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RESEARCH PAPER

Escala de Avaliação de Papéis Familiares: assessment of psychometric properties

Escala de Avaliação de Papéis Familiares: avaliação das propriedades psicométricas

Escala de Avaliação de Papéis Familiares: evaluación de las propiedades psicométricas

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Abstract

Theoretical framework: The involvement of family members in the provision of informal care makes it important to assess the distribution of family roles.
Objectives: To develop and validate a *Escala de Avaliação de Papéis Familiares* (Family Role Assessment Scale). A convenience sample (n=909) and a questionnaire were used. The information was coded and processed using the SPSS software, version 18.0.
Methodology: A descriptive exploratory study was carried out.
Results: The following eight factors were created: *papel de prestador cuidados à criança* (child-caregiver role) (α=0.963); *papel de dona de casa* (housekeeper role) (α=0.923); *papel de dona de casa cuidados externos* (housekeeper role, care outside the home) (α=0.624); *papel organizador de atividades recreativas* (recreational organiser role) (α=0.837); *papel terapêutico* (therapeutic role) (α=0.811); *papel sexual* (sexual partner role) (α=0.839); *papel provedor de família* (family provider role) (α=0.695), and *papel socializador* (socialiser role) (α=0.719). Each factor was assessed using subscales, resulting in a KMO=0.916 and χ^2=35065.895, with a degree of freedom of 2278 and α=0.894 for all items.
Conclusion: Results showed satisfactory psychometric properties. This instrument has the potential to be applied to research activities and the supervision of family roles.

Keywords: role playing; family; assessment.

Resumo

Enquadramento: Pela inclusão dos familiares na prestação de cuidados informais é importante avaliar a distribuição dos papéis familiares.
Objetivo: Construir e validar uma Escala de Avaliação de Papéis Familiares. Recorreu-se a uma amostra de conveniência (n=909). Foi utilizado um questionário. A informação foi codificada e tratada no programa SPSS 18.0.
Metodologia: Foi realizado um estudo descritivo exploratório.
Resultados: Impusemos a criação de oito fatores aos quais lhe atribuímos a nomenclatura: papel de prestador cuidados à criança (α=0,963); papel de dona de casa (α=0,923); papel de dona de casa cuidados externos (α=0,624); papel organizador de atividades recreativas (α=0,837); papel terapêutico (α=0,811); papel sexual (α=0,839); papel provedor de família (α=0,695) e papel socializador (α=0,719). Cada fator foi avaliado por sub-escalas, resultou KMO=0,916; χ^2=35065,895 um grau de liberdade 2278, com um α=0,894 para todos os itens.
Conclusão: Os resultados demonstraram propriedades psicométricas satisfatórias. Este instrumento tem potencialidades de aplicação em atividades de investigação e monitorização de papéis familiares.

Palavras-chave: desempenho de papéis; família; avaliação.

Resumen

Marco contextual: Por la inclusión de los miembros de la familia en la prestación de cuidados informales es importante evaluar la distribución de los papeles familiares.
Objetivos: Construir y validar una *Escala de Avaliação de Papéis Familiares* (escala de evaluación de papeles familiares). Se utilizó una muestra de conveniencia (n=909). Se utilizó un cuestionario. La información fue codificada y tratada en el programa SPSS 18.0.
Metodología: Se realizó un estudio descriptivo exploratorio.
Resultados: Se impuso la creación de 8 factores a los que se les atribuyó la nomenclatura: *papel de prestador cuidados à criança* (papel de proveedor de cuidado infantil) (α=0,963); *papel de dona de casa* (papel de ama de casa) (α=0,923); *papel de dona de casa cuidados externos* (papel de ama de casa de cuidados externos)(α=0,624); *papel organizador de atividades recreativas* (papel de organizador de actividades recreativas) (α=0,837); *papel terapêutico* (papel terapéutico) (α=0,811); *papel sexual* (papel sexual) (α=0,839); *papel provedor de família* (papel de proveedor de la familia) (α=0,695) y *papel socializador* (papel socializador) (α=0,719). Cada factor fue evaluado por subescalas, resultado KMO=0,916; χ^2=35.065,895 un grado de libertad de 2278, con α=0,894 para todos los ítems.
Conclusión: Los resultados mostraron propiedades psicométricas satisfactorias. Este instrumento tiene un gran potencial para aplicación en actividades de investigación y vigilancia de papeles familiares.

