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ORIGINAL ARTICLE

Vietnamese version of the coronary artery disease education questionnaire—Short version: Translation, adaptation and validation

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Abstract

What is known and objective: Coronary artery disease (CAD) is the leading cause of mortality worldwide. Patient education is an essential part of cardiac patients' care targeting self-management behaviour to reduce risk factors and subsequent events. There has been no Vietnamese questionnaire to assess patient's knowledge about CAD; therefore, the purpose of this study was to translate, cross-culturally adapt and validate the Coronary Artery Disease Education Questionnaire—Short Version (CADE-Q SV) for use in Vietnam.

Methods: Translation and cross-cultural adaption of the tool were carried out in five stages: (a) two independent translations from English into Vietnamese were produced; (b) these two translations were then synthesized; (c) two translators blinded to the outcome measurements independently created separate back translations into English; (d) nine experts reached consensus on all items of the Vietnamese version of the CADE-Q SV; and (e) a pilot study was conducted on 35 patients with acute coronary syndrome (ACS). The validity and reliability of the questionnaires were then evaluated in 117 Vietnamese patients with ACS. The internal consistency and test-retest reliability were assessed by Cronbach's alpha and Cohen's kappa coefficient, respectively. Construct validity was determined by examining the relationship between knowledge scores and patient characteristics.

Results: The Vietnamese version of CADE-Q SV was created, including 20 items divided into two domains: medical and psychological condition, and nutrition and exercise. There was good equivalence between the original and the Vietnamese versions in all four areas: semantic, idiomatic, experiential and conceptual equivalence. Cronbach's alpha coefficients were acceptable for the questionnaire as a whole (0.78) and for the two domains: medical and psychological condition (0.71) and nutrition and exercise (0.52). All Cohen's kappa coefficients confirmed test-retest reliability (Kappa > 0.600; $P < .001$). Construct validity was confirmed by a significant correlation of knowledge scores with education level ($P = .004$).

Thang Nguyen is co-first author

What is new and conclusion: The Vietnamese version of CADE-Q SV can be considered a valid and reliable questionnaire to evaluate patient's knowledge of CAD. Further studies could investigate the influence of knowledge scores on adherence to medications and clinical outcomes of patients with CAD.

KEYWORDS

adaptation, coronary artery disease, questionnaire, translation, Vietnamese

1 | WHAT IS KNOWN AND OBJECTIVE

Coronary artery disease (CAD) is the leading causes of mortality worldwide. According to a report from American Heart Association, CAD was responsible for one in seven deaths in 2017, and there was approximately 16.5 million patients with CAD in the United States.¹ In Vietnam, cardiovascular diseases were responsible for 31% of total deaths in 2016 and the number of CAD deaths reached 58 452 or 11.58% of total deaths in 2017.^{2,3}

The mortality rate among patients with CAD could increase due to their lack of knowledge about this disease. In addition, accurate knowledge can motivate patients to adhere to healthy behaviours, including physical activity, diet, weight management and medication adherence.^{4,5} Unfortunately, few studies assess patients' knowledge about CAD and the ones that do indicate it remains at low levels. For example, a study in Muscat, Oman, showed that 60.5% of patients had an inadequate knowledge score regarding risk factors for CAD.⁶ Among 3522 patients in the United States, Australia and New Zealand involved in another study, more than 60% had low knowledge levels.⁷ The assessment of patient knowledge can help to guide the design of public health programmes by informing the content of educational plans.⁸

Ghisi Sandison and Oh⁹ developed and psychometrically validated the Coronary Artery Disease Education Questionnaire—Short Version (CADE-Q SV) in English. CADE-Q SV is a 20-item questionnaire that was designed as a short, quick and appropriate tool to apply in clinical practice and research. However, using a questionnaire in a new country, culture, and/or language requires translation and cross-cultural adaptation to reach equivalence between the original source and the target languages.¹⁰ To our knowledge, there has been no Vietnamese questionnaire to assess patient's knowledge about CAD. The aim of this study was to translate the CADE-Q SV into Vietnamese, cross-culturally adapt it and assess the validity and reliability of the questionnaire.

2 | METHODS

2.1 | Participants

Patients were recruited from a hospital at Ho Chi Minh City, Vietnam, between 21 February and 12 March 2017 for the translation and cultural adaptation phase of this study (stages 1 to 5). The psychometric

validation of the questionnaire occurred from 17 April to 21 May 2017, with 2 interviews scheduled. Eligible patients had a discharge diagnosis of acute coronary syndrome (ACS), including unstable angina (UA), non-ST segment elevation myocardial infarction (NSTEMI) or ST segment elevation myocardial infarction (STEMI). Patients were excluded if they were unable to communicate in Vietnamese or had a serious health condition that would prevent them from answering the questionnaire. Validation of the questionnaire also excluded patients did not have use of a telephone, died during the course of the study, could not be contacted, or had a score on the mini mental state examination of ≤ 17 .

