Identification of Challenges and Needs to Improve Community Health Workers Performance: Narratives of Accredited Social Health Activists (ASHA) from Two Indian Districts

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ABSTRACT

Background: Community health workers (CHW) are recognized for their value in providing reproductive, maternal, and child health services at the community level. Although available research points to challenges that they face, discussion on how they perceive these challenges or what they need to improve their work experience is not extensive.

Methods: We conducted a qualitative study of Accredited Social Health Activists’ (ASHAs) professional experiences. We interviewed 49 randomly selected ASHAs and their family members from two districts in India over a period of one month from 10 June to 12 July 2014. Inductive and deductive codes were applied to identify key themes.

Results: Within the health system, ASHAs were given insufficient equipment and supplies, delayed payment of incentives, and inadequate training for the tasks required. ASHAs also faced disrespect and abuse from facility-based health staff. Within the community, ASHAs struggled with marginalized segments of the population who resisted their advice and guidance due to socio-cultural norms. ASHAs expressed a need for timely incentives, sufficient materials and trainings to perform their tasks, and greater support in reaching out to hard to educate populations.

Conclusions: ASHAs face challenges from the health system and community, and their needs emanate from these two main areas. Support should be offered in such a way as to enhance their legitimacy within the health system and the community leading to improved effectiveness and performance.

INTRODUCTION

India’s Accredited Social Health Activist (ASHA) program was introduced in 2005 by the National Health Mission as a mechanism to promote people’s participation in health. ASHAs are female community health workers (CHWs) aged between 18-45 years, selected from the villages they represent (1 per 1000 population), with a minimum of eight years of education and demonstrable leadership skills. In communities which are overwhelmingly illiterate, the educational requirement is relaxed. ASHAs promote health through education and counseling and provide preventive and basic curative care. Their responsibilities include educating and mobilizing communities, particularly marginalized communities, to adopt healthy behaviors and utilize health services, participate in health campaigns, and claim health entitlements [1]. Reproductive, maternal, neonatal, child, and adolescent health (RMNCH+A) is an important area for ASHAs that includes motivating and escorting women to access antenatal care (ANC) and facility-based delivery, providing post-natal care, promoting and facilitating use of contraception and immunizations, and counseling about pregnancy-related issues such as anemia management.

Globally, CHWs have helped build individual and community capacity for health and treatment-seeking behavior by providing a range of services such as outreach, health education, home visits, counseling, and social support [2-4]. CHWs have been shown to be effective in maternal and child health by promoting uptake of breastfeeding and immunization and providing essential newborn care and health education, which has reduced child morbidity and mortality [5,6]. Despite these successes, CHWs face challenges in delivering services [3,4,7,8]. Given the potential for CHWs to improve the quality of and access to health care and reduce health care costs [7,9], it is important to identify and address the challenges being faced by the CHWs in effectively discharging their responsibilities.

Compensation is an often-cited issue for the CHWs. A systematic review found that although the CHWs were motivated by altruism, social recognition, knowledge gain and career development, not receiving a salary was their major concern [2]. Among the salaried CHWs, there was dissatisfaction with the pay levels [4]. In India, as most community health programs are located between the formal health system and communities and involve a range of stakeholders from local, district to state levels, their governance is complex. A 2009 evaluation of a CHW program observed that the transfer of funds from the national to lower levels was delayed at the state level, and CHWs went without payment for several months [10]. Indeed, ASHAs have expressed dissatisfaction with their incentive structure and timely payments [11,12].

Other health system-level challenges include the lack of access to quality and relevant training. Rude behavior of facility-based health professionals can make CHWs reluctant to refer clients to the facility [2]. In India, ASHAs lack proper training, skill development, and supportive supervision and endure a burdensome workload and constantly changing scope of work [11,13]. Lack of infrastructure and medical supplies, unfriendly and abusive supervisors, and difficult physical work environments are other systemic factors identified [11,14]. In 2009 and 2010, the National Health Systems Resource Centre (NHSRC) in India conducted an assessment which found that despite ASHAs’ crucial role in providing post-natal counseling and encouraging breastfeeding, only 50-70% women with children under 6 months had received a service from ASHAs, indicating their limited reach. The assessment also found that ASHAs play a role in increasing institutional delivery rates but have little influence on immunization rates [15].