Palabras clave: desempeño de papel; familia; evaluación.

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Introduction

As a profession in the health area, the purpose of Nursing is to provide nursing care to healthy or ill human beings, throughout their life cycle, and the social groups to which they belong so that they maintain, improve and recover their health projects. Therefore, it becomes important to understand how family roles evolve and their impact on family functioning. To this end, it is important for nurses to assess the functional category of the various roles targeting the family and not only the individual (Wrigth & Leahey, 2002; Ordem dos Enfermeiros, 2012). Given the lack of an original measurement instrument for the Portuguese population that assessed the distribution of the different family roles, an assessment scale was developed for this purpose. Thus, the objective of this study was to develop an instrument to assess family roles and verify its psychometric properties when applied to families with only healthy members, regardless of the family typology. The development of the *Escala de Avaliação de Papéis Familiares* is an added value to Nursing Science to better identify the nurses' foci of intervention among families.

The recognition of this need is at the basis of a major transformation of paradigm in the field of Nursing care: from a care perspective with the family as context to a paradigm with the family as an intervention system. The need was felt to develop this instrument because families are being asked to assume more responsibilities in health care. They are expected to care for their healthy family members and/or those with acute and chronic diseases.

Background

The family is currently seen as a group of human beings considered as a social unit or a collective whole, composed of people connected by consanguinity, emotional affinity or legal kinship, including people who are important to the individual (Conselho Internacional de Enfermeiros, 2006). The family is a social system composed of one or more persons who coexist within a given context with some expectations of reciprocal affection, mutual responsibility and temporary duration. It is characterised by commitment, joint decision-making and sharing of goals. This way of perceiving the family allows including the different settings and compositions of families that exist in contemporary society.

Understanding the structure, role and processes of each family unit is of extreme importance to characterise the family's health as well as the contributions to the health of both individuals and groups.

Contemporary families have undergone several changes, but the most visible one has been in its structure, which is defined as "the ordered set of relationships within the family, and between the family and other social systems" (Hanson, 2005, p. 86). To determine the family structure, it is first necessary to identify the individuals making up the family, their relationship to each other, and the relationships between the family and other social systems. Hanson advocates that the organisational patterns of a family are more or less stable and some of its changes throughout its lifecycle may be predictable.

Even nowadays, society expects the family to play specific roles to meet the needs of the family itself. From an international perspective and within the scope of health sciences, specifically Nursing, it is important to understand both the family functions and processes. These represent a type of Nursing phenomenon with specific characteristics. They are based on the ongoing positive or negative interactions and patterns of relating among family members (Conselho Internacional de Enfermeiros, 2006).

Other authors suggest that the family process is an ongoing interaction between family members through which instrumental and expressive tasks are accomplished. Hanson (2005) believes that the process is what makes every family unique and, even though families may have similar structures and functions, they may interact differently, thus promoting the singularity of each family.

For the family to survive, family members develop expectations about how each member should behave while interacting with each other. To this end, they take on different roles and adopt unique and distinct behaviours within each family unit.

In social psychology and sociology, the concept of *role* is characterised by gender-related attitudes and behaviours, thus expressing a normative dimension (Amâncio & Oliveira, 2002).

Talcott Parsons was one of the first sociologists to use the concept of *role* associated with the individual's

gender, conceiving it from a functionalist perspective at both the family structure and socialisation process levels. The author reminds us that, from the very beginning, women were socialised to play an expressive role as leaders within the family, which guaranteed the well-being of the social unit. On the contrary, men were socialised to act as providers and meet the family's needs (Amâncio & Oliveira, 2002). The concept proposed by Parsons in the 1950s evolved and has now a central position in the theory of social sciences. It was intensely worked upon in the 1980s within the field of gender studies and is now a key concept to analyse family-related roles, as it is also within the family that gender roles are produced, reproduced and manifested.

The literature search confirmed the evolution of the concept of *role* throughout the years. According to Burr (1998), the concept of *role* corresponds to the set of behaviours, duties and expectations attached to occupying a particular position in the social hierarchy. The author adds that applying such concept to sexual roles corresponds to a set of behaviours, expectations and duties attached to belonging to a specific group.

