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| **Abstract:** | This document proposed to establish a new deliverable for the FG-AI4H with a glossary with agreed terminology in artificial intelligence (AI) for health. The objectives of the new deliverable are the consistent term use across the various Deliverables as well as to promote the harmonized use of important AI for health terms across the different disciplines involved in this cross-disciplinary field. Rev.1 contains an update to accommodate comments received; Rev. 2 lists all contributors in alphabetical order and proposes serving as DEL0.1 instead of DEL11. |

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|  | | **International Telecommunication Union** | | |
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| **ITU-T** | **FG-AI4H Deliverable** | |
| TELECOMMUNICATION STANDARDIZATION SECTOR OF ITU | | (draft V0 2021-09-01) |
|  |  | | | |
|  | DEL0.1  Common unified terms in artificial intelligence for health | | | |
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Summary

This document contains a glossary with agreed terminology in artificial intelligence (AI) for health for use not only across the various FG-AI4H Deliverables, but also to promote the harmonized use of important AI for health terms across the different disciplines involved in this cross-disciplinary field.

Keywords

Glossary, terminology, artificial intelligence, health, medical devices

Change Log

This document contains Version [1] of the Deliverable DEL0.1 on "*Common unified terms in artificial intelligence for health*" [approved at the ITU-T Focus Group on AI for Health (FG-AI4H) meeting held in (draft V0 2021-09-01)].

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Draft new ITU-T FG-AI4H Deliverable DEL0.1

Common unified terms in artificial intelligence for health

# Introduction

The International Telecommunication Union (ITU) is the UN specialized agency for information and communication technologies. The World Health Organization (WHO) is the UN specialized agency for health. Both organizations partnered to establish an open group of experts to develop a generalizable benchmarking framework for health solutions based on artificial intelligence (AI), the ITU/WHO Focus Group on AI for Health (FG-AI4H).

A glossary with agreed terminology for the field of artificial intelligence for health can be of great help for many actors in this interdisciplinary area. Common unified terms and definitions may foster the dialogue between experts of different professional backgrounds such as clinicians, developers, machine learning scientists, regulators, ethicists and public health officials. This document contains an initial collection of selected terms and definitions to be extended later as needed. The document adopts terms and definitions from both the scientific literature and authoritative sources when available, and provides new definitions in the AI4H context. The document also provides a collection of acronyms and abbreviations typically in the field, a bibliography with all references and a summary existing of guidance documents and regulations.

The design principles for the document are as follows. The authors differentiate between "terms defined elsewhere" in the sections x.1 and "terms defined here" in the sections x.2. Where a definition originates from elsewhere, e.g., from standards or scientific literature, this definition is taken as given and quoted verbatim, as far as possible, remaining faithful to the original. In the case of concerns regarding a definition, either a better definition from a different literature source can be identified or the definition amended under "terms defined here" in section x.2. In order to promote synergy with other groups, the authors first try to rely on existing definitions from reputable literature/standardization sources. Nevertheless, some of the sources were taken but need not be definitive, if there are others that are more suitable. It is all up for discussion at this draft stage of the glossary.

# Technical terms and definitions

## Terms defined elsewhere

This draft glossary adopts the following technical terms defined elsewhere:

**2.1.1** **Algorithm [IMDRF/SaMD-N41]:** a finite set of instructions (or rules) that defines a sequence of operations for solving a particular computational problem for all problem instances for a problem set.

**2.1.2 Application [ITU-T H.764]:** A functional implementation realized as software running in one or spread over several interplaying hardware entities.

**2.1.3 Artificial Intelligence (AI) [Nilsson 1998]:** Artificial intelligence, broadly (and somewhat circularly) defined, is concerned with intelligent behaviour in artefacts. Intelligent behaviour, in turn, involves perception, reasoning, learning, communicating, and acting in complex environments.

NOTE – The definition of [Nilsson 1998] shall serve as a starting point in this draft glossary for exploring, collecting, reconciling, and consolidating different definitions of the term "AI", which is subject of controversial discussions.

