

**Report of the meeting of the
WHO-FIC Asia Pacific Network**

10-11 September 2007, in Kyoto, Japan

Executive Summary

The Asia Pacific Network (APN) aims at improving health information implementing consistently ICD, and other members of the WHO-FIC. Approaches for implementation depend on national differences, as stage of implementation, and infrastructure. Subgroups of the APN will work on: 1. mortality, 2. morbidity and functioning, 3. health information systems; an additional group will focus on issues arising from the small and scattered structures in the Pacific region.

Improving health information affects all elements of an information system, as diagnosing, reporting, coding and evaluation. All actors in the information chain need training for their task, independently from their professional background. For example, coding physicians need coding training. Standardization of all steps allows joint development of relevant training materials.

Steps are standardized in mortality information. However, there is a lack of coding experience. The WHO-FIC Network in collaboration with IFHRO has just compiled appropriate international materials and curricula for training.

No standards exist, apart ICD, in morbidity information, as shown in the SEARO workshop on coding, in presentations from Indonesia, Thailand, Pakistan and Japan, and in the sessions of the working groups. Morbidity reporting has to be standardized and improved. This is the basis for internationally comparable data and development of international training for reporting, in morbidity. Comparable data and collection methodologies would then allow creation of a standard data audit methodology. Existing systems are designed for individual national information systems.

Sustainable implementation and health information systems require active commitment of the government of a country. External initiatives will always need own funding for delivery of assistance. Organizations with activities in this field of health focus on funding individual projects (like DFID and AusAID), catalyzing health information systems at country level (HMN), or have experience in provision of funds and training (JICA).

The APN will explore these sources for funding and training for their suitability to the activities of the HMN, in addition to direct funding from WHO.

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1 Opening

Dr. Shuto (Chair), Dr. Yamamoto (JHA), and Dr. Jakob (WHO) welcomed the participants to the meeting. Past work and goals of the current were laid out and thanks were addressed to the JHA for its generous support to the work of the network.

1.1 Introduction of WHO-FIC

Dr. Jakob introduced the WHO Family of International Classifications and its network of Collaborating Centres. Centres are established by country, and some by language. There are 9 designated centres and 8-10 centres in various stages of designation. The centres collaborate with WHO in the WHO-FIC Network. The Network has committees that focus on education, electronic tools, and development of the WHO-FIC, implementation, and maintenance (update and revision). Working groups solve problems of use of the different classifications in their different uses. Such reference groups currently exist for mortality (ICD), morbidity (ICD), functioning and disability (ICF), and terminology.

1.2 Objectives of the meeting

Dr. Shuto presented the draft goals of the APN:

1. Implementation of WHO-FIC means improving:
 - a. Mortality and Morbidity Statistics
 - b. Health Information System
2. Networking means:
 - a. Human relationships
 - b. Interactivity
 - c. Sharing information
 - d. Contributions to the APN; developing countries are invited to contribute

The goals for this second meeting of the APN include analysis of present status, target setting, and deciding about first steps. Analysis will include human resources, financial resources, and intellectual resources. Mechanisms for gathering and sharing knowledge will be explored. The meeting edited the agenda to include disability and functioning.

2 Analysis of present status

Dr. Jakob presented an analysis of the present status of implementation. Only 45% of countries in WPRO/SEARO report to WHO. There is a gap between implementation of ICD and reporting of ICD data. Detailed information exists for 12 countries of the Asia Pacific Region. Several countries use ICD in mortality. Australia, Thailand, and Korea are using ICD in morbidity in a systematic fashion, in a modified version, for example for reimbursement. In the region, 6 different language versions of ICD-10 are in use.

Detailed information on implementation is available online at (www.who.int/classifications/implementation/) and is continuously improved. Awareness of implementation, and standardized use would inform countries mutually and permit sharing implementation strategies.

