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Acknowledging How Older Australian Women Experience Life After Stroke: How Does the WHO 18-Item Brief ICF Core Set for Stroke Compare?

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We examined older women's qualitative experiences of stroke with the World Health Organization's 18-item Brief

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International Classification of Functioning, Disability and Health Core Set for Stroke. Women were participants of the Australian Longitudinal Study on Women's Health, born between 1921 and 1926, who had experienced a stroke in the previous 3 years. An inductive thematic analysis was conducted of women's qualitative experiences of stroke, which were then examined with the 18-item Brief Core Set for Stroke for congruency. Our analysis showed that for older Australian women, their concerns of poststroke living were not adequately classified, potentially impeding a full recovery.

With an ageing population in many postindustrial countries and an increase in the number of women living longer, there is currently no evidence that describes the life experiences of older women who are living with stroke. Stroke is a cardiovascular disease with debilitating effects making it a major cause of disability in postindustrialized countries (Henshaw, Polatajko, McEwen, Ryan, & Baum, 2011), with up to one-third of people diagnosed with stroke unable to manage their everyday lives without the assistance of family or service providers (Jackson & Mishra, 2013). In countries with an ageing population, the incidence of stroke is decreasing whilst the prevalence is still increasing, resulting in an increase in the number of stroke survivors, particularly among older women (Donnan, Fisher, Macleod, & Davis, 2008; Eilertsen, Kirkevold, & Bjørk, 2010). Compared with men, women tend to live longer, experience stroke at an older age, and have greater levels of disability (Maselko, Bates, Avendano, & Glymour, 2009). Our study examines the 18-item Brief ICF Core Set for Stroke with the lived experiences of older women after stroke. We used thematic methods to analyze the free-text comments recorded by women born between 1921 and 1926, on their postal surveys as participants in the Australian Longitudinal Study on Women's Health (ALSWH).

Women's health can have a direct impact on those around them. In older women, who may already have known multiple adverse events throughout their lifetime, the experience of stroke must be very challenging. For example, researchers indicate that Australian women with a history of stroke can also be at a twofold risk of comorbidities such as depression (Jackson & Mishra, 2013) and reduced long-term survival (Byles, Francis, Chojenta, & Hubbard, 2015). Experiencing more problems in performing activities of daily living in older age can affect women's identity as wives, mothers, and grandmothers (Kivgne, Kirkevold, & Gjengedal, 2004). There is currently, however, little in-depth study into the life experiences of older women who have survived stroke, and what matters to them.

Women of different ages and backgrounds have reported that their health care and medical practitioner interactions are less than positive. Women can feel that their doctor does not take them seriously (van den Muijsenbergh & Lagro-Janssen, 2006) or that information they provide to

their practitioner was not listened to (Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2011). Women have described receiving insufficient information about their medical condition (Suurmond et al., 2011) and experiencing a “discord” between the help being sought and what the general practitioner considers irrelevant (Joos, Musselmann, & Szecsney, 2011; Poynton, Dowell, Dew, & Egan, 2011). Stereotypes about old age can lead to health professionals dismissing problems as just being part of ageing (National Institute on Aging, 2008). Older women in particular have long reported feeling neglected and disrespected by medical practitioners, and their problems ignored or undertreated (Lewis, 1986). Experiencing a stroke, alongside the process of ageing in general, can be especially hard as older adults may not “bounce back” to good health as they once did.

The International Classification of Functioning, Disability and Health (ICF) was created by the World Health Organization (WHO) to provide a framework to enhance understanding of how different health conditions can influence a person’s functioning and ability to participate in everyday life (Glässel, Coenen, Kollerits, & Cieza, 2012; Scott, Phillips, Johnston, Whyte, & MacLeod, 2012). The ICF was further adapted to people who experienced a stroke through the development of the ICF Core Set for Stroke (Geyh et al., 2004; ICF Research Branch, 2013; Quintas et al., 2012). One set included 130 categories and was identified as “Comprehensive,” and the other included 18 of the 130 categories and was identified as “Brief.” The Core Set aimed to assist health care providers gain insight into the functional outcomes for people who have had stroke, and their needs for care and other services (Paanalahti, Lundgren-Nilsson, Arndt, & Sunnerhagen, 2013; Quintas et al., 2012). The ICF Core Set for Stroke has been applied to measure emotional processing and social participation (Scott et al., 2012), levels of participation following stroke (Tse, Douglas, Lentin, & Carey, 2013), and a person’s ability to communicate their health care needs (O’Halloran, Worrall, & Hickson, 2012). The framework has been validated quantitatively in countries such as Sweden (Alguren, Lundgren-Nilsson, & Sunnerhagen, 2010), Slovenia (Goljar, Burger, Vidmar, Leonardi, & Marinček, 2011), Finland (Saltychev, Tarvonen-Schröder, Eskola, & Laimi, 2013), and China (Wang et al., 2014). It has also been validated qualitatively in Sweden (Paanalahti et al., 2013), the United Kingdom (Sumathipala, Radcliffe, Sadler, Wolfe, & McKevitt, 2012) and Germany (Glässel et al., 2012).

