Cross-cultural adaptation of the original version of the Older Adults Socio-familial Evaluation Scale to the Brazilian context

Luciana Shirley Pereira Zanela[1]
Jesús Vicente García Gonzalez[2]
Albert Schiaveto de Souza[3]
Samuel Leite Oliveira[4]
Alexandra Maria Almeida Carvalho[1]

Abstract

Objective: To cross-culturally translate and adapt the Spanish Older Adults Socio-familial Evaluation Scale (*Gijón Scale*) to the Brazilian context. *Methods*: A methodological procedure of cross-cultural adaptation with translation (Spanish-Portuguese), back-translation (Portuguese-Spanish), evaluation of semantic, idiomatic, experimental, and conceptual equivalences, and pretest of the Brazilian version in a sample of 30 older adults. For the concordance analysis, proportionality and the Kappa Cohen-Fleiss index (κ) were measured. In addition, internal consistency was confirmed by Cronbach's alpha. *Results:* Translations (T1 and T2), back-translations (RT1 and RT2), and evaluations of the synthesis version (T12) were carried out by a Committee of Experts, and a neutral judge ensured the evaluative essence of the original version of the scale in T12. The evaluation of the 34 components of T12 showed semantic (100%) and idiomatic (94%) adequacy, and adequacy greater than 70% for experimental and conceptual equivalences. There was almost perfect concordance among the experts of the Committee: semantics (κ=0.95), idiomatic (κ=0.97), experimental (κ=0.98), and conceptual (κ=0.99). The T12 pretest resulted in substantial reliability of the instrument with a Cronbach's alpha of 0.77. *Conclusion:* The present study ensures the cross-cultural adaptation of the Socio-familial Evaluation Scale to the context of the older person living in Brazil. The equivalence evaluation resulted in almost perfect concordance among experts. The target audience did not report difficulties in understanding the assertions of the scale. The instrument

Keywords: Validation Study. Risk. Health of the Elderly. Social Vulnerability.

[1] Universidade Federal de Mato Grosso do Sul, Faculdade de Medicina, Programa de Pós-graduação em Saúde e Desenvolvimento na Região Centro-Oeste. Campo Grande, MS, Brasil.

[2] Servicio de Transformación y Gestión del Conocimiento; Consejería de Salud de Asturias. Oviedo, Asturias, España.

[3] Universidade Federal de Mato Grosso do Sul, Instituto de Biociências, Pós-graduação em Saúde e Desenvolvimento na Região Centro-Oeste. Campo Grande, MS, Brasil.

[4] Universidade Federal de Mato Grosso do Sul, Instituto de Física. Campo Grande, MS, Brasil.

The authors declare there are no conflicts of interest in relation to the present study.

Funding: Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – Brasil (CAPES), Código de Financiamento 001, sob processo n. 88882.458315/2019-01.

Correspondence
Luciana Zanela
lucianazanela@yahoo.com.br

Received: November 25, 2020
Approved: June 7, 2021

http://dx.doi.org/10.1590/1981-22562021024.200338

proved to be reliable considering the Cronbach's alpha obtained. After validating the scale, an ongoing study, a reliable instrument will be made available for tracking the socio-familial situation of older adults in the Brazilian context.

INTRODUCTION

Recent agreement points to the need for interdisciplinary actions based on the interaction between specific knowledge from different sciences to optimize care for the older person[1–3]. Characteristics such as family environment[4], gender, and ethnicity should be considered in the evaluation of the health-disease process as the imbalance between these factors may result in health inequities or inequalities experienced by the individual during life[5]. Including psychosocial factors in health evaluation favors more comprehensive interventions[6,7], planning actions that can be preventive, rehabilitative, or therapeutic[8] and impact the population's health conditions and the investments made by the healthcare system[9].

However, the association of other dimensions related to the global care is still a point of interest of the academic community[9–11]. The theme related to cognitive and functional aspects stands out among investigations, especially studies aiming to ensure the adequacy of instruments to track the profile of the older population living in Brazil[12]. This direction points to the hierarchization of care, focusing on cognitive and physical functional evaluation and being the starting point of the Brazilian healthcare model[13]. The integrated care capable of covering the triad formed by the individual, social, and programmatic aspects of the life of this population[14–16] focuses on possible situations of social vulnerability resulting from the aging process[17,18].

The conditions and quality of life of older adults are related to their social context and affect their social and economic structure[4,19]. Therefore, the multidimensionality of care, from the initial evaluation to the follow-up of the individual, encourages their protagonism and their network of relationships and social support[20]. These specific dimensions can be evaluated with the support of different instruments that meet the development and validation criteria for use in Brazil[12,21,22]. However, evaluating social aspects in human aging still presents a reductionist approach[12,20] with fragmented and disconnected actions among care providers. Furthermore, it is noteworthy that the indicators from the evaluation of the social aspects enable to structure public policies and more efficient and comprehensive actions to meet the demands of the older population[9].

