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A narrative review and model for sleep health equity in South African healthcare

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Background: Insomnia disorder (ID) is a prevalent but often overlooked sleep disorder characterised by persistent difficulties initiating or maintaining sleep, with significant health consequences. Global prevalence ranges from 5% to 50%, with South African rates at 8%, rising to over 20% in vulnerable populations. ID presents substantial physical, psychological, and socio-economic challenges.

Aim: This review examines ID as a complex clinical condition affecting both patients and healthcare practitioners (HCPs). It analyses global and local management practices and disparities within South Africa's public health system, highlighting the need for sleep equity. A key motivation is to advocate for routine sleep discussions during consultations to encourage early behavioural intervention and prevent chronic ID.

Setting: The study was conducted within South Africa's public health system, where limited resources, high patient loads, and inequitable access to care shape how sleep disorders are recognised and managed.

Methods: A literature review was conducted using Google Scholar, EBSCOhost, and PubMed, focusing on peer-reviewed studies from lower-middle- to high-income countries, with emphasis on South Africa.

Results: Of 186 articles identified, 15 seminal papers were retained and analysed to inform findings on ID management.

Conclusion: This narrative review explores the multifactorial aetiology, clinical assessment, diagnosis, and management of ID, highlighting disparities between global best practices and South Africa's dual healthcare system. It advocates early intervention through routine sleep inquiries, behavioural therapies, and multidisciplinary collaboration, while identifying directions for future research.

Contribution: As the most common sleep disorder, ID remains underdiagnosed and undertreated. This review proposes a pathway to strengthen management and improve outcomes.

Keywords: insomnia disorder; sleep health equity; cognitive behavioural therapy for insomnia; South African healthcare; sleep disorders management.

Introduction

Insomnia poses a significant health problem and is a prevalent yet often neglected sleep disorder characterised by difficulty getting to sleep, staying asleep or waking too early. Disrupted sleep causes problems in occupational function, attention and concentration, mood changes and personal distress, which lead to maladaptive coping strategies.[1]

Global prevalence rates vary from 5% to 50% but generally show that at least one-third of adults are affected. Compared to the global statistics, insomnia rates are estimated at 8% in South Africa but escalate to over 20% among older adults and individuals with compromised health, pain or trauma.[2]

Chronic insomnia has severe consequences for physical and mental health, including increased risk for weight gain, cardiovascular disease, neurodegenerative disorders, depression and anxiety.[3] Comorbidities associated with insomnia, including other sleep and medical disorders, can present significant complexity. Most psychiatric disorders, particularly anxiety and

depression, have a sleep component.[4] Insomnia disorder is associated with high suicide ideation.[5] Daytime function, cognitive ability, mood regulation and social interactions are compromised by ID and exacerbated by medical or other sleep disorders.[6] The challenges for health care practitioners (HCPs) while encountering ID patients is to understand the nuances and brevity of symptom presentation, and assess, diagnose and formulate an appropriate treatment plan while navigating the practical issues that concurrently occur.

In South Africa, insomnia has historically been under-researched by a few researchers but began to emerge in the last decade. Notably, older adults in low-income settings in South Africa are particularly vulnerable to sleep disturbances.[2] Interestingly, experts similarly concluded that insomnia may affect half the population over 50 years old.[4]

Hale et al. propose that sleep health determinants encompass various sleep characteristics, including duration, continuity, timing, alertness and satisfaction. They argue that proactive, positive interventions can mitigate numerous adverse outcomes, such as cardiovascular disease, obesity, mental health disorders and neurodegenerative conditions. Central to their argument is that improving sleep health begins with individual-level behavioural recommendations. However, these recommendations must be supported across multiple contextual levels, including families, schools, workplaces, media, policy and healthcare settings, to achieve meaningful and sustainable improvements in public health.[7]

Aim of the review

This article is a narrative review.[5] The reviewers aimed to establish ID as a complex clinical condition with profound implications for patients and HCPs. By examining global and local ID management practices and disparities within South Africa's public health system, the reviewers highlighted the need for sleep equity across South Africa. A motivation for the review was to advocate the need for incorporating sleep discussions in all consultations by HCPs to encourage early intervention and prevent the progression to chronic ID.

