interaction with the environment. The possibilities for a new term should be explored. The suggested new definition draws attention to handicap as a disadvantageous encounter of the individual with the environment. To date there has been no attempt to develop severity scales for handicap.

A progress report on environmental factors and the ICIDH (Dr P. Fougeyrollas) will be discussed by the newly formed task force on this topic within NACC, which has multi-disciplinary and multi-sectoral input (ESS/ICIDH/C/94.10 bis). The aspiration to develop guidelines on how environmental aspects might be investigated was welcomed.

h) UNSTAT
(Dr M. Chamie)

A summary of the work of UNSTAT (ESS/ICIDH/C/94.11 - Annex VI) on development of Statistics related to Impairment, Disability and Handicap also included the recommendations of the expert group on disability statistics of the previous week (Expert Group Meeting on the Development of Impairment, Disability and Handicap Statistics), drawing attention to the parallel and dependent relationship between international guidelines for IDH statistics and the use of the ICIDH. The highlights of this UNSTAT meeting included recommendations that:

- further work on I, D and H statistics take into account the results of the ICIDH revision;
- a recommendation that those working on the revision of the ICIDH develop an overall "umbrella" term for I, D and H (this issue was discussed but not resolved);
- the wording of terminology in population statistics, such as "disability-free life expectancy", be carefully considered to avoid implying that people who experience I, D or H are of lesser worth.

i) WHO OVERVIEW
(Dr M.C. Thuriaux, Dr R.H. Hapsara)

Within the WHO secretariat there is now a group of four persons who deal with disability particularly with regard to the ICIDH: Dr A. Goerd, Rehabilitation (RHB), Dr B. Thylefors, Programme for the Prevention of Blindness (PBL), Dr M. Thuriaux - statistics/epidemiology (ESS), and Dr B. Üstün - Mental health (MNH). In addition to NGOs working in the field who have official relations with WHO, sister organizations such as UNICEF, ILO and UNESCO have also been contacted in this regard.

Dr R.H. Hapsara closed the discussion on behalf of WHO. The ICIDH is closely linked to aspects of community development and lifestyle in the many different societies of the world, and is an expression of equity. The long-term objective of health development is HFA (beyond year 2000). In renewing strategies of Health For All, part of the reorientation should focus on community action and policies for health and human development. He stressed the need to be realistic, to consider feasibility and to consider linkages with other concepts, as well as care in wording and definitions in order that they be understood in different cultures.

General discussion (Item 7 - incorporated in report on Item 6)

Introduction, special groups (Item 8)

a) THE ICIDH AND CHILDREN
(Dr S. Brown, Dr D. Avard, Mrs D. Farmer, Dr F. Chapireau)

The North American Task Force report on Issues Related to Children for the revision of the ICIDH, was preceded by mention of the Declaration of Salamanca on the education of children (UNESCO). The spirit of this statement is captured in the work of the children's group (ESS/ICIDH/C/94.12). There are three areas of emphasis: the family environment, the need for developmentally appropriate (age-relevant) information, and the need to document the domain of learning. One strategy in the revision should be to promote simplicity and usability in the classifications, with common domains that could be used in various settings, including service provision and demographic and statistical surveys.

Dr F. Chapiro presented a trial undertaken in France (ESS/ICIDH/Backg/94.21). The experience of this trial underlined that the ICIDH is a descriptive framework; ICIDH deals with consequences rather than causes. Cause should not be a discriminating factor in the classification of I, D, and H, even though there may be a process linking psychopathology and medical and social consequences. Care should be taken not to put blame on the parents. The field testing for this work took four years: it is therefore advisable that field testing for ICIDH be undertaken as promptly as possible.

b) THE ICIDH AND THE ELDERLY
(Dr H. Gardent)

A progress report on the use of the ICIDH to assess the situation of the elderly (ESS/ICIDH/C/94.13) included an information survey carried out at the European level (Council of Europe) on the content of assessment scales. Initial results from 21 scales show that most categories can be fitted into the IDH framework, although some fall between I and D, and D and H. Although not always explicitly incorporated into scales, the concepts of the ICIDH are generally acknowledged.

Taxonomy : introduction (Item 9)
(Dr W. Hirs)

Dr W. Hirs considered three steps in the classification of concepts (ESS/ICIDH/C/94.14 - Annex VII)

- select concepts and relationships which construct the classification required for a specific domain;
- select entities and attributes belonging to the domain or subject field we want to classify;
- select a term which has a one-to-one relation to each concept. The concepts rather than the words themselves should be translated to various languages.

Taxonomic requirements for ICIDH may be met by three independent hierarchies of interference with individual performance:

- at anatomical/physiological structure/function organizational level, "below the level" of the individual;
- at the individual level;
- at the level of interaction with society, "above the level" of the individual.

Items 8 and 9 were further discussed in parallel working groups (Agenda items 10 and 11)

Severity scales in the ICIDH (Item 12)
(Drs H. Miedema and M. Hopman-Rock)

A project reviewing the current Severity of Disability (SDS) Scale in ICIDH analyzed how current scales and instruments assess the severity of disability (ESS/ICIDH/C/94.15) was presented. Further stages of the project will include statistical analysis of data from a pilot and a further cohort study. The results of this project will be used to make proposals about the improvement of the current SDS in the ICIDH. Participants were strongly encouraged to complete and disseminate to other workers in the field a questionnaire about their experience with severity scales.

Review: What needs to be done now? (Item 13)

Breakout sessions discussed the following points

- 1) Mental Health, Children and the Elderly
- 2) Disability-Handicap-Environment
- 3) Overlap ICD-ICIDH

They were followed by a plenary discussion which centred around the following:

- field trials;
- environment;
- handicap definition;
- handicap-disability overlap;
- solo/compound disabilities;
- structure versus function in the Impairments classification.

For each of these items, an attempt was made to identify products, tasks, and schedule.

FIELD TRIALS

The draft revision of the ICIDH should be field tested in a variety of settings and in different countries and languages, in two main types of field trials:

- general field trials for applicability, ease of use, goodness of fit of the categories;
- focused field trials on specific issues (children, the elderly, other areas)

The procedures suggested for MH/BCD were based on those developed for the field testing of ICD-10, accessing an already existing network of institutions. Field testing will also be carried out in collaboration with UNICEF (eg. concerning psychological disabilities due to war trauma) and other interested NGOs. The WHO Division of Mental Health will assume Secretariat functions for these field trials. Similar arrangements can be made for focused field trials on other specific issues.

The working groups on children and on the elderly should be closely involved with all field testing. Translation of classification and instruments should be undertaken as soon as expedient. Once the definitions for different items are identified and agreed upon, assessment instruments can be tailored for ICIDH, in order to address the particular application needs in special groups.