Establishing a relationship between the environmental and socioeconomic factors ensures the expansion of interventions on the level of social and family cohesion as well as other individual factors that may be associated with morbidity and mortality in this population[7,20]. However, for this measure, it is necessary to use an instrument covering different social dimensions[14,15].

In an evaluation of the social context of older adults' lives, these dimensions are related to environmental adjustment, personal adaptation, subjective welfare, and their social interactions[15]. It is possible to measure these dimensions using the Older Adults Socio-familial Evaluation Scale (OA-SFES), also known as *Gijón's scale*[15]. In its internal organization, it assesses the socio-familial situation of the interviewee on an individual basis and points out the social situation in three different sectors[14–16].

Originally built and validated in Spain, it is used as a gerontological, multidimensional tool for social screening purposes with substantial reliability and good trustworthiness[15]. In Portugal, the scale underwent a validation study comprising gerontological tracking protocols[14]. In Peru, it was adequate without the validation criteria and is part of the protocol "*Valoración Clínica del Jovens Mayor*"[16]. The scale also investigates older adults in other Spanish-speaking countries without the validation process[23–25].

Even without being subjected to the methodological rigor to adapt and validate evaluation instruments, the scale is used in Brazil to evaluate services in the Integrated Comprehensive Care project (ICC)[26]. The use of the scale by social workers from

the ICC multidisciplinary team enabled the detection of cultural and language gaps, which motivated interest in the development of this research, which consists of cross-cultural adaptation (CCA) and subsequent validation.

Thus, it is urgent to expand the list of evaluative instruments to the context of older adults living in Brazil[12,21,22]. The present work aims to cross-culturally translate and adapt the Older Adults Socio-familial Evaluation Scale to the context of the older population living in Brazil. It is worth noting that the translation and the CCA represent the initial stages of the scale validation and give attributes and dimensions appropriate to the instrument variables[27]. Furthermore, adapting and validating the OA-SFES to the Brazilian context will raise new health indicators and establish a relation between living conditions and the health-disease process of older adults[14,15].

METHOD

The Older Adults Socio-familial Evaluation Scale (OA-SFES) evaluates the socio-familial situation of older people from a multidimensional perspective. Validation studies conducted in Spain and Portugal report that the scale can be self-administered or preferably conducted by a social worker professional[14,15].

Among its inner characteristics, the scale is organized into five domains to measure different aspects of the older person's life: I- Family situation; II- Economic situation; III- Housing situation; IV- Social relations; V- Social support network[14,15]. Each domain comprises five assertions with values from one to five. The interviewer selects only one assertion per domain. The sum of the values assigned to each assertion results in the global score organized into three distinct intervals: adequate social situation (5 to 9 points), social risk (10 to 14 points), or social problem (above 15 points)[15]. The present study presents the cross-cultural adaptation (CCA) of the OA-SFES to the context of older adults living in Brazil.

Methodological studies intend to obtain, organize, and analyze data and enable the development, validation, or evaluation of research instruments and techniques[27–29]. The CCA comprises this type of study, measures the accuracy of the results, and reduces the risk of distortions of information and interpretations when handling the scale[27].

To use the original version, prior authorization of the validation study was obtained from the main author. Moreover, he approved the cross-culturally adapted version[27].

As listed in Figure 1, different steps were taken to adequately adapt the scale considering countries with cultural and/or language differences[27].