Search strategy

This article originated as a situational enquiry asking where South Africa is regarding recognising the brevity of insomnia as a disorder in public healthcare. There is growing concern that insomnia is under-recognised and under-treated across many healthcare contexts, including South Africa. Despite growing global evidence for early intervention and behavioural management, clinical practice remains inconsistent and often pharmacologically driven. Insomnia management in South Africa faces distinct challenges, including limited public health resources, socio-economic stress and delayed help-seeking, often via traditional healing pathways.[8] These factors highlight the need for early intervention in primary care. This review engaged with global evidence to examine the clinical value of routine sleep discussions and early behavioural strategies to prevent progression from disrupted sleep to chronic ID, with a focus on their relevance in the South African context.[2,7]

Search strategy databases – Google Scholar, EBSCOhost and PubMed – informed the review. The review targeted peer-reviewed literature from lower-middle to higher-income countries and South African contexts, focusing on ID management, patient and practitioner experiences and public health perspectives. These articles were collected from January to October 2024.

Attempts to find ID research carried out in South Africa did not initially yield any results. The search was refined to include all ages, with no date specification and terms such as 'prevalence', 'insomnia', 'insomnia disorder', 'symptoms', 'distress', 'experience' (of patients and practitioners), 'help-seeking behaviours' and 'sleep equity' were included with zero return.

On a basic Google search using only 'insomnia in South Africa' without date specification, 82 400 articles emerged. When results were filtered for the last two decades, 1420 results emerged. These articles were saved to Zotero, a research reference manager, and perused for pertinence to the title and research questions (detailed in the next section). In total, 186 articles were retained and further refined to 15 seminal articles without compromising the content to comply with the protocol for this journal.

The literature was divided into four parts: (1) a search for state-of-science global expert articles defining insomnia, looking at the pathophysiology, assessment and treatment of ID; (2) articles on sleep disorders conducted in South Africa, where insomnia is mentioned; (3) articles on the public health system in South Africa supporting the concept of sleep health and sleep equity; and (4) quantitative and qualitative studies on the opinions of patients and HCPs globally and locally.

This article is structured as a synthesis of the multifactorial aetiology and risk factors of insomnia, and an examination of assessment, diagnosis and treatment protocols for the management of ID globally while considering the South African healthcare system[9] and the possibly unique aetiological factors that impact ID management in South Africa.[2] The intention is to clarify the unique barriers and opportunities in the South African healthcare system, which is essential for developing a practical, tailored model for managing ID. There is a call for the first intervention to be behavioural as per gold standard guidelines. Moreover, sleep health equity can be promoted using an at-a-glance model in urgent public healthcare settings.

Rationale for a model of insomnia management in South Africa

The following research questions were considered:

- Where does South Africa stand in ID management compared to the best global standards?
- How can ID be best managed within South Africa's parallel (private and public) healthcare system?

- What steps are needed to promote better ID management in South Africa?

This narrative review is structured to achieve three key objectives:

1. *Promote a paradigm shift in ID management in South Africa*: Advocate for early intervention to prevent disrupted sleep progression to chronic insomnia, applying a proactive, harm-reduction approach.[3,4]
2. *Emphasise sleep health equity*: Integrate routine sleep inquiries into all healthcare consultations to encourage preventative care across diverse patient populations.
3. *Highlight multidisciplinary collaboration*: Support education, training and collaborative sleep health practices across all healthcare disciplines, including doctors, nurses, counsellors, psychologists, physical therapists and occupational therapists, in private and public health sectors.

Together, these objectives support a transformative approach to ID management in South Africa by promoting early intervention and patient equity in sleep health and encouraging education and training among HCPs to address ID proactively and collaboratively.

Where is South Africa currently situated in our understanding of insomnia disorder management compared to countries more advanced in sleep research?

Over the last two decades, sleep disorders in South Africa have emerged via training programmes and the collaboration of a minority of HCPs interested in the field. The evolution of ID management has relied heavily on white papers and clinical guidelines from higher-income countries and education, particularly from pharmaceutical companies. Hale et al. propose that the determinants of sleep health are modifiable, suggesting that HCPs will benefit from using a multilevel context, such as clinics, schools, workplaces, media and policy, to address disparities in sleep health.[7] More recent innovations promulgated at the South African Society for Sleep Health (SASSH) Congress 2024 focus on sleep equity for all South Africans under the lens of cultural and economic disparities (www.sassh.co.za).