2.1 Training trainers in ICD, SEARO 2008

Ms Sue Walker reported of the first training of trainers' workshop in India (organized by SEARO) that was attended by 9 out of 11 SEARO countries. WPRO is planning to hold a similar one, soon. This meeting showed that in the region several challenges persist:

Lack of:

- management awareness of importance of ICD coding
- human and financial resources
- materials – coding books, training materials
- engagement with private sector
- utilisation of coded data – locally, nationally
- trainers and national experts in coding

and poor quality of

- coding
- certification
- medical records

result in high percentages of ill defined deaths or diseases.

2.2 Country activities of WHO and HMN

WHO and HMN are collaborating on improvement of Health information Systems in a set of countries. HMN activities include workshops, development of indicators of health statistics. Country work consists of training courses on ICD for hospital staff in Vietnam, or support to assessment, strategic planning, and setting up a HIS in Cambodia. Plans for Mongolia include

situation analysis, development of a work plan and establishing a National Health Data Warehouse. Lao is developing a strategy plan and next month will start training of trainers in basic statistic data. India has a well-established health information system, and government funds evaluation of health information.

In discussion, participants noted:

- meaning of and differences between electronic information systems (network) and health information systems (ICD) have to be clarified

2.3 Focus on HIS for Improvement of Health Service & Management/ Health Situations

Dr. Abo presented experiences from a project in Pakistan that was carried out between January 2004 and February 2007. In the past, health information was collected in scattered and not connected systems. The project aimed at development of a National Action Plan for the Improvement of HIS. Steps included a situation analysis, setting up a Steering Committee, pilot testing in 4 districts, development of DHIS Software, and monitoring & evaluation of the pilot test. Finally, a National Action Plan was formulated that would reform and create an enabling environment for the HIS to continuously evolve, improve, and to respond to the information needs of the health sector.

Special software constituted the backbone of the project. It has user specific data entry sheets and reporting features. The software is designed for use in hospitals and primary health care settings. It uses ICD-10, and includes only a few other health indicators, yet. Because it was specifically developed for implementation and running at low costs, it has a comparative advantage to HIS software used in Japan. The software can be adapted to local needs for use in other countries, as well. The copyright for the program is jointly owned by Pakistan and Japan.

3 Country Case Studies

In preparation to the meeting, Malaysia and Indonesia prepared country reports on implementation of ICD-10 that served for discussion of groups in the workgroup session of the meeting.

3.1 Malaysia

Dr. Bin Lailanor reported about the situation in Indonesia. ICD-10 is implemented for morbidity and mortality. Mortality data are usually medically certified and the cause of death is coded with ICD-10. Non-medically certified death data are coded by the Statistics Department (in collaboration with the MoH). A pilot project on verbal autopsy (pilot project) was used for comparison with “medically certified death”.

Case-mix was first implemented in Malaysia about 7 years ago, and starting from October 2007, it will be implemented nationwide. Physicians formulate the discharge diagnosis. Record officers do the coding. There is no standard procedure coding system in the country: Ministry of Health (MoH) hospitals use ICD-10 PCS; case mix pilot MoH hospitals use ICD-9CM. MoH hospitals code diagnoses for inpatients and outpatients with ICD-10. Outpatient units report information along the chapters of ICD that is coded in a second step. Only 40% of diagnoses from private hospitals are ICD-10 coded. 134 government hospitals have 2 or more coders, and 233 private hospitals have at least 1 coder. The Malaysian government does not pay license fees for use of ICD-CM and ICD-PCS in the pilot studies. The grouper software is used in government hospitals, only. The government sent only few staff to the UK and Australia for training in medical record management, because of its limited budget. This staff then trained other coders in Malaysia. Quality of documentation is improved by programmatic 3-day documentation awareness sessions.

ICF is implemented for research, only. The MoH organised a 2-day session that raised awareness of the International Classification of Functioning, Disability and Health (ICF) among senior MoH officers.

The MOH plans for a stepwise implementation of the FIC. A National Health Informatics Centre will coordinate the national approach to management of health & health related information using standardized classification. A National Health Data Warehouse will manage information and allow for evidence based health planning. International networks will inform the country about lessons learnt and best practice to strengthening HIM and enhancing use of classifications in the country.