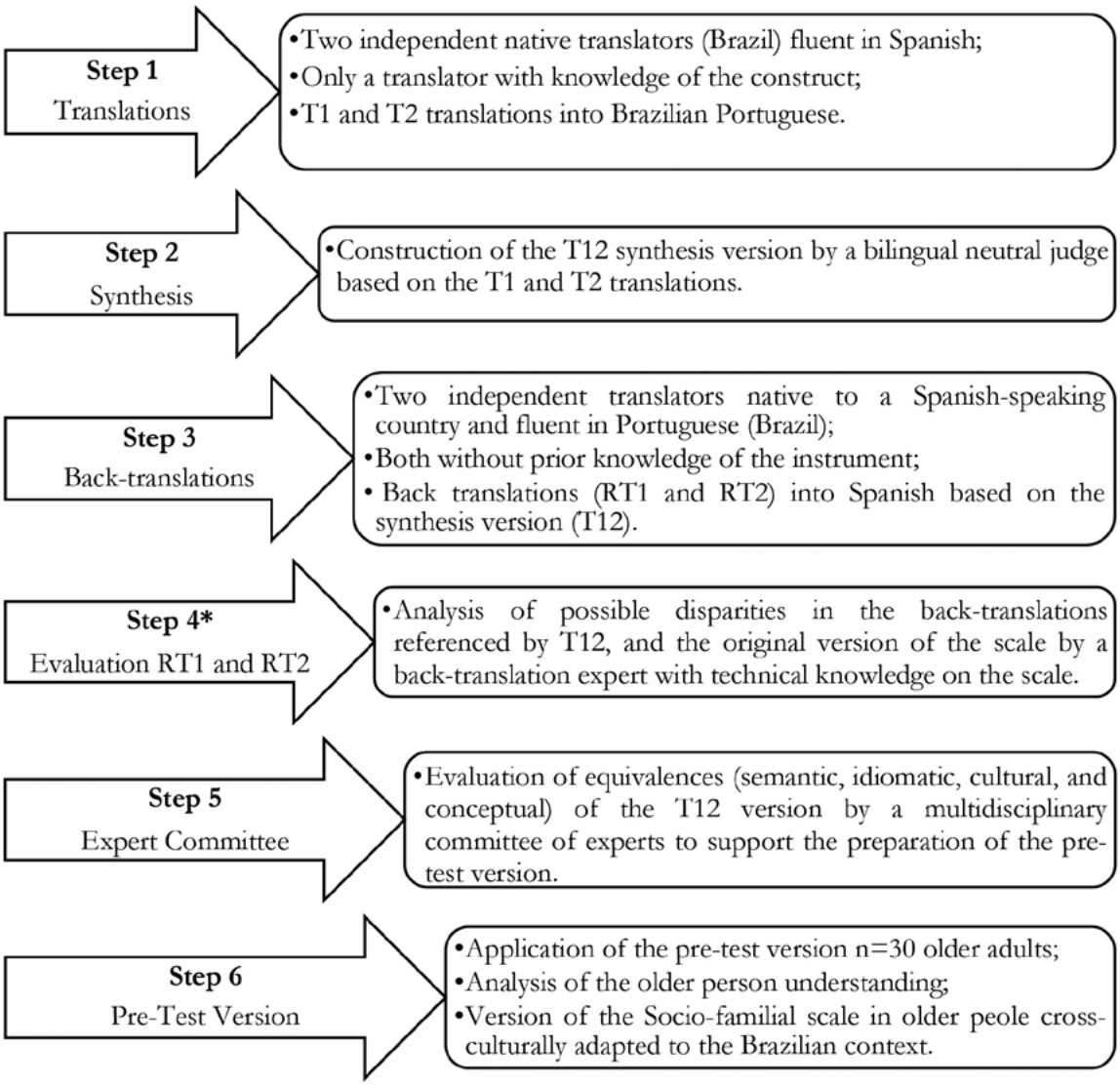

Figure 1. Steps for Cross-Cultural Adaptation of the Older Adults Socio-familial Evaluation Scale.

Source: Beaton et al. (2002), amended by the author; *Step proposed by the research team.

According to the method[27] adopted in the present study the five steps for the CCA were completed, and one extra step was added. The 34 components of the scale underwent CCA in each step: scale title (1 item); domains (5 items); assertions (25 items); score (3 items).

Data were analyzed with the support of the SPSS version 23. The Cronbach's alpha coefficient[29,30] was adopted to verify the homogeneity and dimensions of the scale items in the pretest version.

Step 1 - Translation

Two Brazilian translators proficient in the Spanish language participated in the first step. The translations took place independently, resulting in versions T1 and T2. Each component of the scale was translated, and the translators' comments were transcribed.

The interpreter responsible for T1 was previously informed about the research and the object of the

study. The interpreter of the T2 version translated it without knowing the scale, keeping the focus on the language, preventing ambiguous effects on the original instrument that the first translator might not have identified[27].

Step 2 - Synthesis

In the second step, the synthesis version called T12 was created. Finally, a neutral judge proficient in the Spanish language analyzed the level of concordance according to the following criteria:

- Total concordance: identical translations;
- Partial concordance: changes of up to two words in the translated sentence;
- Difference between translations: situations of ambiguity, conceptual and/or cultural conflicts between translations.

The result of this analysis enabled the neutral judge to select the translation of greater idiomatic and cultural consistency or propose changes in the instrument's adequacy to the context of the older person living in Brazil. To finalize version T12, the neutral judge took one of the following actions: suggested a new translation; chose T1; chose T2; maintained T1 and T2 (when identical); merged T1 and T2.

Step 3 - Back-Translation

T12 underwent back-translation in the third stage. Two bilingual interpreters native of a Spanish-speaking country and living in Brazil for over 10 years participated. Back-translations were carried out blindly and independently without knowledge of the scale and its internal organization. Thus, two versions (RT1 and RT2) back-translated to the Spanish language were obtained[27].

Step 4 - Evaluation of back-translations

The fourth step was included, although not foreseen in the original methodology, to guarantee the semantic equivalence in T12, evaluating its validity, inconsistencies, and conceptual errors. An expert with substantial knowledge on the scale in its original version evaluated RT1 and RT2.

Said evaluation determined the adequacy or inadequacy of the back-translations using T12 and the scale in its original version as references. When conceptual and/or grammatical disparities were found in any back-translation, the evaluator selected the most appropriate version considering the main object of the construct.

Step 5 - Expert Committee

Step 5 was carried out by the Expert Committee comprising eight professionals from different areas: methodologist, linguist, psychologist, social worker, physician, and nurse. They conducted the assessments supported by the "Evaluative Compilation", a document with the versions produced in the previous steps and a theoretical review related to each component of the scale. This evaluation gave rise to the version submitted to the pretest.

