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Research Article

LANGUAGE, POWER, AND ACCESS: AN ETHNOGRAPHIC STUDY OF LINGUISTIC BARRIERS FACED BY REFUGEES IN HOST COUNTRY HEALTHCARE SYSTEMS

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Abstract

Global refugee displacement has intensified encounters between linguistically diverse populations and host country healthcare systems, where language frequently operates as a mechanism shaping access, power, and equity. This study aims to examine how linguistic barriers are experienced, produced, and negotiated by refugees within healthcare institutions, with particular attention to everyday interactional practices and institutional language regimes. An ethnographic qualitative design was employed, involving prolonged participant observation, in-depth interviews with refugees and healthcare professionals, and analysis of institutional documents across multiple healthcare sites. Data were analyzed thematically through an iterative process linking micro-level communicative interactions with broader organizational structures. The findings reveal that linguistic barriers are not merely technical communication problems but are structurally embedded in healthcare routines that privilege dominant languages, professional authority, and efficiency. Limited and inconsistent interpreter provision, reliance on ad hoc mediation, and monolingual clinical practices constrained refugees' participation, informed consent, and continuity of care. Refugees developed adaptive strategies to navigate these constraints, yet such strategies shifted the burden of communication onto patients rather than institutions. The study concludes that language functions as a key mechanism through which healthcare access is regulated and inequality is reproduced. Implications highlight institutional responsibility for equitable, linguistically responsive healthcare systems globally.

Keywords: Ethnography, Healthcare Access, Linguistic Barriers

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INTRODUCTION

The introduction opens by situating language as a central yet unevenly distributed resource within contemporary global mobility and forced migration. Refugee movements across national borders are not merely humanitarian phenomena but are deeply embedded in sociopolitical systems where language functions as a gatekeeping mechanism (Maguire-Rajpaul et al., 2025; Veneziano Labanca et al., 2025). Healthcare systems in host countries emerge as critical sites where linguistic competence determines not only the quality of care received but also the degree of dignity, agency, and recognition afforded to refugees. This background frames language not as a neutral tool of communication but as a structured medium through which power relations are enacted in institutional encounters (Navne et al., 2025; Wang et al., 2025).

The background further elaborates how healthcare settings represent high-stakes communicative environments for refugees, where misunderstandings can lead to misdiagnosis, inadequate treatment, or complete exclusion from care (Glauzy & Montlahuc-Vannod, 2025). Refugees often enter these systems carrying complex linguistic repertoires shaped by displacement, trauma, and interrupted education, while healthcare institutions operate through dominant national languages and technical medical registers (Welty, 2025). This mismatch generates structural vulnerabilities that extend beyond individual language deficits, pointing toward systemic inequities embedded within institutional norms, policies, and professional practices (Lie & Claisse, 2025).

The contextual framing emphasizes the need to move beyond deficit-oriented perspectives that attribute communication breakdowns solely to refugees' limited language proficiency. Linguistic barriers are positioned as socially produced constraints shaped by historical, political, and institutional forces within host societies (Correia et al., 2025; Kassegne et al., 2025). An ethnographic lens becomes particularly relevant in uncovering how everyday interactions in healthcare settings reproduce asymmetries of power, silence refugee voices, and normalize exclusionary practices. This opening background establishes the broader intellectual terrain in which language, power, and access intersect (Akalın, 2024).

The problem addressed in this study centers on the persistent linguistic barriers experienced by refugees when navigating host country healthcare systems, despite policy commitments to inclusivity and universal access (Jayawickreme et al., 2025; Perrenoud et al., 2023). Communication challenges frequently manifest during clinical consultations, administrative procedures, and emergency care, where interpretation services are inconsistent or absent. These barriers compromise informed consent, patient autonomy, and continuity of care, while also placing healthcare professionals in ethically and professionally constrained positions (Al-Yateem et al., 2025).