Global definitions, assessment, diagnostic criteria and treatment protocols provide a foundation for best practice in South Africa, rather than 'reinventing the wheel'. South Africa is currently in a transitional phase of ID management – drawing on international guidelines while contending with resource limitations, limited access to behavioural treatments and pluralistic health-seeking behaviours. Although Cognitive Behavioural Therapy for Insomnia (CBT-I) is the global standard, it remains underutilised in South Africa because of training and systemic constraints. Local initiatives such as SASSH are beginning to bridge these gaps with culturally responsive models and early intervention tools.

Global definitions of insomnia disorder

Insomnia disorder is difficulty falling asleep, staying asleep or waking up too early, with significant daytime impairment for at least 3 months[3,4,10] Diagnostic criteria from the International Classification of Sleep Disorders (ICSD)-3 emphasise symptom frequency and duration, defining ID as occurring at least 3 nights per week for 3 months, leading to impaired daytime functioning. Life events often precipitate acute insomnia, which can evolve into ID, particularly when associated with conditions such as medical, neurological and psychiatric conditions.[11]

A recent European guideline states that insomnia, a condition 'causing a great deal of personal suffering', is simply a struggle to get off to sleep or stay asleep, with some individuals having both issues and awakening earlier than they would like to.[3]

International guidelines for ID, such as those of Italy, recommend consistently assessing insomnia by examining both night and daytime symptoms.[12]

Assessment of insomnia disorder

Effective management of insomnia begins with a comprehensive clinical interview that gathers a detailed sleep history. The first encounter with a patient offers vital insights into the patient's lived experience of the problem, mainly if the patient can tell their sleep story and feels heard by the practitioner.[1,13] The sleep story can reveal precipitating and perpetuating factors.[14] Hyperarousal is a key feature of ID, particularly in emotionally distressed individuals. Individuals predisposed to emotional distress are particularly vulnerable to insomnia.[15] A routine suicide risk assessment is also critical because of the high association of ID with suicidality.[5] The first encounter with the patient should thus be seen as a valuable opportunity to gather sensitive information.

Tools such as sleep diaries, actigraphy and validated questionnaires such as the Insomnia Severity Index (ISI) and Athens Insomnia Scale (AIS) enhance assessment accuracy but are more frequently used in private and research settings.[3] In comparison, polysomnography (PSG) is the gold standard assessment for sleep disorders but is rarely necessary for typical ID cases unless comorbidities are suspected.[15]

The 3-P model of insomnia, encompassing predisposing, precipitating and perpetuating factors, offers a biopsychosocial framework for understanding the onset and chronicity of ID. It supports tailored assessment and treatment by mapping the interaction between individual vulnerability, triggering events and maladaptive coping patterns that maintain sleep disturbance.[14] By tailoring treatments to the precipitating symptom expression, patient profile and trajectory of the sleep disturbance, healthcare providers can improve patient outcomes and reduce the chronicity of ID.

Diagnosis of insomnia disorder

Diagnosis relies on patient-reported symptoms and a clear understanding of the trajectory of ID. Subtyping helps to compartmentalise the presentation of insomnia. Subtypes include psychophysiological insomnia – driven by heightened arousal or learned associations with sleep settings. Paradoxical insomnia is a 'subjective' insomnia with a mismatch between perceived sleep and actual objective sleep. Idiopathic insomnia is a rare, lifelong insomnia, possibly neurologically based.[3]

Recognising the heterogeneity of ID and its interactions with comorbid conditions, genetic vulnerability and personality is essential for clinicians in order to tailor effective treatment. Accurate diagnosis is crucial for effective treatment and reducing unnecessary interventions.[4]

Practitioner and patient challenges

There appears to be a shared experience between patients and practitioners in North America, Europe, Australia and South Africa. Further research is required to confirm these opinions.

Health care practitioners face numerous challenges in providing adequate care, including resource limitations and time constraints.[9] Time constraints limit constructive conversations.