In our study we aim to use the 18-item Brief ICF Core Set for Stroke as a framework to examine the lived experiences of Australian women who have had a stroke.

METHODS

Study Data

The data for this study were provided by participants in the 1921–26 birth cohort of the Australian Longitudinal Study on Women’s Health (ALSWH;

www.alsw.org.au). The ALSWH is a longitudinal population-based cohort study funded by the Australian Department of Health which began in 1996, when women in the 1921–26 cohort were aged 70–75 years (Survey 1), and has collected data on a 3-yearly basis up to 2011 (Survey 6).

This study used written free-text data provided by the women who participated in Survey 2 of ALSWH in 1999 (10,434 respondents who were aged between 73 and 78 years) and who reported that they had been told by a doctor that they had stroke “in the last 3 years.” The free-text data were provided at the end of the survey in response to open questions “Have we missed anything? Is there anything else you would like to tell us?” Survey 2 was chosen as the point for identifying stroke incident among women in this age group, since Survey 1 only asked if the women had “ever” had a stroke and the timing of the stroke could not be determined (Byles & Dobson, 2011). Women also provided survey responses regarding level of education, area of residence, and self-rated general health. Approval for ALSWH was granted by the Human Research Ethics Committees of the University of Newcastle and the University of Queensland, and access to the data for this analysis was approved by the ALSWH Publications, Sub-studies and Analyses committee.

Data Analysis

The women’s free-text comments were imported into NVivo (V10) for thematic analysis. A general inductive approach was used, whereby one author (A.T.) conducted a detailed reading of the comments to derive codes (Thomas, 2006), assigned to segments of text. These were then aggregated together to form categories, from which primary concepts (themes) were identified and discussed between two authors (A.T. and M.T.). The thematic coding system was then examined separately by three authors (A.T., M.T., I.J.H.) with the ICF definitions of the 18-item Brief Core Set for Stroke with reference to the ICF’s illustration library definitions (refer to Appendix 1).

The 18-item Brief ICF Core Set for Stroke has four categories: body functions, body structures, activities and participation, and environmental factors (Quintas et al., 2012), and it consists of 18 different functions including orientation, memory, language, muscle power, walking, health services/systems/policies, and the immediate family (Geyh et al., 2004; Quintas et al., 2012).

RESULTS

From the 10,434 women who responded to Survey 2, 289 reported a stroke in the past 3 years (2.8%). Of these women, 159 also wrote a free-text comment, with 38% reporting being in good, very good, or excellent health; 40% living alone; 45% living in a major city of Australia; 65% living in a house; and 45% living with their spouse.

TABLE 1 Themes, Categories, and Codes From Women's Qualitative Experiences of Stroke

Theme (<i>n</i> = 9)	Category (<i>n</i> = 32)	Codes (<i>n</i> = 474)
Stroke experience	Stroke effects	56
	Time of stroke	50
	Stroke severity	22
	Paralysis	10
	Stroke onset	7
	Stroke experience	7
	Memory	5
Restrictions and illnesses	Illnesses	51
	Eyesight	7
	Pain	4
Health and well-being	Positive emotions	18
	General health	16
	Energy	8
	Diet and nutrition	4
Health needs and care	Health care	34
	Medication	6
Recovery and coping	Aids	11
	Recovery	10
	Coping	9
	Independence	7
Support and assistance	Social environment	16
	Receiving assistance	11
	Family	8
Mobility and ability	Housework	20
	Walking	7
	Mobility	4
	Writing	3
Activities and daily living	Activities: pre- and post-stroke	17
	Living conditions	16
Stress and worry	Negative emotions	18
	Stress and worries	10
	Financial worries	2

Lived Experiences of Older Australian Women

From the women's free-text comments, a total of 474 codes were identified and grouped into 32 categories which were summarized as nine themes (Table 1).