It was also suggested to hold field trials to assess severity scales. The field trials should also assess the psychological reactions to disablement, as a modifying factor. There was some unresolved discussion about the need for a formally sanctioned document; it was agreed that such a document was less important in the case of small-scale trials. It is important that field trials include all regions of the world, including sub-saharan Africa, and that persons with disabilities be associated with all aspects of the planning, implementation and analysis of trials. In order to expand participation in field trials, organizations and researchers currently planning appropriate studies should be identified and asked if their plans could encompass a field trial of aspects of ICIDH. Dr Badley was asked to draft a text for use in the ICIDH newsletters soliciting participation in field trials. The United Nations Regional Commissions (ESCWA, ESCAP, ECA and ECLAC) should be invited to participate in the field tests of the ICIDH. The meeting was informed of a forthcoming ESCWA Regional training workshop on statistics for disability and aging, and of ESCWA supported surveys with disability-related questions planned in the ESCWA region from 1996 onwards.

A complementary approach to field testing could be secondary analysis of existing data. It was suggested that the Australian Bureau of Statistics be approached in this respect, as well as other institutions to be identified, e.g. through UNSTAT.

Product: A preliminary plan for field testing, with appropriate consultations. This draft plan should be prepared by the MB/BCD task force, available by the end of February 1995.

ENVIRONMENT

The task force on environment will develop a list of environmental factors for the 1995 meeting (drafts should be available for comment and revision prior to that). Existing lists of environmental aspects should be taken into account - these can be provided with assistance of UNSTAT, ISO and similar organizations. The working group will also develop explanatory examples of use of these environmental variables within I, D, and H codes. Personal characteristics, such as family support, should be covered as an environmental factor. The environment is an important component, but will not be a fourth classification.

Product: A list of environmental factors for the 1995 meeting (drafts should be available for comment and revision prior to that).

HANDICAP DEFINITION

The task force concluded that, based on comments and proposals discussed in several earlier meetings, the definition of handicap could be modified to express better the importance of interaction with the environment, as follows:

the result of an interaction between an individual with an impairment or disability and the social, cultural or physical environment.

The classification of handicap is at a level "above the person" which transcends the individual.

The conclusion of the working group was considered favourably and would be reviewed in depth by members of the Disability and Handicap task forces and the Environment task force. The task force will go forward with the classification of the H plane to assess the suitability of the new definition.

Product: Formal agreement on the revised definition, following consultation.

HANDICAP-DISABILITY OVERLAP

There was discussion about the potential overlap of complex disabilities and handicaps. It was not possible to resolve this issue within the frame of this meeting, and it was proposed that a small group representing the D and H task forces and the environment task force meet early in 1995 to formulate proposals, which will be circulated for comment. Dr Gray offered to coordinate this meeting, including the identification of the necessary resources.

Product: Criteria to facilitate the partitioning between D and H. These criteria may be applied on an empirical basis to reach an acceptable distribution of items within D and H.

SOLO/COMPOUND DISABILITIES

The disability task force suggested that the revised disability classification use the complexity of activity as a first criterion of classification. In this way, the classification arranges activities on a range of simple to more complex. This was discussed at length, and there was considerable divergence of opinion concerning the implications for potential overlap with the H dimension. The meeting agreed that the disability task force continue its work along the same lines, paying attention to positive and negative measures of disability.

Attention should also be paid to the current lay understanding of disability, as embodied in the term "Americans with Disabilities Act" (not "functional limitations", nor "handicaps"). It would be desirable to respect the current maximum of nine groups (in one-digit classifications). Detailed comments on the current proposals (ESS/ICIDH/C/94.09R and ESS/ICIDH/Backg/94.20), including the two digit level proposed in the annex, by participants in the current meeting should reach the task force by the end of 1994.

It was concluded that, in the same way that anatomical structure was used to elaborate the category of impairments, environmental factors be taken into account as an explanatory factor in the elaboration of the classification of disabilities, especially in the development of severity scales. This applies in particular to technical aids as referenced in the ISO9999 classification issued by the International Standards Organization.

Product: A revised proposal for the disabilities classification, following the lines already proposed, and paying attention to both positive and negative measures. Comments towards the preparation of this proposal should reach the Netherlands CC by the end of 1994.

STRUCTURE VERSUS FUNCTION IN THE I CLASSIFICATION

Dr B. van Ravensberg and Dr Y. Heerkens made some introductory remarks, followed by a discussion about the need for "anatomy/structure" in the classification of Impairments and the possible danger this represented for overlap with the ICD. It was decided that the Dutch CC would describe the structure of anatomical characteristics and indicate the level of detail of this type of characteristics which would be needed within the various chapters.

Product: A description by the Netherlands CC of the structure of anatomical characteristics indicating the level of detail needed within the various chapters; this should be circulated to and discussed with the Nordic and French CCs.

Further agenda (Item 14)

Dr Thuriaux summarized the important achievements from earlier meetings:

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- the principle of a revision (rather than an update) of the ICIDH was agreed upon;
- the words "for trial purposes" were deleted in reprints of the current ICIDH, which include a foreword, mentioning the foreseen revision and listing areas deserving of particular attention therein (role of environmental factors, overlaps with ICD and within ICIDH, causality, definition of handicap, applications to mental health and to specific age-groups, policy implications, culture-bound items, specific items of wording);
- ICIDH CC were entrusted with the technical coordination of the I, D, and H classifications.

WASHINGTON 1993

- a matrix was established for the revision of ICIDH specified activities of CCs and of the WHO Secretariat (including overall coordination and definition of work areas);
- additional tasks were identified for the various CCs in the technical areas of movement, sensory perception, mental health, and other cross-cutting concerns;
- taxonomy guidelines were developed as a tool for the revision process;
- increased collaboration was undertaken with NGOs and other organizations concerned with persons with disabilities;
- UNSTAT and WHO cooperation was enhanced as regards statistics on I, D, and H.

The achievements of the present meeting (Voorburg 1994) could be summarised as follows:

- a clarification and enhancement of the role of environment as a contributing factor in IDH (not as a separate classification);
- a working definition of handicap which better reflects the concept of handicap;
- agreement that, subject to further evaluation, the range of complexity of activities will continue to be the working axis of classification for disability;
- reference to anatomical structures in the I classification where appropriate;
- similarly, reference to environmental factors as contributing explanatory factors to disability categories, particularly as regards to severity grading and to technical aids.

The Collaborating Centres provided a brief overview of their plans for the coming year, as follows:

WCC (NETHERLANDS)

- continue work on disability, subject to resources availability;
- collaborate with CTNERHI on the the need for a distinction between impairments in structure and impairments in function, and on possible overlaps between Impairment and Disability;
- continue work on movement;
- complete the disability proposal, taking into account external comments, and distribute for review;
- pursue work on severity grading;
- discuss with other groups (*e.g.*, MH/BCD) items relevant to the work of more than one group (*e.g.*, movement).

NACC

- organize a spring meeting with the disability group (Netherlands) and the environment and handicap task forces;
- begin a review of criticisms of the Handicap definition and circulate this review;
- initiate work group to develop a paper on policy (for the 1995 ICIDH meeting) in cooperation with France, Canada, the Netherlands, WHO and UNSTAT;
- pursue the draft handicap classification;
- cooperate with the mental health group.