In many cases, insomnia is mismanaged, treated superficially, or with quick pharmacological fixes. Patients often express frustration regarding their medical practitioners when they ask for help, straining the clinician–patient relationship. Individuals will seek help once symptoms impact daytime function, often choosing over-the-counter medications, which complicates treatment.[13]

Cultural practices must be considered, with many South Africans preferring traditional healers or natural remedies. These approaches should be considered to minimise harm.[8]

Treatment approaches

Non-pharmacological treatments, particularly CBT-I, are strongly supported by evidence and should be *the first line of treatment* in primary care settings.[3,6,15] Cognitive Behavioural Therapy for Insomnia has been proven effective across all insomnia symptoms and is particularly valuable when comorbidities are present. Clinical guidelines for ID emphasise improving sleep and alleviating distress through CBT-I.[3,4,15]

However, CBT-I is challenging to implement, costly and time-intensive, and few practitioners are trained in the modality, necessitating alternatives such as Brief Behavioural Therapy for Insomnia (BBT-I), which have shown promising results. Digital Cognitive Behavioural Therapy for Insomnia (dCBT-I) is rapidly gaining credibility as it offers access to immediate treatment for insomnia; however, when patients were asked, their preference was for therapist-led treatment. Evidence suggests that dCBT-I has relative utility, but dual dCBT-I with an HCP produces the best outcome.[6]

Pharmacological treatments, including hypnotics, benzodiazepines, antihistamines and sedating antidepressants, are sometimes necessary for short-term relief. They should not be the primary treatment because of risks of dependence, tolerance and withdrawal. Treatment should generally not exceed 4 weeks in duration; dose increases are not advised because of acceleration of dependency. Current practice formulating pharmacological intervention uses a neurobiological approach focusing on sleep neurochemistry, for example melatonin and orexin-hypocretin antagonists.[3]

A stepped-care approach, integrating CBT-I or other behavioural therapies alongside careful use of medication, can help manage more severe cases.[6] In addition, significant consideration should be given to the patient requiring tapering off medication. Further research is needed to investigate whether the combination of CBT-I and medication works better.[3]

A careful juxtaposition of global standards of practice with cultural sensitivity is needed in the South African context, noting the similarities and differences with other national contexts. Considerations include: (1) whether the disparities between public and private healthcare require a unique approach to ensure inclusive sleep health, (2) what are the conversations and awareness of South Africa regarding sleep and sleep disruption and (3) identifying the context-specific contributory causes of disrupted sleep in South Africa.

Management of insomnia disorder in South Africa: A global and local perspective

Collaborative efforts across disciplines – including medical, psychological and allied health domains, are gaining traction through initiatives such as SASSH, which promote integrated and context-sensitive approaches to insomnia care in South Africa. Optimal management is evidence-based. The patient's sleep story during the intake session is important, and behavioural treatments are the first line of treatment for ID. The shared experiences of ID for both patient and practitioner is a theme found in global literature.[4,13] Further research on ID in South Africa is needed to explore these dynamics and replicate or refute findings for this country.

The global context

Studies in the United Kingdom highlight factors such as patient beliefs about symptom development and subsequent help-seeking behaviours. The participants feared social stigma and personal isolation, preferring to wait it out because they felt they were not taken seriously by the HCP.[1] These psychosocial factors perpetuate sleep difficulty from

disrupted sleep to an acute stage, increasing patients' distress and the potential for chronic insomnia, which complicates the delivery of effective care.[3,4] Healthcare practitioners are then faced with an overwhelmed patient who is desperate for help with complex symptomatology.

In a qualitative study exploring the lived experience of patients with insomnia, patients expressed overt distress and being personally upset precipitated by a lack of understanding of the social context and their experiences with HCPs. Subordinate themes were consistent with psychological distress leading to social avoidance, including feeling misunderstood by HCPs.[13] The lack of empathy from others and the 'inadequacy of the medical profession' to get to the root of the problem created further anxiety, isolation and stigma.[1, p. 137]

Individuals grappling with insomnia perceive fragmented sleep as an insurmountable obstacle. Therefore, practical assessment methods and taking on case-specific interventions are essential.[3,4]

The South African context

To address the current practices in managing insomnia in South Africa, this section summarises the predominant treatment approaches and contextual challenges shaping care delivery. South Africa's dual healthcare system – public (71%) and private (27%) – faces unique challenges in ID management. Public healthcare is burdened by limited resources, long waiting times, and poor infrastructure, while socio-economic disparities worsen these issues.[9]

A range of socio-cultural, economic and environmental factors further complicate the management of ID in South Africa. South Africa's diverse landscape necessitates a culturally nuanced approach to insomnia evaluation and treatment.[9] Environmental factors, such as noise, safety concerns and extreme temperatures, are particularly relevant in South Africa, where many individuals live in densely populated urban areas or settings with inadequate housing conditions. Ingenuity will come from adapting words such as 'bedroom' because sleeping spaces are shared, often in one room.