Theme: Stroke experience. The women wrote about the stroke event and what it felt like. For example, "I suffered a lower spinal stroke whilst on 4 months touring holiday. Luckily I was near [a hospital] and took a taxi there when I experienced pins and needles travelling up my legs." They also wrote about the adverse effects of stroke, such as "temporary memory loss" and having a "paralyzed larynx and two vocal cords."

Theme: Restrictions and illnesses. Women wrote about living with numerous comorbidities, and they listed details of their medical history, including cancer, angina, cysts, diabetes, and osteoarthritis.

Theme: Health and well-being. The women reflected on both good and failing health, alongside growing older. Women wrote about being “generally healthy” and “for my age, my health is good.” Lack of energy was also evident, with some women feeling “healthier and able to walk quicker, but a few months ago I just slowed down in every aspect.”

Theme: Health needs and care. Women wrote about hospital admissions, their need for care following their stroke, future operations, and planning ahead for health interventions. Some women mentioned the lack of access to certain services, for example, “Access to specialist and hospital depends on the problem . . . no one here said they were qualified to anesthetize me.”

Theme: Recovery and coping. Women described rehabilitation and the personal determination required to recover. They wrote about “managing,” “improving,” and “independence.” They wrote of receiving rehabilitation, “hoping to improve a lot and look after myself,” and generally feeling “much better now [but] still on the weak side.”

Theme: Support and assistance. Women wrote about the need to go out and spend time with friends, and receiving assistance from family. Having home help was a recurring comment, or receiving “Meals-on-Wheels,” help with personal care, gardening, general household maintenance, or all of these tasks. Women both received and gave family support, such as being the primary carer of a husband or taking care of grandchildren.

Theme: Mobility and ability. It was clear that the stroke had adversely affected the ability of women to participate in their day-to-day lives, such as no longer being able to easily use public transport or drive a car. Women still wrote, however, of being able to continue with activities such as housework and walking shorter distances.

Theme: Activities and daily living. This theme included comments about the women’s living situations, their activities prior to the stroke, their current restrictions, and anticipating institutionalized care in the future. Some women wrote of wanting to live at home but were unable to do so. For example, as one husband wrote, “My wife is in a nursing home. She constantly wants to come home, but her conditions do not allow this.” Other women lived with family members in order to help them manage.

Theme: Stress and worry. Women expressed a range of concerns including not being eligible for home-based assistance; not having private health insurance, which meant that they had to wait for more than a year for an operation; and not feeling that rehabilitation was improving their recovery outcomes. For example, one respondent stated feeling as though “I can never be normal again,” having “not much to smile for,” and feeling “very tired and disinterested in life.”

Congruency With the 18-Item Brief ICF Core Set for Stroke

Of the 32 categories identified through thematic analysis of the women's free-text comments, 18 categories (56%) were congruent with items in the 18-item ICF Core Set for Stroke. This particularly applied to "stroke effects" and "health care," with 28 and 26 codes matching ICF criteria, respectively. The remaining 14 (44%) categories held no codes that were congruent with any of the 18 items in the ICF Core Set for Stroke. These were "illness," "time of stroke," "general health," "medication," "negative emotions," "positive emotions," "coping," "financial worries," "eyesight," "energy," "mobility," "pain," "social environment," and "stress and worries."

In summary, 218 out of the 474 codes identified from the qualitative analysis of women's free-text comments (46%) could *not be linked* to an item in the 18-item Brief ICF Core Set for Stroke. Table 2 provides a summary of qualitative categories cross-checked against ICF criteria. This illustrates where congruency between the 18-item Brief Core Set for Stroke did exist and, in contrast, where no clinical criteria were present that could represent the experiences expressed by older women following stroke.

DISCUSSION

In our group of older women who had survived a stroke, most did not report feeling in good health. They described a lived experience where their stroke is partly responsible for limited participation in everyday activities and a challenging future. Despite this, some older women who survived a stroke had the potential to achieve functional independence and a sense of personal well-being. The results demonstrate that the 18-item Brief ICF Core Set for Stroke has some congruency with the lived experiences of older women who have survived a stroke, but it was unable to code the full experiences of women with stroke.