NORDIC COUNTRIES

- continue work on overlap between the ICD and the ICIDH;
- give support to French Collaborating Centre work on impairment;
- collaborate with Dutch on movement as related to impairment.

AUSTRALIAN COLLABORATING CENTRE

- seek comments on the Nordic centre's paper on ICD/ICIDH overlap from experts in the field in Australia (including experts in the Australian Bureau of Statistics);
- seek to establish a multidisciplinary reference group, including representatives of people with a disability, to provide comment on the work of the H-working group and the environment task force;
- seek the involvement of the Australian Bureau of Statistics and others in trials for a new draft ICIDH.

CTNERHI (FRANCE)

- work with Dutch Collaborating Centre on Impairment
- elaborate a draft for sensory aspects, incorporating taste and smell, with external assistance (Dr Hoffman);
- provide assistance to the Mental Health draft for Impairment in collaboration with NACC;
- continue to seek participation from people with disabilities in France.

WHO SECRETARIAT

ESS

- continue as focal point in WHO input, including collaboration with Regional Offices, CCs and other relevant organizations;
- obtain and provide detailed comments on the proposed revisions;
- assist on the preparation of the 1995 meeting;
- circulate a list of proposed definitions for Impairment, Disability, Handicap;
- take part in CC activities and meetings as requested.

MH/BCD

- the produce a protocol for general field trials of ICIDH for applicability and goodness of fit of the categories, and function as secretariat for the field trials;
- conduct a current practice survey covering the needs of potential users of ICIDH;
- develop an item pool for I, D, and H.

The participants acknowledged the contributions of the World Health Organization's Division of Epidemiological Surveillance and Health Situation and Trend Assessment to the ICIDH revision. They noted that it is essential to the success of the revision process that the WHO Secretariat continue to provide direction and coordination to the Collaborating Centres and other organizations doing the work of the revision. Participants agreed to inform appropriate officials in their nations of the role of WHO, and to encourage the continued support of WHO's work.

1995 ICIDH revision meeting (Item 15)

Dr Deveau informed the participants that this was still scheduled for the autumn of 1995 in Paris but that, should a Paris location not be feasible, Canada was considering hosting the meeting in Ottawa in November 1995. Participants will be fully informed by WHO at the earliest opportunity.

Closure (Item 16)

Dr Hirs thanked Statistics Netherlands and their staff for the accommodations for the meeting. Dr Thuriaux closed the meeting after thanking all participants and observers, the rapporteurs, and the staff of WCC and Statistics Netherlands for making this meeting a fruitful and enjoyable occasion.

List of Annexes

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III	List of documents	ESS/ICIDH/C/94.03
IV	French report of the revision of the ICIDH concerning the sensory, perception, and communication impairments	ESS/ICIDH/C/94.24
V	French note on the impairment revision process	ESS/ICIDH/C/94.25
VI	Summary of the work of UNSTAT on development of IDH statistics	ESS/ICIDH/C/94.11
VII	Proposed taxonomic guidelines for the ICIDH	ESS/ICIDH/C/94.14
VIII	Executive summary, WHO meeting on the ICIDH (1993)	WHO/SES/ICIDH/93.35



THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/C/94.01
ENGLISH ONLY

Voorburg, Netherlands
14-17 November 1994

ANNEX I

REVISED AGENDA

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Revised agenda

Monday, November 14

Item		
	Registration	9.00
1.	Opening (WCC and WHO)	9.30
2.	Election of officers	
3.	Adoption of agenda	
4.	Introduction of participants	
5.	Report of the 2nd revision meeting	
	Break	11.00
6.	Progress reports (15-20 minutes):	11.15
	a) Movement	WCC
	b) Sensory, perception and communication	CTNERHI
	c) Mental health/ behaviour/ cognitive and developmental aspects	NACC
	d) Cross-cutting concerns, ICD/ICIDH overlap	Nordic
	Lunch	12.30-13.30
	e) Impairment	CTNERHI
	f) Disability	WCC
	g) Handicap/ environment	NACC
	h) Statistical application	UNSTAT
	Break	appr. 15.00
	i) WHO overview	WHO
7.	General discussion	

Tuesday, November 15

8.	Special groups: introduction	9.15
9.	Taxonomy : introduction	
	Parallel session	10.15
10.	ICIDH and Children ICIDH and Elderly Taxonomy	10.15
	Break	
	Parallel sessions continue	

	Lunch	12.30-13.30
	Parallel sessions continue. Rapporteurs to prepare a brief written statement for reading and discussion in plenary session	
	Break	15.00
11	Rapporteurs report (5 minutes) and general discussion	15.30
Wednesday, November 16		
12	Severity scales in the ICIDH: inventory of disability scales and proposal for a revision of scales (disabilities) General discussion	9.15
	Break	10.00
13	Review (plenary): what needs to be done now? a) Movement b) Sensory, perception, communication	
	Lunch	12.30-13.30
	c) Mental health/ behavior /cognitive and developmental aspects d) Cross-cutting concerns, ICD/ICIDH overlap	
	Break	15.00
	e) Impairment f) Disability g) Handicap/environment	
Thursday, November 17		
14	ICIDH-revision agenda; specific commitments and objectives of collaborating institutions	9.15
15	1995 and following meetings: preparations and objectives	10.00
	Break	10.30
16	Report and recommendations	11.00
17	Closure	
	Lunch	
	Departure	



THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS,
DISABILITIES, AND HANDICAPS