**2.1.4 Batch Learning [CTA-2089]:** Method of training where examples are presented in groups to the model. Typically used when a large amount of pre-recorded data.

**2.1.5** **Bias [ISO/IEC 22989]:** Systematic difference in treatment of certain objects, people, or groups in comparison to others.

NOTE – Bias is used both in a technical/statistical context and in ethical/legal discussions with different definitions. See [clause 6.1.5](#biassoc) for the ethics perspective on this term.

**2.1.6 Class-activation map [SPIRIT-AI]:** Class-activation maps are particularly relevant to image classification AI interventions. Class-activation maps are visualisations of the pixels that had the greatest influence on predicted class, by displaying the gradient of the predicted outcome from the model with respect to the input. They are also referred to as "saliency maps" or "heat maps".

**2.1.7 Continuous Learning [ISO/IEC 22989]:** Incremental training of an AI system that takes place on an ongoing basis during the operation phase of the AI system life cycle

**2.1.8** **Convolutional Neural Networks (CNN) [Deep Learning]:** Convolutional networks, also known as convolutional neural networks, are a specialized kind of neural network for processing data that has a known grid-like topology.

**2.1.9** **Deep Learning (DL) [ISO/IEC 22989]:** Approach to creating rich hierarchical representations through the training of neural networks with many hidden layers.

NOTE 1 – Deep learning is also known as deep neural network learning.

**2.1.10** **Fine-tuning [SPIRIT-AI]:** Modifications or additional training performed on the AI intervention model, done with the intention of improving its performance

**2.1.11** **Locked Algorithm [FDA]:** An algorithm that provides the same result each time the same input is applied to it and does not change with use.

**2.1.12** **Machine Learning (ML) [CONSORT-AI]:** A field of computer science concerned with the development of models/algorithms that can solve specific tasks by learning patterns from data, rather than by following explicit rules. It is seen as an approach within the field of AI.

**2.1.13 Neural Networks (NN) [CONSORT-AI]:** Simplified from Artificial Neural Networks (ANN). An ANN is based on a collection of connected units or nodes called artificial neurons which loosely model the neurons in a biological brain. Each connection, like the synapses in a biological brain, can transmit a signal to other neurons.

**2.1.14 Reliability [ISO/IEC 22989]:** Property of consistent intended behaviour and results.

**2.1.15 Semi-supervised Machine Learning [ISO/IEC 22989]:** Machine learning that makes use of both labelled and unlabelled data during training.

**2.1.16 Supervised Machine Learning [ISO/IEC 22989]:** Machine learning that makes use of labelled data during training.

**2.1.17 Training [ISO/IEC 22989]:** Process to establish or to improve the parameters of a machine learning model, based on a machine learning algorithm, by using training data.

**2.1.18 Training Dataset [ISO/IEC TR 24028:2020]:** A dataset used in the training process to establish or improve the parameters of a machine learning model based on a machine learning algorithm.

**2.1.19 Unsupervised Machine Learning [ISO/IEC 22989]:** Machine learning that makes use of unlabelled data during training.

## Terms defined here

This draft glossary defines the following technical terms:

**2.2.1 Test dataset:** A subset of the data that is never shown to the model during training, used to verify that the model has learned what it was supposed to.

NOTE – Adapted from [ISO/IEC 22989], which defines "test data: data used to assess the performance of a final machine learning model. [...] Test data is disjoint from training data and validation data. [...]. The test set is used to verify that the model has learned what it was supposed to.")