3.2 Indonesia

Dr. Soewarta Kosen reported about the situation of Indonesia. All births and deaths should in principle be reported to the local civil registry offices; estimated completeness of registered deaths is below 50 %, and the rate of registered births is less than 40 %. There is a lack of specific cause of death data for health policy, monitoring and research. In urban areas, a mandatory burial permit requirement ensures a better coverage than the rural area (65%). Morbidity statistics are routinely collected at health facilities, as hospitals or health centres. The Ministry of Health prepares the national annual morbidity statistics that are based on hospital admissions and hospital out-patient visits, as well as on data from community health centres. Hospital statistics coverage is about 70 %. After decentralization, quality of health centre statistics deteriorated significantly. Since 1995, disease information is based on ICD-10 (using 3-character categories). Data are usually coded locally, by physicians or coders. ICD-10 is also used in medical surveillance, community based survey and health insurance. Physicians in health facilities do not necessarily follow principles of ICD-10 while assigning multiple causes of death. The majority is only familiar with the Direct Cause of Death, not with the Underlying Cause of Death. There is an urgent need to apply ICD fully in the health sector, including assigning Underlying Cause of Death based on ICD Rules. While preparing for universal use of ICD and improvement of vital registration system, a “quasi sample registration system” in several areas may accommodate the needs of morbidity and mortality statistics, as well as be an indicator to monitor MDG targets. ICD has been introduced in medical schools, teaching good documentation technique and not the coding itself. The Ministry of Health supports the training of coders.

For ICF, the understanding of its relevance is improving; and with funding of additional programmes, government activities towards implementation of ICF may increase. The Ministry for Social Welfare funded a survey on ICF that focused on physical handicaps.

3.3 Report back of group work discussion

The participants analyzed the case reports in workgroups. At the report back to the plenary the outcome of the discussions were:

- The sustainability of health information collection depends on financial resources and local political commitment. In Pakistan, Mr. Abo’s project, 60% of the funding came from the country, and only a part of the costs was borne by the Japanese partners. By the time Japan ended its support, the project was running without external support.
- Assignment of multiple diagnoses, reporting of causes of death, formulation of simplified manuals, and shortage of ICD experts deserve special attention. The situation can be improved e.g. including training of ICD in the curricula of Schools of Medicine.
- Coding can be done e.g. by trained nurses, as in Vietnam. Nurses’ salaries are below the ones of physicians and they have knowledge in medical terminology.

- Improving the quality of information includes standardizing reporting, e.g. standardizing summary front sheets in medical records and training health care providers in reporting.
- Integration of health information is an important key task. ICD can be useful in this context beyond its statistical use. Integration of other information like ICF is also important.

The participants agreed this information be forwarded for discussion to the implementation committee of the WHO-FIC Network.

4 Goal Setting and Methodology for Assessment

4.1 Assessment and Targets improving Vital and Health Statistics

Dr. Yamauchi presented a study, the “Yamamoto project” that compared the relationship between accuracy of death certificates and quality of morbidity and mortality statistics. In 2006 & 2007, pairs of death certificates and patient discharge summaries of 123 health care facilities were collected. Causes of death were double-checked and coded by a group of physicians, and a group of health information managers. In 20% of cases, ICD codes differed between death certificate and discharge summary, at the level of the third digit (8% at the first digit).

Conclusions of the of the Yamamoto Project are:

- 1) Accuracy of death certificates is better than was assumed
- 2) Significant number of special inaccuracies in death certificates was found
- 3) Education programs for certifiers of cause of death were suggested
- 4) Doctors need to know also about the rules for selection of causes of death
- 5) More cooperation between doctors and health information managers is necessary

In a paper by Mathers, et al, few countries have “high quality” data. Data were 100% complete in 64 countries. No cause of death information was available (back to 1990) in 75 countries. Assessing the quality of reported causes of death is difficult, because quality relevant steps include reporting in records, certification, and coding.