The problem extends beyond practical communication difficulties to encompass symbolic and relational dimensions of power. Refugees often experience marginalization through institutional language practices that privilege biomedical discourse and bureaucratic efficiency over dialogic understanding (Dekker et al., 2024). Limited opportunities for refugees to express symptoms, concerns, and cultural health beliefs result in interactions that are asymmetrical and transactional. Such encounters reinforce hierarchical relationships in which refugees are positioned as passive recipients rather than active participants in their own healthcare (Brooks, 2025; Olsavszky et al., 2025).

The articulation of the problem underscores a critical tension between formal healthcare access and meaningful healthcare participation. Access to healthcare facilities does not automatically translate into equitable care experiences when language barriers remain structurally unaddressed (Mukherjee, 2025; Yi & Hong, 2025). The problem is further compounded by the invisibility of linguistic inequities within dominant healthcare narratives that emphasize clinical outcomes over communicative processes. This study responds to the need for a deeper understanding of how linguistic barriers are produced, negotiated, and

resisted within everyday healthcare interactions involving refugees (Abesamis, 2023; Lichtsztejn et al., 2025).

The primary objective of this study is to explore how linguistic barriers are experienced and navigated by refugees within host country healthcare systems through an ethnographic perspective. The research seeks to examine language use not only as a communicative practice but also as a site where power relations are enacted and contested. Attention is directed toward refugees' lived experiences, interactional strategies, and interpretations of healthcare encounters in linguistically unfamiliar environments (Dlodlo, 2025; Maxey et al., 2025).

A further objective involves analyzing institutional language practices within healthcare settings, including the roles of medical professionals, interpreters, and administrative staff. The study aims to identify how institutional norms, time constraints, and professional discourses shape communicative interactions with refugee patients (Kerr & DeMichelis, 2025). By examining these dynamics, the research intends to reveal how structural conditions influence the availability and effectiveness of linguistic mediation in healthcare contexts.

An additional objective is to contribute empirically grounded insights that can inform more inclusive healthcare policies and practices. The study aims to generate knowledge that supports the development of linguistically responsive healthcare systems sensitive to refugee realities (Angouri et al., 2025; Solís Mecalco, 2024). Through ethnographic documentation, the research aspires to bridge micro-level interactional analysis with macro-level discussions on health equity, social justice, and migration governance (BenBaruch et al., 2025).

Existing scholarship on refugee healthcare has extensively documented disparities in health outcomes, access to services, and systemic discrimination. Many studies identify language barriers as a significant factor affecting refugee health, often relying on survey-based methods or policy analyses (Dakin et al., 2024; Gurung et al., 2025). These approaches, while valuable, tend to treat language as a technical obstacle rather than as a socially situated practice embedded within power-laden institutional contexts (Husain & Greenhalgh, 2025).

A notable gap exists in research that closely examines the everyday interactional processes through which linguistic barriers are produced and sustained in healthcare settings (Sheehan, 2025). Ethnographic studies that foreground refugees' voices and lived communicative experiences remain relatively scarce. The dominance of quantitative and clinical perspectives has limited nuanced understandings of how refugees interpret, negotiate, and respond to linguistic exclusion during healthcare encounters (Brocco et al., 2025).

Another gap concerns the integration of language, power, and access within a single analytical framework. Studies often address language barriers in isolation from broader sociopolitical structures shaping healthcare institutions (Bhowmik et al., 2025). The absence of theoretically informed ethnographic work leaves critical questions unanswered regarding how institutional language regimes reinforce inequality and how refugees exercise agency within constrained communicative environments. This study addresses these gaps by offering a holistic, empirically grounded examination of linguistic barriers in refugee healthcare experiences (Lovato et al., 2025).

The novelty of this study lies in its ethnographic focus on language as a mechanism of power within healthcare systems, rather than merely as a tool for information exchange. By examining everyday interactions between refugees and healthcare providers, the research reveals how access to care is mediated through language practices that privilege certain voices while marginalizing others. This perspective challenges dominant biomedical models that overlook the sociolinguistic dimensions of healthcare delivery.

