

International Classification of Functioning, Disability and Health: a Content Analysis

Classificação Internacional de Funcionalidade, Incapacidade e Saúde: uma Análise de Conteúdo

Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud: un Análisis de Contenido

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ABSTRACT

Objective: The study's purpose has been to produce a content analysis of the International Classification of Functioning, Disability and Health, aiming to describe and interpret it. **Methods:** It is a research with a qualitative approach and showing a theoretical basis of Georges Canguilhem in "The Normal and the Pathological". **Results:** Based on the findings, the following categories appeared: Biological organism and the normality/pathology relationship; Disability and functioning influenced by the environment. **Conclusion:** It is concluded that the normatively contained in International Classification of Functioning, disability and Health, by principle, does not meet the population diversity. Nonetheless, it shows an articulate attempt towards medical and social models, which can extend the nurses' perspective beyond metrics, with regards to the relation of environment and body under pathological and normal condition.

Descriptors: International classification of Functioning, Disability and Health, Health, Disease, Nursing.

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RESUMO

Objetivo: Produzir uma análise de conteúdo da Classificação Internacional de Funcionalidade, Incapacidade e Saúde. **Métodos:** Trata-se de uma análise de conteúdo para descrever e interpretar os conteúdos da Classificação Internacional de Funcionalidade, Incapacidade e Saúde, a partir de uma perspectiva qualitativa e com aporte teórico de Georges Canguilhem em “O Normal e o Patológico”. **Resultados:** Emergiram as seguintes categorias: Organismo biológico e a relação de normalidade/patologia; Incapacidade e funcionalidade influenciadas pelo ambiente. **Conclusão:** A normatividade contida na Classificação Internacional de Funcionalidade, Incapacidade e Saúde, por princípio, não atende a diversidade da população, apesar disso, apresenta uma tentativa de articulação dos modelos médico e social, o que pode ampliar a perspectiva dos enfermeiros acerca da relação do ambiente e do corpo na patologia e na normalidade, para além das métricas.

Descritores: Classificação Internacional de Funcionalidade, Incapacidade e Saúde, Saúde, Doença, Enfermagem.

RESUMEN

Objetivo: Producir un análisis de contenido de la Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud. **Método:** Se trata de una análisis de contenido para describir e interpretar los contenidos de la Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud, desde una perspectiva cualitativa y una base teórica de Georges Canguilhem en “Lo normal y lo patológico.” **Resultados:** Surgieron las siguientes categorías: organismo biológico y la relación de la normalidad/patología; discapacidad y funcionalidad influenciadas por el ambiente. **Conclusión:** Se llegó a la conclusión de que la normatividad contenida en la Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud, en principio, no comprende la diversidad de la población, aunque presenta un intento de articular los modelos médicos y sociales, lo que puede ampliar la perspectiva de los enfermeros sobre la relación del ambiente y del cuerpo en la patología, y en la normalidad, además de las métricas. **Descriptor:** Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud, Salud, Enfermedad, Enfermería.

INTRODUCTION

The International Classification of Functioning, Disability and Health (ICF) is part of the “family” of classifications developed by the World Health Organization (WHO). The WHO family of international classifications aims to provide a system for the coding of health information using a standardized language that facilitates communication about health and health care in all countries, across different disciplines and sciences.¹

The ICF is described as a “multipurpose” classification, with a number of specific objectives, including: establishing a common language for describing health and health-related states, contributing to the dialogue among various professionals, including health professionals and for the development of interdisciplinary understanding and global classification system.¹

It is emphasized that nurses are an important professional category in the health area and as such, they understand the need to use ICF as a working tool.² Nevertheless, it is understood that nurses need to understand the explicit and implicit contents that this classification has. These contents

present questions related to physiology and anatomy in relation to functionality and disability, in a normative perspective intrinsic to the pre-established metric.

Hence, this study targets to produce a content analysis of the International Classification of Functioning, Disability, and Health.

