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Job satisfaction, mental health, and workplace well-being of community health workers: a cross-sectional study

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Abstract

Background Community health workers (CHWs) are increasingly recognized as essential to the public health workforce, yet little is known about CHWs' workplace well-being. We examined CHWs' job satisfaction, mental health, and workplace experiences.

Methods We conducted a cross-sectional online survey of CHWs across the state of New Jersey. Job satisfaction was measured using an adapted version of the Multi-Dimensional Motivation Scale for Community Health Workers with scores ranging from −2 to 2 on dimensions of quality of supervision, feeling valued & capacitated, peer respect & support, and compensation & workload. Mental health was assessed using the Patient Health Questionnaire-4 (PHQ-4). We also examined positive and negative work experiences, including accomplishments, skill learning, career growth, stress, bullying, and discrimination using items on a 5-point Likert Scale. A descriptive analysis was conducted.

Results 52 CHWs completed the survey (69% female; 46% Hispanic, 27% non-Hispanic Black, 21% non-Hispanic White). Median (interquartile range) scores indicated high degree of satisfaction for quality of supervision [1.0 (0.9 to 1.9)], feeling valued [1.3 (0.9 to 1.7)], and peer support [1.4 (1 to 2)], but lower satisfaction for compensation and workload [0.4 (-0.4 to 1.2)]. Nearly all participants agreed or strongly agreed that their job gave them a chance to learn new skills (90%), however only 61% believed their job provided opportunities for advancement. Among participants, 23% reported typically feeling stressed out during the workday, 21% felt emotionally drained from their work, and 10% indicated that their job negatively impacted their mental health. PHQ-4 scores indicated that 12% had a positive depression screen and 16% had a positive anxiety screen. 15% reported ever having been subjected to workplace bullying and 21% had experienced workplace discrimination.

Conclusions CHWs' overall job satisfaction was high. However, dissatisfaction with compensation, lack of opportunities for advancement and job-related stress were prominent challenges. Research is needed to identify and evaluate policies to improve CHW job conditions and promote workplace well-being.

Keywords Community health workers, Job satisfaction, Workplace well-being, Mental health, Health equity

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Introduction

Community health workers (CHWs) are increasingly recognized as essential to the public health workforce [1]. As trusted members of the communities in which they serve, CHWs have a unique capacity to assess the health needs of their community, address barriers to care, provide health education, and connect people to health and social services [2]. The Bureau of Labor Statistics estimated that more than 60,000 CHWs were employed in the U.S. in 2023 and that their employment would grow 13% from 2023 to 2033, much faster than the average for other occupations [3]. Public health departments employ the greatest number of CHWs, however, a wide range of organizations including hospitals, health systems, health care providers, public and private health plans, and community-based organizations have increased their employment of CHWs in recent years [4].

Yet while the demand for employing CHWs grows, employment turnover among CHWs remains high, with nearly 12% of the estimated U.S. CHW workforce leaving their job in 2021, either because they were laid off or voluntarily resigned [5]. High turnover is a significant challenge to the effectiveness of CHW programs, which rely on consistent engagement of CHWs with clients built on trust and rapport [2]. Policy advocates have attributed CHW turnover rates to lack of sustainable funding, low wages, and lack of career pathways [6, 7].

In lower-income countries, where CHWs have been a mainstay of health systems for decades, studies on CHW job satisfaction and motivation have shown that CHWs are motivated by intrinsic factors like gaining the trust and respect of their community and feeling a sense of achievement, leadership, and recognition, while extrinsic factors like lower than expected financial incentives negatively influenced motivation [8–13]. In addition, CHWs in lower-income countries report high levels of burnout and stress [14, 15]. Volunteer (unpaid) CHWs in particular report greater levels of psychological distress and more stressful life events compared to their non-CHW peers [8, 16]. In this context, policies that improve supportive work environments for CHWs through equitable financial compensation, manageable workloads, provision of resources, and programs to support recognition of CHW work have been identified as key factors to positively impact motivation and work performance [9, 12, 17, 18].

