

# Adaptation of the inventory of ethical problems to the child health context

Adaptação do inventário de problemas éticos para o contexto da saúde da criança

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## Descritores

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## Abstract

**Objective:** To describe the adaptation process of the “Inventory of Ethical Problems in Primary Health Care” (IPE-APS) to the child health context.

**Methods:** Methodological study, based on the universalist model. The following phases of equivalence were undertaken: conceptual, item, semantic and operational. Ten experts and 30 nurses from Family Health Services participated.

**Results:** In the item and semantic equivalence developed by the judges, the first dimension of the IPE-APS presented the largest number of items with agreement <70 %, totaling five out of 18. In the pretest, the target population assessed the instrument as easy to understand, but suggestion a slight adjustment in the instruction and layout. The mean completion time was 15 minutes.

**Conclusion:** The adaptation of the IPE-APS to the child health context was developed successfully. The tool is feasible and the subsequent validation phases will permit its inclusion in professional nursing practice.

## Resumo

**Objetivo:** Descrever o processo de adaptação do “Inventário Problemas Éticos na Atenção Primária em Saúde” (IPE-APS) para o contexto da saúde da criança.

**Métodos:** Estudo metodológico, baseado no modelo universalista. Seguiram-se as etapas de equivalência: conceitual, de itens, semântica e operacional. Realizado com a participação de 10 especialistas e de 30 enfermeiras de Unidades de Saúde da Família.

**Resultados:** Na equivalência de itens e semântica, realizada pelos juízes, a primeira dimensão do IPE-APS apresentou maior número de itens com concordância <70 %, total de cinco entre 18. No pré-teste, a população-alvo avaliou o instrumento como de fácil compreensão, porém sugeriu pequeno ajuste na instrução e no *layout*. O tempo médio de preenchimento foi de 15 minutos.

**Conclusão:** A adaptação do IPE-APS para o contexto da saúde da criança foi realizada com sucesso. O instrumento é viável e a continuidade da validação possibilitará sua inclusão na prática profissional de enfermeiras.

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## Introduction

In Primary Health Care (PHC) practice, different interactions exist, particularly the interactions the professionals experience with the user/family, with the team and with the health system itself. Therefore, it is associated with various ethical issues, such as the limit of these professionals' interventions in the context of the user's private life. As opposed to what happens at the tertiary level, however, they are more subtle, even if highly complex.<sup>(1)</sup>

Thus, the health care delivered at Primary Health Care Services (UBS) needs to be considered in bioethical discussions, as ignoring it makes the circumscription of bioethics incomplete in view of the heterogeneous services and actions performed at this level of the Unified Health System (SUS).<sup>(2)</sup>

In that sense, it can be affirmed that, in clinical practice, health professionals are confronted with Ethical Problems (EP) in the individual sphere, considered as the aspects, questions or ethical implications common in the practice of PHC, without fundamentally representing a dilemma.<sup>(1)</sup> What distinguishes an EP from a Dilemma/Conflict is that, while the latter entails several admissible ways out, generating doubts on what to do, in the latter, the possible solutions are always dichotomous.<sup>(3)</sup>

These EPs can be experienced in the execution of the priority care lines of PHC. In this article, the singularity of Child Health (CH) is highlighted, justified by the peculiarity of going through the growth and development process.<sup>(4)</sup> In addition, the child population attended in the programs the Family Health Strategy (FHS) offers is mostly under two years of age, entailing limitations for the exercise of autonomy.

In the scarce production available in the literature, the most frequent ethical problems in pediatric practice can be described. In a literature review, Mendiola<sup>(5)</sup> identified EP in prenatal diagnosis, in the immunization program, in care programs for disabled children, in care delivery to child victims of violence, in care for children from religious families, with regard to drug prescriptions and in medical-scientific research. Guedert et al.,<sup>(6)</sup> in a qualitative study, acknowl-

edged that the EP concerned the spheres of the physician-patient relationship (confidentiality and difficult personal relationships), of the health professionals' conducts (disagreements on therapeutic indications) and in the socioeconomic sphere and the public health policies (adverse economic conditions), inappropriateness of the health care network and work environment and violence against children).