Older Women Experiences of Living With Stroke

The women in this study wrote about the challenges of coping with changes in their physical functioning, their abilities to perform everyday activities, and their social roles. In addition, there were also many nonphysical changes following a stroke experience, including increased worry about where to live and not being able to afford health insurance or home assistance. The women wrote of experiencing changes in mood, for example, feelings of frustration, dependency and loss, and reduced self-efficacy (White et al., 2008). which are all known complications in people who have experienced a stroke (Scott et al., 2012). They described the challenges resulting from loss of independence, including that of being a burden on family and friends.

TABLE 2 Congruency Summary of Qualitative Themes and Categories With the 18-Item Brief ICF Core Set for Stroke

Themes	Categories	List of congruent 18-item Brief ICF criteria
Stroke experience	Stroke effects	Muscle power functions
		Orientation
		Speaking
		Dressing
		Memory functions
		Attention functions
		Structure of brain
	Walking	
Time of stroke*	Did not apply*	
Stroke severity	Muscle power functions	
Paralysis	Muscle power functions	
Stroke onset	Structure of brain	
Stroke experience	Immediate family	
	Muscle power functions	
	Speaking	
Memory	Memory functions	
Restrictions and illnesses	Illnesses*	Did not apply*
	Eyesight*	Did not apply*
	Pain*	Did not apply*
Health and well-being	Positive emotions*	Did not apply*
	General health*	Did not apply*
	Energy*	Did not apply*
	Diet and nutrition	Eating
Health needs and care	Health care	Health professionals
		Health services, systems and policies
	Medication*	Immediate family
		Did not apply*
Recovery and coping	Aids	Walking
	Recovery	Muscle power functions
		Walking
	Coping*	Did not apply*
Independence	Immediate family	
Support and assistance	Social environment*	Did not apply*
	Receiving assistance	Immediate family
		Washing oneself
	Family	Immediate family
Mobility and ability	Housework	Eating
		Dressing
		Washing oneself
	Walking	Walking
	Mobility*	Did not apply*
	Writing	Muscle power functions

(Continued on next page)

TABLE 2 Congruency Summary of Qualitative Themes and Categories With the 18-Item Brief ICF Core Set for Stroke (*Continued*)

Themes	Categories	List of congruent 18-item Brief ICF criteria
Activities and daily living	Activities: pre- and post-stroke	Muscle power functions
	Living conditions	Immediate family
Stress and worry	Negative emotions*	Did not apply*
	Stress and worries*	Did not apply*
	Financial worries*	Did not apply*

*Represent the 14 out of 32 categories (44%) that did not cross-check with the 18-item Brief ICF Core Set for Stroke.

This evidence adds to the knowledge that although stroke can adversely impact upper, lower, or both limb function; sensation; visual acuity; cognition; swallowing; and communication (Clarke, 1999; Kitzmuller, Haggstrom, & Asplund, 2013; National Stroke Foundation, 2010), its consequences reach beyond physical function or the participation in everyday activities, and need to be acknowledged. Even after the initial recovery period that may include time in rehabilitation, regaining social roles and reintegrating back into the community can be very challenging for older women who have survived stroke (Clarke, 1999), highlighting the importance of service provision that supports emotional and cognitive recovery.

This study found that maintaining a sense of well-being, despite poor health and physical limitations, was more attainable for women with social support. This aligns with evidence indicating a positive association between higher levels of social support and better outcomes poststroke (Boosman, Schepers, Post, & Visser-Meily, 2011; Salter, Foley, & Teasell, 2010) and the adverse impact of long-term unmet needs (LoTS care LUNS Study Team, 2013). These women expressed concerns about the impact of stroke on both themselves and their family and friends. As Wood and colleagues found (Wood, Connelly, & Maly, 2010), social reintegration can be particularly challenging in the first year for community-dwelling stroke survivors. Results from this study indicate that consideration should be given to *both* physical and nonphysical poststroke complications in the clinical management of older women living with stroke.