In the U.S. context, only a small number of studies have investigated CHW work environments. Three studies conducted during the COVID-19 pandemic found evidence of occupational stress among CHWs [19–21]. One study examining job retention among CHWs working in local and state health departments found that CHWs dissatisfied with organizational support, pay, or job security were more likely to report an intent to leave the job [22]. Another study of CHWs in New York found that CHWs with higher levels of anxiety and lower job satisfaction were more likely to have experienced burnout and compassion fatigue [38]. A qualitative study of CHWs in Baltimore City identified several occupational hazards including burnout and discrimination [23].

Yet, there is little research examining views of CHWs employed in the U.S. on workplace well-being more broadly, including levels and predictors of job satisfaction, mental health and workplace experiences including bullying and discrimination. Understanding CHWs' workplace well-being is critical to developing and expanding equitable and effective CHW programs that value and retain talented workers. In this study, we conducted an online survey of CHWs across New Jersey (NJ) to assess their workplace well-being, including measures of job satisfaction and mental health, and how these measures vary by CHW demographic and employment characteristics. We also measured workplace attributes and experiences including accomplishments, skill learning, career growth, stress, bullying, and discrimination.

Methods

This study was conducted in collaboration with the NJ Department of Health (DOH) as part of an evaluation of the expansion of CHWs trained through the Colette Lamothe-Galette (CLG) Community Health Worker Institute (CHWI). The CLG-CHWI was established in 2020 by the NJ DOH to create a standardized CHW training and certification program with the goal of developing a sustainable CHW workforce in the state [24]. The NJ DOH also developed the CHW Hub, which is comprised of organizations and CHWs from across the state to support the training, employment, and sustainable pathways of the CHW workforce [25].

Academic-community partnerships that include CHWs across all aspects of the research process are crucial for conducting relevant, equitable, and effective research [26, 27]. By including CHWs throughout the research process, such partnerships leverage CHWs' unique expertise to improve research design, interpretation, and validity. This inclusive approach promotes trust and balances power dynamics [27]. In research assessing CHW well-being, CHWs are uniquely qualified to contribute their expertise and perspectives. In this study, CHWs were involved in the design and interpretation of the research. We co-developed a survey with CHWs and organizations who were a part of the CHW Hub focused on CHW job satisfaction, mental health, and workplace well-being. We piloted the survey with six CHWs and refined it following CHW feedback. Refinements included adding topics based on CHW interests and concerns, including on discrimination and bullying, as well as changes in survey items to improve comprehension and clarity. Later,

preliminary survey results were presented in a series of feedback sessions with CHWs to enhance contextual understanding of results and engage in policy discussions with NJ DOH and NJ Hub partners.

The sampling frame was CHWs who had graduated from the four county colleges across NJ participating in the CLG-CHWI between October 2022 – May 2023. These individuals were emailed a description of the study with a link to the anonymous online survey. A reminder email was sent after one week, a second reminder sent after another nine days, and a final reminder sent after another 13 days, at varying times of day. Eligibility criteria were that the respondent had participated in the CLG-CHWI and was currently working as a CHW. Participants who completed the survey received a $25 Amazon e-gift card.

The survey collected information about CHWs' demographics, employment conditions (workload, hours, length of employment, and compensation), job satisfaction, mental health, and workplace experiences. Job satisfaction was measured using an adapted version of the Multi-Dimensional Motivation Scale for Community Health Workers, which contains 22-items that assess four sub-indices: quality of supervision, feeling valued and capacitated in their work, peer respect and support, and compensation and workload [28]. Some items in the scale were adapted or revised based on feedback during the development and piloting phase. This included shortening and modifying the language of some items for better comprehension. Additionally, two original items in the compensation and workload subindex were removed and two items were added for improved relevancy to CHWs in NJ. Appendix Table 1 shows each item in the original scale and the modifications made. Respondents indicated how satisfied they were with each item on a five-point scale, ranging from "Very dissatisfied" (coded as −2) to "Very satisfied" (coded as 2), with an additional option for "Not applicable". Items over each sub-index were averaged for a score ranging from − 2 to 2 and the overall index score was the sum of each sub-index, with a possible range of −8 to 8. "Not applicable" responses were rare and ignored in mean calculations. Finally, an additional question on amount of hourly wage was added to the survey after study launch based on feedback from CHW employers who participated in the CHW Hub program.