International Classification of Functioning, Disability and Health

The current ICF model was approved in May 2001 by the World Health Assembly from the WHO. WHO is a United Nations international organization responsible for people's health. WHO experts develop health guidelines and standards, helping countries address public health issues. WHO also supports and promotes health research and it is through this that governments can jointly address global health issues and improve people's well-being.

The WHO is made up of 192 Member States, which govern the institution through World Health Assemblies, in which only the official representatives of the Member States have the right to vote. Currently, WHO has a structure with six Regions (Americas, Africa, Europe, Eastern Mediterranean, Southeast Asia and Western Pacific) and a Headquarters, located in Geneva. Each Region has a Regional Committee and a Secretariat. The meetings of the Committee are held each year and are represented by all the countries of the Region. The Secretariat acts as a Regional Office and is chaired by a Director General, elected by the Regional Committee, ratified by the WHO Executive Board and appointed by the Chief Executive Officer of the WHO.³

In the WHO international classifications health states (disease, disorders, among others) are classified according to the International Classification of Diseases, Tenth Revision (ICD-10), which provides an etiological basis structure. While the functionality and disability associated with health status are classified in the ICF. Therefore, ICD-10 and ICF are complementary and allow an expanded and significant view of the health of people or the population, which can contribute to decision-making.¹

ICF differs from ICD-10 because it presents elements, called Contextual Factors, which present society as co-responsible in the constitution of barriers that imply a better functioning of the evaluated people.¹

The ICF model is based on the articulation of medical and social models, using a biopsychosocial approach to visualize the integration of the various dimensions of health (biological, individual and social).^{1,4} In this sense, the concepts contained in ICF introduce a new paradigm for thinking and working for disability and disability, which are determined by health/illness conditions, context (physical and social environment), different cultural perceptions and attitudes towards disability, availability of services and legislation.⁵

Functionality is prioritized, according to ICF, as a component of health, considering the environment as a facilitator or as a barrier to the performance of activities and participation. Thus, disability is the result of a set of situations and conditions that encompass the environment, living conditions and personal conditions.¹

The ICF provides a unified language and constitutes a framework for describing health and health-related states. It has a universal application and can be used in all people and in any health condition, by professionals of various areas of knowledge.¹

According to the WHO,¹ the ICF has been used as a statistical, research, clinical, social and pedagogical policy tool. In clinical practice it is used by several specialties, contributing to evaluation and the decision-making process. Its political-social application is revealed in some countries in the framework of legislative or political changes and social regulation. Already in the educational system as a conceptual framework for the teaching/learning process or curricular units.⁶

It is worth mentioning that ICF-related publications are increasing, but are evidenced in the areas of rehabilitation, pediatrics, care for the elderly, chronic diseases, stroke, spinal cord injury and mental illness, developed mainly by speech therapists, occupational therapists, physiotherapists.⁷

There is evidence in the literature that nurses are not accustomed to the concepts of ICF.⁸ Nonetheless, studies point out that ICF has a potential structure for nursing, expanding the dimensions of nurses' thinking about health and disability.^{2,7,9,10} It is considered a valuable tool in the search for best practices and positive results for patients.⁷ It assists in the evaluation and planning of the health needs of disabled people who are in the care of nurses, as well as being a useful conceptual framework for nursing education, practice and research.² ICF terminology and codes can be used in problem statements as well as in etiology and signs and symptoms.¹⁰

The following definitions are given in the ICF:

The Body Functions are the physiological functions of organic systems (including psychological functions). Body structures are the anatomical parts of the body, such as organs, limbs, and their components. Disabilities are problems in body functions or structures, such as a major deviation or a loss. Activity is the execution of a task or action by an individual. Participation is the involvement of an individual in a real-life situation. Limitations of activity are difficulties that an individual may have in performing activities. Participation restrictions are problems that an individual may face when engaging in real life situations. Environmental factors constitute the physical, social, and attitudinal environment in which people live and lead their lives [emphasis added].^{1:13}