# Statistical Terms

## Terms defined elsewhere

This draft glossary adopts the following statistical terms defined elsewhere:

**3.1.1** **Area under the receiver operating characteristic curve (AUROC) [Ekelund 2012]:** The area under a receiver operating characteristic curve is a measure of the usefulness of a test in general, where a greater area means a more useful test, the areas under ROC curves are used to compare the usefulness of tests

## Terms defined here

This draft glossary defines the following statistical terms:

**3.2.1** **term:** definition

# Clinical & Scientific Terms

## Terms defined elsewhere

This draft glossary adopts the following clinical and scientific terms defined elsewhere:

**4.1.1** **term:** definition

## Terms defined here

This draft glossary defines the following clinical and scientific terms:

**4.2.1** **term:** definition

# Evaluation terms and definitions

## Terms defined elsewhere

This draft glossary adopts the following evaluation terms defined elsewhere:

**5.1.1** **Clinical Data [IMDRF/MDCE-N57]:** Safety, clinical performance, and/or effectiveness information that is generated from the clinical use of a medical device

**5.1.2** **Clinical Evaluation [IMDRF/MDCE-N57]:** A set of ongoing activities that use scientifically sound methods for the assessment and analysis of clinical data to verify the safety, clinical performance and/or effectiveness of the device when used as intended by the manufacturer.

**5.1.3** **Clinical Evidence [IMDRF/MDCE-N57]:** The clinical data and its evaluation pertaining to a medical device.

**5.1.4** **Clinical Investigation [IMDRF/MDCE-N57]:** Any systematic investigation or study in or on one or more human subjects, undertaken to assess the safety, clinical performance and/or effectiveness of a medical device

**5.1.5** **Clinical Outcome [SPIRIT-AI]:** Measured variables in a clinical trial that are used to assess the effects of an intervention

**5.1.6** **Clinical Outcome Assessment [FDA-NIH BEST]:** Assessment of a clinical outcome ["clinical outcome" is in the source[FDA-NIH BEST] specifically defined as: "An outcome that describes or reflects how an individual feels, functions or survives"] can be made through report by a clinician, a patient, a non-clinician observer or through a performance-based assessment. There are four types of COAs. clinician-reported outcome, observer-reported outcome, patient-reported outcome, performance outcome

**5.1.7** **Clinical Performance [IMDRF/MDCE-N57]:** The ability of a medical device to achieve its intended clinical purpose as claimed by the manufacturer.

**5.1.8** **Clinical Trials [IMDRF/MDCE-N57]:** A properly conducted clinical investigation, including compliance to the clinical investigation plan and local laws and regulations, ensures the protection of human subjects, the integrity of the data and that the data obtained is acceptable for the purpose of demonstrating the SaMD's conformity to the Essential Principles

**5.1.9** **Clinical Validation [IMDRF/SaMD-N41]:** The ability of a SaMD to yield a clinically meaningful output associated to the target use of SaMD output in with the target health care situation or condition identified in the SaMD definition statement

**5.1.10** **Development environment [SPIRIT-AI]:** The clinical, and operational settings from which the data used for training the model are generated. This includes all aspects of the physical setting (such as geographical location, physical environment), operational setting (such as integration with an electronic record system, installation on a physical device) and clinical setting (such as primary, secondary and/or tertiary care, patient disease spectrum)

**5.1.11** **Effectiveness [IMDRF/MDCE-N57]:** The ability of a medical device to achieve clinically meaningful outcome(s) in its intended use as claimed by the manufacturer.

**5.1.12** **Input data [SPIRIT-AI]:** The data that needs to be presented to the AI system to allow it to serve its purpose.

**5.1.13** **Intended Use [SPIRIT-AI]:** The objective intent of the manufacturer regarding the use of a product, process or service as reflected in the specifications, instructions and information provided by the manufacturer.

**5.1.14** **Output data [SPIRIT-AI]:** The predicted output given by the AI system based on processing of the input data. The output data can be presented in different forms, including a classification (including diagnosis, disease severity or stage, or recommendation such as referability), a probability, a class-activation map, etc.

**5.1.15** **Performance error [SPIRIT-AI]:** Instances in which the AI system fails to perform as expected. This term can describe different types of failures, and it is up to the investigator to specify what should be considered a performance error, preferably based on prior evidence. This can range from small decreases in accuracy (compared to expected accuracy) to erroneous predictions or the inability to produce an output, in certain cases.