Community and socio-cultural factors also influence CHW performance. In Pakistan, gender norms prevent female CHWs from traveling far from their villages [16] while in India, an ASHA’s caste and status affect her work as she is expected to give priority to household work over her professional work [13]. Additionally, education level affects their performance. ASHAs with more than the required education are perceived by their coworkers and supervisors as less interested in field-based work while those with less education are perceived to have limited capacity.
Absenteeism due to pregnancy and not being a resident of the village where the ASHA works were also found to affect performance [13]. The USAID’s Applying Science to Strengthen and Improve Systems (ASSIST) Project undertook a qualitative exploratory investigation into the challenges and needs ASHAs have at the family, community, and institutional levels in Gurdaspur and Mewat districts in India. The objective of the research was to identify opportunities to support ASHAs in providing quality RMNCH+A services in their communities. This paper describes ASHAs’ perspectives on the barriers they face and their needs to effectively carry out their responsibilities.

**MATERIALS AND METHODS**

**Study Population and Settings**

The study was conducted in two blocks of two districts (Gurdaspur, in Punjab State, and Mewat, in Haryana State), which were selected purposively for their socio-economic, religious and health indicators diversity. A block is an administrative unit consisting of several villages within a district, covering approximately a population of 100,000 inhabitants, and having at least three primary health centers (PHC) and one secondary health unit. In terms of health indicators, Gurdaspur has a maternal mortality rate (MMR) of 155 per 100,000 live births and infant mortality rate (IMR) of 26 per 1000 live births [17] compared to the national average of 178 per 100,000 and 40 per 1000 live births, respectively [18]. Mewat has an MMR of 160 per 100,000 live births and an IMR of 64 per 1000 live births [17]. Although Gurdaspur has high ANC coverage and institutional delivery rates, it has one of the lowest sex ratios in the country (895 girls per 1000 boys) indicating a culture of son preference. Mewat has low rates of institutional delivery (40.3%), ANC coverage (30.5%), and full immunization (20.8%) [17], perhaps due to systemic factors and socio-cultural norms that hinder health care utilization.

**Study Recruitment and Data Collection**

One block in each district was selected purposively for the study. In the selected block in Gurdaspur district, 10 sub-centers were selected on the basis of performance of RMNCH+A indicators: five were high performing and five were poor performing. Separate lists of ASHAs working in these two groups of sub-centers were compiled. The first 12 ASHAs from each list were selected. In Mewat district, the selected block had four PHCs, each of which had between three and four sub-centers. One sub-center from each PHC was purposively selected to represent diverse caste and religious groups. Lists of ASHAs working in those sub-centers were compiled and the first six ASHAs on each list were selected for participation. None of the selected ASHA’s refused to participate. One ASHA in the sample had no decision-making family member (e.g., husband or mother-in-law) living with her, therefore, we interviewed her son. However, to compensate for this, we selected an additional ASHA who did have a decision-making relative living with her.

A total of 49 eligible ASHAs and their 49 family members were selected for participation, which provided a sufficiently large enough sample to achieve saturation. They were interviewed by trained data collectors with the aid of a semi-structured interview guide. Data were collected over an entire month from 10th June 2014 to 12th July 2014. Prior to initiation of the study, the data collectors were trained at a two-day workshop on in-depth interviewing techniques, qualitative research, and research ethics. The interview guide included questions on the influence of ASHAs’ family, community, and health system on their work and their ability to deliver services. Questions were included based on the study’s research objectives and literature review with the guide going through several rounds of review with the study project staff. Family members were asked on the same topics besides their own role in the ASHA’s work. Interviews were conducted in private settings and separately for the ASHA and her family member. Interviews were recorded with the participants’ prior permission. Interviews lasted an hour on average. They were conducted in Hindi and Punjabi and later transcribed and translated into English by the data collectors.

**Ethical Considerations**

Written informed consent was obtained from all respondents. The consent form was read out to
the respondents and the interviewer signed on the behalf of those respondents who were illiterate after obtaining their consent to participate. The study was approved by the Institutional Review Boards of University Research Company (URC) in Maryland, USA and the Centre for Media Studies (CMS) in New Delhi, India.