It should be noted that ICF organizes information into two parts and each part has two components. The first part consists of functionality and disability and its components are: body; activities and participation. The Body component includes two classifications, one for the functions of the organic systems and another for the body structures. In both classifications the chapters are organized according to the organic systems. The Activities and Participation component covers the full range of domains that indicate aspects of functionality, both from an individual and a social perspective.¹

The second part refers to the contextual factors and their components are: environmental factors and personal factors. The component, environmental factors have an impact on all components of functionality and disability and are organized sequentially, from the most immediate environment of the individual to the overall environment. Personal factors are not yet classified by the ICF due to the great social and cultural variation associated with them.¹

Each part also presents constructs that are the qualifying agents of the limits and possibilities of the individual. All ICF classifications can be positive or negative and are organized by an alphanumeric system, in other words, they are indicated by coders (letters and numbers) that determine what they are referring, and followed by qualifying agents that are represented by numbers. Each component is defined by a letter that will compose the encoder. The Body Functions are defined by the letter "b" (body), the Structures by the letter "s" (structure), the Activity and participation by the letter "d" (domain) and the Environmental Factors by the letter "e" (environment).¹

Table 1 shows the qualifiers according to the ICF, which will accompany the alphanumeric codes and that will allow them to be assigned meaning. Then, they will be identified by means of metrics, in other words, quantitatively.

Table 1 – Qualifiers of the ICF. Adaptation: WHO, São Paulo city, Brazil - 2003.

Components	First qualifier	Second qualifier	Third qualifier
Body functions (b)	xxxx.0 NO disability 0-4% xxx.1 SLIGHT disability 5-24% xxx.2 MODERATE disability 25-49% xxx.3 SERIOUS disability 50-95% xxx.4 COMPLETE disability 96-100% xxx.8 not specified xxx.9 not applicable	None	None
Body structures (s)	xxxx.0 NO disability 0-4% xxx.1 SLIGHT disability 5-24% xxx.2 MODERATE disability 25-49% xxx.3 SERIOUS disability 50-95% xxx.4 COMPLETE disability 96-100% xxx.8 not specified xxx.9 not applicable	0 no change in structure 1 total absence 2 partial absence 3 additional part 4 abnormal dimensions 5 discontinuity 6 position deviation 7 qualitative changes in structure, including fluid retention 8 not specified 9 not applicable	SUGGESTED 0 more than one region 1 right 2 left 3 both sides 4 anterior part 5 back 6 proximal 7 distal 8 not specified 9 not applicable
Activity and participation (d)	PERFORMANCE xxxx.0 NO deficiency 0-4% xxx.1 SLIGHT deficiency 5-24% xxx.2 MODERATE deficiency 25-49% xxx.3 SERIOUS deficiency 50-95% xxx.4 COMPLETE deficiency 96-100% xxx.8 not specified xxx.9 not applicable	CAPACITY Generic qualifier. * Same as the performance qualifier;	None
Environmental factors (e)	xxx.0 NO obstacle 0-4% xxx.1 SLIGHT obstacle 5-24% xxx.2 MODERATE obstacle 25-49% xxx.3 SERIOUS obstacle 50-95% xxx.4 COMPLETE obstacle 96-100% xxx.0 NO facilitator 0-4% xxx.1 SLIGHT facilitator 5-24%	In preparation	None

xxx-2 MODERATE facilitator 25-49%
xxx-3 SERIOUS facilitator 50-95%
xxx-4 COMPLETE facilitator 96-100%
xxx-8 Obstacle not specified
xxx-8 facilitator not specified
xxx-9 not applicable

of Functioning, Disability and Health. São Paulo city: Publishing company from the Universidade de São Paulo - EDUSP; 2003.