The latest conceptions show that family roles may be understood as established patterns of behaviour of family members based on the goals set out by the family itself (Wright & Leahey, 2002). A role is a constant behaviour in a given situation; it is developed in the interaction between individuals and influenced by different standards, beliefs and values. Family members take on different roles throughout the individual and family lifecycle.

Despite the lack of studies in the area of family roles, Hanson (2005) identifies eight roles associated with the spouse/partner: provider, housekeeper, child-caregiver, socialiser, sexual partner, therapist, recreational organiser and kinship member.

The *provider* role, or *head of family* role, relates to the need to protect and ensure the necessary income to meet the family's needs. The *housekeeper* role relates directly to all types of household chores, including house maintenance and gardening. The *child-caregiver* role entails caring for one's children to satisfy their basic human needs for safety and entertainment. The *socialiser* role implies the interaction between family members and external members. The *sexual partner* role is characterised by a set of actions such as sharing of affection, emotional support and interest in sex life - everything that promotes a satisfactory relationship between both partners. The *therapeutic* role involves types of help such as sharing of concerns, willingness to listen to others, active participation in problem-solving and emotional support; it also includes health promotion and prevention activities, as well as rehabilitation activities in case of disease. The *recreational organiser* role covers the planning and implementation of leisure and free time activities, as well as events with family members and others. Finally, the *kinship* role involves keeping in touch with other family members and friends.

Methodology

A descriptive exploratory cross-sectional study was carried out with the purpose of designing the *Escala de Avaliação de Papéis Familiares* (EAPF) (Family Roles Assessment Scale) and validating its psychometric properties. Data were collected using a questionnaire. A convenience sample (n=909) was selected consisting of family members residing in a district in northern Portugal. In fact, this sampling technique is particularly appropriate when the researcher has a prior knowledge of the population homogeneity. Sample size was calculated based on Anastasi's recommendations (1990), *i.e.* 10 participants per scale item.

Participants - inclusion criteria

The inclusion criteria were households in which no member had functional or cognitive limitations. Similarly to other studies, all household members aged 12 or more could participate in the study (Onso, 1988; Derogatis, 1993).

Data collection instrument

Based on Hanson's theoretical framework (2005) and the qualitative analysis of interviews with families and experts in family Nursing (a study which was previously conducted and is not presented in this article), the *Escala de Avaliação de Papéis Familiares* (EAPF) was designed, *i.e.* its dimensions were operationalised and items were set out. The first version of the scale included eight dimensions (to assess family roles) in a total of 74 items. All items were assessed on an ordinal scale (a Likert-type scale) ranging from 1 to 5 (Never, Rarely, Often, Always and Does not apply).

The scale included two groups of questions: Group I - socio-demographic variables; and group II - family role variables.

Procedures

Following the development of the questionnaire, the empirical phase of the study started. To implement this scale and aiming at accessing a large number of participants, collaboration and consent were obtained from a group of students attending a higher education institution. After institutional permission was granted, we met with the students and explained them the objectives and purpose of the study, as well as the organisations and institutions involved. They were also informed of their right to refuse to participate. Therefore, the access to the families for completion of the data collection tool was facilitated through the higher education institution and, consequently, the students, who acted as a link between us and their families.

A total of 950 questionnaires were distributed to several households, with 918 questionnaires being returned. Of these, nine were removed, because they had not been completely filled in. Thus, a total of 900 questionnaires were used. The collected data were codified, stored and, subsequently, processed. Data were analysed using the statistical software SPSS, version 18.0.

In a first stage, data were analysed using descriptive statistics, namely measures of central tendency, dispersion and frequency. The psychometric characteristics of the EAPF were calculated using the Principal Components Analysis with orthogonal Varimax rotation. The number of factors was selected following the guidelines recommended by Polit and Hungler (1997): (1) eigenvalues >1; (2) the exclusion of factor loadings less than 0.30; (3) the application of the principle of discontinuity. The internal consistency of the scale was calculated using Cronbach's alpha value and the test-retest method.

Results

Participants answered all EAPF questions, which indicates a good fit of the instrument to the sample. The sample was composed of 900 participants, of these 535 (59.4%) were female and 365 (40.6%) were male. Their ages ranged between 12 and 89 years, with a mean age of 34.29 years and a standard deviation of 15.274. As regards the participants' marital status, 443 (49.2%) were married, 428 (47.6%) were single, 13 (1.4%) were divorced and 16 (1.8%) were widowed.