Participants' mental health was measured using the four-item Patient Health Questionnaire-4 (PHQ-4) which consists of the PHQ-2 depression screening tool and the Generalized Anxiety Disorder-2 (GAD-2) screening tool [29, 30]. Each item is scored on a four-point Likert scale that ranges from 0 (not at all) to 3 (nearly every day) and the total PHQ-4 score ranges from 0 to 12. Scores were categorized as no symptoms (0–2), mild symptoms (3–5), moderate symptoms (6–8), and severe symptoms (9–12). The 2-item depression and anxiety subscales are considered positive for scores of 3 or above. The PHQ-4 showed good internal consistency in our data, as indicated by a Cronbach's alpha value of 0.91.

Workplace well-being was assessed in several ways. First, questions on positive and negative workplace experiences and attributes were derived from the short-form of the Minnesota Satisfaction Questionnaire (MSQ) [31]. The MSQ is a well-recognized tool that has been used to assess extrinsic and intrinsic factors affecting job satisfaction among a wide variety of healthcare professionals, including CHWs [32–34]. Examples of items related to positive experiences were the following, rated on a five-point Likert scale: "My job provides me with steady employment"; "My job gives me the chance to do different things from time to time"; "My job gives me the chance to make a difference in the community"; "The amount of work I am expected to do each week is reasonable"; "I get a feeling of accomplishment from my job", "My job provides opportunities for advancement" and "It is likely that I will be working as a CHW in 2 years". Items related to negative experiences included: "I feel emotionally drained from my work" and "I typically feel stressed out or tense during the workday". Participants were also asked how their job as a CHW has impacted their mental health, with response options including "Very negatively", "Somewhat negatively", "Neither positively nor negatively", "Somewhat positively", and "Very positively". Finally, participants were asked about their experiences with bullying and discrimination. Following previous literature [35], bullying was measured by defining bullying and asking participants to indicate whether they had been subjected to or witnessed workplace bullying and by whom. Discrimination was measured by asking participants whether they experienced discrimination and by whom using the U.S. Equal Employment Opportunity Commission's definition for employment discrimination [36].

A descriptive analysis was conducted to examine distributions of participant responses across the measures. We examined the median and interquartile range (IQR) of the job satisfaction subindices, and the percentage of participants who responded that they were satisfied or very satisfied for each item. We calculated the percentage of participants in each PHQ-4 category and the percentages who had positive screens for depression and anxiety. Using bivariate linear regression, we examined differences in job satisfaction and PHQ-4 scores across participant demographic and job-related characteristics. We then used multivariate linear regression to examine the combined associations between these characteristics and job satisfaction and mental health scores. Finally, we examined the percentage of participants who responded that they agreed or strongly agreed with the positive

and negative workplace experiences and attributes, and the percentage who responded that their job impacted very negatively or somewhat negatively on their mental health. As a robustness check to examine the extent of non-response bias among our sample, we used data obtained from NJ DOH on the demographics of the full cohort of graduates from CLG-CHWI in 2022–2023. We calculated differences in the full cohort compared to the survey respondents using Pearson chi-squared tests. Ethical approval for this study was provided by Rutgers University Institutional Review Board.