Data Analysis

Translated transcripts were uploaded to Atlas.ti version 7.1.8 and coded using an initial coding scheme based on the research questions and literature review. This scheme was revised with new and emerging codes generated by field experiences and new insights into the data [20,21]. The data presented here come from interview segments related to four broad questions: a) What kind of problems do you face in your job?, b) What kind of impact do you feel you have made in the health behaviours and attitudes of the people in your community?, c) What do you think needs to be done to make your work easier?, d) What do you think needs to be done to improve maternal and child health in the community, and do you feel you can be part of that change? Codes related to these segments were compared and contrasted and major themes identified, which were then categorized under separate heads.

RESULTS

Participants’ Characteristics

ASHAs in both districts had an average age of 32 years. Compared to ASHAs in Mewat, those in Gurdaspur spent a higher average number of years in school (6.5 versus 9.7, respectively), had fewer children (4 versus 2), and had more experience as an ASHA (2 versus 5 years). There were nine Muslim and 15 Hindu ASHAs in Mewat, and 21 Sikhs, one Hindu, and three Christians in Gurdaspur.

Health System and ASHA Program Challenges

Across both districts, ASHAs narrated the difficulties they had in attending night deliveries, travelling to distant parts of their catchment areas, not having enough job aids and health education materials, and not being paid their incentives on time or incentives being insufficient for the required level of effort. ASHAs in Gurdaspur also spoke about the lack of food provision and places to rest when they attended night deliveries. They talked of the difficulties of not being given a mobile phone allowance to communicate with pregnant women and other members of the community, as well as the lack of transportation to accompany pregnant women for ANC:

“It is very difficult as there is no place in the hospital in which we could lie down for some time rather there is [even] no place to sit down. Sometimes we have to stay hungry for the whole day as we could not get time to cook or to eat…. I feel ashamed that I have to ask for money from my husband for bus fare and for other things when I don’t get incentives on time.” -ASHA #32, Gurdaspur

“There is no arrangement for ASHAs in hospitals to stay at night. So it is difficult for them to spend entire night there.” -Husband #26, Gurdaspur

In Mewat, main problems were with inadequate supplies, equipment, and job aids:

“We give out the medicines and necessary medical assistance to the pregnant women. But there is a shortage of these items. Women ask for a urine kit during her pregnancy and other necessary items. We provide whatever we have but what we don’t, we cannot produce it from anywhere.” -ASHA #14, Mewat

ASHAs in Mewat also felt they were tasked with responsibilities for which they were not trained:

“Actually I haven’t received the training for home-based postnatal care. So I feel difficulty in doing that job.” -ASHA #11, Mewat

Related to insufficient training relative to the expectations was the ASHAs level of education. While the program did mandate ASHAs have eight years of education, practically ASHAs with less education were recruited in areas of need. Several ASHAs in Mewat were illiterate, hindering them from completing forms. They
solicited help of neighbors and family members
to complete these tasks which were sometimes
refused:

“I was given some paper work I didn’t know
how to do. I asked someone for her help
and she got very angry at me and said I
have no time. I felt very bad at that time.”
-ASHA # 2, Mewat

Payments of incentives were delayed for those
ASHAs who needed time and help completing
the necessary forms. Even ASHAs who were
educated experienced difficulties conducting
some technical work such as calculating the
expected date of delivery of pregnant women or
providing health information with technical
details such as about different methods of
contraception:

“I am not able to calculate expected date of
delivery, last menstrual period columns in
the card. Also some of my co-ASHA
workers are uneducated. I am now told to
fill home-based post-natal care card. We
find difficulty in filling them.” -ASHA #17,
Mewat

**Loss of Credibility with the Patients**

ASHAs faced several challenges to their
credibility as health care providers. ASHAs
viewed their reputation as being in jeopardy
when facility-based services were of poor quality
or were unavailable. One ASHA’s husband
explained:

“Sometimes there is problem with
government hospitals. Few days back, we
took one delivery case to CHC (community
health centre) but there was no doctor at
night duty. So the patient’s family got angry
with us. Then they went to private
hospital...We felt very bad; there is loss in
patient’s trust in us.” -Husband #44,
Gurdaspur