In discussion, the participants agreed on the following points:

- A relationship between GDP and the quality of data can be considered in comparison between countries, but not inside a country.
- Developing a standard training for medical doctors or students that could be a model for all countries is necessary. There may be a need to adapt such standard materials to local needs. A coding curriculum for physicians on morbidity and mortality exists already. Based on that, WHO-FIC Education Committee has started compilation of standard training materials and formulation of lessons for an electronic training tool.
- Research activities should focus on how to establish a scheme or methodology for assessment of quality of health information. A quantitative evaluation system would allow effective and comparable evaluation in the future. Assessment of quality of documentation and the quality of coding is now being undertaken in Vietnam. The WHO-FIC Education Committee is looking at the process of collecting, doing documentation auditing, then coding audit (recoding) and comparing these to the original codes. Evaluation systems are important and every country should have them.

- Evaluating medical records could be approached setting standards: e.g. a complete front sheet, a registration number, one record for one patient and the inclusion of test results. This would allow verifying the completeness of a medical record, remains the accuracy of doctors' diagnosis of patient. Japan is running a project on assessment of health record quality. It is currently based only on small samples from a few hospitals because the project is based on volunteer work.

Level and dimensions of quality have to be taken into account in quality assessment. Countries reported their experience in this field:

- **Australia:** software (PIC) for use in combination with the Australian modification of ICD-10, verifies quality based on patterns of codes. Any anomaly is analyzed with ACBA in more detail.
- **Indonesia:** quality of diagnosis is assessed by surveys that are carried out by universities comparing medical records and verifying examining the patients.
- **Japan:** there are audits for DPC, and a clinical trial for the methodology of such audits is completed. Japan aims at building a system that would allow evaluating the accuracy of each country's data. Further discussion is necessary whether such a standardized approach is welcome and feasible.
- **Korea:** the hospitals are assessed every 3 years, and 70 % of the assessment questionnaire relates to the audit system. In addition, each hospital has its own internal assessment for diagnostic completeness and quality on a monthly basis. Also, data are used for health claims and not for statistics, and the data are reviewed by trained nurses
- **Malaysia:** draws samples for assessment, without letting internal coders know It should be useful if WHO had a standard approach to methods of quality assessment.
- **Pakistan:** JICA has established an audit system, where one coordinator is responsible for one district. Samples are drawn to verify data and coding. Basic goal is to give feedback to the users, and provide training, as necessary.
- **Singapore:** coding quality is relevant since ICD codes are used for the reimbursement system. External auditors code and compare the results to codes produced by the hospital. Since implementing external audit system, the error rate has dropped to less than 5%, but the auditing is expensive. Singapore selects the hospitals to be verified based on stratification and then does random sampling. Hospitals often make their own modifications, so to check accuracy there is a system of inter-institutional evaluation to give feedback results to the coders, and carry out education programs, as necessary.
- **Thailand:** the quality of coding of the diagnoses is verified, based on the medical records. Audits are done for doctors, coders, and audits for hospitals for the reimbursement scheme every 6 months.

4.2 International Training and Certification Program

Ms. Walker presented the international training and certification programme of the WHO-FIC Education Committee. Purpose of this program is to assist and advise WHO and the WHO-FIC Network in improving the level and quality of use of the WHO Family of International Classifications (WHO-FIC) in Member States developing an education, training and certification strategy for the WHO-FIC, identifying best training practices and providing a network for sharing expertise and experience on training. The first priority is for the reference terminologies, ICD and ICF.

Accomplishments to Date are development of standard core curricula for morbidity and mortality coder education, assessment of training materials, feedback to developers regarding adequacy/completeness, piloting test for underlying cause-of-death coders in Korea and Canada (with another two pilots in Korea and Japan in 2007).