In view of that perspective, a group of Brazilian researchers verified the need to acknowledge the ethical problems that occur in the daily work of PHC professionals to discuss them. Hence, along almost 12 years of study, they developed the Inventory of Ethical Problems in Primary Health Care (IPE-APS). This tool was theoretically based on Diego Garcia's deliberative bioethics and constructed through interviews with physicians and nurses, aiming to identify the EP the professionals experienced, with a view to improving the quality of care delivered at that care level.<sup>(7)</sup>

The IPE-APS is multidimensional and the following evidence of validity and reliability has been found: content validity, in a study involving 46 PHC professionals from São Paulo and 15 Bioethics experts;<sup>(4)</sup> validation of understandability, investigated in a group of nine PHC experts from São Leopoldo-RS;<sup>(7)</sup> construct validity and internal consistency in a study involving 237 PHC professionals from Porto Alegre-RS;<sup>(8)</sup> besides a cross-cultural adaptation in the city of Porto-Portugal.<sup>(9)</sup>

Thus, considering: the lack of instruments to identify ethical problems experienced in child health care in PHC in the investigated databases (Portal Capes, Pubmed, Biblioteca Virtual em Saúde, Cinahl); the availability of the IPE-APS, formulated in and for the reality of the Unified Health System (SUS)<sup>(8)</sup> and the need to offer a measure of ethical issues associated with the child age range, we decided to adapt the IPE-APS to the CH context.

In view of the above, the objective was to describe the adaptation process of the "Inventory of Ethical Problems in Primary Health Care" to the child health context.

## Methods

A methodological study was undertaken, which used systematic procedures to adapt the IPE-APS in the CH context (Figure 1). In view of the diverse methods to adapt an instrument, one had to be chosen: the universalist model by Herdman,<sup>(10-12)</sup> which includes the following equivalences: conceptual, item, semantic and operational.

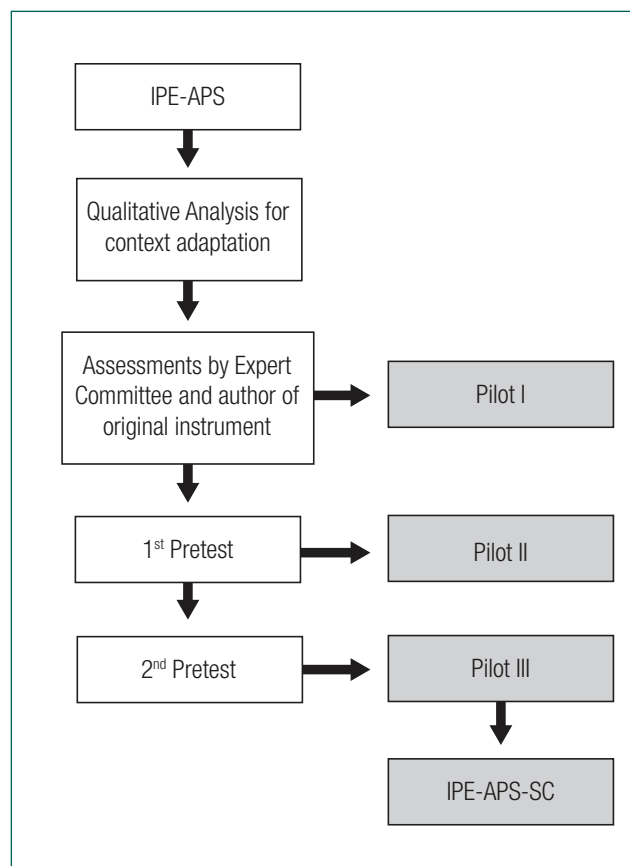
The IPE-APS was applied in three Brazilian regions: in the Southeast,<sup>(13)</sup> Central-West<sup>(14)</sup> and Northeast,<sup>(15)</sup> and also in the city of Porto-Portugal.<sup>(9)</sup> In its original version, the instrument consists of 38 items, distributed in three dimensions of the construct ethical problems: (1) EP in the relations with users and family, containing 18 items, refers to issues that happen in the health professionals' daily relation with the USF users; (2) EP in the team's relationships, containing eight items, involves the demands in the interpersonal relationships of the USF team; (3) EP in the relations with the organization and the health system, involving aspects of SUS management, consisting of 12 items. Each item is scored on a Likert scale from 0 to 3, considering how frequently the EP happens, in increasing order of agreement: 0-never, 1-rarely, 2-commonly and 3-always. In addition, a question is asked to assess the perception of whether or not the situation described is an ethical problem.<sup>(13)</sup>