Experts evaluated the T12 version in search of semantic, idiomatic, cultural, and conceptual equivalences of the 34 components of the scale, assigning the following scores: (1) - extreme adequacy without the need for any change, (0) - adequacy with the need for change, and (-1) - inadequacy. A proportion equal to or greater than 80%[31] is expected for adequate concordance among experts. To assess the T12 concordance, the Cohen-Fleiss Kappa coefficient was adopted (κ)[29] considering the following levels: non-existent (<0), mild (0–0.2), moderate (0.21–0.4), strong (0.41–0.60), very strong (0.61–0.80), almost perfect (0.81–0.99), and perfect (1)[32].

Step 6 - Pretest

The objective of the pretest was to analyze the respondents' understanding of the instrument and possible difficulties with the interviewer's application of the OA-SFES.

At this step, three instruments were used: the pretest version (T12), a form to analyze the interviewee's understanding of the scale, and a questionnaire to collect sociodemographic data.

The pretest was applied to a group of 30 older adults[27] and comprised a non-probabilistic and judgmental sample.

Adults aged 60 years or older, of both sexes, who were in outpatient care or in the inpatient unit of Hospital São Julião de Campo Grande (MS) during data collection (October to November 2017) were included.

The present study meets the standards for research with human beings described in Resolutions No. 466/2012 and No. 510/2016 and was evaluated and approved by the Human Research Ethics Committee of Universidade Federal de Mato Grosso do Sul (UFMS), registered under Opinion N. 58735616.8.0000.0021. The use of the Older Adults Socio-familial Evaluation Scale (Spanish version) was authorized by the first author of the validation study via email.

The older adults were included in the list of respondents after they read and signed the Informed Consent Form (ICF). The interviews were conducted in such a way to ensure the confidentiality of the responses not interfering with care.

RESULTS

Translations and Synthesis Version

First, the Older Adults Socio-familial Evaluation Scale (Spanish version) was translated into Brazilian Portuguese by two independent translators, resulting in two versions (T1 and T2). The comparison between the 34 translated components showed 53% of total concordance among the translators, 29.4% of partial concordance, and 17.6% of difference between the translations.

Then, the neutral judge evaluated T1 and T2 and altered or pointed out the most appropriate translation for each component, which resulted in the synthesis (T12). This version was organized based on language, evaluative context of the scale, and reality of the Brazilian older population. Chart 1 reports the actions of the neutral judge regarding each translated component, striving for a version with better equivalence to the Portuguese spoken in Brazil.

Chart 1. Description of the actions of the neutral judge in the evaluation of the translations to develop the T12 version (n=34). Campo Grande, MS, 2017.

Description	=			T1	T2
Name of the Scale	1 item	-	-	-	-
5 - 9 points	1 item	-	-	-	-
10 - 14 points	1 item	-	-	-	-
Over 15 points	1 item	-	-	-	-
Domain title	5 items	-	-	-	-
Assertions Domain A	-	A.2; A.3	A.1; A.5	-	A.4
Assertions Domain B	B.4	B.3	B.2; B.5	B.1	-
Assertions Domain C	-	-	C.1; C.2; C.3; C.4	C.5	-
Assertions Domain D	D.1; D.2; D.3;D.4	-	-	-	D.5
Assertions Domain E	-	-	D.1; D.2; D.3; D.5	E.4	-
Total	14 items	3 items	12 items	3 items	2 items

(=) Identical translations; () Combination of the two translations; () The neutral judge's suggestion to change the translations; (T1) Choice of translation T1; (T2) Choice of translation T2.

Fourteen items (41%) were found to be identical components and they were kept. The divergent translations were handled in two ways by the neutral judge. T1 and T2 were combined for 3 (8.9%) components. T1 was chosen for another 3 (8.9%) items, and T2 for 2 items (5.9%). In these cases, the chosen version adequately represented the language aspects guided by the evaluative context of the scale. The neutral judge suggested adjustments in 12 (35.3%) translated components.

Back-translations

The back-translations allowed the comparison between the original instrument and version T12. Considering the 34 components back-translated in RT1 and RT2, there was 58.8% of total concordance among the interpreters, 32.4% of partial concordance, and only 3 (8.8%) components showed differences in the back-translations. Therefore, T12 complies with the evaluative essence proposed compared to the content of the original version of the scale.

Evaluation of Back-Translations

The expert evaluated RT1 and RT2 based on the T12 version and the original scale in the Spanish version. Chart 2 shows the expert's evaluation of the back-translations. When conceptual and/or grammatical disparities were found in any component of the back-translations or synthesis, the most appropriate version was selected considering the main objective of the construct. In identical back-translations, the expert concluded that 70.6% of them met the objectives of the construct. However, with conflicting back-translations, RT2 was chosen most of the time (17.6%) compared to RT1 (8.8%).