These environmental conditions were made more prominent by coronavirus disease 2019 (COVID-19) and were associated with increased poverty and unrest. Environmental stressors contribute to heightened vigilance and conditioned arousal, making it challenging to achieve restorative sleep.[3,4,15] Socio-economic conditions, such as violence and poverty, potentially exacerbate the symptom presentation and treatment of ID,[2] while challenges in managing ID include substance use, irregular work schedules, undiagnosed comorbid sleep disorders and medical conditions. The implications of sleep deprivation on productivity, driving safety and chronic health conditions such as diabetes highlight public health priorities and sleep equity.[9]

The fact that 80% of older adults report sleep disturbances with comorbidities such as pain, anxiety, depression and memory problems is not unique to South Africa.[2,3,7] Nor is the profile of insomnia a South African dilemma[3]; however, biological markers causing vulnerability to ID are under the lens to explain why attention needs to be paid to this condition in this country.[3,4,15]

The impact of ID on mental health in South Africa emerges as a deep concern for HCPs working with ID. There is, however, a notable gap in research addressing the relationships between safety concerns, sleep disturbances, anxiety and depression,[5,9] comorbidities and their combined impact on mental health in South Africa. Further research into these dynamics should begin to provide more information about the South African situation.

There are a range of factors affecting mental health in South Africa. Addressing these interconnected factors requires culturally sensitive, collaborative, multidisciplinary strategies tailored to South Africa's unique socio-economic landscape.

The way forward for managing insomnia disorder in South Africa

Addressing the challenges of insomnia disorder in South Africa

As the most reported sleep disorder, ID deserves an essential place in South African healthcare's current initiative and equity profile.[7,9] Insomnia disorder management in South Africa begins with integrating global best practices into local healthcare systems with socio-economic and cultural sensitivity. Training HCPs is imperative in using global educational resources such as clinical guidelines, protocols and algorithms as part of the curriculum to validate the role of sleep in biological health.[3] Selsick et al. provide a step-by-step algorithm for diagnosing and treating ID, enabling efficient decision-making even in resource-limited settings.[4] Paying due attention to well-established standards of practice for sleep medicine should scaffold the process.[10] Thereafter, management becomes a matter of professional skills in the healthcare context.

Given the time constraints in South African healthcare clinics, early intervention is an opportunity to educate South Africans, prevent unnecessary complications and free up more time in the long run by applying practical, hands-on, multidisciplinary approaches. Early, routine enquiry into patients' sleep stories should be a priority across all scopes of clinical practice. Active listening not only aids diagnosis but also empowers patients to manage their condition effectively.[1,3,4,15]

A proposed model emphasises simplicity, practicality and time efficiency, leading to swift clinical decision-making and early intervention[4,5,13] (Figure 1).

Central to this model is the role of HCPs as a primary resource for promoting sleep health. They must adjust to