Results

The survey was sent to 160 email addresses of CHWs, among which 34 were found to be duplicates and seven bounced, leaving 119 CHWs invited. Among those invited, 101 opened the survey, and among those, 31 were not eligible and 18 did not complete the survey. In total, 52 CHWs completed the survey, a response rate (completed/[invited - ineligible]) of 59% [37]. Appendix Table 2 compares the participants to the full cohort of CHWs trained via the CLG-CHWI, with no significant differences across gender, age, or race and ethnicity. Table 1 shows the characteristics of participants. Most survey participants were female (69%). Just under half (46%) were Hispanic, 27% were non-Hispanic Black and 21% were non-Hispanic White. Among the participants, 10% had a high school diploma, 23% had some college, 38% had graduated from college, and 29% had earned a graduate degree. Half of participants were married or in a relationship (50%) and about half had children (52%) with 15% having children under the age of 5. More than half of participants (52%) spoke another language besides English. Most worked full-time (67%) compared to part-time (33%), and most had been employed as a CHW for at least seven months (67%). More than one in five (21%) had an additional job to their job as a CHW. Participants were deployed at a range of organizations, including NJ DOH, municipal health department, other government agency (4%), hospital, health system or clinic (12%), family, maternal, and child health organization (17%), and other social or community service organization (65%), which included youth-based, faith-based, educational or career services, immigration services, or other nonprofit. Of the 12 participants that answered the question on amount of compensation, 7 (58%) reported being paid less than $20 per hour and 5 (42%) reported being paid over $20 per hour.

Figure 1 shows the distribution of average scores for each sub-index in the CHW motivation scale. Scores for quality of supervision, feeling valued, and peer support showed overall high levels of satisfaction, with median (IQR) scores of 1.1 (0.9 to 1.9), 1.3 (0.9 to 1.7), and 1.4 (1 to 2), respectively. However, for compensation and workload, the median (IQR) was 0.4 (−0.4 to 1.2), indicating that respondents were more dissatisfied with items related to compensation.

The items with the lowest satisfaction were "Amount you get paid" (44% satisfied or very satisfied) and "Your long-term job security" (42% satisfied or very satisfied) (Appendix Fig. 1). Low satisfaction was also observed for "When and how often you get paid" (67%), "Your sick leave time" (63%), and "Your paid time off/vacation days" (60%). Among items within quality of supervision, "Coordination between supervisor, community leaders, and stakeholders" received the lowest satisfaction (79%), while among items related to feeling valued, "Consideration of your views by community leaders and stakeholders" also received the lowest satisfaction (79%). All other items had satisfaction of 80% or above.

Table 2 shows the percentage of participants with elevated PHQ-4 scores, by total score and by subscale. Among participants, 14.3% had scores in the mild range, 6.1% in the moderate range, and 6.1% in the severe range. In the subscales, 12.2% had a positive screen on the depression sub-scale and 16.3% had a positive screen on the anxiety subscale.

The results of bivariate and multivariate models examining predictors of job satisfaction and mental health are shown in Appendix Tables 3 and 4. In bivariate models, participants who had children under age 5 had higher job satisfaction (6.0 compared to 3.8, $p = 0.01$) and those who worked full-time compared to part-time had higher satisfaction (4.7 vs. 3.1, $p = 0.02$). Participants who had graduated from college had worse mental health than those with other levels of education ($p = 0.02$), while those with full-time employment had somewhat better mental health ($p = 0.09$). In the multivariate models, the only significant predictor of job satisfaction at the 0.05 level was having a child under 5, while working full time as compared to part time was significantly associated with better mental health (Appendix Table 4). In addition, working in a health system or clinic was associated with a higher (worse) mental health score, as compared to a maternal and child health organization.

Figure 2 shows the percentage of participants who agreed or strongly agreed with statements about their workplace experiences and attributes. Most CHWs agreed that their job gave them a chance to make a difference in the community (96%), learn new skills (90%), gives them a feeling of accomplishment (87%), and gives them a chance to do different things (86%). Fewer agreed that the job provided steady employment (75%), that the amount of work expected was reasonable (71%), and that they were included in decisions at their organization (71%). Items pertaining to career growth were lowest: only 61% agreed that the job provided opportunities for