Voorburg, 14-17 November 1994

ANNEX II

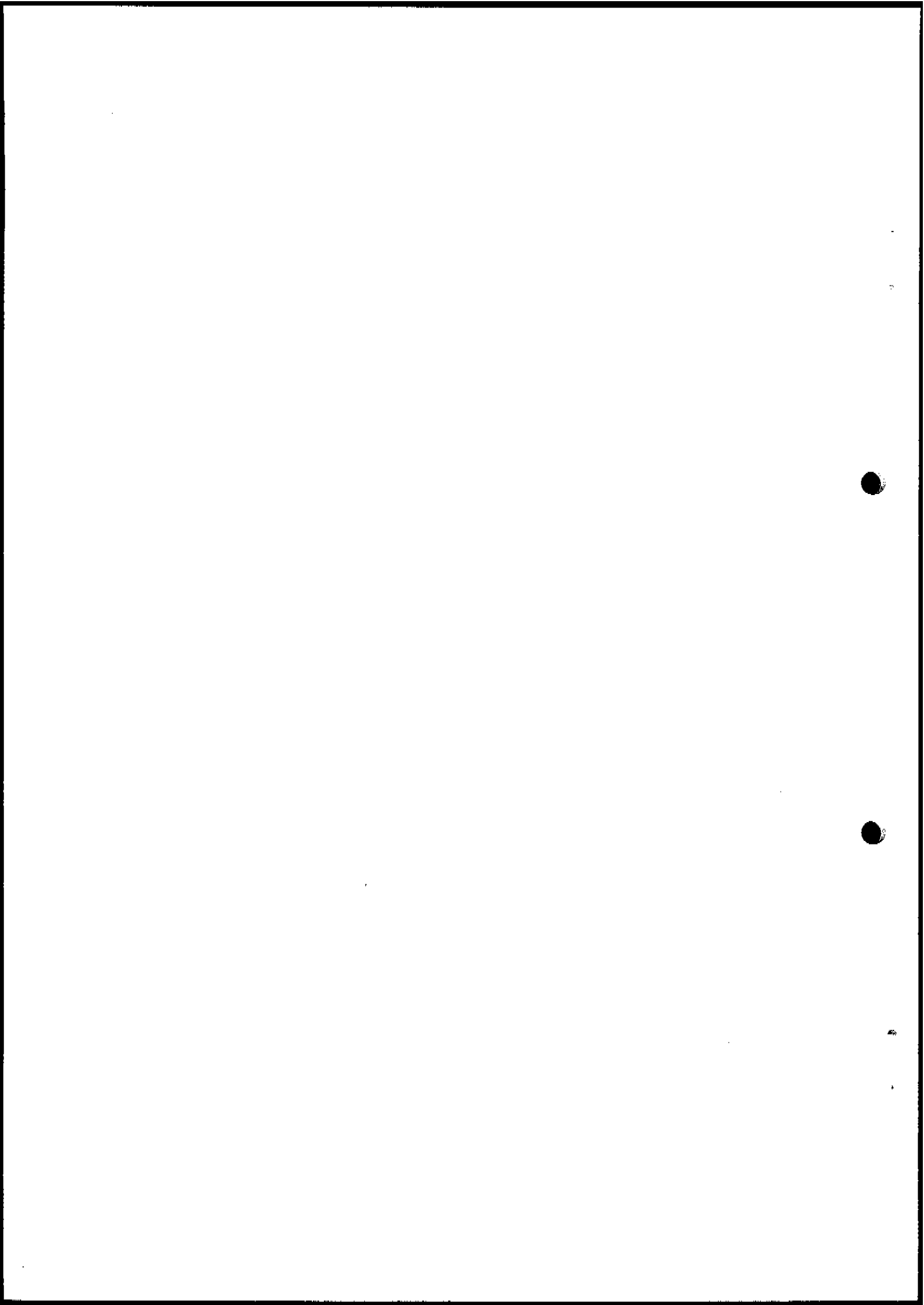
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THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/C/94.03
ENGLISH ONLY

Voorburg, Netherlands
14-17 November 1994

ANNEX III

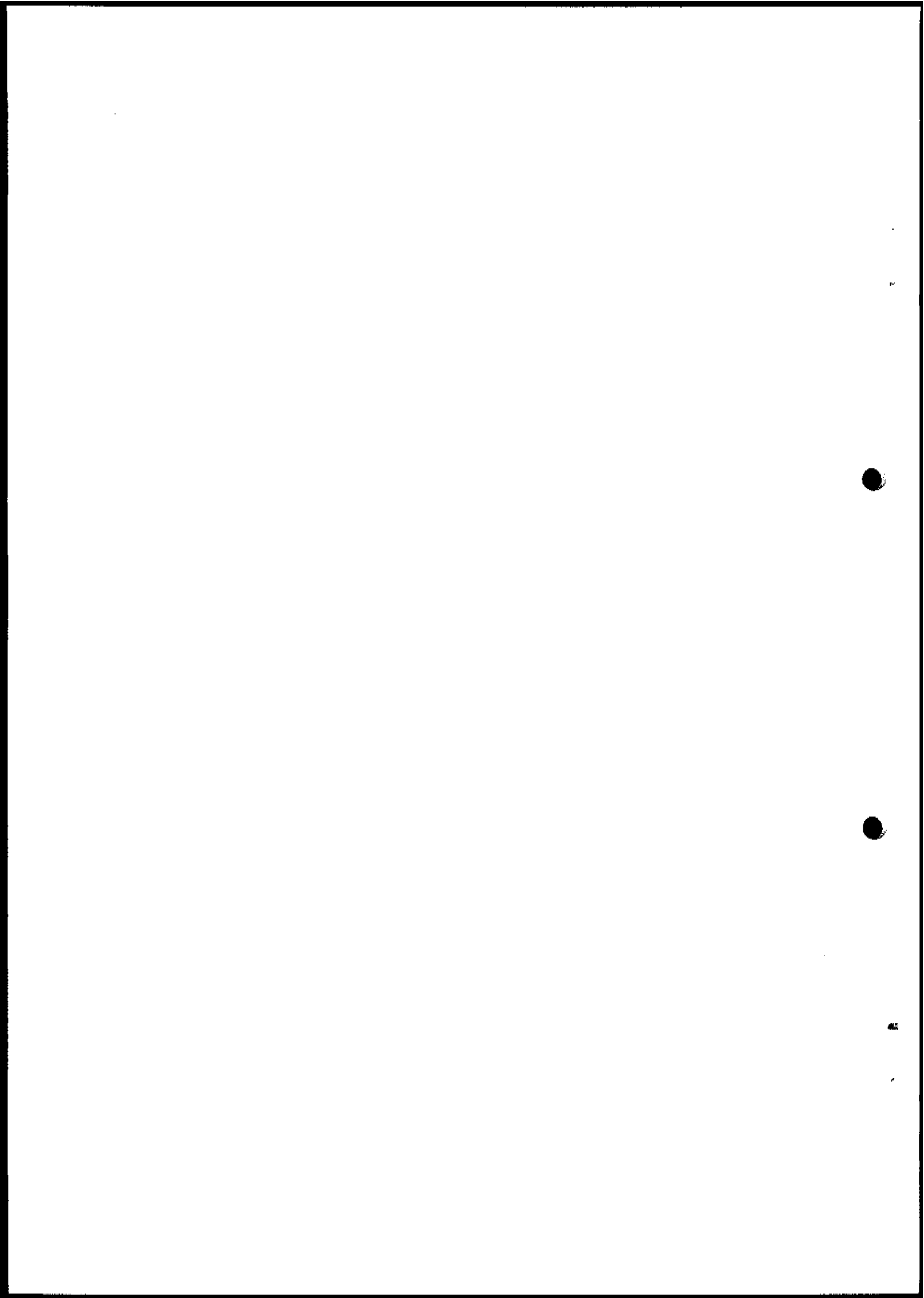
LIST OF DOCUMENTS

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List of Documents

Progress Report on "Movement"	ESS/ICIDH/C/94.04
Proposition française de révision des déficiences de l'appareil oculaire	ESS/ICIDH/C/94.05
Proposition française de révision des déficiences auditives	ESS/ICIDH/C/94.06
Report of the International Task Force on Mental Health and Behavioural-Cognitive-Developmental Aspects of ICIDH Revision	ESS/ICIDH/C/94.07
Progress report from the Nordic WHO Collaborating Centre for ICD and other health related classifications (Draft - Overlaps between the ICIDH and ICD-10, with Annex)	ESS/ICIDH/C/94.08
Progress report for the 3rd ICIDH revision meeting - Disabilities	ESS/ICIDH/C/94.09R
Proposal for the revision of the handicap classification	ESS/ICIDH/C/94.10
ICIDH and environmental factors: A fourth dimension	ESS/ICIDH/C/94.10 bis
Report from the task force on issues related to children for the revision of the ICIDH	ESS/ICIDH/C/94.12
Progress Report - The use of the ICIDH to assess the situation of the elderly	ESS/ICIDH/C/94.13
The development of a proposal for revision of the severity of disabilities scale of the ICIDH	ESS/ICIDH/C/94.15