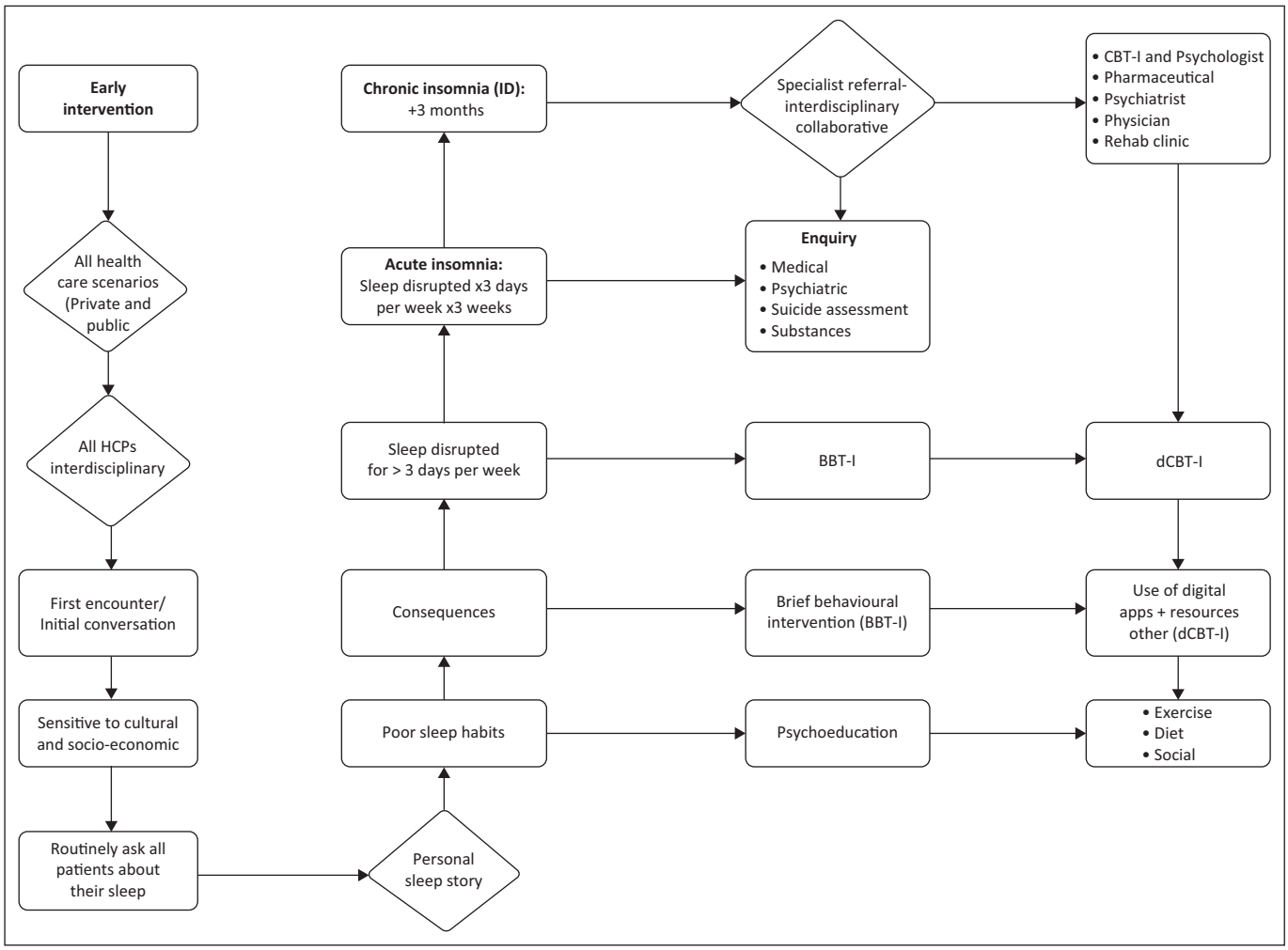
public and private healthcare disparities, cultural practices and socio-economic challenges. At the first encounter with the patient, no matter what the referral question is, ask, 'Tell me, how is your sleep?'. This open-ended question opens a conversation about the patient's *sleep story* within the context of their daily life. If poor habits and maladaptive strategies or overt neglect of sleep are evident, the practitioner can implement BBT-I protocols – guidance on sleep schedules, stimulus control (what to do if awake), psychoeducation on sleep hygiene and advice on tools available on their cell phone, such as CBT-I Coach™ mobile app.

If there is an indication of a chronic problem with sleep, the HCP refers the patient to the medical officer on duty or a sleep specialist practitioner to make an informed decision on comorbidity management.

Sleep health is a fundamental indicator of overall health. It is time for a paradigm shift in the diagnosis, management and equity of sleep health and ID in South Africa using a multilevel approach to address disparities.[7] The equity of sleep health in South Africa is an imperative for the SASSH (www.sassh.co.za).

