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The validation and translation of Multidimensional Measure of Informed Choice in Greek

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ABSTRACT

Objective: to translate the original English version of the Multidimensional Measure of Informed Choice (MMIC) into Greek, to adapt it culturally to Greece, and to determine its psychometric properties for the assessment of informed choice in antenatal screening for Down syndrome.

Design: survey using self-administrated questionnaires.

Setting: public hospital in Athens, Greece.

Participants: 135 pregnant women with gestational age between 11th and 20th week just prior to having antenatal screening for Down syndrome.

Findings: 96% of women had a positive attitude towards screening and 45% had a good level of knowledge concerning the screening process for Down syndrome. Using a standard measure of informed choice, validated for use in Greek, it was found that 44% of women made an informed choice, and thus 56% of women made an uninformed choice. The internal consistency of the scales was good; Cronbach's alpha was found to be 0.76 for the attitude scale and 0.64 for the knowledge scale, suggesting that all items were appropriate to measure. The performed factor analysis of the attitude scale indicated three factors with an eigenvalue over 1.0. Those factors were responsible for 87% of the variance.

Key conclusions: this study indicates that the Greek version of the MMIC appears to be a reliable and valid tool for measuring informed choice in antenatal screening for Down syndrome. Due to its short length and consumption of time, it seems to be a practical instrument for use in Greek antenatal clinics.

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Background

In an informed choice model, the patient receives information from their health-care professional and then makes their own decision about the treatment they want to receive in discussion with the health-care professional (Charles et al., 1999). In this model, the health-care professional communicates information concerning all the available options to the patient, and is involved in informing, but not directing, the decision-making process. The amount and type of information must be sufficient to enable the patient to make an informed choice. In the case of antenatal screening for Down syndrome, there is no recommended course of action that improves the health of the mother or infant (Marteau et al., 2005).

According to Bekker et al. (1999), 'an informed decision is defined as a reasoned choice which is made by a reasonable individual using relevant information about the advantages and disadvantages of all possible courses of action in accord with the

individual's belief'. Many definitions have been given for informed choice. Operationalising the majority of definitions of informed choice, as a measure, requires the measurement of two core characteristics: knowledge and values toward screening for Down syndrome. This achievement may be obstructed by the lack of a standardised measure that assesses the multidimensionality of informed choice, because measures of informed choice are often either single dimensioned measures or measures of self-report. Existing measures of informed choice either use items to assess a single dimension (such as a measure of knowledge) of informed choice or use items about whether women thought that they had exercised informed choices (O' Cathain et al., 2002). These types of measures have many limitations, as single dimension measures are unable to reflect the multidimensionality of the construct of informed choice (Marteau et al., 2001), and self-assessment of information and self-report of informed choice is not a reliable measure of actual informed choice (Green et al., 2004). One multidimensional measure of informed choice for use in antenatal screening for Down syndrome that has assessed both knowledge and individuals' beliefs and behaviours was developed by Marteau et al. (2001). The measure was latterly extended by the addition of

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two new items (regarding the life expectancy and the abilities of a child with Down syndrome) in the knowledge scale and two new items in the attitude scale (Dormandy et al., 2005), and was named the 'Multidimensional Measure of Informed Choice' (MMIC). This takes into account the congruence of three elements of informed choice: (a) knowledge about the screening test and the Down syndrome condition, (b) attitude towards screening, and (c) uptake of the test.

This questionnaire is short in length, easy to answer (multiple choice), has been developed for the general pregnant population and has been successfully used in different settings (Dormandy et al., 2005; Jaques et al., 2005; Rowe et al., 2006; Gourounti and Sandall, 2008). According to the developers, the MMIC was proved to be accurate and reliable in identifying women who make informed choices concerning antenatal screening for Down syndrome. Cross-cultural validation of an existing measure has the great advantage of avoiding the lengthy process of development of a new questionnaire (Sapountzi-Krepia et al., 2005). Furthermore, translation and cultural adaptation of an already reliable scale into different languages makes it possible to use the questionnaires in comparative international studies (Sapountzi-Krepia et al., 2005). Therefore, it was decided to translate, retranslate and then check the validity, reliability and psychometric properties of the MMIC for a Greek population.