Families blaming ASHAs for poor quality care
was exacerbated in cases of adverse events or
unintended outcomes, which also impacted their
credibility in the community. One ASHA (#46,
Gurdaspur) narrated an incident of a newborn’s
illness for which she was blamed by the
newborn’s family. The ASHA then became
apprehensive of taking care of a high-risk
pregnant woman from the same family who was
in need of specialized care. Another spoke of the
fear and apprehension she had if a couple in her
community conceived for a third time indicating
that she would be blamed by her supervisor for
not having motivated the couple to use
contraception. The following excerpt reflects the
ASHAs’ anxiety of adverse events:

“We have fear of maternal and infant
death...we can’t change anyone’s fate. A
few months ago, at M Hospital, one mother
and newborn died because of fever. Staff
tried their best to save them. But both
mother and newborn died after delivery. Her
mother-in-law didn’t inform the ASHA of
their village, they were alone. If ASHA had
accompanied them then people and family
members would have blamed the ASHA.”
-ASHA #46, Gurdaspur

ASHAs’ integrity was also affected by the
attitude of doctors and nurses toward them:

“We go for deliveries and accompany the
patients....They do not know anything about
how things work in the hospital. The only
thing they know is that they have to come
with us so we explain to them that if you
deliver your child in the hospital then you
will get better care. That is why we are
taking you to the hospital. Then the patient
says that you stay with me. So for their
sake we will go, even during the night, with
them. But when after all this effort someone
raises their voice on us in front of the
patient and says, ‘keep quiet, mind your
own business and do not talk useless
nonsense’, then it is hurtful and humiliating.”
-ASHA # 12, Mewat

**Socio-cultural and Religious Norms
within the Community**

Although the ASHAs reported that people in the
community generally followed their advice and
accessed care, there were households which
were immune to their health promotion activities.
ASHAs in both districts expressed frustration
that some community members did not heed
their advice due to reported lack of education,
social norms or cultural taboos. ASHAs in
Gurdaspur confronted resistance from the
Gujjars, a marginalized tribe:
"I face more difficulty when I talk with Gujjars. They are not even ready for simple blood test. They would say - she is fine, madam, don’t advise us. We don’t want to go to hospital - They are not ready for ultrasound. It is very difficult to get them ready for immunization." -ASHA #46, Gurdaspur

Another said:

"There are some Gujjars who don’t seek care at sub-centre or PHC...because they believe in Fandas and Ilam (black magic). Illiteracy is the main cause." -ASHA #26, Gurdaspur

ASHAs in Mewat faced misconceptions among the community about effects of immunization and use of contraceptives:

"Most problems I face are during immunization. There are so many females who still do not come for vaccination. If I go to their houses, they ask me to go. They feel that injection might make them sterile. Then I explain to them, go there again and again...some ladies even abuse me." -ASHA #8, Mewat

One Muslim ASHA (#25, Mewat) ascribed the lack of demand for contraceptives to religious taboos and implicated herself in the non-use of contraceptives:

"Respondent: [Women] said we don’t want any contraceptive even if we get pregnant again in 6 months. They don’t even take sanitary napkins... They say the [contraceptives] produce heat in the body... I keep asking them again and again. Those who ask for contraceptive, I give them but those that don’t, I don’t ask them.

Interviewer: How many are there who do not take contraceptives?

Respondent: Mostly females are like this only in Muslims. Nobody takes contraception.

Interviewer: Not even you?

Respondent: (Laughs) Yes."

In Gurdaspur, the cultural preference for male children made it difficult for ASHAs to register a pregnancy in the first trimester:

"People don’t inform us about pregnancy. Most problems come in case of a second baby. Because if there is first daughter and people want a son the second time. So they don’t reveal about pregnancy." - ASHA #38, Gurdaspur

Misperceptions, marginalization, cultural and religious norms may have kept some households from utilizing health care services and hindered ASHAs from carrying out their responsibilities. ASHAs tried to motivate these families through repeated visits and, if necessary, engaging the auxiliary nurse midwife (ANM) to accompany them to households to "persuade" the people. To dispel fears of the health care system and health care staff, ASHAs arranged pregnant women and their families to visit health facilities so "they can see for themselves". Despite these efforts, there were still some families that ASHAs were unable to influence, and the only recourse left to them was to "go back again and again" to try and convince them to access care.