METHODS

It is a content analysis¹¹ to describe and interpret the contents of the ICF, with the intention of producing a theoretical essay, from a qualitative approach and with the theoretical contribution of Georges Canguilhem in “The Normal and the Pathological.”¹²

According to Moraes,¹⁰ content analysis helps reinterpret the messages contained in the text and reach an understanding of their meanings at a level above a common reading. It should be noted that the raw material of this analysis can consist of numerous materials from verbal or non-verbal communication, such as letters, magazines, books, autobiographical reports, recordings, interviews, personal journals, photographs, videos, etc. However, these data are presented as raw data and require processing in order to facilitate the work of understanding, interpretation, and inference.

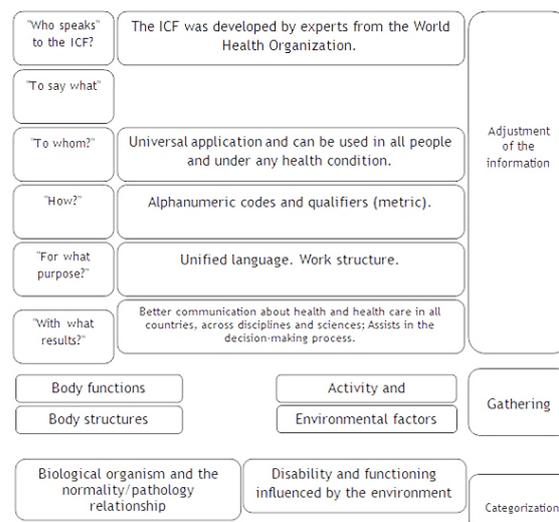
In a qualitative perspective, the analysis of content starts from a series of assumptions, serving as an aid for the symbolic sense. This sense is not always manifest and its meaning is not unique.¹¹ In this study, the theoretical contribution of Georges Canguilhem,¹² was used as a basis for the analysis.

The ICF content analysis was followed by five steps, as follows: Preparation of information; Gathering or transformation of content into units; Categorization or classification of units into categories; Description; Interpretation. In the preparation of the information, a reading of the ICF was carried out and possible answers were sought for the questions: “Who speaks” to the ICF? “To say what?” “To whom?” “How?” “For what purpose?” “With what results?”. Then, the process of gathering the data was performed, in other words, the re-reading of the text was carried out in order to define the unit of analysis. This unit of analysis is the unitary element of content to be subjected to categorization.¹¹ It is emphasized that the nature of the unit of analysis needs to be defined by the researcher. Therefore, these units can be either words, phrases, themes, etc.¹¹ Herein, we chose to select the units of analysis from the existing division in the ICF. This is divided as follows: Body functions; Body structures; Activities and participation; Environmental factors.

From the units of analysis, the categorization was carried out, which consists of the grouping of data considering the common part existing between them. Based on the findings, the following categories appeared: Biological organism and the normality/pathology relationship; Disability and functioning influenced by the environment.

Figure 1 shows the matrix of the ICF¹ content analysis process using the theoretical basis of Canguilhem.¹²

Figure 1 – Matrix of the ICF content analysis process. Rio Grande city, Brazil - 2017.



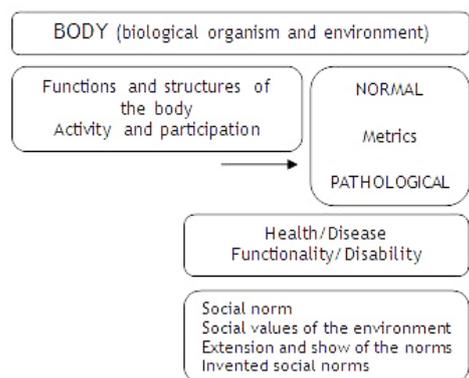
Source: Author, 2017.

This study did not need to be submitted to an ethics committee because it is a content analysis of the “International Classification of Functioning, Disability, and Health”, which is a public domain source.

RESULTS AND DISCUSSION

From the analysis of ICF content, through the theoretical contribution of Georges Canguilhem, 12 categories emerged: Biological organism and the relation of normality/pathology; disability and functionality influenced by the environment.