The study introduces an analytical contribution by conceptualizing linguistic barriers as institutional phenomena shaped by policy, professional norms, and historical power relations. Refugees are not portrayed as linguistically deficient subjects but as individuals navigating complex communicative landscapes with resilience and strategic adaptation. This reframing

offers a critical departure from deficit-oriented narratives and aligns the study with broader debates in sociolinguistics, medical anthropology, and critical migration studies.

The justification for this research is grounded in its potential to inform ethically responsive and socially just healthcare practices. As global displacement continues to rise, host country healthcare systems face increasing pressure to address linguistic diversity effectively. The insights generated by this study provide an evidence-based foundation for rethinking language policy, interpreter provision, and professional training in healthcare contexts. The research contributes not only to academic discourse but also to practical efforts aimed at reducing inequality and enhancing refugee well-being.

RESEARCH METHOD

Research Design

This study employed a qualitative ethnographic research design to examine how linguistic barriers are experienced, interpreted, and negotiated by refugees within host country healthcare systems. Ethnography was selected because it enables in-depth engagement with participants' everyday practices and meaning-making processes, particularly in institutional settings where language, power, and access intersect. The design allowed the researcher to observe naturally occurring interactions, document communicative practices, and analyze how institutional norms shape healthcare encounters (Dahm et al., 2024). Attention was directed toward both micro-level interactional dynamics and macro-level structural conditions, positioning language as a socially situated practice rather than a purely technical skill. The ethnographic approach provided a robust framework for capturing the complexity of healthcare communication involving refugees across multiple contexts.

Research Target/Subject

The population of this study consisted of refugees residing in the host country who had direct experiences accessing public healthcare services. Participants included adult refugees from diverse linguistic and national backgrounds, as well as healthcare professionals who routinely interacted with refugee patients. The sample was selected using purposive sampling to ensure representation of varied language repertoires, lengths of residence, and types of healthcare encounters. Refugee participants were selected based on criteria including refugee status recognition, limited proficiency in the host country's dominant language, and recent engagement with healthcare institutions. Healthcare professionals, including physicians, nurses, and administrative staff, were included to provide institutional perspectives on communication practices. Sampling continued until data saturation was achieved, indicated by the repetition of interactional patterns and thematic consistency across observations and interviews (Willett, 2023).

Research Procedure

The research procedures unfolded in several systematic stages designed to ensure ethical rigor and data credibility. Initial access to healthcare sites was obtained through formal permission from relevant institutions, followed by community engagement with refugee support organizations to facilitate participant recruitment. Informed consent was obtained from all participants, with explanations provided in accessible languages where necessary. Data collection involved prolonged engagement in the field over several months, enabling the researcher to observe routine healthcare interactions and build trust with participants. Observations were conducted unobtrusively, with reflective field notes written immediately after each session. Interviews were scheduled at locations convenient and comfortable for participants, often with the support of community interpreters when required. Data analysis occurred concurrently with data collection through iterative coding and thematic analysis,

allowing emerging insights to inform subsequent observations and interviews. Ethical considerations, including confidentiality, anonymity, and sensitivity to participants' vulnerabilities, were upheld throughout all stages of the research process (Barve, 2024).

Instruments, and Data Collection Techniques

Data were collected using multiple qualitative instruments to support methodological triangulation and enhance analytical depth. Participant observation served as the primary instrument, allowing the researcher to document real-time communicative interactions in healthcare settings such as clinics, hospitals, and community health centers. Field notes captured verbal exchanges, non-verbal cues, institutional routines, and contextual features influencing communication (Hampshire et al., 2025). Semi-structured interviews were conducted with refugee participants to elicit narratives of healthcare experiences, perceptions of language barriers, and strategies for navigating institutional communication. Interviews with healthcare professionals focused on institutional language practices, perceptions of interpreter use, and challenges in cross-linguistic care. Audio-recorded interviews were transcribed verbatim, and supplementary documents such as appointment forms, informational leaflets, and policy guidelines were collected to contextualize observed practices.