2.2 | Study design

The design of this study consisted of a series of cross-sectional, observational studies. The process of translation and cross-cultural adaptation followed the five stages described by Beaton et al (2000, 2007).^{10,11}

2.2.1 | Stage 1: Translation

The CADE-Q SV was translated from English into Vietnamese. Two independent translators who were fluent in English and spoke Vietnamese as their mother tongue were involved in this stage. One had a clinical background and knowledge about research concepts whereas the other was not informed of the objectives of this research and had no clinical or medical background. They produced the T1 and T2 translations.

2.2.2 | Stage 2: Synthesis

The two translations were synthesized by another person who had experience in methodology, resulting in a translation called T-12.

2.2.3 | Stage 3: Back translation

Two translators blinded to the original questionnaire, and outcome measurements independently created two back translations of the

T-12 version in English. These two back translations were compared with the original CADE-Q SV in the next stage.

2.2.4 | Stage 4: Expert committee

An expert committee consisted of nine professionals (a methodologist, two clinicians, all translators from the previous stages and the author of original questionnaire) reviewed all CADE-Q SV versions generated from previous steps, including the original and translated questionnaire, as well as instructions and scoring documentation.

Step 4.1: The equivalence between the original and the translated version was assessed in four domains: semantic equivalence, idiomatic equivalence, experiential equivalence and conceptual equivalence. For each item, the expert could choose 1 (equivalence) or 0 (non-equivalence). Based on the average score of items, the experts suggested some changes to T-12 version. This step aimed to improve the equivalence between the original and the translated version.

Step 4.2: The equivalence between the original and the modified T-12 version was determined with the same criteria and score range as in step 4.1.

The stage 4 resulted in the prefinal version, which was used for pilot testing in the next stage.

2.2.5 | Stage 5: The pilot study

Patients from the target population were surveyed with the prefinal CADE-Q SV version. The ideal sample size was about 30 to 40 people. The purpose of this stage was to explore the clarity of the prefinal version. Therefore, patients were asked to rate each statement on a Likert-type scale ranging from 0 (unclear) to 10 (very clear). If the mean score was less than 9, the expert would review these items and make necessary modifications. In addition, characteristics of patients (age, gender, discharge diagnosis, comorbidities and educational level) were collected through medical reports and interviews.

2.3 | Psychometric validation of the questionnaire

For the psychometric validation of the Vietnamese version of the CADE-Q SV, two psychometric properties were tested: reliability and validity. The internal consistency and test-retest reliability were assessed by using Cronbach's alpha and Cohen's kappa coefficient, respectively. For test-retest reliability, participants answered the questionnaire in two different dates, which are called in this study the first and the second interviews. The second interview is conducted after two weeks from the date of the first interview. The content validity was based on the score for the degree of equivalence between the translation and the original of the questionnaire.

The construct validity was based on establishing a significant relationship between the results of the first questionnaire answer and patient characteristics.

2.4 | Statistical analysis

SPSS 20.0 software package was used for data entry and analysis. Descriptive analysis of all variables was performed. A mean total score was computed to reflect total knowledge. *t* tests, one-way analysis of variance, chi-square tests and factorial ANOVA were used as appropriate to assess differences in total knowledge based on patient's socio-demographic and clinical characteristics.

2.5 | Ethical considerations

All personal information of participants in the study was stored on a password-protected computer and used only for research purposes. The research was approved by the scientific council of hospital studied in Ho Chi Minh City.

2.6 | Permission

We received permission from the original questionnaire author (Gabriela Lima de Melo Ghisi) to translate it into Vietnamese.

3 | RESULTS

3.1 | Translation and adaptation

After cultural adaptation, the translated questionnaire was considered highly equivalent to the original version, with mean score of equivalence equals to 0.99 for four domains (Appendix 1). This version was used for the pilot study with 35 patients (mean age = 59.97 ± 7.20 years old and males = 22; 62.9%) (Appendix 2). The average clarity score for all 20 items was 9.85 ± 0.78 , with none of them lower than 9 (Appendix 3).

After discussions between the expert committee, the questionnaire was divided into two domains: medical and psychological condition, consisting of eight items; and nutrition and exercise, consisting of 12 items.