Most participants had some level of education: 130 (14.5%) had completed primary education, 146 (16.2%) had the 6th grade, 282 (31.3%) had the 9th grade, 222 (24.7%) had completed secondary education, 25 had completed a 3-year degree (*bacharelato*) (2.8%), 86 had a bachelor's degree (*licenciatura*) (9.6%), 3 had a master's and doctoral degree (0.3%), and 3 (0.3%) had no level of education.

Principal Components Analysis

The Principal Components Analysis (PCA) assesses item/factor loadings (item loading on each factor, thus indicating the item-factor covariance). A total of 14 factors (roles) were identified through this statistical procedure; however, as Hanson (2005) advocates, an 8-factor solution was forced for conceptual reasons. The same sphericity coefficient (KMO) was obtained with both 8-factor and 14-factor solutions. A KMO of 0.916 ($p=0.000$) was obtained, which implies a significant sphericity for our factors. As a result, the chi-square increases, which implies a strong relationship between the variables in the factors.

With regard to factor analysis, and our concern being the development of a reliable instrument to assess the different family roles, we decided to delete all items loading less than 0.3, *i.e.* five items were deleted. Subsequently, a new PCA was performed (Table 1). A KMO $= 0.916$; $\chi^2 = 35065.895$ and $p=0.000$ were obtained, as well as a Cronbach's alpha of 0.894 for all items, which is excellent according to Hill and Hill (2000). Thus, after applying the abovementioned tests, the KMO value reinforced a very good correlation between the different variables, while the Bartlett's test of sphericity showed a very significant correlation between most variables of the EAPF scale. Internal consistency was also very good in each factor, namely: Factor 1 with a Cronbach's alpha of 0.963; Factor 2 with a Cronbach's alpha of 0.923; Factor 3 with a Cronbach's alpha of 0.837; Factor 4 with a Cronbach's alpha of 0.811; Factor 5 with a Cronbach's alpha of 0.839; Factor 6 with a Cronbach's alpha of 0.695, Factor 7 with a Cronbach's alpha of 0.719, and Factor 8 with a Cronbach's alpha of 0.624.

Thus, after several simulations were performed using factor analysis, internal consistency and intraclass

correlation coefficient (consistency and absolute agreement) and after adjustments have been made, the final version was reduced to 68 items with the following characteristics: The EAPF measures different family roles. The scale has eight subscales to assess the various roles: provider or head of family (6 items); Housekeeper (10 items); Child-caregiver (14 items); Socialiser (4 items); Sexual partner (6 items); Therapist (11 items); Recreational organiser (14 items); Outside home care (3 items).

The internal consistency was assessed through Cronbach's alpha coefficient. This statistical method is indicated for Likert-type scales and assesses whether the total test variance is associated with the sum of the individual item variance. The internal consistency of the scale was *alpha* = 0.894. All subscales demonstrated adequate internal consistency values: the lowest value was 0.624 and concerned the care outside the home role (3 items), and the highest value was 0.963 and referred to the child-caregiver role (14 items). A Cronbach's alpha >0.80 is an indicator of good internal consistency, with values greater than 0.60 being considered acceptable in scales with small numbers of items (Ribeiro, 1999; Freire & Almeida, 2001).