Note that the expert indicated assertion A.2 (Domain A) of version T12 as the version with greater equivalence when compared to RT1, RT2, and the original version.

Once this step was completed, the discussion with the neutral judge was resumed for the conclusion of T12 and the finalization of the Evaluative Compilation for submission to the Expert Committee.

Chart 2. Evaluation of back-translations regarding the T12 and the original version of the Older Adults Socio-familial Evaluation Scale (n=34). Campo Grande, MS, 2017.

Description	RT1	RT2	Evaluation
Name of the scale	A	A	RT1 and RT2
Score range: 5 – 9 points	A	A	RT1 and RT2
Score range: 10 – 14 points	A	A	RT1 and RT2
Score range: Over 15 points	A	A	RT1 and RT2
Domain A	A	A	RT1 and RT2
Assertion A.1	A	A	RT2
Assertion A.2	A	A	T12
Assertion A.3	I	A	RT2
Assertion A.4	I	A	RT2
Assertion A.5	A	A	RT2
Domain B	A	A	RT1 and RT2
Assertion A.1	A	A	RT1 and RT2
Assertion B.2	A	A	RT1 and RT2
Assertion B.3	A	A	RT1 and RT2
Assertion B.4	A	A	RT1 and RT2
Assertion B.5	A	A	RT1 and RT2

to be continued

Continuation of Chart 2

Description	RT1	RT2	Evaluation
Domain C	A	A	RT1 and RT2
Assertion C.1	A	A	RT1
Assertion C.2	A	A	RT1
Assertion C.3	A	A	RT1 and RT2
Assertion C.4	A	A	RT1 and RT2
Assertion C.5	A	A	RT1 and RT2
Domain D	A	A	RT1 and RT2
Assertion D.1	A	A	RT1 and RT2
Assertion D.2	A	A	RT1 and RT2
Assertion D.3	A	A	RT1 and RT2
Assertion D.4	A	A	RT2
Assertion D.5	A	A	RT1 and RT2
Domain E	A	A	RT1 and RT2
Assertion E.5	A	A	RT1 and RT2
Assertion E.2	A	A	RT1
Assertion E.3	A	A	RT1 and RT2
Assertion E.4	A	A	RT2
Assertion E.5	A	A	RT1 and RT2

A=Adequate; I=Inadequate; T12=Synthesis; RT1=Back-translation 1; RT2=Back-translation 2.

Expert Committee

The Expert Committee suggested not using metaphors, colloquial languages, or ambiguous nouns and verbs as a guideline to analyze the T1, T2, T12, RT1, and RT2 versions to optimize the understanding of the scale components. The Committee suggested changes or replacements based on the study of each component based on the Evaluative Compilation.

The concordance ratio among experts in the evaluation of the adequacy of the components of the version to be submitted for pretest was higher than 80% in both semantic (100%) and idiomatic (94%) equivalence. In turn, the experimental and conceptual equivalences showed concordance ratios of 71% and 73%, respectively. Finally, to guarantee the experimental and conceptual equivalence, the synthesis version was re-evaluated by the committee members to consolidate the version submitted to the pretest. The kappa indices associated with this version show near-perfect concordance[32] between the semantic (κ=0.95), idiomatic (κ=0.97), experimental (κ=0.98), and conceptual (κ=0 .99) evaluations.

Pretest

The respondents' answers were objective and clear during the use of the T12 version in the pretest. The average time for applying the scale was 7 minutes.

To evaluate the understanding of the older adults regarding the instrument, every assertion of the scale was read by the interviewer. Then, the respondent was asked to interpret the item and confirm or deny a clear understanding of the component presented. All participants reported total comprehension, not reporting difficulties in understanding the scale's assertions.

Among the 30 older Brazilians participating in the pretest, 60% (18) declared less than 3 years of education or never attended school.

The socio-familial evaluation with the instrument indicated that 66.7% of older adults had an adequate or acceptable social situation.

The total Cronbach coefficient for the results of the application of the pretest version indicates substantial internal consistency. Adopting as a reference the 0.61-0.80 range for substantial internal consistency[29,30], the exclusion of any of the domains does not impact the interpretation of the total reliability of the scale, which presented a total alpha value of 0.77 (Table 1).

After completing all steps of the CCA process, the Older Adults Socio-familial Evaluation Scale adapted to the Brazilian context was unanimously analyzed and approved by the Expert Committee and by the main author of the Spanish version. Thus, it was not necessary to carry out a review and a new pretest.

The Brazilian version of OA-SFES (Chart 3) supports the survey for validating and measuring the psychometric properties of the instrument that are in progress.

The Brazilian version of the OA-SFES (Chart 3) supports the ongoing investigation to validate and measure its psychometric properties.

Table 1. Standard deviation, average, and Cronbach's alpha in case of exclusion of any evaluative domain (n=30). Campo Grande, MS, 2017.