3.2 | Psychometric validation of the questionnaire

3.2.1 | Participants' characteristics and relationship with the answers of CADE-Q SV

There were 117 participants in the first interview and 108 in the second interview (Figure 1).

FIGURE 1 Study population flow chart. ^aPatients were marked as 'unable to contact' after seven unsuccessful phone calls (the first day: three times, a call every 30 min, and the next four consecutive days, once a day)

The mean age was 61.66 ± 8.23 years. The results showed that there was a difference in knowledge scores in regards to gender, with males having significantly higher scores than females in univariate analysis ($P = .04$), but not significant in multivariate analysis ($P = .534$). There was a significant relationship between education level and knowledge scores, with higher educated participants showing better

knowledge about CAD ($P < .001$ in univariate and $P = .004$ in multivariate analyses) (Table 1).

3.2.2 | Internal consistency

The overall Cronbach's alpha was 0.78. Cronbach's alpha in each domain was 0.71 (medical and psychological condition) and 0.52 (nutrition and exercise) (Table 2).

3.2.3 | Test-retest reliability

The test-retest reliability of the questionnaire was assessed based on whether the 108 participants answered questions in the same way during the first and second interviews of patients. The results were expressed as Cohen's kappa coefficients, and all items meet the minimum recommended standard (Table 3).

Overall, the Vietnamese version of CADE-Q SV was presented in Appendix 4.

4 | DISCUSSION

This study aimed to translated, culturally adapted and psychometrically validated the first available version of a Vietnamese questionnaire to assess cardiac patients' knowledge in this country. Clarity of

	Number (N = 117)	%	Mean $\pm$ SD	P-value ^a	P-value (ANOVA) ^{b,*}
Gender					
Male	92	78.60	14.00 ± 2.32	.040	.534
Female	25	21.40	12.96 ± 2.32		
Comorbidities					
Hypertension	80	68.40	13.91 ± 2.20	.530	
Diabetes	23	19.70	13.91 ± 2.25	.450	
Dyslipidaemia	23	19.70	13.78 ± 1.93	.810	
Smoking history					
Yes	48	41.03	14.19 ± 2.26	.100	
Educational level					
Elementary school	16	13.70	12.31 ± 1.92	<.001	.004
High school	82	70.08	13.45 ± 2.20		
College/ University/higher	19	16.22	16.41 ± 0.90		
Intervention					
Yes	59	49.60	13.61 ± 2.25	.470	
No	58	50.40	13.95 ± 2.44		

TABLE 1 Characteristics of patients and relationship with the answers of CADE-Q SV

^at test was used to analyse the impact of patient characteristics on knowledge scores..

^bTwo-way factorial ANOVA was used to analyse the impact of gender and education on knowledge scores..

*P-value of the impact of interaction (gender*education) on knowledge scores was 0.833.

TABLE 2 Cronbach's alpha values of the questionnaire

Domains	Items	Cronbach's alpha if the item is removed	Cronbach's alpha of each domain	Cronbach's alpha for all items
Medical and psychological condition	1	0.70	0.71	0.78
	3	0.72		
	6	0.66		
	7	0.69		
	10	0.63		
	11	0.66		
	15	0.64		
	19	0.67		
Nutrition and exercise	2	0.50	0.52	
	4	0.46		
	5	0.52		
	8	0.48		
	9	0.48		
	12	0.52		
	13	0.54		
	14	0.44		
	16	0.51		
	17	0.48		
	18	0.53		
	20	0.54		

TABLE 3 Kappa coefficients of the questionnaire

Items	Kappa coefficient	P
1	0.699	<.001
2	0.824	<.001
3	1.000	<.001
4	0.762	<.001
5	0.828	<.001
6	0.780	<.001
7	0.841	<.001
8	0.868	<.001
9	0.740	<.001
10	0.632	<.001
11	0.806	<.001
12	0.663	<.001
13	1.000	<.001
14	0.801	<.001
15	0.848	<.001
16	0.859	<.001
17	0.763	<.001
18	0.839	<.001
19	0.758	<.001
20	0.663	<.001

items, internal consistency, test-retest reliability and validity were all established, and demonstrates the utility of the Vietnamese version of the CADE-Q SV.

Results showed that there was an association between education level and knowledge scores ($P < .001$). Patients who had a college or post-graduate education had higher average scores than those with lower educational levels ($P < .001$). This result is similar to other studies^{6,9,12} and demonstrates that lower educated patients require more assistance and different strategies to increase their knowledge.