ASHAs’ Needs

ASHAs expressed a need for timely payment of incentives and suggested higher incentives or a fixed salary would increase their motivation. They also felt travel and mobile phone allowances would facilitate their work. ASHAs in both districts expressed the need for food and a place to rest in the hospital when they attended night deliveries:

"We have to spend whole night there [at facility for deliveries at night]. There must be a room, where we can sit or sleep. We get tired by continuous standing." -ASHA #28, Gurdaspur

"There is problem of commuting as there is no bus service from our village. So this also a main problem. So government should give some travel allowance to us." -ASHA #31, Gurdaspur

There was also a need for training before being assigned a new task such as conducting home-based post-natal care. ASHAs wanted to be provided with new information about government
schemes so they, in turn, could inform the community. Although they did not overtly voice a need for communication skills training, when asked about what support they would like in their job, one ASHA mentioned that more awareness should be spread in the village:

“In my area…please explain to the females regarding health and regarding contraception.” - ASHA #2, Mewat

Another said:

“If you people [referring to the interviewers who were educated and urbane] also go in the field and spread awareness among the people of village, they would understand things better.” - ASHA #11, Mewat

ASHAs’ need for help in motivating community members could be interpreted as a need for building their own communication skills.

Several ASHAs’ needs were related to facility-based services and their impact on the ASHA’s reputation in the community:

“When there is question of scanning, they (meaning community members) have to spend much money on that which they can’t. Then they feel cheated, and say ‘what is the use of coming to government hospitals?’ So it is requested to provide scanning machines in government hospitals. As we have to go to M Hospital but they do not even see the patient. We request them at least they should understand the condition of the patient. Doctors should at least see the patient.” -ASHA#42, Gurdaspur

ASHAs wanted more respect to be given to them by their supervisors and others in the health system. They wanted doctors and nurses not to reprimand them in front of the clients:

“The thing is that we also want a little bit of respect so that if a patient comes with us she is convinced that she is with someone who is respected for her work and therefore the patient is in right hands.” -ASHA #20, Mewat

ASHAs also felt disrespected when there were unrealistic expectations of what could be accomplished:

“We are supposed to maintain registers for birth record and vaccinations of infants from 0 to 5 years. We are even required to provide the year in which the vaccinated people were born. This is not feasible because the members of the family themselves have no record.” -ASHA #20, Mewat

While ASHAs did not want to be held accountable for the tasks that could not be completed, there was an interest in taking on more responsibility, especially to provide basic curative services. They wanted medicines for fever and minor illnesses, pregnancy testing kits, weighing machines, and blood pressure instruments to provide basic services to pregnant women:

“We should be provided with pain killers, PCM syrups [paracetamol] and health tonics. People demand these medicines from us very frequently. I tell them I don’t have such medicines.” -ASHA #44, Gurdaspur

Support from the community was viewed as essential to engage hard-to-reach or resistant families, and ASHAs suggested involving religious leaders and male health workers. It was also suggested that traditional birth attendants be trained on hygienic birth practices. For one ASHA, incentivizing attendance at community meetings would promote wider participation, facilitating health promotion and education:

“By calling ANM, village panchayat members, sarpanch [village head] all ASHAs and villagers they have a say so the work will surely become comfortable. Once they [community members] start earning some incentives of attending meeting they will come again and again.” -ASHA #10, Mewat

DISCUSSION

ASHAs’ effectiveness can be impaired by supply side factors, as has been found in several
Transportation and stock-outs have been noted as significant challenges faced by CHWs in other countries, affecting motivation and level of activity [4, 23,24]. Our study highlights a number of dimensions emanating from the supply side that affect ASHAs’ work. Insufficient supplies and materials affect ASHAs’ functionality and credibility in the community. Community members are reluctant to take ASHAs’ advice to use facility-based services when facilities lack pregnancy kits or blood pressure instruments. In addition, our findings point to the context-specific problems faced by ASHAs. In Gurdaspur, ASHAs reported insufficient funds to accomplish their work, while those in Mewat reported insufficient supplies, highlighting the need for problem-solving at the local level rather than relying on centrally-driven policies.