**5.1.16** **Post-market clinical follow-up study (PMCF-study) [ISO/TR 20416]:** Study carried out following marketing approval intended to answer specific questions relating to clinical safety or performance (i.e. residual risks) of a medical device when used in accordance with its approved labelling.

**5.1.17** **Post-market surveillance (PMS) [ISO 13485]:** Systematic process to collect and analyse the performance of medical devices that have been placed on the market.

**5.1.18** **Safety [IMDRF/MDCE-N57]:** Acceptability of risks as weighed against benefits, when using the medical device according to the manufacturer's labelling.

**5.1.19** **Scientific Validity (Valid Clinical Association) [IMDRF/SaMD-N41]:** The extent to which the SaMD's output (concept, conclusion, measurements) is clinically accepted or well founded (based on an established scientific framework or body of evidence) and corresponds accurately in the real world to the healthcare situation and condition identified in the SaMD definition statement (corresponds to the level of clinical acceptance of the SaMD's output)

**5.1.20** **Verification [ISO 9000]:** Confirmation, through the provision of objective evidence, that specified requirements have been fulfilled.

NOTE 1 – The objective evidence needed for a verification can be the result of an inspection or of other forms of determination such as performing alternative calculations or reviewing documents.

NOTE 2 – The activities carried out for verification are sometimes called a qualification process.

NOTE 3 – The word "verified" is used to designate the corresponding status.

**5.1.21** **Validation [ISO 9000]:** confirmation, through the provision of objective evidence, that the requirements for a specific intended use or application have been fulfilled.

NOTE 1 – The objective evidence needed for a validation is the result of a test or other form of determination such as performing alternative calculations or reviewing documents.

NOTE 2 – The word "validated" is used to designate the corresponding status.

NOTE 3 – The use conditions for validation can be real or simulated.

## Terms defined here

This draft glossary defines the following evaluation terms:

**5.2.1** **term:** definition

# Ethics terms and definitions

## Terms defined elsewhere

This draft glossary adopts the following ethics terms defined elsewhere:

**6.1.1 Anonymization [WHO AI-EG]:** With respect to personal data, a sub-category of de-identification whereby both direct and indirect personal identifiers are removed, and technical safeguards are used to ensure zero risk of re-identification.

**6.1.2 Automation bias [WHO AI-EG]:** A lack of consideration by a healthcare provider of whether an automated technology meets their needs or those of the patient. This may lead a provider to overlook errors that should have been spotted by human-guided decision-making.

**6.1.3 Autonomy [WHO GHE]:** Most often taken to refer to the ability of an individual to be his or her own person, to make his/her own choices on the basis of his/her motivations, without manipulation by external forces. However, others in a more Kantian tradition see autonomy as being firmly related to accepting and acting on the basis of one's obligations, i.e. acting morally, the precise oppose of what one wants.

**6.1.4 Beneficence [WHO GHE]:** Principle requiring that governments, health care providers, and researchers do good for, provide benefit to, or make a positive contribution to the welfare of populations, patients and study participants.

**6.1.5** **Bias [WHO AI-EG]:** A threat to inclusiveness and equity that represents a departure, often arbitrary, from equal treatment.

NOTE – Bias is used both in ethics/legal discussions and in a technical/statistical context with different definitions. See [clause 2.1.5](#biastech) for the technical perspective on this term.

**6.1.6 Biosurveillance [WHO AI-EG]:** A form of surveillance for health data and other biometrics, such as facial features, fingerprints, temperature, and pulse.

**6.1.7 Black-box algorithms [WHO AI-EG]:** Algorithms that make inferences and decisions that are not understood, including by their developers.

**6.1.8 Confidentiality [WHO GHE]:** The obligation to keep information secret unless its disclosure has been appropriately authorized by the person concerned or, in extraordinary circumstances, by the appropriate authorities.

**6.1.9 Control problem [WHO AI-EG]:** Wherein developers and designers of AI may not be held responsible, as AI guided systems function independently of their developers and may evolve in ways that the developer could claim were not foreseeable.