Table 1
Factor analysis of the Escala de Avaliação de Papéis Familiares

FACTORS	Score explained by each item (weight)
Fator 1 – Papel Prestador de Cuidados à Criança	
Costuma dar banho aos seus filhos/netos?	0.900
Costuma dar de comer aos seus filhos/netos?	0.895
Costuma vestir os seus filhos/netos?	0.895
Costuma deitar os filhos/netos na cama?	0.892
Costuma ajudar os seus filhos/netos a ir ao WC ou mudar a fralda?	0.866
Consegue ter tempo para brincar com os seus filhos/netos?	0.858
Costuma levar o(s) seu(s) filho(s)/neto(s) à escola?	0.821
Tem ajuda nos cuidados básicos do(s) seu(s) filhos/netos?	0.797
Tem tempo para cuidar do(s) seu(s) filho(s)/neto(s)?	0.788
Consegue conciliar a sua profissão com os cuidados à criança?	0.792
Costuma levar os seus filhos/netos à vacina?	0.763
Acompanha os seus filhos/netos em atividades fora de casa?	0.757
Leva os seus filhos/netos a locais de interesse para eles (cinema, teatro, centro comercial, parque, ou outros)?	0.735
Faz com os seus filhos/netos discussão sobre problemas sociais?	0.660
Explained Variance	15.739%
Cronbach's Alpha	0.963
Fator 2 – Papel Dona de Casa Cuidados Internos à Casa	
Costuma ajudar na limpeza da casa?	0.875
Costuma ajudar nas tarefas domésticas?	0.851
Costuma lavar a loiça/meter a loiça na máquina?	0.846
Costuma participar na confeção da comida?	0.810
Costuma lavar a roupa / colocar a roupa na máquina de lavar?	0.814
Costuma passar a roupa a ferro?	0.802
Costuma fazer a cama?	0.764
Costuma substituir o rolo de papel higiénico?	0.707
Costuma tratar da manutenção da casa?	0.674
Costuma levar o lixo para a rua?	0.542
Explained Variance	13.114%
Cronbach's Alpha	0.923

Fator 3 – Papel Organizador de Atividades Recreativas	
A família envolve-se nessas atividades?	0.638
Tem tempo para atividades lúdicas/lazer com a família?	0.628
Tem por hábito organizar atividades de fim de semana?	0.607
Fazem atividades com amigos?	0.574
Durante o ano fazem festas em que convidam tios e primos?	0.577
Tem por hábito criar momentos e conversas em família?	0.554
Tem por hábito conversar ao telefone com familiares?	0.550
Os parentes mais próximos costumam frequentar a sua casa?	0.537
Mantém convívio com primos e segundos tios?	0.536
Tem por hábito ver televisão com a família?	0.522
Costuma manter contacto com os seus parentes?	0.522
Tem por hábito ir de férias com a família?	0.499
Os seus familiares costumam ajudar quando a sua família necessita?	0.452
Costuma organizar festas em sua casa?	0.448
Explained Variance	7.457%
Cronbach's Alpha	0.837
Fator 4 – Papel Terapêutico	
Costuma sugerir aos seus familiares para fazerem vigilância de saúde?	0.639
Quando alguém se magoa em casa presta os primeiros socorros?	0.633
Quando alguém está doente prepara os medicamentos tendo em conta a hora?	0.607
Quando alguém se queixa de alguns sintomas dá conselhos para ir ao médico?	0.566
Quando há alguém que necessita de cuidados em casa, costuma ser você a fazê-los?	0.543
Preocupa-se com o estado de saúde dos outros membros da família?	0.532
Costuma ser você a comprar os medicamentos?	0.483
Costuma fazer consultas de rotina e exames de rastreio?	0.440
Quando algum familiar vai ao médico, costuma acompanhá-lo?	0.477
Quando alguém se queixa de má disposição faz um chá?	0.476
Discute os problemas em família?	0.370
Explained Variance	4.682%
Cronbach's Alpha	0.811
Fator 5 – Papel Sexual	
Mantém afetividade com o seu parceiro?	0.844
Desempenha um papel ativo na satisfação sexual do seu parceiro?	0.834
Mantém interesse pela sua vida sexual?	0.735
Oferece ao seu cônjuge presentes?	0.734
Tem tempo para ouvir o seu companheiro quando ele tem um problema de saúde?	0.714
O ambiente da família afeta o seu papel sexual?	0.618
Explained Variance	3.586%
Cronbach's Alpha	0.839
Fator 6 – Papel Provedor ou Chefe de Família	
Em situações de conflito toma defesa da sua família?	0.705
Sente-se representante da sua família?	0.626
Numa multidão protege os membros da sua família?	0.642
Quando necessita tomar decisões, consulta outros elementos da família?	0.624
Costuma verificar ruídos suspeitos a meio da noite?	0.625
Liga para casa quando prevê chegar mais tarde?	0.485
Explained Variance	3.165%
Cronbach's Alpha	0.695
Fator 7 – Papel Socializador	
Você mantém relacionamentos próximos com vizinhos?	0.850
Os vários membros da família relacionam-se com os vizinhos?	0.774
Os vizinhos costumam frequentar a sua casa?	0.758