### I Phase - conceptual and item equivalence

This phase comprises the qualitative analysis for the adaptation of the context; the analysis of the target context, the assessment by an expert committee and the pretest; and is intended to identify if the construct, dimensions and items of the original tool are relevant to the new context.<sup>(16-18)</sup>

For the qualitative analysis, a broad literature review was undertaken, in with the base could be identified for the general theory of ethical problems, which is the bioethicist Diego Gracia's moral deliberation,<sup>(8)</sup> but no specific theories were found for the CH context.

Next, a psychometric survey was undertaken of all versions of the IPE-APS, starting from its con-



**Figure 1.** Phases for adaptation of Inventory of Ethical Problems in Primary Health Care (IPE-APS)

struction, carefully assessing each of the changes made in the items in the course of the validations, as well as the methods used to validate the instrument. To consolidate this analysis, two authors of the original instrument were asked to assess the relevance to the new context.

Then, the IPE-APS was analyzed by a committee of 10 experts<sup>(17)</sup> knowledgeable in CH, PHC and bioethics, including: two bioethicists; two researchers in CH and two in PHC; two representatives of the target population (USF nurses), two professionals knowledgeable in psychometrics.

First, the experts were contacted by e-mail and telephone. The assessment took place in two rounds. After the experts agreed to participate, they received the instructions for completion and the assessment form. In the first round, the following question was asked: "Do you consider that this is an ethical problem that happens in child health care in the Family Health Strategy?"

For the quantitative analysis of this phase, the Agreement Percentage was calculated for each item.<sup>(18,19)</sup> Items with an agreement percentage superior to 70% were considered suitable, based on Brazilian<sup>(20)</sup> and international research findings.<sup>(21)</sup>

The items that obtained agreements levels inferior to 70 % in the first round were resubmitted to a second round of expert assessment to obtain a higher agreement level.

In the second round, the question was asked whether the expert agreed with or disagreed from the context the item addressed, including room for justifications and new proposals.<sup>(17)</sup>

## II Phase - semantic equivalence

The goal of this phase is to look for adaptations of the items to the CH context and comprises the assessment by the expert committee and by the author of the original instrument, followed by the application of a pretest.<sup>(16)</sup>

The question the experts considered in the first round was “Does the wording need to be adapted for the child health context?”, providing rephrasing of the item that was not considered clear or appropriate to the context. In the second round, the items that did not reach appropriate agreement were presented, each item with the previous version and the version after the inclusions. Then, the understanding of the items was questioned, including space for suggestions.

After including all adjustments the experts proposed in the two rounds, the instrument was submitted to the primary author of the IPE-APS for assessment, culminating in the formulation of Pilot I.

The objective of the pretest was to assess some aspects of the instrument: the appropriateness of the items and expressions to the linguistics and context of CH. In addition, the acceptability and understanding were assessed.<sup>(15)</sup> Thirty nurses from the USF in Feira de Santana-Bahia participated in this phase. The data were collected during the meetings of the USF supervisors. After the presentation of the study proposal, they were invited to participate. The professionals who accepted received the Pilot I version, in which the clarity of the language and the need to rephrase the items were questioned,

with a view to enhancing the semantic pertinence of the instrument.

## III Phase - operational equivalence

This phase aimed to assess the structure, layout and instructions of the IPE-APS and includes the application of the pilot to the target-population.<sup>(10-12)</sup>

After assessing the layout of the instrument used in the most recent study,<sup>(14)</sup> it could be observed that some changes were made in the original format. These changes were included in Pilot I to facilitate its completion.

During the application of the first pretest, when the nurse handed in the completed instrument, the researchers asked about the clarity of the instructions and layout. In addition, they asked what term would be more understandable for one of the options of the IPE-APS Likert scale: frequently or commonly.