Figure 2 – Results matrix. Rio Grande city, Brazil - 2017.



Source: Author, 2017.

Biological organism and the normality/pathology relationship

The ICF initially observes the biological organism and then emphasizes its relation to the environment. In this understanding, there is a limit, which is that of the body, that is, when classifying this body (functions and structures), according to ICF, it is necessary to understand what are the

functions and structures of this body considered normal to then indicate the extent and/or the nature of the disability. The extent of disability in ICF will be identified by means of evaluative instruments based on metrics, such as the scale named Functional Independence Measure (FIM),¹³ to interrelate with the own qualifiers of the ICF.

Normality/pathology appears in the ICF as the basis for sustaining the WHO discourse. This classification has a determining role in the gaze that is directed to society, and also, in the public policies that will be structured from their data.

Accordingly, when thinking about the phenomenon of health/illness, disability/functionality, it is important to emphasize that the human being constantly seeks a state of health, a state of functionality, these are taken as a norm, constituting a social norm imposed, being almost unconsciously accepted. Focusing on what you think about illness and disability. From this perspective, it can be said that today the individual, besides being healthy, must be functional.

In this understanding, Canguilhem, referring to Jaspers, refers, from the biological perspective of the human being, that “more than the opinion of doctors, it is the appreciation of patients and the dominant ideas of the social environment that determines what is called ‘disease.’”^{12:76} Therefore,

[...] are the patients who often judge - from very different points of view - whether they are no longer normal or have been. For a man who imagines his future almost always from his past experience, to return to normal means to resume an interrupted activity, or at least an activity considered equivalent, according to individual tastes or the social values of the environment.^{12:74-5}

This admits the uniqueness and different perceptions present in human beings and the esteem of “the social values of the environment.” Therefore, “what characterizes either a normal object or a fact, in reference to an external or immanent norm, is to be able to exist, in turn, taken as a point of reference in relation to objects or facts still waiting to be classified as such.”^{12:188} Thus, the norm is the extension and the display of the norm.¹²

What is not desired in medicine is expressed only by what is not desired in the social, because disease is the extension of a person's desires to return to an earlier state of non-weakness, in other words, society in the pursuit of health and of functionality, is tied to an idea of normality that underlies the medical sciences.

Given this perspective, the health represented by the conception of WHO, through the ICF carries, in its historical baggage, the understanding of what is normal or not, from the idea of something not desired. By not rethinking the concepts of health and disease ends up supporting the spread of the concept of disease as an abnormality. Therefore, the nurses, when using ICF, must understand the explicit and implicit contents, and then consciously recognize their limits and surmount them.

According to Canguilhem's thoughts,

When it comes to human norms, this study recognizes that these norms are determined as the ability to act of an organism in a social situation, and not as functions of a body regarded as a mechanism linked to the physical environment. The form and functions of the human body are not only the expression of conditions imposed on life by the medium but the expression of the socially accepted ways of living in the middle.^{12:218}

The normal, according to this author, is not due to the absence of normality, this is effective because it presents another normality different from the one that becomes predominant or that is desirable. So, the author stresses to the understanding that states that indicate an imbalance are somehow a state of living and pathological states would be in their understanding an intolerance of the individual to new life forms. Such intolerance generated by multiple factors. Therefore, recovery and/or cure is not at any time a return to the previous state, what happens is the appearance or not of new conditions adaptive to other norms of life.

What persists is that the standard of normality established in medical vision begins with the idea of fixing imperfections and abnormalities present in people, in a strictly functional perspective. This idea ignores that diseases are also forms of a reaction of the organism to certain situations. Therefore, medical attention to patients is offered for the restructuring of absent or non-functional organic functions.

Consequently, even if the medical sciences progress by emphasizing that there is a relationship between the biological organism and the environment, what persists is the predominance of the biological organism over the environment. There is an overlap of biology, not a dialectical relationship with the individual and the environment. The ICF, in this understanding, seeks the interconnection with the social in the classification of the health situations of the people, but does so from the biological normality of the organism in relation to the environment. This provokes a way of imposing normality from the point of view of the medical sciences.