Table 1 Characteristics of survey participants (*N* = 52)

	n (%)
Gender	
Male	13 (25%)
Female	36 (69%)
Non-binary, non-conforming, or other	3 (6%)
Age	
20–29	19 (37%)
30–44	16 (31%)
45+	17 (33%)
Race and Ethnicity	
Non-Hispanic Black	14 (27%)
Non-Hispanic White	11 (21%)
Hispanic	24 (46%)
Missing	3 (6%)
Education	
High school diploma or GED	5 (10%)
Some college or trade school	12 (23%)
Graduated from college	20 (38%)
Graduate degree	15 (29%)
Marital status	
Married or in a relationship	26 (50%)
Single	25 (48%)
Missing	1 (2%)
Has children	
No	24 (46%)
Yes	27 (52%)
Missing	1 (2%)
Has children under 5	
No	43 (83%)
Yes	8 (15%)
Missing	1 (2%)
Speaks multiple languages	
No	25 (48%)
Yes	27 (52%)
Has additional job to CHW	
No	41 (79%)
Yes	11 (21%)
Hours worked per week	
Part-time (< 30)	17 (33%)
Full time (30+)	35 (67%)
Employment length	
Less than 6 months	17 (33%)
7 months or more	35 (67%)
Type of organization	
NJ DOH, municipal health dept, or government agency	2 (4%)
Hospital, health system or clinic	6 (12%)
Family, maternal & child health organization	9 (17%)
Other social or community services	34 (65%)
Missing	1 (2%)
Paid >$20	
No	7 (13%)
Yes	5 (10%)
Missing	40 (77%)

Other social or community services includes school or youth-based, faith-based, educational or career services, immigration services, or other non-profit

advancement and only 55% agreed that they would likely be working as a CHW in two years.

There were also reports of negative workplace experiences. Among participants, 23% reported that they typically felt stressed out during the workday and 21% reported feeling emotionally drained from their work. In addition, 21% reported that they had experienced workplace discrimination. About 6% had experienced discrimination from a coworker, 8% from a supervisor, and 6% from a client (Appendix Table 5). About 15% of participants reported that they had been subjected to workplace bullying. About 8% had been bullied by a coworker, 6% by a supervisor, and 2% by a client (Appendix Table 5). Finally, 10% of participants indicated that their job as a CHW had very negatively or somewhat negatively impacted their mental health.

Discussion

Results from this cross-sectional survey of CHWs in New Jersey indicated that CHWs have overall high levels of job satisfaction, including in areas of quality of their supervision, feeling valued in their work, and supported by their peers. CHWs also reported many positive workplace experiences and attributes, including making a difference in the community, learning new skills, and having a feeling of accomplishment from their work. However, results also indicated that CHWs contend with several significant challenges including dissatisfaction with compensation, lack of opportunities for advancement, and low job security. We did not observe many significant differences in job satisfaction by individual characteristics, however, CHWs who had younger children had higher satisfaction scores.

Few studies have examined the mental health or work-related stress of CHWs in the U.S [19, 21–23, 38]. The role of CHWs involves deeply connecting with community members on a personal level, as well as navigating complex and challenging issues including food and housing insecurity, chronic disease and mental illness, and social isolation [20, 21]. Encountering these challenges daily can take an emotional toll on CHWs and generate compassion fatigue and burnout [19, 23, 38, 39]. Our results indicated that more than one in five CHWs reported feeling emotionally drained due to their job, 21% felt typically stressed during the workday, and 10% felt that their job had negatively impacted their mental health. In a multivariate model controlling for demographic and employment characteristics, CHWs who worked part-time compared to full-time reported significantly worse mental health. Our results are consistent with reports of burnout, stress, and poor mental health among front-line health care workers more broadly. In 2023, across health care occupations, 35% of health care workers experienced feelings of burnout and 21% experienced