After analyzing the operational aspects of this pretest, slight adjustments were needed in the instructions and layout of the heading. Consequently, the researchers decided to apply the second pretest to five representatives of the target population, with a view to testing the suitability of the recommended adaptations.<sup>(22)</sup>

After all of these phases, the operational version called Inventory of Ethical Problems in Primary Health Care-Child Health (IPE-APS-SC) was obtained.

The study complied with Brazilian and international ethical standards for research involving human beings and the adaptation of the IPE-APS started with the authorization of the instrument's primary author.

## Results

### Assessment of conceptual and item equivalence

The literature review on ethical problems in the context of CH and the assessment by the authors of the IPE-APS revealed that the concepts related to the ethical problems of family health were relevant to the universe of CH, as they arose from the reality of the Unified Health System (SUS). Thus, it was concluded that the three dimensions of the instrument were appropriate to the new context.

Overall, the three dimensions of the IPE-APS obtained high item agreement ratios in the two rounds with the experts. The first dimension (EP in Professional-Child/Family Relationship), however, presented more items with agreement levels inferior to 70%: five out of 18 (Table 1).

Item 1 stood out with a low agreement level of 30% (1st round) and 60% (2nd round). Thus, in line with experts' suggestion, the word "users" was replaced by "the child and the parents (or responsible caregivers)", besides adding "clinical relationship within professional limits". Despite the inclusion of these suggestions, however, the item did not reach a 70-percent agreement in the second round. The justification stated that "proximity and bonding" facilitate the maintenance of the clinical relationship.

**Table 1.** Inter-rater agreement on equivalences of IPE-APS

Item	Item equivalence	
	1st Round n(%)	2nd Round n(%)
1	3(30.0)	6(60.0)
5	6(60.0)	10(100.0)
8	5(50.0)	9(90.0)
13	6(60.0)	10(100.0)
17	4(40.0)	7(70.0)
Item	Semantic equivalence	
	1st Round n(%)	2nd Round n(%)
1	6(60.0)	9(90.0)
2	6(60.0)	10(100.0)
3	5(50.0)	9(90.0)
5	5(50.0)	8(80.0)
7	6(60.0)	10(100.0)
8	5(50.0)	8(80.0)
9	5(50.0)	10(100.0)
11	6(60.0)	10(100.0)
12	6(60.0)	8(80.0)
13	6(60.0)	8(80.0)
14	4(40.0)	9(90.0)
15	6(60.0)	10(100.0)
17	6(60.0)	9(90.0)
18	5(50.0)	9(90.0)

IPE-APS - Inventory of Ethical Problems in Primary Health Care

In item 5, some experts suggested changes in the order of the phrase and the replacement of the word user by child/family, after which a consensus was reached (Chart 1).

In item 8, the term "treatment" was replaced by "monitoring (consultations, vaccination, healthy eating)", as the PHC perspective is prevention.

In the analysis of item 13, the phrase "[...] the health of one of the family members when that person is unable to manage self-care and is exposed to risks" was replaced by "[...] the health of the child to other family members when care neglect or the child's exposure to risks is identified". The risks to CH are considered related to maltreatment.

In item 17, the inclusion of the nurse was suggested as a professional who also indicates tests for the children, considering the existence of municipal protocols permitting this conduct. Hence, the phrase "[...] to follow medical indications or to undergo tests" was changed to "[...] to follow medical indications or to undergo tests the doctors and nurses indicated to the children". Nevertheless, the agreement on the item was borderline (Chart 1).

### Assessment of semantic equivalence

Concerning the semantic pertinence, items were found with agreement levels inferior to 70% in the first dimension. The proposals to rephrase items 5,7,8,9,11,12,17,18 in the first round were associated with changing the term "user" to "child and/or parents (or responsible caregivers)". After this change, the agreement level in the experts' second assessment was superior to 70%.

In this phase, the researchers also chose to replace some formal terms by other colloquial ones: "they feel impotent" by "they feel difficulties"; "reveals" by "tells"; "without their participation" by "without their inclusion". Other items underwent slight grammatical changes, such as verbal flexion and the use of synonyms to enhance the understanding of the assertions (Chart 1).