Our findings point out that while timely payment of incentives can be a motivating factor, the effects of these incentives diminish when payment is delayed, especially when the level of effort required to accomplish the tasks is perceived to be high. Indian studies have found that the incentive structure limits ASHAs’ motivation and performance [11,13,14]. One evaluation proposed direct disbursement from the central to the local panchayat, however, the state governments were reluctant to divulge the power to panchayats for governing CHW programs [10]. In settings where telephone penetration is high, mobile phones are valuable tool to improve dialogue with community, yet ASHAs we interviewed were not provided resources for mobile phones. ASHAs in Punjab and Haryana were recently provided Closed User Group (CUG) connections to communicate with fellow ASHAs, ANMs, or PHCs free of charge, and were provided some credits (INR50) for calling outside the CUG [25,26]. Spreading this program to other Indian states could facilitate ASHA performance.

Other studies from India have touched upon the community’s lack of trust in the public health care system [22] and pervading myths, religious, and cultural beliefs that prevent community members from seeking health care or trusting ASHAs [13]. Our findings illuminate ASHAs’ views on the misperceptions and cultural norms among community members that impact service delivery. The geographic and social distance between ASHAs and the religious minority and socially marginalized groups they serve require greater attention and effort. ASHAs in our study expressed a need for greater external support in “convincing” such groups to use the health system. The ASHA program envisioned community involvement as support from village-level bodies such as self-help groups, women committees, and village health sanitation committees, yet this support is rarely forthcoming. ASHAs have a need for cooperation from local organizations to solve local issues and thus to improve performance [22]. A community health system strengthening approach which draws on quality improvement methods has been found to increase community engagement with and support of CHWs [27].

Many ASHAs regardless of their education level and literacy had limited technical knowledge around health issues. Basic knowledge and skills could be developed through ongoing capacity building. In an evaluation of the ASHA program, the NHSRC recommended providing ASHAs with competency-based training and improving counseling skills [15].

Finally, many of the problems described by ASHAs relate to a lack of perceived respect, bringing concerns around collegiality and legitimacy of CHWs in the health system into focus [28-30]. A systematic review found that facility-based providers’ rude behavior caused CHWs’ reluctance to refer the clients to facilities [2]. Clients referred by ASHAs are not prioritized at facilities, and communities as a result see no value in seeking help from ASHAs. In their narratives, ASHAs described the disrespect shown to them when they accompany clients, but also the perceived absence of consideration or recognition as professionals when ASHAs stay at facilities for night deliveries. Such situations persist despite the Ministry of Health’s recognition of the important contributions made by CHWs and its recommendation to strengthen community-level health care services [31]. Sensitizing facility-based providers to ASHAs’ roles and responsibilities could improve relations and promote mutual respect and recognition.
CONCLUSIONS

The ASHAs, as with other CHWs, face challenges from the health system and community as well as have their own personal limitations. Efforts aimed at improving ASHAs’ work performance must address issues around their legitimacy and credibility with both the health system and the community. ASHAs often become the face of health system in their villages and thus face the communities’ resistance due to inefficiencies in the system. Our findings highlight the problems that are context specific requiring local solutions. Skills in counselling and interpersonal communication need to be built over time for ASHAs to effectively engage marginalized community members. Specific efforts at revitalizing community structures and establishing their linkage with ASHAs would in turn lend credibility to their work and build community networks to support them. The findings are relevant to other low resource settings where community health workers are relied upon to bear major responsibilities in making health care accessible to the rural poor.

AUTHORS’ CONTRIBUTIONS

ES was responsible for designing the study, conducting the training, supervising data collection, conducting data analysis, and structuring the manuscript. AS and SKK conducted literature review, contributed to writing the discussion and conclusion parts. SSL contributed to data analysis, structuring the result section, and giving a critical review of the manuscript. All authors have read and approved the final manuscript.

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CONFLICT OF INTEREST

Authors have declared that no competing interests exist.

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