**6.1.10 Co-regulation [WHO AI-EG]:** Wherein governments and companies rely on each other to assess and regulate a technology. While such models of oversight may assist governments in understanding a technology, they may limit a government's exercise of independent judgment and encourage governments to trust that companies are willing to strictly self-regulate their practices.

**6.1.11 Data altruism [WHO AI-EG]:** Also known as data solidarity, this allows companies to collect personal and non-personal data on individuals for projects that are in the public interest.

**6.1.12 Data colonialism [WHO AI-EG]:** Generating data from low- and middle-income countries in which the data are used for commercial or non-commercial purposes without due respect for consent, privacy, or autonomy.

**6.1.13 Data portability [WHO AI-EG]:** The right of individuals to obtain their personal data in a machine-readable format from one controller that can be sent to another controller.

**6.1.14 Data protection laws [WHO AI-EG]:** Rights-based approaches that provide standards for regulating data processing that both protect the rights of individuals and establish obligations for data controllers and processors.

**6.1.15 Data triangulation [WHO AI-EG]:** Techniques that can be used to reconstruct a de-identified, incomplete dataset by a third party for re-identification of an individual.

**6.1.16 De-identification [WHO AI-EG]:** With respect to personal data, preventing any connection of personal identifiers to information.

**6.1.17 Digital divide [WHO AI-EG]:** The uneven distribution of access to, use of or effect of information and communication technologies among any number of distinct groups.

**6.1.18 Digital welfare state [WHO AI-EG]:** The use of AI to provide public services, including an assessment of whether an individual qualifies for certain services. Digital data and technologies are used to automate, predict, identify, or disqualify potential recipients of social welfare, including healthcare benefits. There is concern that the digital welfare state could undermine access to social services and welfare and especially affect poor and marginalised populations.

**6.1.19 Ethics [WHO GHE]:** Branch of knowledge concerned with questions about right versus wrong conduct and what constitutes a good or bad life, as well as the justificatory basis for such questions.

**6.1.20 Explainability [WHO AI-EG]:** Improving the scientific understanding of an algorithm to understand how a system arrives at a decision. AI technologies should be explainable to the extent possible and according to the capacity of those to whom the explanation is directed. Those who might request or require an explanation should be well informed, and the educational information must be tailored to each population, including, for example, marginalized populations.

**6.1.21 Fairness [WHO AI-EG]:** Ensuring that all persons are treated fairly, which includes the requirement to ensure that no person or group is subject to discrimination, neglect, manipulation, domination, or abuse.

**6.1.22 Federated data [WHO AI-EG]:** A way to enable access to health data, including genomic data, that must remain inside a country or institution because of their sensitivity. Data do not leave the participating organization that holds them, but authorized users can make queries that allow them to access data, for example to train an algorithm.

**6.1.23 Human Rights [WHO GHE]:** Fundamental freedoms and rights enshrined in a set of universal legal statements. Some of the most important characteristics of human rights are that: they are acknowledged in international declarations; states and state actors are obliged to respect them; they cannot be waived or taken away (although the enjoyment of particular human rights may be limited in exceptional circumstances); they are interdependent and inter-related; and they are universal.

**6.1.24 Human warranty [WHO AI-EG]:** Evaluation by patients and clinicians in the development and deployment of AI technologies. Regulatory principles are applied upstream and downstream of the algorithm by establishing points of human supervision. Points of human supervision are identified by discussions among professionals, patients, and designers.

**6.1.25 Impact assessment [WHO AI-EG]:** An impact assessment is used to predict the consequences of a current or proposed action, policy, law, regulation or, as in the case of use of AI for health, a new technology or service. Impact assessments can provide both technical information on possible consequences and risks (both positive and negative) and improve decision-making, transparency, and participation of the public and introduce a framework for appropriate follow-up and measurement.

**6.1.26 Inclusiveness [WHO AI-EG]:** A requirement that AI is designed to encourage the widest possible appropriate, equitable use and access, irrespective of age, gender, income, ability or other characteristics.