Frequenta com assiduidade a igreja/religião?	0.374
Explained Variance	3.067%
Cronbach's Alpha	0.719
Fator 8 – Papel Dona de Casa Cuidados Externos à Casa	
Costuma fazer trabalhos de bricolage?	0.689
Costuma lavar o carro?	0.672
Costuma tratar do jardim?	0.490
Explained Variance	2.731%
Cronbach's Alpha	0.624

The mean score was calculated for each subscale of the EAPF, *i.e.* the sum of the subscale was divided by the number of applicable items (Table 2).
According to Table 2, factors 7 and 8 obtained the lowest weighted scores, which indicate that these roles were hardly visible in the families under study, contrary to factors 3 and 1, which were highly visible roles in the same context.

Table 2
Scores of the EAPF

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Factor 1	900	17.00	70.00	58.5244	13.93288
Factor 2	900	10.00	50.00	29.0967	8.63630
Factor 3	900	21.00	70.00	39.6611	6.23347
Factor 4	900	15.00	55.00	34.6433	5.20679
Factor 5	900	6.00	30.00	21.8178	4.28102
Factor 6	900	9.00	30.00	20.2922	3.22569
Factor 7	900	4.00	20.00	10.7056	2.76055
Factor 8	900	2.00	15.00	7.7378	2.91750

Discussion

The recent organisation of health care leads to an increase in the amount of care under the responsibility of the family, thus causing an overload of family roles, especially in situations of health promotion and/or treatment of diseases. Based on our literature review on family roles, we were confronted with the lack of a scale or other instruments to assess the distribution of family roles. Thus, the development and validation of the EAPF represents a contribution to Nursing Science.
The results of this study confirm that the EAPF has satisfactory psychometric properties. This instrument has the potential to be applied to research activities and the supervision of family roles. The psychometric results were confronted with guidelines from different authors and compared to other scale validation studies (Fernandes & Almeida, 2001; Freire & Almeida, 2001; Xavier, Pereira, Corrêa, & Almeida, 2002; Gonçalves, Simões, Almeida, & Machado, 2006; Nave, Jesus, Barraca, & Parreira, 2006; Pimenta, Leal, & Maroco, 2008).
The versatility of this type of assessment instrument enables its use in the various domains of both the individual or group behaviours, and makes it suitable to be applied in adults, adolescents and even children (Freire & Almeida, 2001).
Thus, considering the limitations related to the type of sample and not taking into account the different types of families, we believe that the EAPF may be applied to all household members aged 12 years or more, provided that they show no cognitive impairments preventing them from understanding the questionnaire. In situations of illiteracy, visual difficulties or illiteracy, appropriate support is foreseen (survey questionnaire), and the average time of completion is approximately 15 minutes. This study contributed to filling a gap in Nursing Science, particularly in Family Nursing.

Conclusion

With this study, we aimed at describing the development and validation of a scale that assessed the various family roles, which may be performed by different members of a family unit. Theoretical, empirical and analytical procedures were used. At the theoretical level, it was important not to proceed with the design and validation processes without first duly explaining the underlying theory. At the empirical level, the plan, the various stages and the measures to be considered in the different moments or stages of the implementation and validation of the scale were explained. Finally, the statistical analytical procedures highlighted the sensitivity, accuracy and validity of the instrument.

It was also our purpose to include in our sample only those individuals who showed no physical or cognitive dependence.

The findings in this study allowed us to conclude that the EAPF meets validity and reliability criteria. The instrument is well structured, with clear terminology and, though being somewhat lengthy, it was well accepted by participants. As regards the item contents, the study of the inter-subscale correlations revealed no atypical or contradictory associations. It is an easy-to-apply instrument, which makes it particularly suitable to be used in populations with low levels of education and facilitates its possible use in oral format.

As the promotion of family health is a challenge for Nursing, the strategy to (re)focus on the distribution of family roles may be considered as essential for the families' well-being and to achieve healthy families and, therefore, healthy communities. Thus, we suggest the implementation of the EAPF as an inclusive assessment instrument that is part of the clinical records of families registered with Family Health Units and/or Health Care Centres. The data obtained through the application of this scale may be of interest to the decision-making process on the provision of care to the families.

We recommend that further studies on the use of the EAPF should take into account different types of families and compare the different realities experienced in both healthy families and families in which some of the members have chronic diseases.

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