Evaluative Domains	Standard Deviation	Scale average if the item is excluded	Cronbach's alpha if the item is excluded
Domain A [1]	1.2	7.57	0.77
Domain B [2]	0.8	6.40	0.82
Domain C [3]	0.9	8.33	0.70
Domain D [4]	1.1	8.00	0.66
Domain E [5]	0.8	8.50	0.65
Scale total	1.21	**9.7**	0.77

[1] Family Situation; [2] Economic Situation; [3] Housing Situation; [4] Social Relations; [5] Social Support Network.

Chart 3. Older Adults Socio-familial Evaluation Scale (Brazilian version) in the pretest version. Campo Grande (MS), 2018.

Component		Description
Domain A		Family Situation
Assertion A.1		Lives with the family without physical or psychological dependence
Assertion A.2		Lives only with spouse of about the same age without physical or psychological dependence
Assertion A.3		Lives with family (and/or spouse) and has some degree of physical or psychological dependence
Assertion A.4		Lives alone and has child(ren) who live nearby
Assertion A.5		Lives alone and has no child(ren) or child(ren) reside(s) far away
Domain B		Economic Situation
Assertion B.1		Individual income above 2.4 times the minimum wage
Assertion B.2		Individual income from 1.3 to 2.4 times the minimum wage
Assertion B.3		Individual income from 1 to 1.3 times the minimum wage
Assertion B.4		Individual income from BPC/LOAS
Assertion B.5		No individual income or income less than 1 minimum wage
Domain C		Housing Situation
Assertion C.1		Adequate housing for the older person's needs (basic sanitation, water supply, electricity supply, and accessibility)
Assertion C.2		House with architectural barriers (stairs, steps, narrow doors, etc.)
Assertion C.3		Housing with poor hygiene, humidity (mold and fungi), inadequate ventilation and lighting
Assertion C.4		Housing without telephone and/or elevator (in case of a two-story house or apartment)
Assertion C.5		Inadequate housing (declared to be destroyed, shacks, tenements, etc.) and/or lack of basic infrastructure (water supply, electricity supply, sewage, or septic tank) or living on the streets
Domain D		Social Relations
Assertion D.1		Social relationship with support network (family, neighbors, work, friends, community, etc.)
Assertion D.2		Social relationship only with family and neighbors
Assertion D.3		Social relationship only with family or only with neighbors
Assertion D.4		Does not leave the house, but receives visits
Assertion D.5		Does not leave the house nor receive visits nor have any social relationships with the support network
Domain E		Social Support Network
Assertion E.1		Receives social support from family or neighbors
Assertion E.2		Receives volunteer service at home from the public and/or private network
Assertion E.3		Has no social support network, but is able to stay home and perform self-care
Assertion E.4		Needs to join the LTCF due to a situation of social vulnerability
Assertion E.5		Needs permanent care in the LTCF for basic and instrumental activities of daily living

Global Score		
From 5-9 points		Adequate or acceptable social situation
From 10-14 points		There is social risk
Over 15 points		There is a social problem

Note: Use the blank field to mark the alternative corresponding to the social context reported by the person interviewed.

DISCUSSION

It is important to emphasize that the adequate availability of this instrument will contribute to the planning of public policies and actions with the older population in Brazil in their different social contexts. The expanded view on different dimensions enables the organization and mobilization of the older person's social network, preventing frailty or worsening their health condition[12,13].

The interpreters discussed the technical and linguistic aspects of T1 and T2 to perform the translations. In possession of these translations, the neutral judge built the synthesis (T12) that referenced the next steps. The composition of T12 met language aspects guided by the evaluative context of each component of the scale and was subsequently back-translated (RT1 and RT2). The RT1, RT2, and T12 versions were evaluated by an expert with technical knowledge on the scale in the Spanish version. The evaluation indicated that T12 consistently corresponds to the evaluative proposal of the Older Adults Socio-familial Evaluation Scale (Spain).

Based on the concordance ratio between experts regarding the experimental and conceptual criteria[28], the reevaluation of the scale components resulted in an adequate pretest version to assess the interviewer's understanding and handling, as well as the respondent's understanding. With an almost perfect concordance rate among experts, the evaluation of semantic, idiomatic, experimental, and conceptual equivalences reflected positively on the results arising from the application of the pretest version.

The assertions making up the scale in the pretest version (T12) were read individually to each one of the 30 participants, who unanimously declared good understanding.

By measuring its domains, the global internal consistency of the Brazilian pretest version had a Cronbach's alpha of 0.77, higher than those obtained for the Portuguese (0.41)[14] and Spanish (0.45)[15] versions which denote reasonable internal consistency[30].

With a more discriminative than descriptive purpose, the evaluative domains of the OA-SFES measure different aspects, which can reduce homogeneity[29]. To assess the socio-familial condition of the older adult, the scale considers, on the one hand, the family situation, social relationships, and social support and, on the other hand, the economic situation and housing conditions. Thus, the social evaluation encompasses different dimensions comprising different variables so that it would not be relevant to renounce any evaluative dimension, even if it impacts the result of internal consistency.