**6.1.27 Informed consent [WHO GHE]:** Agreement to a certain course of action, such as treatment or participation in research, on the basis of complete and relevant information by a competent individual without coercion.

**6.1.28 Many hands problem [WHO AI-EG]:** Since the development of AI involves contributions from many agents, it is difficult, both legally and morally, to assign responsibility, which is diffused among all the contributors to the AI-guided technology.

**6.1.29 Nonmaleficence [WHO GHE]:** A principle requiring that health care providers and researchers do not inflict undue harm, either intentionally or through negligence.

**6.1.30 Peer disagreement [WHO AI-EG]:** Disagreement between two competent experts – an AI machine and a doctor, where in there is no means of combining the decisions or of reasoning with the algorithm, and no clear rules for determining who is right.

**6.1.31 Privacy [WHO GHE]:** Privacy seeks to protect a person from scrutiny by others. Respect for privacy implies that a person should not be expected to share personal information unless they so choose. Any violation of privacy requires ethical justification although it might be outweighed by other considerations in some cases (i.e. for the protection of the common good).

**6.1.32 Pseudo-anonymization [WHO AI-EG]:** The processing of personal data in such a way that the data can no longer be attributed to a specific data subject without the use of additional information provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person.

**6.1.33 Responsibility [WHO AI-EG]:** Responsibility ensures that individuals and entities are held accountable for any adverse effects of their actions and is necessary to maintain trust and to protect human rights.

**6.1.34 Responsiveness [WHO AI-EG]:** A requirement that designers, developers and users continuously, systematically, and transparently examine an AI technology to determine whether it is responding adequately, appropriately, and according to communicated expectations and requirements in the context in which it is used.

**6.1.35 Sustainability [WHO AI-EG]:** AI technologies that can be fully integrated and sustained in a health-care system and designed to minimize its ecological footprint and increase energy efficiency.

**6.1.36 Transparency [WHO AI-EG]:** Transparency requires that sufficient information be published or documented before the design and deployment of an AI technology. Such information should facilitate meaningful public consultation and debate on how the AI technology is designed and how it should be used. Such information should continue to be published and documented regularly and in a timely manner after an AI technology is approved for use.

## Terms defined here

This draft glossary defines the following ethics terms:

**6.2.1** **term:** definition

# Product terms and definitions

## Terms defined elsewhere

This draft glossary adopts the following product terms defined elsewhere:

**7.1.1** **Software as a Medical Device (SaMD) [IMDRF SaMD-N12]:** Software intended to be used for one or more medical purposes that perform these purposes without being part of a hardware medical device.

## Terms defined here

This draft glossary defines the following product terms:

**7.2.1** **Total Product Life Cycle (TPLC):** Total Product Life Cycle (TPLC) is a conceptual framework for holistically managing any product or service throughout all of its stages, e.g. from inception to introduction, growth, maturity, and decline.

# Policy Terms

## Terms defined elsewhere

This draft glossary adopts the following policy terms defined elsewhere:

**8.1.1** **High Income Countries (HIC)**: List of countries with higher levels of income that is defined by the World Bank and reviewed regularly, as found at [https://datahelpdesk.worldbank.org/‌knowledgebase/articles/906519](https://datahelpdesk.worldbank.org/knowledgebase/articles/906519).

**8.1.2** **Low- and lower-middle income countries (LMIC)**: List of countries with lower levels of income that is defined by the World Bank and reviewed regularly, as found at <https://datahelpdesk.‌worldbank.org/knowledgebase/articles/906519>.

## Terms defined here

This draft glossary defines the following policy terms:

**8.2.1** **Focus Group**: An ITU-T Focus Group is a group created under the provisions of [ITU-T A.7] to help advance the work of the ITU Telecommunication Standardization Sector (ITU-T) study groups and to encourage the participation of members of other standards organizations, including experts and individuals who may not be members of ITU. Focus group activities may include an analysis of gaps between current Recommendations and expected Recommendations, and provide material for consideration in the development of Recommendations. They augment an ITU-T study group work programme by providing an alternative working environment for the quick development of specifications in their chosen areas. (Adapted from [ITU-T A.1].)