BACKGROUND DOCUMENTS

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- Vermeer, A. ICIDH and Children
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- Reynders, K. On the definition of handicap in the use of the ICIDH in child rehabilitation
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- Dutch Collaborating Centre for the ICIDH. Appendices "Movement"
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THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/C/94.24
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Voorburg, Netherlands
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ANNEX IV

French report on the revision of the ICIDH concerning the sensory, perception, and communication impairments

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3rd World Health Organization meeting on the revision of the international classification of impairments, disabilities and handicaps

Voorburg, Netherlands, 14-17 November 1994

French report on the revision of the ICIDH concerning the sensory, perception and communication impairments.

As France is in charge of those specific subjects, three working groups have been set up. French experts have been called upon to participate to those groups. They have been chosen according to two main criteria:

- their great knowledge of their medical speciality,
- their belonging to international medical societies which permits them to know what international debates concerning their medical speciality are, and if other classifications are used on their medical field.

Even those who didn't know the ICIDH before working for its revision, well understood the difference with ICD, which they have a deep knowledge of. They accepted not to challenge the general spirit of that classification.

CTNERHI gave them a few instructions concerning what was expected from them:

- * the revision shouldn't lead to a complication of the impairments code: the existing impairments classification includes too many items rather than not enough.
- * It would be better if they could modify the impairment they study without completely changing its structure. A complete modification is intellectually acceptable, but difficult to put into practice and leads to numerous difficulties for comparisons between old and new data. A complete modification of an impairment had to be kept for fields in which many important modifications in medical knowledge have appeared since the first edition of the ICIDH.
- * The first work they have to do is to revise the Impairment code. An analysis of the implications of sensory impairments on disabilities would be important, but may take place in a second time.

The groups working on aural and ocular impairments decided to keep the general structure of the impairment code they were working on, although they considered many medical progress have been realised since 1975, specially concerning the residual vision. The group working on language impairments decided to change more basically the impairment code, as the analysis of language impairments figuring in the present classification seems now no more satisfactory.

The three groups decided to analyse the impairments at first; the disabilities consecutive to those impairments may extend over many categories of disabilities which may also be studied by other working groups. So the work they could do, may be completely redundant, or completely opposite to what may be done in other groups. It seemed more rational to work on disabilities due to sensory impairments after revised drafts on disabilities have been proposed by the groups which have that work in charge.

Drafts concerning visual impairments and mental impairments were finished Summer. They were sent to different experts in Canada, Great Britain, Netherlands, Sweden, United States and to WHO. Those experts had received before before a letter which asked them whether they were other classifications used on those subjects, in order to make sure we didn't ignore something used in foreign countries.

Those reactions to french drafts are not very numerous, but they generally agree on the drafts we sent. You can have a copy of these drafts and reactions we received by asking us here, or writing to CTNERHI in France.

Concerning visual impairments, it seems that much greater consideration is now given to residual vision, than it was the case twenty years ago. The question is: should we try to classify that new notion, or is it wiser to wait until that notion is to try to classify it and its consequences in terms of abilities/disabilities?.

The draft concerning language impairments is not available yet as that subject mix more different medical specialities and more different medical theories than the other ones. The most important orientations of the work concerning language impairments are the following:

- communication has to be precisely defined (are we always sure that a communication trouble is an impairment, could it be considered as a disability, when and what are the consequences of such an analysis)
- the overlaps between communication and language have to be better clarified (is one part of the other, to which extend?);
- language has to be divided into verbal and non verbal language,
- voice and speach have to be distinguished;
- an analysis of developmental and acquired impairments may be interesting.

November 1994



THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/C/94.25
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ANNEX V

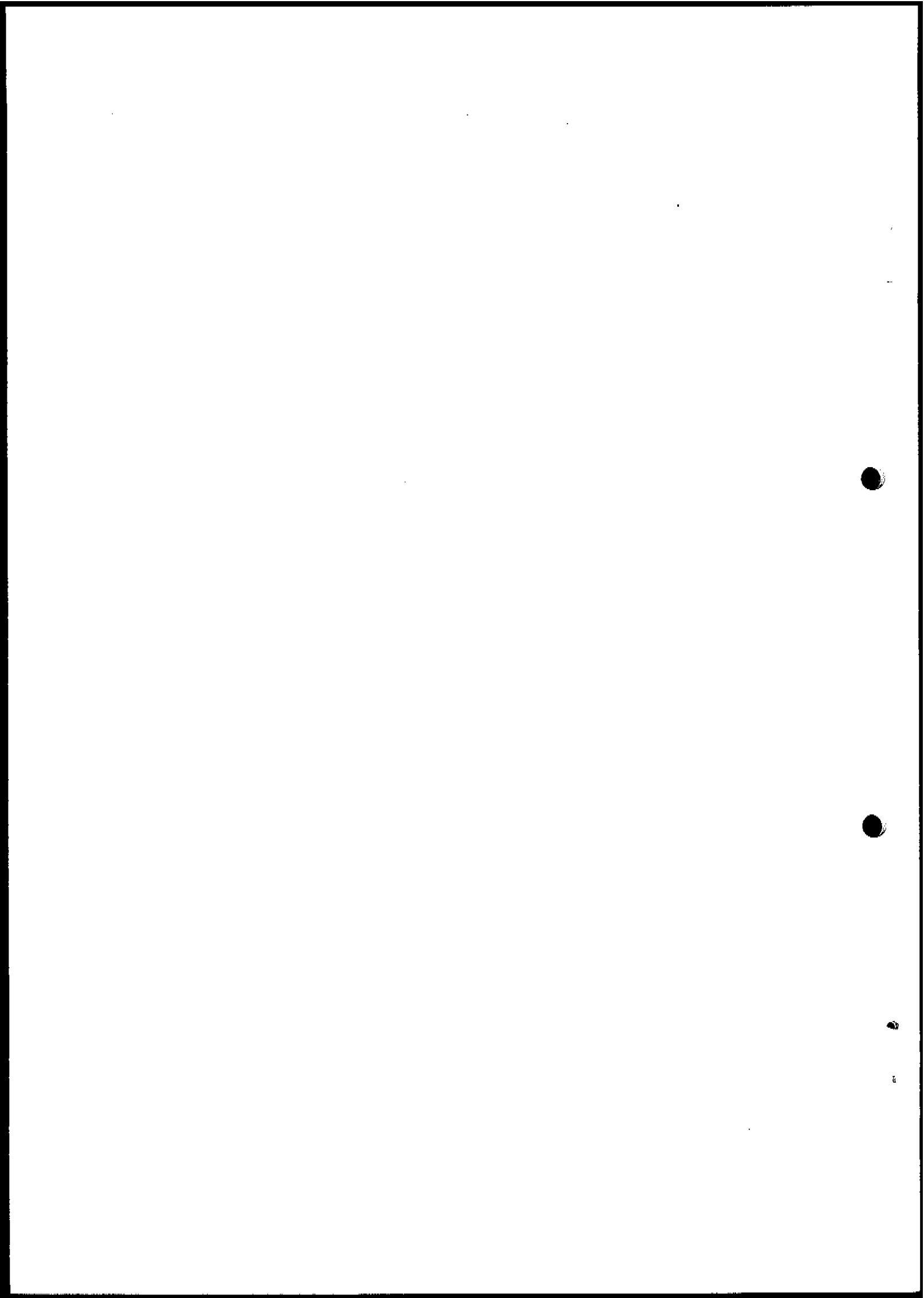
French note on the impairment revision process