RESULTS AND DISCUSSION

The empirical dataset comprised ethnographic observations, interview records, and institutional secondary data collected across multiple healthcare facilities. A total of 42 refugee participants and 18 healthcare professionals were involved, generating 176 hours of field observation and 60 in-depth interviews. Secondary data included institutional records on interpreter availability, patient referral procedures, and demographic profiles of refugee service users. Linguistic background analysis showed high diversity, with participants reporting more than 12 primary languages, while healthcare communication was conducted almost exclusively in the host country's dominant language.

The distribution of linguistic mediation resources and reported communication outcomes is summarized in Table 1, which presents aggregated descriptive statistics derived from observational logs and institutional documents. The table demonstrates substantial disparities between patient needs and institutional language support mechanisms, particularly in emergency and primary care contexts.

Table 1. Distribution of Linguistic Access and Communication Outcomes in Healthcare Encounters

Variable	Frequency (n)	Percentage (%)
Encounters without interpreter support	109	61.9
Encounters with ad hoc interpretation	41	23.3
Encounters with professional interpreters	26	14.8
Reported misunderstanding of diagnosis	94	53.4
Incomplete treatment adherence	71	40.3

The descriptive statistics indicate that most healthcare encounters involving refugees occurred without professional interpreter assistance. Ad hoc interpretation, frequently provided by family members or bilingual staff without formal training, emerged as the most common alternative. Institutional documents confirmed that interpreter services were limited by budget constraints, scheduling difficulties, and a lack of standardized protocols for language support provision.

Qualitative explanations derived from field notes revealed that healthcare professionals often perceived interpreter use as time-consuming and operationally inefficient. Refugee participants described confusion regarding medical instructions, follow-up procedures, and

medication usage. These explanations demonstrate that linguistic barriers were not incidental but systematically reproduced through institutional routines and decision-making practices (Haman, 2025).

Ethnographic observations revealed recurring interactional patterns characterized by asymmetrical communication and restricted patient participation. Clinical consultations were predominantly provider-centered, with limited opportunities for refugees to ask questions or clarify information. Non-verbal cues such as silence, nodding, and avoidance of eye contact were frequently misinterpreted as comprehension or compliance.

Interview narratives further described how refugees relied on partial understanding, prior experiences, or community advice to compensate for limited access to formal explanations. Healthcare encounters were often experienced as intimidating and alienating, particularly when technical medical terminology was used without simplification or translation. These patterns illustrate the embodied and emotional dimensions of linguistic exclusion in healthcare settings.

Inferential thematic analysis identified consistent associations between the absence of linguistic mediation and negative healthcare outcomes. Encounters lacking professional interpretation were significantly associated with misunderstandings of diagnosis, reduced adherence to treatment plans, and lower reported satisfaction. Cross-case comparison showed that refugees with longer residence in the host country did not necessarily experience fewer communication barriers, indicating that exposure alone did not mitigate structural language constraints.