**8.2.2** **Sustainable Development Goals (SDGs)** (Adapted from UN-SDGs]): The Sustainable Development Goals of the United Nations are urgent "calls for action" by all countries in 17 areas of human development in a global partnership. They recognize that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all while tackling climate change and working to preserve our oceans and forests. SDG 3 "Ensure healthy lives and promote well-being for all at all ages" is particularly relevant for AI for Health.

# Abbreviations and acronyms

|  |  |
| --- | --- |
| AI | Artificial Intelligence |
| AI-MD | AI based medical device |
| AI4H | Artificial Intelligence for health |
| API | Application Programming Interface |
| CfTGP | Call for Topic Group Participation |
| CNN | Convolutional Neural Network |
| COA | Clinical outcome assessment |
| CONSORT-AI | Consolidated Standards of Reporting Trials |
| DEL | Deliverable |
| DL | Deep Learning |
| FDA | Food and Drug Administration |
| FG | Focus Group |
| FG-AI4H | Focus Group on AI for Health |
| GDPR | General Data Protection Regulation |
| IMDRF | International Medical Device Regulators Forum |
| IP | Intellectual property |
| ISO | International Standardization Organization |
| ITU | International Telecommunication Union |
| LMIC | Low-and middle-income countries |
| MDR | Medical Device Regulation |
| ML | Machine Learning |
| NGO | Non-Governmental Organization |
| NN | Neural Networks |
| SaMD | Software as a Medical Device |
| SDG | Sustainable Development Goal |
| TDD | Topic Description Document (specifies the standardized benchmarking for a topic on which each TG of the FG-AI4H works) |
| TG | Topic Group |
| TPLC | Total Product Life Cycle |
| UN | United Nations |
| WG | Working Group |
| WHO | World Health Organization |
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# Annex A Summary of Guidance and Regulations

## Evidence Reporting Guidance:

* *SPIRIT-AI and CONSORT-AI:*<https://www.clinical-trials.ai/>
* *EQUATOR NETWORK:*<https://www.equator-network.org/reporting-guidelines/>
* *STARD-AI:*Sounderajah V, Ashrafian H, Aggarwal R, et al. Developing specific reporting guidelines for diagnostic accuracy studies assessing AI interventions: The STARD-AI Steering Group. Nat Med 2020; 26: 807–08
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* SaMD: Key Definitions (N10)
* SaMD: Possible Framework for Risk Categorisation and considerations (N12) 2014
* SaMD: Application of Quality Management System (QMS) (N23) 2015
* SaMD: Clinical Evaluation (N41) 2017
* SaMD: Clinical Evidence (N55) 2019
* SaMD: Clinical Evaluation (N56) 2019
* SaMD: Clinical Investigation (N57) 2019

WHO Guidance:

* WHO. Monitoring and Evaluating Digital Health Interventions, 2016: <https://www.who.int/reproductivehealth/publications/mhealth/digital-health-interventions/en/>
* WHO DHI Digital Health Strategy. Draft, July 2020: <https://www.who.int/health-topics/digital-health#tab=tab_1>

International Organisation for Standardization (ISO):

* ISO/IEC CD 23053 Framework for Artificial Intelligence (AI) Systems Using Machine Learning (ML): <https://www.iso.org/standard/74438.html>
* ISO/IEC DIS 22989 Information technology – Artificial intelligence – Artificial intelligence concepts and terminology: https://www.iso.org/standard/74296.html?browse=tc

International Regulatory Guidance:

* *US-FDA:* Proposed Regulatory Framework for Modifications to Artificial Intelligence / Machine Learning [AI/ML]- Based Software as a Medical Device (SaMD) 2019
* *ITU-T: FG-AI4H-I-036:* Guidelines for AI based medical device: Regulatory requirements (Draft: April 2020)
* *EU:*
* European Union Medical Device Regulation EU 2017/745
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* NICE: Evidence Standards Framework for Digital Health Technologies 2019. <https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies>
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