Proceeding with the semantic assessment of the IPE-APS, the Pilot II version was applied to 30 USF nurses from the city of Feira de Santana. In the first pretest, the presence of women was predominant (93.3%), the majority working at USF located in the urban area (60%), holding a post-graduate degree (96.6%), a mean age of 36 years, mean time since graduation 21 years, mean length of experience at USF and in child care six years.



Chart 1. Comparison between original version and adapted version of the IPE-APS	
Original version (IPE-APS)	Adapted version (IPE-APS-SC)
<b>1st Domain: ethical problems in the relationships with the child/family</b>	
<p>1.The proximity and bonding between the professionals and the users make it difficult to stay impartial in the relationship</p> <p>2.If the FHS team prejudges the users and relatives based on prejudices and stigmas</p> <p>3.The professional treats the user with a lack of respect</p> <p>4.The professionals give inappropriate or wrong prescriptions</p> <p>5.The professionals prescribe drugs the user will not have money to buy when no other drug can be prescribed</p> <p>6.The professionals prescribe a more expensive drug even if its efficacy is equal to that of the cheaper one</p> <p>7.During the medical or nursing consultation, the users request tests, drugs or other inappropriate or unnecessary procedures</p> <p>8.The professionals feel powerless to convince the user to proceed with the treatment</p> <p>9.The professionals request diagnostic tests without informing the user on what is being asked and why.</p> <p>10. The ACS comments on unnecessary information on the family and the couple's intimacy with the health team</p> <p>11.It is difficult to maintain the user's privacy in home care due to the interference of other family members or neighbors</p> <p>12.The ACS tells information obtained during his work about users and families to the neighbors</p> <p>13.The professional tells information about the health of one of the family members when that person is unable to manage self-care and is exposed to risks</p> <p>14.The professional is unable to identify to what extent he can interfere in the families and users' habits and customs with a view to them having a healthy lifestyle</p> <p>15.The users refuse treatment because they believe in a divine cure</p> <p>16.People under age visit the UBS and ask the team for tests, drugs or other procedures not established in the Child and Adolescent Statute without the parents' consent and/or authorization</p> <p>17.Users refuse to follow medical indications or to undergo tests</p> <p>18.The team holds an interdisciplinary discussion about the user's health conditions in front of him, without his participation</p>	<p>1. The proximity and bonding between the professionals and the child and parents (or responsible caregivers) make it difficult to stay impartial in the clinical relationship within the professional limits</p> <p>2. The FHS team prejudges the child and the parents (or responsible caregivers) based on prejudices and stigmas</p> <p>3. The professional treats the child and the parents (or responsible caregivers) with a lack of respect</p> <p>4.The FHS professionals give inappropriate or wrong prescriptions to the child</p> <p>5. Despite knowing that the parents (or responsible caregivers) will not have money to buy a certain drug, the professionals prescribe it if there is no other treatment option</p> <p>6. The professionals prescribe a more expensive drug even if its efficacy is equal to that of the cheaper one</p> <p>7. During the medical or nursing consultation, the parents (or responsible caregivers) request tests, drugs or other inappropriate or unnecessary procedures for the child</p> <p>8.The professionals face difficulties to convince the parents (or responsible caregivers) to continue with the child's monitoring (e.g. consultations, vaccination, healthy eating).</p> <p>9. The professionals request diagnostic tests without informing the parents (or responsible caregivers) on what is being asked and why.</p> <p>10. The ACS comments on unnecessary information on the family and the child's intimacy with the health team</p> <p>11. It is difficult to maintain the child's privacy in home care due to the interference of other family members or neighbors</p> <p>12. The ACS tells information obtained during his work about the children and their families to the neighbors</p> <p>13. The professional tells information about the health of the child to other family members when he identifies care neglect, exposure of the child to risks or situations of violence by the parents (or responsible caregivers)</p> <p>14. The professional is unable to identify to what extent he can interfere in the parents' (or responsible caregivers) habits and customs regarding child care with a view to them having a healthy lifestyle</p> <p>15. The parents (or responsible caregivers) refuse treatment prescribed to the child because they believe in a divine cure.</p> <p>16. People under age visit the UBS and ask the team for tests, drugs or other procedures, not established in the Child and Adolescent Statute without the parents' consent and/or authorization</p> <p>17. Parents (or responsible caregivers) refuse to follow medical indicators or to undergo tests the doctors and nurses indicated to the children</p> <p>18. The health team discusses the child's health conditions in front of the parents (or responsible caregivers) without including them in the conversation</p>