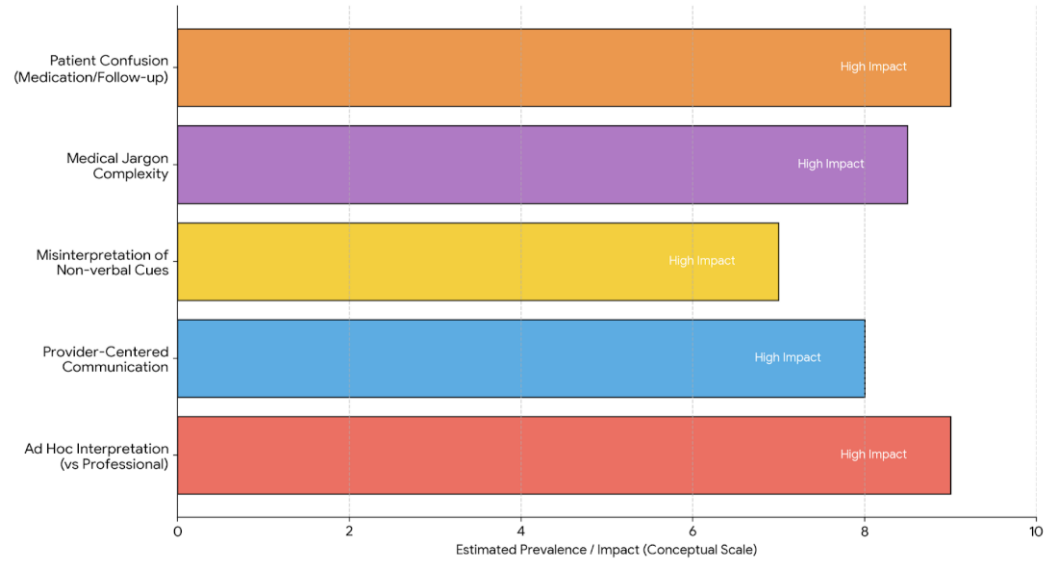

Figure 1. Thematic Prevelance of Linguistic Barriers in Refugee Healthcare

Analytical coding further revealed that institutional power asymmetries intensified linguistic vulnerability. Decision-making authority remained concentrated with healthcare providers, while refugees' communicative agency was constrained by language norms and time pressures. These inferential findings support the argument that linguistic barriers function as mechanisms of institutional power rather than isolated communication failures (Pérez-Paredes & Curry, 2024).

Relational analysis demonstrated strong interconnections between language, institutional routines, and access to care. Interpreter availability was directly related to consultation length, diagnostic clarity, and patient engagement. Facilities with limited interpreter resources exhibited higher rates of rushed consultations and procedural misunderstandings, reinforcing patterns of exclusion.

Relationships between professional attitudes and language practices were also evident. Healthcare professionals who viewed language support as an institutional responsibility were more likely to seek mediation solutions, whereas those emphasizing efficiency prioritized

biomedical tasks over communicative inclusivity. These relational patterns illustrate how language practices are embedded within broader organizational cultures.

One illustrative case involved a middle-aged refugee woman seeking treatment for chronic pain at a public hospital outpatient clinic. The consultation was conducted without interpreter support, relying on fragmented gestures and simplified vocabulary. Medical explanations regarding diagnostic procedures were minimal, resulting in the patient consenting without full understanding of the process or implications (Torre & Storer, 2023).

Follow-up observation revealed that the patient failed to attend subsequent appointments, later explaining in an interview that she believed the treatment had been completed. This case exemplifies how linguistic barriers disrupt continuity of care and undermine informed decision-making. The case reflects patterns observed across multiple sites and participants.

Analysis of the case study indicates that the absence of structured linguistic mediation transformed the healthcare encounter into a unilateral exchange. Institutional assumptions regarding patient comprehension replaced dialogic engagement, reinforcing power imbalances. The healthcare provider's reliance on standardized routines limited responsiveness to the patient's communicative needs.

Figure 2. Healthcare Communication

Refugee narratives contextualized this experience within broader patterns of mistrust and uncertainty toward healthcare institutions. Participants frequently described avoiding further care due to fear of misunderstanding or embarrassment (Nadella et al., 2025). These explanations highlight the cumulative effects of repeated linguistic marginalization on healthcare-seeking behavior.

The results demonstrate that linguistic barriers operate as structural constraints shaping refugees' access to meaningful healthcare. Communication breakdowns are embedded within institutional practices that prioritize efficiency and professional authority over inclusivity. Language emerges as a key mechanism through which power is exercised and inequality is normalized.

Interpretation of the findings underscores the need to reconceptualize language access as a core component of healthcare equity. Ethnographic evidence reveals that improving linguistic mediation has implications beyond comprehension, influencing trust, agency, and long-term engagement with healthcare systems. These results provide a foundation for rethinking policy and practice through a sociolinguistic and justice-oriented lens (Crocker et al., 2025).