Disability and functioning influenced by the environment

It is hoped that with the implementation of ICF, some barriers may be broken and people with some type of disability will have the maximum functionality within society. The development of a prototype based on assistive technology, for example, has sought to reduce the level of dependence and help in the performance of daily activities and self-care of a person with a sequel of large traumatic brain injury. This study demonstrated through its results that the use of strategies for care based on the components of ICF functionality is useful, providing greater independence and skills for self-caring.¹⁴

The ICF as a classification tool seeks to broaden the gaze by establishing correlations with some of the elements of social order for the classification of functionality and disability.

According to the ICF, for example, a visually impaired person does not cross a street, not because he is visually impaired, but because, in addition to having a disability, society has not developed innovative technologies that facilitate their performance and help them cross the street.¹

Therefore, it can be seen that ICF is an attempt to escape the closed diagnosis of ICD-10, expanding the capacity to evaluate the phenomena that comprise health status. According to the ICF, there is an attempt to articulate the medical and social models in their constitution, in a dialectical perspective.¹

The medical model would be represented by the idea that the problem focuses on the person; already the incapacity would be caused by the disease or the deficiency. This model aims to eradicate the problem through healing, adaptation or behavior change, having as political implication, change or reform in health policies. Medical care is the main focus.¹

Already in the social model disability is not a characteristic of an individual, but a complex set of conditions, many of which are created by the social environment. The solution of the problem requires a social action and it is the collective responsibility of society to make the necessary environmental changes. Therefore, it becomes an attitudinal and ideological question, becoming a matter of human rights.¹

In seeking to establish this relationship between the medical and social models in the constitution of ICF, the WHO takes a significant step in the conception of health that it presented, since it seeks to overcome only the idea of a deviation from biological normality. Also pointing to the factors of social order that imply people's incapacity and functionality.

Accordingly, in relation to society, especially with regards to its norms, Canguilhem¹² affirms that in order to relate "social composition with the social organism", in defining the term itself, it would be necessary to be able to think of the "needs and norms of a society "as one thinks of the "needs and norms of life of an organism". However, the organism is configured in an order of functioning, whereas in society this order is not known, so that, consequently, social norms must be invented and not perceived.^{12:205}

Nonetheless, it is enough for an individual to question the needs and norms of a society and to contradict them, so as to understand "the extent to which social necessity is not immanent, to what extent the social norm is not internal, after all, society, is far from being put as a whole."^{12:205}

CONCLUSIONS

The content analysis was appropriate for this study, providing subsidies to observe some explicit and implicit content contained in its structure. Attention was paid to the biological organism and the relation of normality/pathology and the incapacity and functionality influenced by the environment.

Hence, functionality and disability are evaluated according to ideal situations of ICF, emphasizing that disability is

a barrier imposed not only by the biological but also by the issues that arise from the barriers found in society, described in environmental factors. Nevertheless, it is necessary to understand that diagnostic evaluation is submitted beforehand to a certain standard of normality present in society, although it seeks to overcome exclusion by highlighting the barriers imposed by the environment.

It is important to emphasize that life is circumscribed to norms and that without norm there is no life. Understanding that these standards are changeable and reversible, in other words, even with all medical action to return to a state of health, the body will never be the same as before the disease. This happens in relation to disability. The whole process of normalization will make it another way of being and not make it assume an ideal normality. The problem lies in the exclusion that provokes this social normativity that comes from the demands of the fulfillment of cultural norms crystallized as natural. The normativity contained in International Classification of Functioning, Disability and Health, by principle, does not meet the population diversity. Nonetheless, it shows an articulate attempt towards medical and social models, which can extend the nurses' perspective beyond metrics, with regards to the relation of environment and body under pathological and normal condition.

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