Future activities include disseminating the exam worldwide (availability, translation, supervision, recognition), pre-exam education, Korean Medical Record Association process as the model (IFHRO member countries to take forward), promoting the program, seek further training materials, explain benefits, and encourage participation. Standardized rules and guidelines for multiple cause mortality and morbidity coding and analysis are under development by Morbidity and Mortality Reference Groups, based on the WHO version of ICD-10. Such rules are a prerequisite to assessment of morbidity coders. More information is available at <http://www.ifhro.org/whofic.php> and www.who.int/classifications

In discussion, the participants concluded:

- The emphasis of training should be on the persons who assign codes, independently from their other roles in the health system. In addition, there is also a 'certifier' training which has particular emphasis on doctors.
- Countries should adopt such international training standards, and they may adapt parts to their specific needs.
- Resources and tools for education tools have to be shared.
- Use of ICD has to be deeply integrated into the entire health system framework of each country, including data, evaluation, and education.

5 Human Resources

5.1 Technical Training Program of JICA

Dr Tsujii presented the “Technical Training Program” of JICA as a possible funding source for training programs. This program transfers knowledge required by individual countries by training key administrators, technicians and researchers in developing countries and regions. JICA has already training experience on a broad range of subjects, as environment, education, health and medical care. Training for health information management can probably seamlessly be included in JICA’s funding for “Technical Training Program”. Venues for training can be either in Japan or in developing countries. In the fiscal year 2003, 8,066 people from 149 countries and regions took part in this program in Japan, while another 6,531 people participated in the program in developing countries. There are region-focused training programs such as for ASEAN countries and Country-focused training programs for each country.

Applications for funding by JICA and the Ministry of Foreign Affairs require thorough preparation, and several administrative steps. More information is available under phone +81-3-5352-5311/5312/5313/5314, or their webpage at www.jica.go.jp.

In discussion the following points were raised:

- The Japanese HIM course is available in English, as well as Vietnamese, other S.E Asian, and African languages. It can be held in Japan and in countries. JICA covers the costs for training up to one year, if the course is attended in Japan.
- Two types of support programmes exist:
 - country-focused programmes; a country government can apply to the Japanese Embassy in its country
 - region-focused programme; applications are sent to the relevant Ministry of Foreign Affairs JICA has also regional offices in more than 60 regions to help with applications.
- In Japan, JHA has the most established course for Health Information Training, but it is available in Japanese, only.
- A one year course with a certificate will allow prepare trainers for training in their own country. Offering a short training course, for example 2-3 week mortality training, either in Japan or other countries, would be an asset.
- JICA has also distance teaching units that can be accessed through JICA offices, or the internet.
- WHO has a similar network in the Pacific with offices on several islands.
- There is a need for online medical terminology training, as well as coding education.
- The Education Committee should be asked to collaborate in distance learning

- Some years ago, WHO produced a short course in medical research practice and basic administration processes (how to file medical records etc.) and how to run a good medical records service. That program was taken up by a Sri Lankan institute to teach people in that country and from overseas as well. This is a good Training of Trainers model. There is a short 6-week course that is still run in Sri Lanka.

5.2 Financial Resources

The audience reported experiences of collaboration with different bodies, and discussed the way forward to identifying financial resources for the APN's activities.

The participants raised the following points:

Financial resourcing for improvement of health information systems currently come from governmental organizations, and non-governmental organizations.

- DFID is expanding work in South East Asia; WHO and JICA have activities in several countries; AusAID funds Health Information work in Indonesia.
- The APN is discussing with AusAID to fund work on a regional scale. Sometimes pooling money from each country raises interest of donors to join such initiative.
- WHO continuously contributes to the implementation work. Financing of projects requires coordination among WHO country offices, regional offices and headquarters. Coordination with existing and new activities with other donors at regional and cross regional level will enable best use of the present resources. WHO resourcing of the field of health information needs further improvement, in the future.
- A recent training on morbidity information in India was funded by WHO-SEARO. It was discussed whether WHO and HMN could work together. However, HMN activities are still evolving:
- HMN has assessed in 60 countries, but in the field support is envisaged for 6 countries, as Cambodia or Vietnam. Details will be decided at the next HMN board meetings. Some countries of the APN have participated to HMN projects for assessment.
- HMN is working towards improving full Health Information Systems. Activities that are carried out in conjunction with HMN may be funded, whereas isolated projects that e.g. focus only on ICD implementation may have less of a chance to get some support. HMN in collaboration with WHO has produced a Stepping Stones kit for improvement of Health Information Systems on a CD-ROM that includes an electronic version of ICD-10.