There was a difference in the knowledge score between genders. This result was different from the study of Ghisi et al (2015) ($P = .24$), Ghisi et al (2016) ($P = .93$) and Ammouri et al (2016) ($P = .51$).^{6,9,13} It also contrasted with another study, of which knowledge scores of female participants was better than that of males ($P < .001$).¹⁴ However, in multivariate analysis, the difference between male and female was not significant. These results could be explained by the difference in populations among the studies. This result might be affected by the education level between male and female. In our study, the males had higher educational levels than females. In particular, the proportion of males with secondary or higher educational levels was 91.3% (84/92) and for females, 68% (17/25). The educational levels of the patients in our study had an association with scores. Therefore, the difference of scores according to gender might be affected by educational levels.

The average score of the intervention group and the control group was not different ($P = .470$). Because of the intervention, content in randomized clinical trials was focused on counselling on medications use and the importance of adherence to medication.¹⁵ These contents were little or not relevant to the surveyed knowledge in our questionnaire. Otherwise, the patients of the intervention group were consulted on using medications whereas our questionnaire asked about the mechanism of medications (for example, question 11 asked about the mechanism action of statins).

The Cronbach's alpha for 20 items of the questionnaire was 0.78. This value was within the range of 0.70 to 0.90, which indicated that the questionnaire has good internal consistency.¹⁶ Cronbach's alpha in each domain was 0.71 (medical & psychological condition) and 0.52 (nutrition & exercise), and this was appropriate (Cronbach's alpha >0.50).^{17,18} The results of original study had higher values than our study (medical condition: 0.94; risk factors: 0.79; exercise: 0.76; nutrition: 0.84; and psychological risk: 0.91).⁹ Although the questionnaire was translated and evaluated in terms of the content for each item compared with the original questionnaire, the expression of some statements was changed to fit the Vietnamese context. Ghisi (an author of original study) also completely agreed with the structure of the Vietnamese version. In addition, Cronbach's alpha is a typical value for the sample of the surveyed population. Therefore, the patients' characteristics such as age, education levels and comorbidities were different in the two studies, and this might have affected the answers. Translation and adaptations of questionnaires of many studies resulted in Cronbach's alpha values different from the original. The study of Cuenza et al was translated and adjusted

the CADE-Q II into Filipino with Cronbach's alpha value of 0.75, although it was 0.91 in the study of Ghisi et al (2015).^{13,14} Another study was translated and adapted the CADE-Q into English from the Portuguese original; the results show that the Cronbach's alpha of the translated version (0.81) was better than the original study (0.68).^{19,20}

All items of the Vietnamese version of the questionnaire had a kappa coefficient at a good level (Kappa >0.600) showing the stability of the questionnaire through two interviews two weeks apart.¹⁷ Besides that, the stability of the CADE-Q SV (2016) was evaluated by the intraclass correlation coefficient (ICC). The difference between these two assessments was due to the way of encoding and processing data. We encoded options 'True', 'False' and 'Unknown' into categorical variables ('1', '0' and '9', respectively). We believe that data encryption was appropriate and provided a more accurate evaluation than combining incorrect and unknown answers.⁹

4.1 | Strengths and limitations

Our study is the first to translate, cross-culturally adapt, and validate a knowledge questionnaire to Vietnamese cardiac patients. For this work, we followed strict guidelines.¹⁰ This process includes many steps (forward and back translations), along with expert committee advice. The expert committee had nine members, including the original author of the questionnaire (GLMG). This group was involved in the translation, editing, change of terms and, most importantly, cultural adaptation of the CADE-Q SV to fit the Vietnamese context. Moreover, the wording used in the questionnaire was adapted to be simple (ie plain language), easy to understand and suitable for Vietnamese patients. As reported elsewhere, there is no other similar questionnaire/tool to assess patient knowledge about CAD in Vietnam at the time of this study; therefore, there was no other Vietnamese version for comparison and evaluation of criterion validity.

Future studies might use this questionnaire in Vietnam to examine patients' knowledge of CAD and investigate the association between knowledge scores, treatment adherence and clinical outcomes of CAD patients in Vietnam. The questionnaire can also be used to help the design of educational interventions or programmes to improve patient knowledge about CAD.

5 | WHAT IS NEW AND CONCLUSION

The Vietnamese version of CADE-Q SV is equivalent to the original version. The CADE-Q SV in Vietnamese is clear, easy to understand and appropriated to survey on Vietnamese patients. This version had achieved adequate consistency and reliability. Further studies could apply questionnaires to investigate patient knowledge about CAD or could investigate the influence of knowledge score on adherence and clinical outcomes of patients with CAD using the validated tool.

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CONFLICT OF INTERESTS

The authors have no conflict of interest to declare.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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