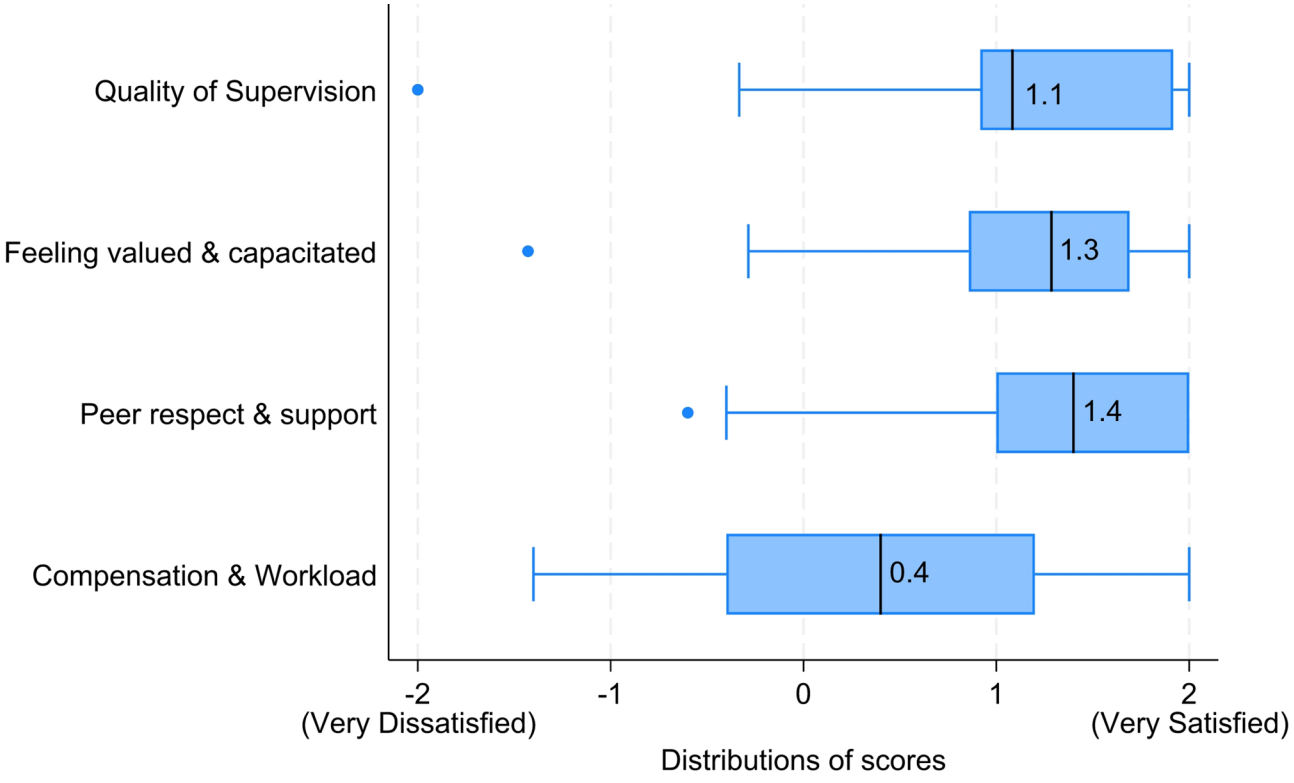

Fig. 1 Distribution of responses for job satisfaction subindices
Notes: For each item in a subindex, responses are scored from −2 (very dissatisfied) to 2 (very satisfied) and averaged for each respondent producing a score for each subindex. The distribution of those scores are shown in the boxplot. Box plots show the median and interquartile range (IQR) of scores as the area in the rectangle, with the whiskers indicating the data points within 1.5IQR. The median line is shown as the dark line in the box, and the number indicates the median

Table 2 Distribution of PHQ-4 scores of participants ($N=52$)

	n **(%)**
PHQ-4 category	
No symptoms	37 (73.5%)
Mild symptoms	7 (14.3%)
Moderate symptoms	3 (6.1%)
Severe symptoms	3 (6.1%)
Positive screen for depression	6 (12.2%)
Positive screen for anxiety	8 (16.3%)