Applying the 18-Item ICF Core Set for Stroke

This study demonstrates that the 18-item Brief ICF Core Set for Stroke has some applicability to survivors of stroke (Sumathipala et al., 2012) but that there are many aspects of the lived experiences of older women that are excluded using this classification and investigation pathway. Thirteen of the 18 items in the Brief ICF Core Set for Stroke were congruent with the women's

descriptions of poststroke living; however, many of the experiences women wrote about could not be endorsed, for example, personal factors such as descriptions of their general health, feelings of hopelessness and not being “normal,” and comments about being lonely and confused, about the difficulty of making friends, and about hardly ever leaving their house. Previous researchers have applied the 130-item ICF Core Set for Stroke (Paanalahti et al., 2013; Sumathipala et al., 2012) and the 166-item ICF Core Set for Stroke (Glässel, Coenen, Kollerits, & Cieza, 2012) using qualitative methodologies, with a number of personal factors also identified that related to stroke recovery.

The relevance of personal factors in those who have experienced stroke, and the need to not only consider physical function when exploring functioning, disability, and health was a consideration in the consensus process used to define the 18-item Brief ICF Core Set for Stroke that as reported by Geyh and colleagues (Geyh et al., 2011); however, we present evidence of persistent limitations in the 18-item Core Set with respect to its sensitivity to personal factors. Although the more comprehensive 130-item ICF Core Set for Stroke contains functions that recognize stress, emotions, and economic self-sufficiency, further consideration needs to be given to the classification of “personal factors” by the ICF in the Brief 18-item measure to fully recognize contextual aspects of health, functioning, and well-being in older women living with stroke.

Study Strengths and Limitations

This study's strengths lie in the fact that the ALSWH survey includes a broadly representative sample of community-dwelling women, including those who have survived stroke. As authors of this work, we had no influence on the free-text comments women chose to write, with women identifying what aspects of their health were most salient to them. The level of detail related to stroke in the comments indicated that the women identified stroke as significantly important to their subsequent health and well-being. Other strengths include the fact that more than one author was involved in the development and cross-checking of codes, categories, and themes from the raw data and in the substantiation process of the coded data with the 18-item ICF Core Set for Stroke that are experienced in qualitative research. Reflexivity was improved by keeping additional handwritten notes and memos in NVivo and comparing them between the first two authors during the data coding process. This rigor means that these findings have increased weight in their translation into the clinical setting.

This study was limited by the fact that we were not able to go back to the women who completed the ALSWH surveys to qualify details in their free-text comments and that the open-ended question did not specifically ask about stroke. Not all women who reported a stroke provided comments. Also, this study does not include written comments from women who died

from stroke prior to ALSWH Survey 2 and those who were too frail to participate.

CONCLUSIONS

In conclusion, we find that the 18-item Brief ICF Core Set for Stroke is inadequate for describing and classifying the range of everyday experiences of older Australian women living with stroke, particularly in relation to their personal factors such as feelings, coping, worry, and sense of well-being. Older women who have experienced stroke require clinical management that gives consideration to both physical and nonphysical complications and that this may need to include increased levels of social support and personal assistance. By implication, there is currently a significant unmet need among stroke survivors for on-going rehabilitation, both in the domains of physical and emotional functioning.

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APPENDIX: CONTENT OF THE BRIEF 18-ITEM WHO ICF CORE SET FOR STROKE

BODY FUNCTIONS = Physiological functions of body systems (including psychological functions)	
b110	Consciousness functions: General mental functions of the state of awareness and alertness, including the clarity and continuity of the wakeful state. Inclusions: functions of the state, continuity and quality of consciousness; loss of consciousness, coma, vegetative states, fugues, trance states, possession states, drug-induced altered consciousness, delirium, stupor. Exclusions: orientation functions; energy and drive functions; sleep functions.
b114	Orientation functions: General mental functions of knowing and ascertaining one's relation to self, to others, to time and to one's surroundings. Inclusions: functions of orientation to time, place and person; orientation to self and others; disorientation to time, place and person. Exclusions: consciousness functions; attention functions; memory functions.
b140	Attention functions: Specific mental functions of focusing on an external stimulus or internal experience for the required period of time. Inclusions: functions of sustaining attention, shifting attention, dividing attention, sharing attention; concentration; distractibility. Exclusions: consciousness functions; energy and drive functions; sleep functions; memory functions; psychomotor functions; perceptual functions.