However, as sleep research in South Africa is still emerging, it is crucial to be specific in future research, create accessible training programmes and practical tools for HCPs, and promote culturally relevant practices that address unique challenges. Focusing on 'holistic health-orientated perspectives on sleep'[7] opens opportunities for educating and training our population, offering various health benefits.

Future research in sleep needs to ask basic questions such as how South Africans define insomnia, what the measure of distress is as an outcome of disrupted sleep, and, vitally, whether South Africans even assign meaning to sleep as a necessity for well-being. In addition, many South Africans – the vast majority, seek medical help late (if at all), preferring traditional healers and natural remedies, making it essential for the model to integrate these cultural practices with insight while upholding the empirical standards of practice for sleep medicine.[5,6,8]



ID, insomnia disorder; CBT-I, Cognitive Behavioural Therapy for Insomnia; BBT-I, Brief Behavioural Therapy for Interventions; HCP, healthcare practitioners; dCBT-I, Digital Cognitive Behavioural Therapy for Insomnia.

FIGURE 1: A practical model to address sleep health equity in South Africa.

Implications and recommendations

Recommendations for early intervention

Three simple guidelines could change the course of sleep health following a simple behavioural model (Figure 1): (1) Sleep scheduling – keep consistent bedtime and waketime; (2) Stimulus control – avoid negative associations with bed and sleep; (3) Sleep hygiene – examine habits and rituals and environment related to bedtime (American Academy of Sleep, provider fact sheet); and (4) Psychoeducation – Diet and exercise.

Recommendations for future research in South Africa

- Conduct epidemiological studies on ID prevalence in South Africa, integrating cultural beliefs, help-seeking behaviours and early intervention strategies.
- Evaluate the cost of chronic insomnia treatment to guide resource allocation and early management planning in healthcare.
- Explore using digital tools to enhance early intervention through HCP training and patient empowerment.
- Utilise qualitative research to understand patient and HCP experiences, identifying barriers to early diagnosis and treatment.
- Align treatment protocols with international standards, integrating research on combined interventions for complex cases to ensure timely management.

Limitations

This narrative review did not adhere to systematic review protocols such as detailed filtration steps or formal appraisal of included studies, and thus is intended as a conceptual synthesis rather than a reproducible systematic review. A narrative analysis is flexible and practical, providing a relevant synthesis and conceptualisation of a subject. However, it does not offer a comprehensive or systematic review. There is a gathering of literature interpretations and guideline statements based on hypothesis-driven selection by the researchers that may introduce bias. While guided by empirical evidence, a reflexive view was taken during the writing to acknowledge and critically examine assumptions and clinical perspectives.

Conclusion

In South Africa, insomnia is often managed by practitioners with limited specialised training in sleep disorders, relying on guidelines that do not address local factors.[9] There is a resonance with Hale et al. to encourage South African HCPs to improve sleep-health outcomes.[7] Healthcare practitioners must treat sleep as a vital biological function, address poor sleep habits and their consequences during initial consultations, and promote sleep equity using the practical model provided (Figure 1). Early intervention can alter the natural progression of insomnia.[14] Behavioural treatment is strongly recommended as a global first-line intervention in all clinical guidelines.[3,4,15]

People do not necessarily adhere to behavioural change. Healthcare practitioners are frontline activists to encourage sleep-health knowledge. Brief Behavioural Therapy for Insomnia, adapted from CBT-I, focuses on behaviour modification to improve sleep.[3]

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This article also forms part of a larger study wherein the conceptual framework was a situational analysis of South African primary health management for ID.

Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

M.L.B. sourced literature, wrote up the first draft and reviewed the data with the other authors to the point of the final submission. D.B. advised, conceptualised a focus on a review, assisted with methodology refinement, provided further literature, and was involved in editing and reviewing. A.J.B. reviewed and edited the original draft, providing a medical and specialist lens for clinical standards of practice for insomnia disorder. C.A., supervisor of the larger research project, conceptualised the situational analysis, provided resources, advised, reviewed several drafts, was involved in editing and encouraged the other authors.

Ethical considerations

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Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

The views and opinions expressed in this article are those of the authors and are the product of professional research. The article does not necessarily reflect the official policy or position of any affiliated institution, funder, agency or the publisher. The authors are responsible for this article's results, findings and content.

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