PHQ-4 is the Patient Health Questionnaire-4. Categories are defined as none (0–2), mild (3–5), moderate (6–8), and severe (9–12). Positives screens for depression and anxiety are defined as subscale score > = 3

high levels of professional stress [40]. Stress and burnout were particularly elevated during the COVID pandemic and have since slowly decreased, yet levels remain high [40, 41]. Societal consequences of workforce burnout and disengagement are high, with estimated annual costs of $5 million as well as over 800 quality-adjusted life years lost [41, 42]. As a critical segment of the public health workforce, CHWs provide essential services for some of the most disadvantaged individuals. In addition to the negative effects on CHWs themselves, mental distress and burnout among CHWs can have significant negative implications for the effectiveness of community health programs, by increasing turnover and lowering quality of care [43]. Supporting CHWs' mental health through workplace strategies to reduce stress, improve coping, and promote work-life balance is critical for supporting the CHW workforce [21, 44].

It is important to consider our results in the context of racial and ethnic economic inequity. CHWs are increasingly recognized as central to public health efforts to address social determinants, improve community health, and advance health equity [4]. Because CHWs reside in and are members of the disadvantaged communities that they serve, CHWs are also members of historically marginalized groups [23]. The professional challenges identified in this study including low pay, inadequate job security, and lack of career advancement may exacerbate the structural economic inequities facing racial and ethnic minority communities [45]. Strategies to address these professional inequities are needed. Some research has focused on strategies for the integration and support of CHWs into organizations, including the policies and procedures that facilitate integration [46–48]. State-level policy proposed approaches have focused on state certification and Medicaid reimbursement for CHW services; yet, a recent study found that Medicaid reimbursement

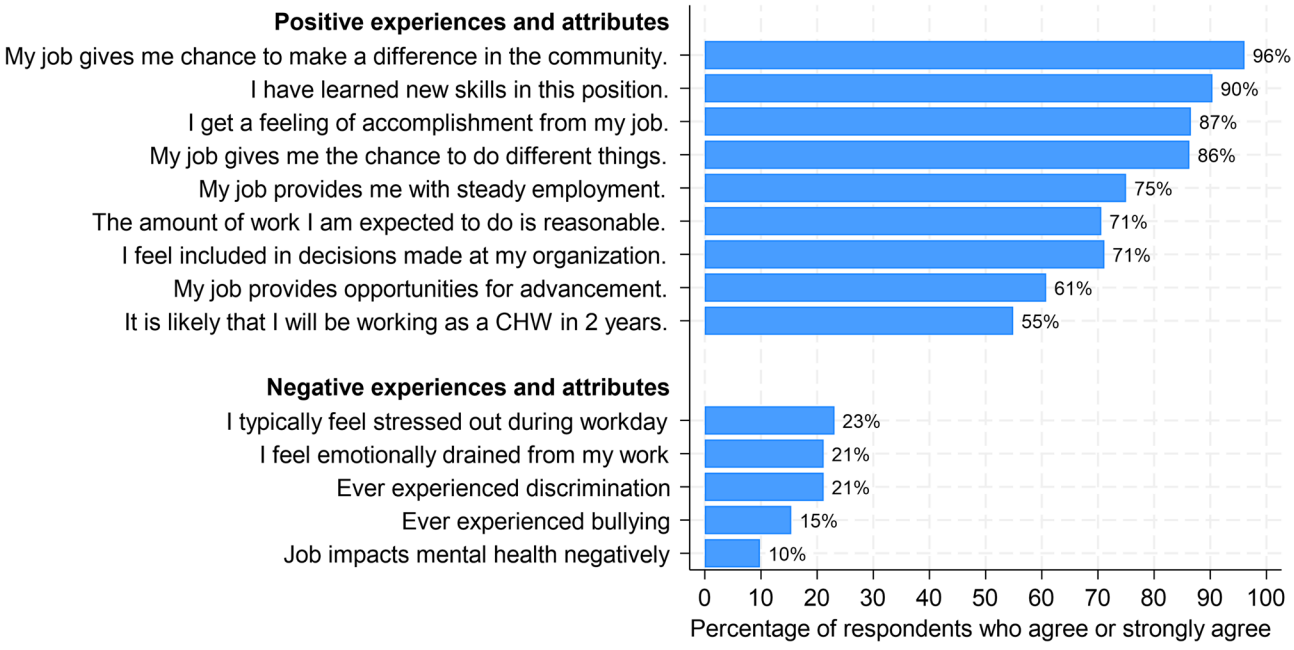

Fig. 2 Percentage of participants with positive and negative work experiences and attributes