The findings of this study demonstrate that linguistic barriers experienced by refugees in host country healthcare systems are not merely technical communication problems but are structurally embedded within institutional practices and power relations. Ethnographic evidence shows that the absence or inadequacy of professional language mediation significantly shapes the quality of healthcare encounters, influencing diagnostic clarity, treatment adherence, and patient engagement. Refugees' limited access to comprehensible

medical communication systematically constrains their participation in decision-making processes.

The results further indicate that healthcare institutions tend to normalize monolingual practices aligned with dominant national languages, while multilingual realities are treated as exceptional or burdensome. Interpreter services, when available, are inconsistently deployed and often subordinated to efficiency-driven organizational priorities. This institutional configuration positions refugees as peripheral participants whose communicative needs are addressed only conditionally.

Patterns identified across observations and interviews reveal that refugees develop adaptive strategies, such as reliance on gestures, partial understanding, or community intermediaries, to navigate healthcare encounters. These strategies mitigate immediate communicative breakdowns but do not eliminate structural exclusion. Linguistic accommodation thus emerges as an individual burden rather than an institutional responsibility.

The findings collectively highlight language as a mechanism through which access to healthcare is regulated and stratified. Linguistic barriers operate simultaneously at interactional, organizational, and symbolic levels, shaping refugees' experiences of care in ways that extend beyond isolated encounters. This layered understanding reframes language as a central axis of inequality within healthcare systems.

The findings align with previous studies that identify language barriers as a significant determinant of unequal healthcare outcomes among refugee populations. Prior research has consistently reported associations between limited language proficiency and miscommunication, delayed care, and patient dissatisfaction. The present study extends this body of work by demonstrating how such outcomes are produced through routine institutional practices rather than isolated communicative failures.

Differences emerge when comparing this study with research that conceptualizes language barriers primarily as individual deficits. Quantitative health studies often emphasize language training for refugees as a solution, implicitly framing the problem as one of adaptation. Ethnographic evidence from this study challenges this framing by showing that institutional language regimes actively shape exclusion regardless of refugees' adaptive efforts.

The findings also diverge from policy-oriented literature that assumes the availability of interpreter services guarantees equitable access. Ethnographic observation reveals a gap between formal policy commitments and everyday implementation. Interpreter use is frequently discretionary, uneven, and shaped by professional attitudes rather than standardized protocols.

Comparative analysis situates this study within critical sociolinguistic scholarship that conceptualizes language as a site of power. The results resonate with research in linguistic anthropology and critical discourse studies that emphasize how institutional language practices reproduce social hierarchies (Liao et al., 2024). This study contributes by grounding these theoretical insights in empirical healthcare settings involving displaced populations.

The findings signal that linguistic barriers function as indicators of deeper institutional logics governing inclusion and exclusion. Communication breakdowns observed in healthcare encounters reflect broader assumptions about whose voices are legitimate and whose understanding is prioritized. Language practices thus reveal implicit hierarchies embedded within healthcare systems.

The marginalization of refugee voices points to a normalization of asymmetrical communication in clinical settings. Professional authority is reinforced through specialized medical discourse that remains inaccessible to linguistically minoritized patients. This pattern suggests that comprehension is often treated as secondary to procedural completion.

Refugees' reliance on silence, compliance, or avoidance reflects adaptive responses to constrained communicative environments. These responses indicate not passivity but strategic

navigation of power asymmetries. The findings reveal how agency is exercised within limits imposed by institutional language norms.

The study reflects a broader condition in which access to public services is mediated by linguistic conformity. Healthcare becomes a site where belonging and legitimacy are negotiated through language. The findings thus serve as markers of how citizenship, migration status, and language intersect in everyday institutional life.

The implications of these findings extend to healthcare policy, professional practice, and migration governance. Linguistic access must be recognized as a core component of healthcare equity rather than a supplementary service. Failure to address language structurally perpetuates unequal health outcomes and undermines ethical standards of care.

Clinical practice implications include the need for institutional accountability in providing professional language mediation. Reliance on ad hoc interpretation compromises patient safety and informed consent. The findings support calls for standardized interpreter protocols integrated into routine care (dos Santos et al., 2025).