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3rd World Health Organization meeting on the revision of the international classification of impairments, disabilities and handicaps

Voorburg, Netherlands, 14-17 November 1994

French note on the impairment revision process

First of all, we apologize for our English which may not be very pleasant for you to listen to; nevertheless we hope we'll succeed in understanding each other. May be Mr Thuriaux will be kind enough to help us if difficulties are too important, unless many of you understand french?

As France is in charge of working on the impairments plane in the ICIDH revision process, we will introduce here the main opinions that run around in France on that subject, and the questions which follow them.

* Concerning the place of Impairments in the ICIDH

As the two planes of disabilities and handicaps seem to be more and more important as time goes by, it has often been discussed whether the impairment plane remains important.

If technical aids and Society succeed in minimizing the consequences of an impairment, does this one still remains something important for the individual?

Major french associations dealing with persons with disabilities are convinced that impairment remains important: whatever the progress will bring in terms of social integration, the person will stay in her own mind someone with an impairment, what we call in France "une personne handicapée". Two obvious exemples of that way of thinking have recently been given:

- that position has been the one the french associations supported in the recent European Forum for disabled people in which a definition of a disabled person had to be adopted,
- the recent "barème", which is used in France to decide wether a person may ask for an allowance due to her "handicap" (a sort of scale), had to take the impairment into account although the initial philosophy of this "barème" was mainly to take the disabilities into account.

This position seems not be a specifically french one, even if american associations do insist on the society responsibility and if french associations do understand the importance of the physical and social environment.

* The impairment plane is not a substitute for diseases

This affirmation seems obvious when people deal with diseases which etiology is completely different from its symptoms: eg tuberculosis, cancer etc. From our point of view this affirmation is still true when diagnosis are very close to symptoms: eg. myopia, deafness, mental retardation etc.

In those cases, the mental impairments, visual impairments or aural impairments still correspond to the definition of "loss or abnormality of psychological, physiological, or anatomical structure or function", even if what is described in ICIDH is not very different from what is described in the ICD. May be the ICD has still some progress to do in the analysis of those symptoms, may be the double belonging of those descriptions is inevitable.

* Concerning some general guidelines in the revision process of impairments

French users generally thinks that they are to many items in the Impairment code.

This overabundance is all the more embarassing that the level of this overabundance is not the same in every category of impairment. This plethora leads the users of ICIDH to use a simplification of ICIDH, and that simplification is not always the same: sometimes a two-digit level,

sometimes a three digit level, sometimes a mix of two and three digit. Those different adaptations make comparisons difficult, if not impossible.

- There is an important difficulty to analyse a sum of impairments a person may present. Those impairments may be different consequences of different diseases or accident, different consequences of a unique disease or accident, different aspects of a unique impairment: eg an individual may present a disfiguring impairment, a sensory impairment, a mechanical impairment, each of them due to a different cause; he may also present a disfiguring impairment, a sensory impairment, a mechanical impairment, all of them due to a fire scar. Those two different cases surely produce different disabilities so that the different consequences of different etiology can be analysed on that plane, but they also may lead to something different on the only point of view of impairment for the individual. How to take this observation into consideration? This point has to be studied.

* The use of the impairment code

The impairment code is used in France for different administrative purposes. The principle ones are the following:

It has been used for a few years to establish national statistics upon children who are in special educational institutions. A working group is presently studying how it can be used in reeducational services to give standardized information on the users of those services in order to set up an adequate tarification of those services.

November 1994

Dutch report concerning movement introduces some very important questions which have to be discussed at a more general level.

- Overabundance or/and lack of relevant items?
The impairment code is the biggest one.
Is it a good solution to introduce a general plethora and ask users of ICIDH to choose the level of detail they need for their own purposes or should we introduce new items in very precise domains where there are obvious missing like impairments in the nervous system for the movement chapter?
- There is a real problem for some special areas (children and elderly). This seems particularly true for some impairments as language impairment for very young babies. Should we classify these specificities or is it wiser to let those problems for the users which may not apply all the impairments or may adapt some impairments for specific age groups? In that case is it a good idea to introduce that reference to age in the definition of impairments.
- Is it necessary, interesting, to work on anatomical impairments in every case or is it better to give interest to those anatomical impairments only when the functional impairment are not sufficient to describe the reality. It seems that in many cases the anatomical lesion is included in a functional impairment, in very few cases only, you don't describe the first ones in describing the second ones.
The french position is to keep the anatomical lesion only in cases when it is not included in a functional impairment.



THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/C/94.11
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Voorburg, Netherlands
14-17 November 1994

ANNEX VI

Summary of the work of UNSTAT on development of IDH Statistics

prepared by UNSTAT

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The work of the United Nations Statistical Division (UNSTAT) on development of disability statistics has progressed in two major areas:

- (1) design of statistical methodology and standards for data collection and for development of global indicators; and
- (2) production of statistics and indicators of disability.

Design of statistical methods and standards

With respect to the first area, UNSTAT is conducting an Expert Group Meeting on the Development of Impairment, Disability and Handicap Statistics from 7-11 November 1994, to be hosted by the Netherlands Central Bureau of Statistics at Voorburg, and whose purpose is to: (a) review existing disability data collection methods and standards, and (b) to prepare based upon the outcome of this review, a guiding set of principles for use in censuses, surveys and registration systems. These guiding principles have been prepared through the collaboration of CBS Netherlands and UNSTAT as a *Draft Handbook: Development of Impairment, Disability and Handicap Statistics* (ESA/STAT/AC.47/5), and will be fully reviewed by the Expert Group prior to its revision and publication by the United Nations in 1995. Specific attention is paid in the Handbook to the use of the WHO International Classification of Impairments, Disabilities and Handicaps (ICIDH) by countries around the world and the WHO revision process. For this reason, the Expert Group meeting is planned to co-ordinate with the next *International Meeting of WHO on the Revision of the International Classification of Impairments, Disabilities and Handicaps*, to be held in the Netherlands from 14-17 November 1994.