Another point to be emphasized is related to the applicability of the scale. Some instruments have been used to assess the social aspects in individuals of different age groups. However, when compared to the internal and operational structure of OA-SFES, they do not encompass the social function in its entirety and present a high degree of complexity for handling[14]. In the validation studies carried out in Spain[15] and Portugal[14], the participant filled the scale. For the use of the OA-SFES in Brazil, it is suggested that the scale be applied by an interviewer so as not to reduce the instrument's reliability.

The education profile of the older population in Brazil reinforces the suggestion of adopting the application of the scale in the modality *face to face*. Studies show that 50.2% of the population living in Brazil aged over 60 years attended school for up to 4 years, and 30.7% had less than one year of education[33]. Low education was also observed among respondents in the present research. Therefore, the self-completion adopted in Brazil could compromise the results of the evaluations.

The cross-cultural adaptation of the instrument to the Brazilian context is essential for the other steps involved in validating the OA-SFES. In its validated version, this scale will enable screening the socio-familial situation of older adults living in Brazil in a more effective and contextualized way regarding the individual's biopsychosocial aspects[34].

CONCLUSION

The Older Adults Socio-familial Evaluation Scale (Spain) was translated and cross-culturally adapted to the Brazilian context. The evaluations of semantic, idiomatic, cultural, and conceptual equivalences carried out by the members of the Expert Committee

had a positive outcome, resulting in the pretest version of the Older Adults Socio-familial Evaluation Scale (Brazilian version). Furthermore, the pretest version showed good internal consistency with reproducible data. The validation study of this instrument is ongoing based on this pretest version.

Edited by: Ana Carolina Lima Cavaletti

REFERENCE

1. Castro JLDC, Passos ALV, de Araújo LF, Santos JVDO. Análise psicossocial do envelhecimento entre idosos: as suas representações sociais. Actual Psicol. 2020;34(128):1-9.
2. Souza DS, Berlese DB, da Cunha GL, Cabral SM, dos Santos GA. Análise da relação do suporte social e da Síndrome de Fragilidade em idosos. Psicol Saúde Doenças. 2017;18(2):1-10.
3. Medina-Walpole A, Barker WH, Katz PR, Karuza J, Williams TF, Hall WJ. The current state of geriatric medicine: a national survey of fellowship-trained geriatricians, 1990 to 1998. J Am Geriatr Soc. 2002;50(5):1-10
4. de Sant'Ana LAJ, D'Elboux MJ. Suporte social e expectativa de cuidado de idosos: associação com variáveis socioeconômicas, saúde e funcionalidade. Saúde Debate. 2019;43(121):1-10.
5. World Health Organization. Ageing and life-course: Healthy Ageing and the Sustainable Development Goals. Geneva: WHO; 2020.
6. Barbosa GC, de Faria TK, Ribeiro PCC, Mármora CHC. The relashionship between biopsychosocial and clinical outcomes of hospitalization, institutionalization and mortality according to the lifespan developement paradigma. Braz J Dev. 2020;6(11):1-10.
7. Carrapato P, Correia P, Garcia B. Determinante da saúde no Brasil: a procura da equidade na saúde. Saúde Soc. 2017;26(3):1-10.
8. Bueno EP. Envelhecer na sociedade contemporânea e o serviço social: perspectiva do trabalho profissional em rede de atenção à saúde da pessoa idosa. In: 16º Congresso Brasileiro dos Assistentes Sociais - CBAS [Internet]. Brasília, DF; 30 out. - 03 set. de 2019. Brasília, DF: CBAS; 2019 [cited 2021 may 01]. Available from: https://broseguini.bonino.com.br/ojs/index.php/CBAS/article/view/335/333
9. de Carvalho IA, Epping-Jordan JA, Pot AM, Kelley E, Toro N, Thiyagarajan JA, et al. Organizing integrated health-care services to meet older people's needs. Bull WHO. 2017;95(11);1-10.
10. Partridge L, Deelen J, Slagboom PE. Facing up to the global challenges of ageing. Nature. 2018;561:1-10
11. Stich AK, Mozygemba K, Lysdahl KB, Pfadenhauer LM, Hofmann B, van der Wilt GJ, et al. Methods Assessing Sociocultural Aspects of Health Technologies: results of a Literature Review. Int J Technol Assess Health Care. 2019;35:1-10.
12. Maia RDS, Torres RA, Oliveira JGA, Maia EMC. Adaptação Transcultural de instrumentos para idosos no Brasil: uma revisão integrativa de literatura. Estud Interdiscipl Envelhec. 2014;19(2):1-10.
13. Rocha JA. O Envelhecimento humano e seus aspectos psicossociais. Rev Farol. 2018;6(6):1-10.
14. Mourão L. Aplicação da escala de Gijón em rastreio de risco social [Internet]. Portugal: Universidade de Aveiro; 2008 [cited 2020 Oct. 10]. Available from: https://ria.ua.pt/bitstream/10773/3280/1/2009000424.pdf
15. Garcia Gonzalez J V, Diaz PE, Salamea GA, Cabrera GD, Menendez CA, Fernandez SA, et al. Evaluacion de la fiabilidad y validez de una escala de valoracion social en el anciano. Aten Prim. 1999;23(7):1-10.
16. Perú. Ministerio de Salud. Organización y Servicios de Salud. Resolución Ministerial. Norma Técnica de Salud para la Gestión de la Historia Clínica [Internet]. Perú: MS; 2018 [cited 2020 Oct. 25]. Available from: http://bvs.minsa.gob.pe/local/MINSA/4379.pdf
17. Barbosa KTF, Costa KNKM, Pontes MLF, Batista PSS, de Oliveira FMRL, Fernandes MGM. Envelhecimento e vulnerabilidade individual: um panorama dos idosos vinculados à estratégia saúde da família. Texto & Contexto Enferm. 2017;26(2):1-10.
18. de Jesus ITM, Diniz MAA, Lanzotti RB, Orlandi FS, Pavarin SCI, Zazzetta MS. Fragilidade e qualidade de vida de idosos em contexto de vulnerabilidade social. Texto & Contexto Enferm. 2018;27(4):1-10.
19. de Melo LD, Arreguy-Sena C, Pinto PF, Gomes AMT, Santos JDC, Brandão MAG. Concepções de Idosos sobre as Políticas (Inter) Nacionais do Envelhecimento Humano. Rev Fam Ciclos Vida Saúde Contexto Soc. 2020;8(4):1-10.