A regional approach for training and funding of implementation work might be preferable to approaching donors by individual countries. The countries that are involved in such a joint initiative are well advised to carefully develop a coherent implementation plan that will foster

understanding goals of a regional implementation project, show sustainability of the different initiatives, and focus donors on countries' needs. Real interest and local initiative in health information at country level is first prerequisite for any sustainable implementation activity.

The APN should develop a strategy for funding of its activities. Participants formulated individual steps:

- Countries identify and report their needs, so that e.g. training courses on relevant subjects can be made available.
- Addressees for those reports have to be identified.
- A repository for the information has to be identified.
- Analysis and summary of the information will inform the funding strategy

The meeting noted, that independently from funding, existing know-how has to be shared, e.g. on a website and on the WHO Asia Pacific SharePoint platform. APN would use a website and information sharing tools to collect and redistribute the contributions, in addition to its online implementation database. WHO has made available its SharePoint site (an information and document sharing internet technology). Interested parties will be informed on access and registration procedures by WHO (Dr. Jakob). Information sharing on the platform should be multilateral. Countries are invited to upload their information and contributions, as well. WHO has made available its information material, already. IFHRO could be invited to contribute to the site, as well.

5.3 Research Activities

The chairs of the APN suggested bundling implementation research in some kind of academic society. For example, there could be an academic session on implementation research at the APN meetings. Information to such work could come e.g. from national and international NGO, as IFHRO, that are working across sectors. However, several countries lack a national medical records association. But, development of such an organization in a country requires little financial resources for coordination, and an annual meeting for information exchange. The participants reported:

- **Japan:** membership of Japanese Medical Record Association (JMRA) includes more than 200 doctors and the head is a medical doctor too.
- **Korea:** the membership of the national medical record association needs further expansion. It is open for people coming from the Health Information technology sector.
- **Malaysia:** the technology for electronic documentation is available but resourcing of implementation of the medical records and of a matching association is low.

- **Singapore:** health information specialists (content) collaborate closely with health information systems specialists (technical infrastructure).

The participants concluded:

- Further discussion on organization of work is necessary.
- IFHRO is working in the field of medical documentation, and should be invited to contribute to the APN's work.

The audience was informed: IFHRO's membership consists of national associations for medical documentation. Its financial resources are limited and its workforce consists to a large extent of volunteers. Annual membership fees may be an obstacle to participation of developing countries, albeit individual membership fee is only USD 10 per year.

6 Plan for future work

6.1 The Role of APN

Dr Shuto highlighted the need to stepwise deploy the network's activities. First priority should be given to implementation of ICD in Asian pacific countries. ICD is an essential tool to health information, as for health records, and other field of public health.

The WHO-FIC Network's Implementation Committee is evolving towards regional networks keeping up information sharing and collaboration between the regional initiatives. The APN would use tools of the WHO-FIC Network and feed back its experience to the WHO-FIC Network. Main activities should include the points below:

- **Mortality statistics:** Issues may differ between developed and developing countries. Strategies for knowledge-transfer are most important in this context.
- **Morbidity and disability statistics:** This means work on counting the ill and disabled by using ICD and ICF, and use of the data for policy making, insurance, etc.
- **Health Information Systems:** Work would result in strategies for integration of work with the broad range players and stakeholders in this field, as businesses or NGO.
- **Information sharing:** Countries that are not yet part of the APM should be informed of outcomes and be invited to become members or contribute to the work otherwise.
- **Planning training** and other developmental issues

It was noted that in the Pacific area the situation is different, because their population is small, isolated and scattered. It was discussed to search for funds and plan a satellite APN meeting of the Pacific countries that could encourage their participation. Alternatively, the WHO Bulletin could be used to inform the Pacific countries that are not participating yet. Planning the training and other developmental issues and monitoring should be discussed within the network.