In anticipation of the Expert Group, UNSTAT and the North American Collaborating Center (National Center for Health Statistics) jointly organized an international meeting on the *Scientific Review of Applications: International Classification of Impairments, Disabilities and Handicaps (ICIDH)* held from 31 May to 3 June 1994 in St. Michaels, Maryland (ECA/STAT/AC.47/INF.1).

Furthermore, a set of global indicators have been prepared in the 1993 framework for the Third Monitoring of Progress towards Health for All (HFA) to be carried out at the national level by all Member States, and includes a disability-related indicator jointly developed by WHO and UNSTAT: "the number of people identified as having one of the following types of disabilities: difficulty seeing, difficulty hearing, difficulty speaking, difficulty moving, difficulty learning/comprehending/remembering, or other (please specify)" and is published in the *Implementation of strategies for health for all by the year 2000. Third monitoring of progress - common framework GFM3* (WHO/HST/GSP/93.3).

A similar indicator has been developed by UNICEF and WHO in collaboration with UNSTAT for use in assessment of progress towards the aims of the World Summit for Children and is reported in the UNICEF/WHO document on *Indicators for Monitoring Health Goals of the World Summit for Children, Recommended by WHO and UNICEF for National Monitoring and Programme Management and International Reporting*, 7 June 1993.

Production of statistics and indicators

With respect to the second area of work of UNSTAT, dissemination and use of the United Nations Disability Statistics Data Base (DISTAT) for the production of statistics and indicators has continued. In 1994, consultants to UNSTAT prepared a report on "A Human Development Agenda for Disability: Statistical Considerations" that suggests possible approaches to including disablement in the monitoring of human development outcomes, a project based on DISTAT and supported by SHIA, the Swedish Organization of Handicapped International Aid Foundation.

A special article "Disability Statistics in Studies of Ageing" was published in the *Demographic Yearbook Special Issue on Ageing* that presents age and sex-specific disability data for 57 countries and discusses the implications for policy formulation and programme planning (Sales No. E/F.92.XIII.9), a project supported by UNFPA.

As a contribution to the International Year of the Family, the percent of persons with disability for 87 countries was published in the *Statistical Chart on World Families*, United Nations publication Sales No. E.93.XVII.9, supported by the Trust Fund for the International Year of the Family.

A report has been prepared by UNSTAT and the World Health Organization for the Fifth ECE/WHO Joint Meeting on Health Statistics, Conference of European Statisticians on the *ICIDH and the Development of Disability Statistics* (CES/AC.36/51) (EURO/ICP/HST/157/51).

The Report of the International Workshop on the Development and Dissemination of Statistics on Persons with Disabilities is now available in English and French and summarizes the conclusions of a meeting organized by Statistics Canada and the United Nations Statistical Division, October 13-16 1992, Ottawa, Canada. It is circulated as an information note to the Expert Group meeting as ESA/STAT/AC.47/INF.1.

UNSTAT has prepared, in collaboration with WHO, a draft statistical training manual for development of disability statistics prepared especially for the use of managers and programme planners in the production of national disability statistics through surveys, censuses and registration systems, to be published by the United Nations in 1995, a project supported by SIDA, the Swedish International Development Authority. This draft manual is currently titled *Manual for the Development of Statistical Information for Disability Programmes and Policies* and has been submitted to the Expert Group for information and discussion prior to its completion and submission for publication (ESA/STAT/AC.47/INF.3).

UNSTAT continues to be involved in the further development of the ICIDH for the production of statistics, especially in population census and survey programmes and in the development of administrative registries, through its participation in the WHO ICIDH revision process.





THIRD MEETING ON THE REVISION OF THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ESS/ICIDH/94.14
ENGLISH ONLY

Voorburg, Netherlands
14-17 November 1994

ANNEX VII

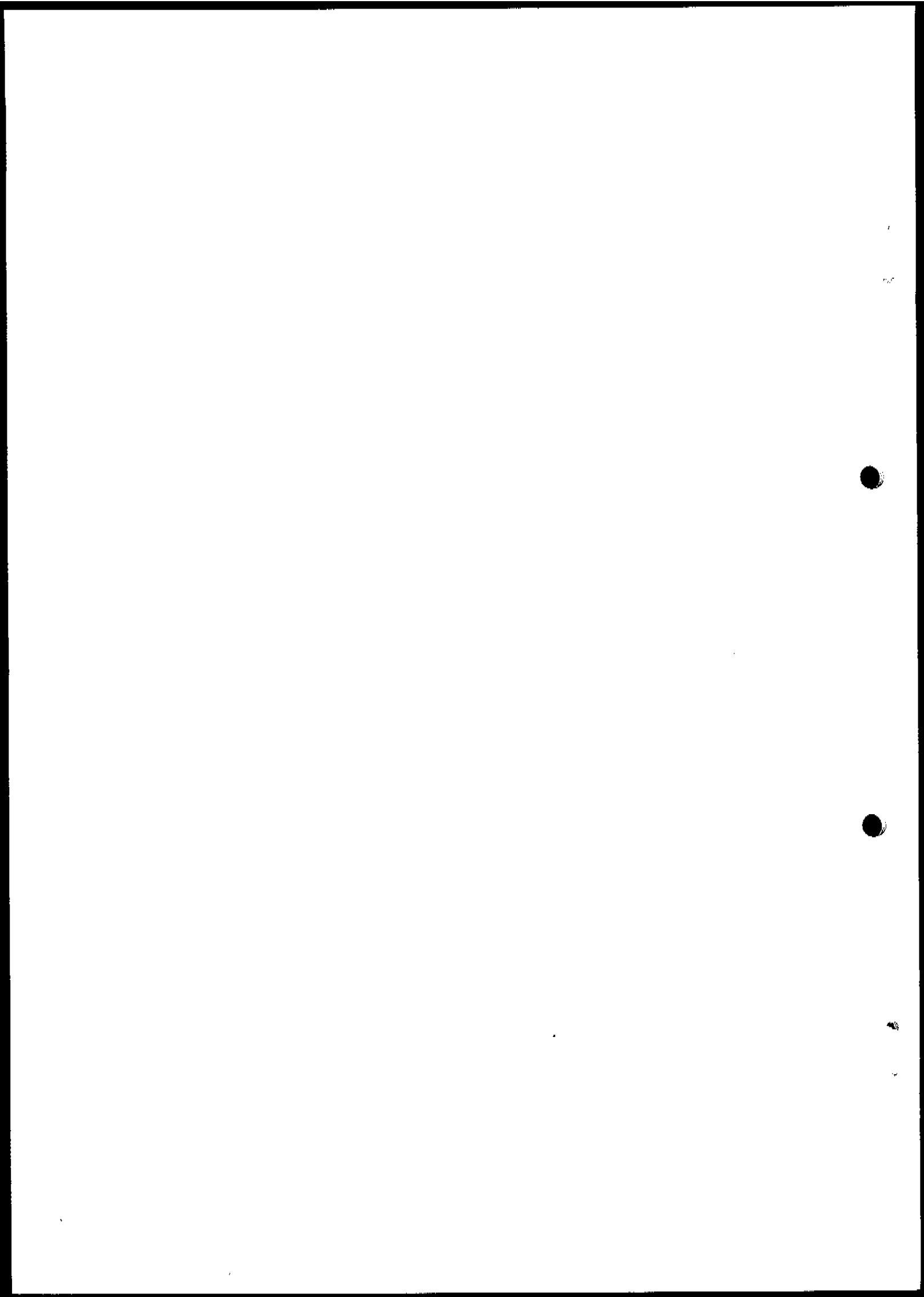
Proposed Taxonomic Guidelines for the ICIDH