<b>2nd Domain - ethical problems in the team's relationships</b>	
<p>19.The FHS team professionals act with a lack of commitment and involvement</p> <p>20. The FHS teams do not cooperate with one another</p> <p>21. There is a lack of respect among the FHS team members</p> <p>22.The team professionals do not display a profile to work in the FHS</p> <p>23.In practice, it is difficult to comply with the role and responsibilities of each family health team professional</p> <p>24.Professionals shirk in case of an inappropriate or wrong prescription</p> <p>25.Users ask one of the family health team members not to give the other members access to some information related to their health, even in situations in which the family's participation in care is necessary</p> <p>26. UBS servants raise doubts on the conduct of the FHS team doctor</p> <p><b>3rd Dimension: ethical problems in the relations with the organization and the health system</b></p> <p>27. The UBS faces problems in the facilities and routines that make it difficult to preserve the user's privacy</p> <p>28.The FHS team professionals feel a lack of support from intersectoral actions, which depend on the organization and management of the system, to discuss and solve ethical problems they face in their practice</p> <p>29.The UBS board does not act transparently in solving problems with the professionals</p> <p>30. Too many families are assigned to each FHS team</p> <p>31.The FHS physician refuses to attend to users without an appointment on that day, which ends up restricting the users' access to the UBS, although welcoming always takes place</p> <p>32.The professionals from private health services ignore the diagnostic or therapeutic conduct by the physicians from the family health team</p> <p>33.The professionals from other public health network levels ignore the diagnostic or therapeutic conduct by the physicians from the family health team</p> <p>34.Difficulties exist in the referral and counter-referral system to undergo complementary tests</p> <p>35.Difficulties exist in the return and reliability of the laboratory test results</p> <p>36. The UBS does not offer conditions to the family health teams to support the practice of home visits</p> <p>37. The UBS has no conditions to deliver emergency care</p> <p>38. There is no rearguard support from a removal service at the UBS</p>	<p>19. The FHS professionals work with a lack of commitment and involvement in child health care</p> <p>20. The FHS teams do not cooperate with one another in child health care</p> <p>21. There is a lack of respect among the FHS team members</p> <p>22. The team professionals do not display a profile to work in child health care</p> <p>23. In practice, it is difficult to comply with the role and responsibilities of each family health team professional in care for the child</p> <p>24.Professionals shirk in case of an inappropriate or wrong prescription for the child</p> <p>25.Parents (or responsible caregivers) ask one of the FHS members not to give the other members access to some information related to the child's health, even in situations in which the entire family needs to participate in care</p> <p>26.UBS servants raise doubts on the conduct of the FHS professionals</p> <p>27. The UBS faces problems in the facilities and routines that make it difficult to preserve the child's privacy</p> <p>28. Lack of support from intersectoral actions to discuss and solve ethical problems they face in their practice in child health</p> <p>29. The UBS manager does not act transparently in solving problems with the professionals</p> <p>30. Too many families are assigned to each FHS team</p> <p>31.The FHS physician refuses to attend to children without an appointment on that day, which ends up restricting their access to the UBS</p> <p>32. The professionals from private health services ignore the diagnostic or therapeutic conduct by the physicians from the family health team</p> <p>33. The professionals from other public health network levels ignore the diagnostic or therapeutic conduct by the physicians from the family health team</p> <p>34. Difficulties exist in the referral and counter-referral system to consult with specialists and for the children to undergo complementary tests</p> <p>35. Difficulties in the return and reliability of the laboratory test results</p> <p>36. The UBS does not offer conditions to the family health teams to support the practice of visits to the children's homes</p> <p>37. The UBS has no conditions to deliver emergency care to children</p> <p>38. There is no rearguard support from a removal service at the UBS</p>