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b144	Memory functions: Specific mental functions of registering and storing information and retrieving it as needed. Inclusions: functions of short-term and long-term memory, immediate, recent and remote memory; memory span; retrieval of memory; remembering; functions used in recalling and learning, such as in nominal, selective and dissociative amnesia. Exclusions: consciousness functions; orientation functions; intellectual functions; attention functions; perceptual functions; thought functions; higher-level cognitive functions; mental functions of language; calculation functions.
b167	Mental functions of language: Specific mental functions of recognizing and using signs, symbols and other components of a language. Inclusions: functions of reception and decryption of spoken, written or other forms of language such as sign language; functions of expression of spoken, written or other forms of language; integrative language functions, spoken and written, such as involved in receptive, expressive, Broca's, Wernicke's and conduction aphasia. Exclusions: attention functions; memory functions; perceptual functions; thought functions; higher-level cognitive functions; calculation functions; mental functions of complex movements.
b730	Muscle power functions: Functions related to the force generated by the contraction of a muscle or muscle groups. Inclusions: functions associated with the power of specific muscles and muscle groups, muscles of one limb, one side of the body, the lower half of the body, all limbs, the trunk and the body as a whole; impairments such as weakness of small muscles in feet and hands, muscle paresis, muscle paralysis, monoplegia, hemiplegia, paraplegia, quadriplegia and akinetic mutism. Exclusions: functions of structures adjoining the eye; muscle tone functions; muscle endurance functions.
BODY STRUCTURES = Anatomical parts of the body such as organs, limbs and their components	
s110	Structure of brain
s730	Structure of upper extremity
ACTIVITIES AND PARTICIPATION = Execution of a task or action by an individual and involvement in a life situation	
d310	Communicating with—receiving—spoken messages: Comprehending literal and implied meanings of messages in spoken language, such as understanding that a statement asserts a fact or is an idiomatic expression.
d330	Speaking: Producing words, phrases and longer passages in spoken messages with literal and implied meaning, such as expressing a fact or telling a story in oral language.

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d450	<p>Walking:</p> <p>Moving along a surface on foot, step by step, so that one foot is always on the ground, such as when strolling, sauntering, walking forwards, backwards, or sideways. Inclusions: walking short or long distances; walking on different surfaces; walking around obstacles. Exclusions: transferring oneself; moving around.</p>
d510	<p>Washing oneself:</p> <p>Washing and drying one's whole body, or body parts, using water and appropriate cleaning and drying materials or methods, such as bathing, showering, washing hands and feet, face and hair, and drying with a towel. Inclusions: washing body parts, the whole body; and drying oneself. Exclusions: caring for body parts; toileting.</p>
d530	<p>Toileting:</p> <p>Planning and carrying out the elimination of human waste (menstruation, urination and defecation), and cleaning oneself afterwards. Inclusions: regulating urination, defecation and menstrual care. Exclusions: washing oneself; caring for body parts.</p>
d540	<p>Dressing:</p> <p>Carrying out the coordinated actions and tasks of putting on and taking off clothes and footwear in sequence and in keeping with climatic and social conditions, such as by putting on, adjusting and removing shirts, skirts, blouses, pants, undergarments, saris, kimono, tights, hats, gloves, coats, shoes, boots, sandals and slippers. Inclusions: putting on or taking off clothes and footwear and choosing appropriate clothing.</p>
d550	<p>Eating:</p> <p>Carrying out the coordinated tasks and actions of eating food that has been served, bringing it to the mouth and consuming it in culturally acceptable ways, cutting or breaking food into pieces, opening bottles and cans, using eating implements, having meals, feasting or dining. Exclusion: drinking.</p>

ENVIRONMENTAL FACTORS = Make up the physical, social and attitudinal environment in which people live and conduct their lives

e310	<p>Immediate family:</p> <p>Individuals related by birth, marriage or other relationship recognized by the culture as immediate family, such as spouses, partners, parents, siblings, children, foster parents, adoptive parents and grandparents. Exclusions: extended family; personal care providers and personal assistants.</p>
e355	<p>Health professionals:</p> <p>All service providers working within the context of the health system, such as doctors, nurses, physiotherapists, occupational therapists, speech therapists, audiologists, orthotistprosthetists, medical social workers. Exclusion: other professionals.</p>
e580	<p>Health services, systems and policies:</p> <p>Services, systems and policies for preventing and treating health problems, providing medical rehabilitation and promoting a healthy lifestyle. Exclusion: general social support services, systems and policies.</p>

Adapted from <http://www.icf-research-branch.org> [accessed 20 April 2015].