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PROPOSED TAXONOMIC GUIDELINES FOR THE ICIDH:

Dr. W. Hirs, Dr. M.C. Thuriaux, Dr. J.E.C. Cooper, Dr. P. Lurie

Introduction

The basic philosophy in terminology is that we do not have as many words in our language as we have concepts in our knowledge. Standard classification may help us to cope with this problem: we can agree on the use of one term for each of those concepts we wish to standardize, but do not need to standardize every word for every concept or every entity.

Three steps can be considered in the construction of a classification of concepts.

Select entities and attributes belonging to the domain or subject field we want to classify.

If the main purpose of the ICIDH is to order and count phenomena relating to the individual, the taxonomic requirements of the ICIDH may be restricted to the individual person and his/her characteristics. Objects which are not under control of the individual person, such as physical and social environment, do not belong to this IDH domain, nor do other intrinsic characteristics of the individual, like disease, age or sex, for obvious reason. However external factors, like environment and role, may become characteristics of the handicap of a person as far as these factors influence the individual's universe. But then, so do the life perspective and personal beliefs of the individual, insofar as these fundamentals influence coping with I, D, H.

Select concepts and relationships which construct the classification required for a specific purpose.

Taxonomic requirements for ICIDH may be met by three independent hierarchies of interference with individual performance:

- at structure/function organizational level (below the individual level);
- at the individual level;
- at the level of interaction with society, above the individual level.

Select a term which has a one-to-one relation to each concept.

In English, we only have to cope with the acceptability of terms such as impairment, disability and handicap. The concepts rather than the words themselves should be translated to other languages.

Guidelines (1-12)

Domain of the ICIDH (1-3)

1. The classifications should encompass the whole range of impairments, disabilities and handicaps, according to the agreed concepts; the current working definitions (dealing respectively with psychological/physiological/anatomical structure or function; with skills/activities, and with disadvantages) should be kept for the time being.

2. The ICIDH should be limited to classification of impairments, disabilities and handicaps:
 - a) only those symptoms and disorders which correspond to impairments should be included - diseases codes as such in the ICD should not appear in the ICIDH;
 - b) other data elements (such as age and sex) should be coded separately and not incorporated into the ICIDH codes;
 - c) lists or classifications of environmental or other external factors for use alongside the ICIDH codes are important adjuncts, but not in themselves part of the ICIDH.
3. Categories of impairments, disabilities, or handicaps which cannot be measured or assessed should be avoided wherever possible.

General classification structure (4-7)

4. Every impairment, disability or handicap must have a single, well defined place in the list of categories.
5. Categories belonging to the same plane (impairment, disability or handicap) should be mutually exclusive (categories in different planes are mutually exclusive by definition).
6. The three planes of the ICIDH should be regarded as related classifications, although each can be viewed (and used) as an independent classification. There should be no overlap among the three planes of the ICIDH (i.e., impairments should not be included in the disability or handicap codes, etc.).
7. The revised ICIDH should be as easy to use as possible. This can be achieved by standardizing definitions and terminology and through adequate indexing and annotations for users of all levels of sophistication.

Classification principles (8-12)

8. Each of the classifications should have a hierarchical structure with subdivisions. The classifications should retain the ability to identify individual conditions separately, and to allow presentation of data for broader groupings of conditions.
9. Impairments, disabilities and handicaps of particular public health importance should have their own categories.
10. Impairments, disabilities and handicaps that occur frequently should have their own categories.
11. There should be residual categories (other and unspecified) for "other" and "miscellaneous" conditions that cannot be allocated to more specific categories. The number of conditions assigned to residual categories should be kept to a minimum.
12. The ICIDH should leave room for expansion. Leave "empty" code numbers to be filled if and when need arises and develop mechanisms for periodic updating.



SES/ICIDH/93.35
ENGLISH ONLY

WORLD HEALTH ORGANIZATION MEETING ON THE
INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS
DISABILITIES AND HANDICAPS

ANNEX VIII

December 7-10, 1993
Pan American Health Organization Headquarters
525 23rd Street, Northwest
Washington, D.C. 20037

Executive Summary

In its capacity as World Health Organization Collaborating Centre for the Classification of Diseases and Health-related Classifications for North America, the National Center for Health Statistics hosted a WHO-sponsored meeting on revising the International Classification of Impairments, Disabilities, and Handicaps (ICIDH), December 7-10, 1993 at the Pan American Health Organization, Washington D.C. This was one in a series of international meetings being held as part of 1990's revision effort. Over 30 experts in disability classification and statistics from 10 countries considered proposals for revising the ICIDH, with special emphasis on mental health. About 30 additional observers from the USA attended the first day of the meeting (December 7), and expressed their willingness to participate in the revision process.

Agreement was reached on a tentative schedule of international meetings towards the revision of the ICIDH. Formalization of the classification will follow usual WHO procedures. It is anticipated that a revised proposal can be finalized for the 50th anniversary of WHO - and the 18th anniversary of the ICIDH - in 1998, and formally issued in 1999. The proposed international meetings (see Annex I) will focus on substantive ICIDH revision themes, as follows: 1994, children and special groups; 1995, policy relevance; 1996, relevance to developing countries; 1997, topics arising from earlier work and final agreement towards a revised draft. Four groups were established to focus on particular problem areas in the classification, with a focal role assigned to Collaborating Centres as follows:

Behaviour and Development (a.k.a. Mental Health) - NCHS (North America)

Sensory, Perception and Communication Functions - CTNERHI (France)

Movement - WCC (Netherlands)

Other and crosscutting concerns - Uppsala (Nordic countries) is considering this

WHO should ensure technical reviews and overall coordination of the process in cooperation with collaborating centres and relevant IGOs and institutions. In addition, it was agreed that the Collaborating Centres would continue their role in revising the various planes of the classifications (Impairments: CTNERHI; Disabilities: WCC; North American Collaborating Centre: Handicap), and that taxonomical guidelines would be prepared for use during the revision process.

At a preliminary meeting held on December 6th, dealing with problems of statistics and surveys on disability and the use of the ICIDH therein, it was recommended that such use be monitored jointly by UNSTAT and WHO.

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