The aim of the present study was to translate the original English version of the MMIC into Greek, to adapt it culturally to Greece, and to determine the psychometric properties, reliability and validity of dimensions for the assessment of informed choice in antenatal screening for Down syndrome.

Methods

Sample

The questionnaires were administered to a sample of pregnant women with a gestational age of between 11 and 20 weeks who were booked for Down syndrome screening in the antenatal clinic of a public hospital of Athens. Women who could not speak or write Greek were excluded from the study because they would not have been able to complete the questionnaires. All women who were booked for screening at the hospital over a two-month period (April to May) in 2005 were invited to participate in the survey. During the recruitment period, 150 women were asked to participate in the study; 93% (140/150) agreed to take part and 90% (135/150) returned completed questionnaires. The study design and the method of data collection are explained in full elsewhere (Gourounti and Sandall, 2008).

Measures

The MMIC is a self-report measure of informed choice in antenatal screening for Down syndrome. The later version of the MMIC (Dormandy et al., 2005) includes a 10-item scale which measures the level of knowledge regarding Down syndrome screening on a range from 0 to 10 (one point for each correct answer), and a six-item scale which measures the attitudes of women regarding the perceived importance and benefits of Down syndrome screening on a six-point Likert scale ranging from 0 to 36. The areas covered by the knowledge scale are: the condition of Down syndrome, the purpose of screening, the percentage of women with a high-risk and a low-risk result, the meaning of a high-risk and a low-risk result, risks of miscarriage from further tests, percentage of women with a high-risk result who have an infant with Down syndrome and the fact that termination is

offered. Women with scores of greater than five (the mid-point of the knowledge scale) were classified as having good knowledge about Down syndrome screening, and those with scores of five or below were classified as having poor knowledge. Women with scores above 18 (the mid-point of the attitude scale) were classified as having positive attitudes towards undergoing Down syndrome screening, and women with scores of 18 or below were classified as having negative attitudes. The cut-off was defined by the scale (mid-point) rather than the sample (median) because there were no agreed external criteria for 'good' and 'poor' knowledge and 'positive' and 'negative' attitudes (Michie et al., 2002). These two measures were combined to provide a classification of choices as informed or uninformed. Once all women who participated in the study had completed the test, the choices were classified as informed when women had a good level of knowledge (above five points) and positive attitudes (above 18 points) towards Down syndrome screening. Choices were classified as uninformed when women had a poor level of knowledge and negative attitudes towards Down syndrome screening, or when women had a poor level of knowledge and negative attitudes or when they had a good level of knowledge and inconsistent attitudes with their behaviour. The third element of the measure is the uptake of screening, which is usually assessed from hospital records. As all of the women who participated in this study had already decided to have the screening test, the element of 'uptake' was not used.

A single item regarding the uncertainty about the decision choice was used and was adapted from a previous study (Lewando-Hundt et al., 2005). Background information (demographic characteristics of the participants) was collected using a researcher-developed instrument.

Translation

In this study, the 'forward-backward' translation was applied to translate the MMIC from English to Greek. Back-translation is highly recommended by experts on cross-cultural research (Maneesriwongul and Dixon, 2004). This process must be conducted carefully because the values that are reflected by an instrument and the meanings of its component constructs may vary from one culture to another (Maneesriwongul and Dixon, 2004). Two independent bilingual health professionals and a professional translator translated the items into Greek, and two other bilingual health professionals then back-translated the agreed Greek version. Furthermore, two native English speakers confirmed the contents between the original English version and the back-translated version. After the back-translation was conducted, the researcher checked the translated version to minimise misunderstandings, especially concerning the terminology. Therefore, a version of the Greek questionnaire, which was linguistically and conceptually equivalent to the English version, was provided.

Pilot study

The questionnaire was piloted using cognitive interviewing methods with the objective of examining the structure of the questionnaire and understanding of the questions, eliminating any ambiguities and errors in questions, predicting the time of completion, and identifying any areas presenting problematic language. The sample for cognitive testing consisted of 10 women with different demographic characteristics to ensure that the main sample was presented. The returned questionnaires were fully and appropriately completed and the response choices were adequate and understandable. However, slight alterations to the

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