6.2 Organization of the APN and establishment of Working Groups

The meeting discussed the implementation work should be split allowing focusing activities and skills on the core tasks that were mentioned above.

In discussion, the participants decided there shall be workgroups that focus on the main activity streams. Each group would have up to 2 co-chairs best representing the two regions. Chairs were elected for most groups:

- Mortality group; chair Dr. Wansa PAOIN (Thailand)
- Morbidity and functioning group; chair Dr. Al Junid (Malaysia)

- Health information systems group, Dr. Chien Earn LEE (Singapore)
- Sub group for data quality; chair to be decided
- Satellite group for the Pacific Islands. Lead to be taken by Australia

The participants confirmed Dr Kenji SHUTO and Dr Sukil KIM as co-chairs of the network. The JHA would continue to serve as a secretariat to the network.

The Chairs will invite membership to their group from the countries of the APN. Communication mechanisms for groups and network include the SharePoint platform t WHO, email and Skype.

Discussions at the meeting had shown major interest in data quality.

Participants suggested:

- Data quality should be handled by a separate group.
- First focus should be on hospital records.

Future activities of the APN may include computerization of information collection and resulting need for use of terminologies. In this context, SNOMED, cultural linguistic issues, and technical problems as use of 2 byte character sets in electronic tooling environment may be discussed.

6.3 Future Meetings

It was proposed to hold the next meeting in Japan, again. JHA will ensure communication between the members of the Asia Pacific Network. Workgroups could consider midyear meetings in Korea in April or May, as necessary.

6.4 Presentation at the annual meeting of the WHO-FIC Network in Trieste.

Dr. Shuto and Dr. Kim will present information on the APN at a plenary session, and give more detailed information at sessions of the implementation committee. Education topics will be discussed in collaboration with Dr. Greenberg and maybe have a common session.

7 Closure

The chairs and WHO thanked the participants for their contributions and the commitment to future work in the APN. Core topics that resulted from the discussions were highlighted:

- Education and research on health statistics need to collaborate.
- Sharing information among countries with different levels of implementation will facilitate to brief this gap.
- It should be considered to disseminate the outcome of this meeting to the WHO Member States, in analogy to the Kyoto protocol of the UN Framework Convention on Climate Change.
- Discussions of the network will continue online.
- Government officers change positions frequently and this is detrimental to continuity of work. The membership of the APN should be kept stable as long as possible.
- Quality of data needs to be improved.
- Implementation of ICD will be brought forward by inviting to the APN meetings both, ICD coders and high ranking government. Government can train only a small number of trainers now, but more hopefully in the future, when the trainers train.

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Annex 2: Agenda

1 Welcome and introductions

2 Approval of the agenda

3 Objectives of the meeting

4 Country case studies

(results from study or test methodology with sample country among participants)

- Country 1 - Malaysia
- Achievements and challenges in the past year
- Capacity for assessment
- Sponsor programmes

- Country 2 - Indonesia
- Achievements and challenges in the past year
- Capacity for assessment
- Sponsor programmes

5 Group work

- Analyze the two countries with the case studies

6 Report back of group work and discussion

7 Content work

- To draft and agree upon a methodology for assessment and learning
 - Assess
 - Identify differences and communalities
 - Learn from them
 - Formulate strategy for improving implementation
- Steps for implementation
 - Analyze the last 60% towards full vital registration

8 Plan for future work

- Mutual visits
- Scholarships - Japan
- Education needs: fields (collection, infrastructure, coding, analysis) and professions (statisticians , politicians, physicians...)