had no impact on CHW wages and that pay increases for CHWs following certification disproportionately benefited White and male CHWs [5]. More research is needed to identify effective multi-level systems interventions and employment policies to improve CHW job conditions, address racial and gender pay equity, and promote economic well-being for CHWs.

Supporting the growth and advancement of the CHW workforce requires concerted efforts to evaluate CHW programs on community outcomes and assess the program inputs, such as aspects of CHW workplace well-being, that lead to improved outcomes. Recent advancements via the CHW Common Indicator's Project identified priority constructs and associated indicators for standardized evaluation of programs and systems involving CHWs [26]. Adoption of common processes and measures can help demonstrate the effectiveness of CHW roles and skills as well as identify key workplace conditions and environments that enable CHWs to thrive [26]. Our survey included many of the process constructs included in the CI project, including job satisfaction, compensation, value of CHWs to the organization, supportive supervision, and CHW integration. In addition, our results suggest that inclusion of constructs such as opportunities for career advancement, job security, stress and burnout, and mental health may be important metrics to collect in CHW settings to further evaluate the supports and challenges experienced by the CHW workforce.

This study has strengths and limitations. We used validated instruments to measure CHW job satisfaction and mental health; however, the CHW job satisfaction index has only been validated in low-income countries. Our sample is racially and ethnically diverse and also represents a growing CHW workforce across a range of types of organizations, both public and private. However, our response rate was 59%, which could limit generalizability and introduce non-response bias [37]. As a robustness check, we compared our sample to the full cohort of graduates from the CLG-CHW institute and we found no significant differences across the demographic variables of gender, age group, and race and ethnicity. During recruitment, we used monetary incentives and multiple reminder messages to increase response rates; however, our survey allowed only one modality (online) for completion. Future studies could explore strategies for increasing response rates, for example, by following up text message recruitment with telephone calls or using alternative modalities or combination of modalities [49]. The question on amount of hourly wage was added to the survey after its launch, thus limiting the number of responses to that question. More research on CHW compensation is needed to gain greater understanding of how wages vary across programs and individual characteristics, and the impact of different funding models on CHW compensation. Finally, as this study was a cross-sectional survey, we are not able to disentangle the causal effects of the CHW role on mental health and the possible selection process into CHW work. Future work using a longitudinal design that follows CHWs over time would better illuminate trajectories in mental health and their predictive factors. In addition, qualitative work that seeks to

deepen our understanding of the experiences of CHWs in their jobs would help identify possible mechanisms and policy implications. Such future work must ensure that CHWs are involved in all aspects of the research process, including the development, implementation, and dissemination of research [26, 27].

Conclusions

In this cross-sectional survey of CHWs in New Jersey, rates of overall job satisfaction were high. However, dissatisfaction with compensation, lack of opportunities for advancement, and job-related stress were prominent challenges. Research is needed to identify and evaluate workplace policies to improve CHW job conditions and promote workplace well-being for CHWs.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12889-025-25546-3.

Supplementary Material 1.

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Authors' contributions

SR designed the study, supervised the collection of data, analyzed and interpreted the data, drafted the manuscript, and revised the manuscript. SHW managed data collection, contributed to data interpretation, and revised the manuscript. NO and KF contributed to data interpretation and revised the manuscript. LK revised the manuscript. All authors read and approved the final manuscript.

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Data availability

Data are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval for this study in accordance with the Declaration of Helsinki was provided by Rutgers University Institutional Review Board. All participants gave written informed consent to participate.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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