20. Guedes MBOG, Lima KC, Caldas CP, Veras RP. Apoio social e o cuidado integral à saúde do idoso. Physis. 2017;27(4):1-10.

21. Domingues MA, Ordonez TN, Lima-Silva TB. Instrumentos de avaliação de rede de suporte social. In: Freitas EV, PY L, orgs. Tratado Brasileiro de Geriatria e Gerontologia. 4a ed. Rio de Janeiro: Guanabara-Koogan; 2016. p. 1570-7.

22. Domingues MA, Ordonez TN, Lima-Silva TB, Nagai PA, de Barros TC, Torres MJ. Revisão sistemática de instrumentos de avaliação de rede de suporte social para idosos. Rev Kairós Gerontol. 2013;15:1-10.

23. Torres LA, Rivera SM, Mendivelso FO, Yomayusa N, Cardenas HM, Hernandez C. Análisis del riesgo de deterioro funcional y sociofamiliar en el adulto mayor hospitalizado. Rev Méd Sanitas. 2019;22(1):1-10.

24. del Brutto OH, Mera RM, Recalde BY, Costa AF. Social Determinants of Health and Risk of SARS-CoV-2 Infection in Community-Dwelling Older Adults Living in a Rural Latin American Setting. J Community Health. 2021;46(2):1-10.

25. Beltrán BE, Motta R, Gamarra MP, Araujo R, Castillo JJ. Comprehensive Geriatric Assessment in Elderly Patients with Aggressive Non-Hodgkin Lymphoma in Peru. Blood. 2018;132(Suppl 1):1-10

26. Ardérius, M., Fournier, M., Alves, M., Bárrios, H., Duarte, M. J., Almeida, M. C. D. Nutritional Status as a Risk Factor in a Cohort of Geriatric Patients in a Specialized Convalescence Unit. Medicina Interna. 2020; 27(3), 4-9.

27. Beaton D, Bombardier C, Guillemin F, Ferraz MB. Recommendations for the cross-cultural adaptation of health status measures. New York Am Acad Orthop Surg. 2002;12:1-9.

28. Alexandre NMC, Coluci MZO. Validade de conteúdo nos processos de construção e adaptação de instrumentos de medidas. Ciênc Saúde Colet. 2011;16(17):3061-8.

29. de Souza AC, Alexandre NMC, Guirardello EB. Propriedades psicométricas na avaliação de instrumentos: avaliação da confiabilidade e da validade. Epidemiol Serv Saúde. 2017;26(3):1-10.

30. Amirrudin M, Nasution K, Supahar S. Effect of Variability on Cronbach Alpha Reliability in Research Practice. J Mat Stat Komputasi. 2020;17(2):223-30.

31. Coluci MZO, Alexandre NMC, Rosecrance J. Reliability and validity of an ergonomics-related Job Factors Questionnaire. Int J Ind Ergon. 2009;39(6):1-10.

32. Landis JR, Koch GG. The Measurement of Observer Agreement for Categorical Data. Biometrics. 1977;33(1):1-10.

33. Travassos GF, Coelho AB, Arends-Kuenning MP. The elderly in Brazil: Demographic transition, profile, and socioeconomic condition. Rev Bras Estud Popul. 2020;37:1-10.

34. Fletcher AE, Jones DA, Bulpitt CJ, Tulloch AJ. The MRC trial of assessment and management of older people in the community: objectives, design and interventions [ISRCTN23494848]. BMC Health Serv Res. 2002;2(1):1-10.