Despite the adjustments the experts suggested, two items remained doubtful according to the nurses: in Item I, they indicated that proximity and bonding facilitate instead of hampering the relationship; in Item 16, they questioned that children visit the service, affirming that the caregivers responsible for the children or adolescents do so.

### Assessment of operational equivalence

During the application of the first pretest, participants proposed the inclusion of the heading on all pages of the instrument. The most indicated term for the Likert scale was frequently. In the analysis of the completed instruments, it could be observed that some nurses, considering that the item “is not an ethical problem”, continued by answering how frequently it occurs. After making these adjustments, the respondents reached a consensus in the second pretest on the layout and instructions of the IPE-APS.

## Discussion

The goal in this article is to describe the adaptation process of the IPE-APS, which departed from the understanding that, when one aims to adapt an instrument constructed in another context, even if it is adapted to the same language, the need to adapt measures is not limited to the conditions involving countries and/or other languages, but the same care is indicated in local and regional adjustments.<sup>(16)</sup>

The adaptation model chosen for this study has previously been used in other Brazilian studies and was successfully executed.<sup>(22-24)</sup> The assessment phases of the conceptual, item, semantic and operational equivalence need to be strictly executed, followed by a pretest.<sup>(10-12,22)</sup>

The item and semantic equivalence phases, using a ten-member expert committee, followed the orientations regarding the number of experts needed to validate the content of instruments like the IPE-APS.<sup>(17,25)</sup> This phase evidenced the complexity of the construct and the difficulty to

work with professionals from diversified backgrounds and practices, which demanded two rounds to achieve the agreement level determined as acceptable.

The conceptual change made in item 8 is justified because, from the perspective of the USE, CH includes preventive actions that start in prenatal care and continue until the child reaches the age of five years.<sup>(26)</sup> In item 13, a broader change was needed because of the “vulnerability” construct, which is typical of this age range.<sup>(4)</sup>

In the item equivalence, item 1 maintained a low agreement level in the two rounds with the experts and the nurses also considered it confusing in the pretest. Therefore, we chose to maintain the wording of the version used in the first IPE-APS study,<sup>(13)</sup> considering that the language was clearer and more coherent with the practical reality of CH.

The changes made in the first semantic assessment round were executed to achieve the semantic equivalence of the instrument to the new context, as confirmed by the high agreement levels in the second round.<sup>(22)</sup>

The sample of 30 nurses in the first pretest was appropriate to the orientations for methodological studies<sup>(17,18,27)</sup> and this test was essential for the construction of pilot II, as it revealed the need for semantic adjustments in some words, the inclusion of the heading on all pages of the IPE-APS, rephrasing of the instructions and possible difficulties the target population could face to complete the instrument.<sup>(22)</sup>

The operational equivalence was confirmed as the nurses positively assessed the instructions and layout of the instrument.<sup>(16)</sup> The application form (self-completion) was also maintained and the mean completion time was lower than in other studies that used the IPE-APS.<sup>(14,15)</sup>

Nevertheless, the lack of studies and measures of CH problems in PHC made it difficult to discuss and compare the adaptation of the IPE-APS. This problem is not restricted to the child population though. In a review on measures in the field of ethics, it was concluded that the development of instruments conceived to

measure bioethical constructs in the assessment areas is just beginning.<sup>(28)</sup>

The need is highlighted to proceed with the validation in order to verify the psychometric properties of the instrument, with a view to expanding the knowledge production on the ethical issues involved in childcare. It should be kept in mind that adaptation and validation are different methods in the measuring process of measures, demanding methodological rigor and care.<sup>(29)</sup>

The limitations of this study are associated with the impossibility of group assessment with the experts and the target population, justified by the geographical distance of the first and the lack of time of the nurses working in the FHS.

Nevertheless, it is considered that the IPE-APS-SC can significantly contribute to the care practice of nurses working in childcare.

## Conclusion

The conceptual, item, semantic and operational adaptation of the instrument was developed successfully, complying with the methodological rigor suggested in international and Brazilian psychometrics experts. The result was the publication of the adapted version of the IPE-APS for Child Health, named IPE-APS-SC. The lack of instruments that measure the occurrence of ethical problems in the context of CH puts forward the IPE-APS-SC as a pioneer in scientific production in this theme area.

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## Collaborations

Santos DV, Rosa DO Zoboli EL and Freitas KS declare that they contributed to the conception of the study, interpretation of the data, writing of the article and final approval of the version for publication.

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