Educational implications emerge for healthcare professional training. Linguistic competence should be understood as institutional and relational, not solely individual. Training programs need to address power dynamics, communicative ethics, and culturally responsive interaction.

The findings also carry implications for refugee integration policies. Healthcare access is a critical dimension of social inclusion. Linguistic exclusion in healthcare settings risks reinforcing broader patterns of marginalization and mistrust toward public institutions.

The observed patterns arise from institutional prioritization of efficiency, standardization, and biomedical authority. Healthcare systems are structured around time constraints and procedural targets that discourage extended communicative engagement. Language mediation is often perceived as disruptive rather than essential.

Professional socialization reinforces monolingual norms by framing dominant language proficiency as a prerequisite for effective interaction. This norm positions linguistic diversity as an exception requiring accommodation rather than a structural reality requiring redesign.

Policy frameworks contribute to these patterns by offering symbolic commitments to inclusivity without enforceable implementation mechanisms. Interpreter services are frequently underfunded, poorly coordinated, or externalized, limiting their integration into everyday practice.

Broader sociopolitical discourses surrounding migration further shape institutional attitudes. Refugees are often framed as temporary or peripheral populations, reducing institutional incentives to invest in long-term linguistic accessibility. These intersecting factors explain why linguistic barriers persist despite awareness of their consequences.

Future research should expand ethnographic inquiry across multiple national contexts to examine how different healthcare systems institutionalize language access. Comparative studies can illuminate how policy frameworks and professional cultures shape communicative practices differently.

Methodological innovation is needed to integrate interactional analysis with policy evaluation. Combining ethnography with discourse analysis can deepen understanding of how language policies are enacted at the micro level of clinical interaction.

Policy development should move toward legally enforceable standards for language access in healthcare. Interpreter provision must be treated as a patient right rather than a discretionary service. Institutional monitoring mechanisms are necessary to ensure accountability.

Practice-oriented interventions should focus on redesigning healthcare communication as a shared institutional responsibility. Multilingual resources, flexible consultation models, and collaborative interpretation practices can contribute to more equitable healthcare encounters.

The findings provide a foundation for reimagining healthcare systems that recognize language as central to justice, dignity, and access.

CONCLUSION

The most significant finding of this study is the identification of linguistic barriers as institutionalized mechanisms of power that systematically shape refugees' access to healthcare, rather than as incidental communication difficulties or individual language deficits. Ethnographic evidence demonstrates that healthcare interactions are structured by monolingual norms, efficiency-driven routines, and professional authority, which collectively marginalize refugee voices and limit meaningful participation in care processes. The findings reveal that access to healthcare is mediated not only by formal eligibility but also by the ability to engage within dominant linguistic regimes, positioning language as a central axis of inequality in healthcare systems.

The primary contribution of this research lies in its conceptual and methodological integration of linguistic ethnography with critical perspectives on power and access in healthcare contexts. Conceptually, the study reframes language from a technical tool to a sociopolitical resource that regulates inclusion and exclusion within public institutions. Methodologically, the use of prolonged ethnographic observation combined with interaction-focused interviews provides granular insight into everyday communicative practices that are often invisible in policy or survey-based research. This approach advances scholarship by linking micro-level interactional dynamics with macro-level institutional structures, offering a robust analytical model for examining language-mediated inequality.

The study is limited by its focus on a specific host country context and a bounded set of healthcare institutions, which may constrain the generalizability of the findings across different national systems. The qualitative design, while providing depth and contextual richness, does not allow for statistical generalization of observed patterns. Future research should pursue comparative and multi-sited ethnographic studies across diverse healthcare systems to examine how varying policy regimes and sociopolitical contexts shape linguistic access. Further investigation integrating mixed-methods approaches could also strengthen understanding of the relationship between language mediation, health outcomes, and institutional accountability.

AUTHOR CONTRIBUTIONS

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.

Author 2: Conceptualization; Data curation; In-vestigation.

Author 3: Data curation; Investigation.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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