Original Article

Healthy Lifestyle Practice among a Selected Rural Community of Sirajganj District

Sailendra Nath Biswas[1], Rubaiyat Farzana Hussain[2], Mohd. Raisul Hasan[3], Taslima Akber Happy[4], Mahaidhe Hassan[5], Md. Mahmudul Haque[6].

Abstract

Background: *Healthy lifestyle is one which helps keeping and improving health and well-being. This means maintaining hygiene, eating balanced diet, getting regular exercise, avoiding tobacco and drugs and getting adequate rest and recreation. Objective(s): To assess healthy lifestyle practice among selected rural-community of Sirajganj district.* ***Materials and methods:*** *This cross-sectional study was conducted among people living in selected villages of Sirajganj. A total of 490 respondents were interviewed face-to-face using a semi-structured questionnaire.* ***Results:*** *Among the respondents 73.3% were female, mean age was 40.29 ± 15.84 years and 56.9% were literates. Mean monthly income was 10812.30±10039.63 taka. Majority (97.3%) said that they wash their hands 'before eating', 89.0% said 'after coming from washroom', 18.6% mentioned of 'after coming in contact with sick person', 3.9% said 'after playing and 3.1% mentioned of 'after holding coins'. About 84% used soap and water for hand washing. One third (33.9%) washed their hands for a period of more than 20 seconds. About 28% consume meat, fish, and egg daily. Majority (77.8%) consumed extra salt daily, 81.8% never took part in playing of doing exercises and 9.8% were current smokers.* ***Conclusion:*** *Subjects were rural-people and showed lack of many elements of healthy lifestyle. Proportion of tobacco-use was less. Yet a big proportion consumes extra salt, don't do any exercise, don't eat fruits and cannot eat protein rich food.*

Key words: *Healthy lifestyle, practice, rural community, Sirajganj.*

Date of received: *16.09.2020.*

Date of acceptance: *25.11.2020.*

KYAMC Journal.2021;11(4):193-198.

DOI: https://doi.org/10.3329/kyamcj.v11i4.51996

Introduction

A healthy lifestyle is one which helps keeping and improving people's health and well-being.[1] Many government and non-governmental agencies work at promoting healthy lifestyles. They measure the benefits with critical health numbers, including weight, blood glucose, blood pressure, and blood cholesterol. Healthy living should be a lifelong effect. The ways to being healthy include eating healthy, performing regular physical activities, weight management and management of stress.[1,2]

Good health is not just the absence of disease or illness, it is a state of complete physical, mental and social well-being. This means eating a balanced diet, getting regular exercise, avoiding tobacco and drugs and getting plenty of rest and recreation. Healthy habits help avert certain health disorders, such as heart disease, stroke, and high blood pressure. If we take care of ourselves, we can keep our cholesterol and blood pressure within a safe range. This keeps our blood flowing smoothly, decreasing our risk of cardiovascular diseases.

To ensure equitable healthcare to every residing human in Bangladesh, an extensive network of health service has been established in Bangladesh. It is a winding form of healthcare network spread across the country ranging from policy-making bodies to healthcare facilities down to the community level. Infrastructure of healthcare facilities can be distributed into three levels: Medical University, Medical College Hospitals, Specialized Hospitals exist at Tertiary Level. District Hospitals, Mother and Child Welfare Centers as Secondary Level.

1. Professor (cc), Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
2. Associate Professor, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
3. Lecturer, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
4. Associate Professor, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
5. Lecturer, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
6. Professor, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.

Correspondence: Sailendra Nath Biswas, Professor, Department of Community Medicine, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh. Cell phone: 01711704307, E-mail: snbiswas2003@yahoo.com

Upazila Health Complex, Union Health and Family Welfare Centers, Community Clinics (Lowest-level healthcare facilities) are the Primary Level healthcare providers. Several NGOs (Non-Government Organization) and private institutions also contribute to this intricate network.[3] In recent times, our country is making important gains in health outcomes. In terms of providing primary health care, the country has made important steps and most of the health indicators are showing steady advances and the health status of the people has improved. Currently a number of steps have been taken by the government to improve its leadership and regulatory role to improve equity and quality of services, especially to reach the poor and the disadvantaged group of population.[4]

In Bangladesh the proportion of people maintaining healthy lifestyle is not known. A number of studies on personal hygiene among different groups were conducted but no countrywide survey on healthy lifestyle was done before. Now it is time to conduct a survey throughout the country which might help in knowing the gaps in expectation of performing healthy lifestyle and the actual situation. Eventually there might be intervention to improve the current status of healthy lifestyle among the people of Bangladesh.

Materials and Methods

This descriptive cross sectional study was conducted among the people living in Jugnidaha, Nalua, Barabil and Tetierkanda Villages of Shahjadpur upazila in Sirajganj district. Data were collected during the December 2019 and January 2020. A total of 490 respondents were interviewed face to face using a semi-structured questionnaire. Convenience sampling technique was adopted. Collected data were checked, cleaned and analyzed with SPSS software. The frequency tables were made in Microsoft Word and the figures were made using Microsoft Excel.

Results

Table I: Socio-demographic characteristics of the respondents n=490

Attribute	Frequency	Percent
Sex		
Male	131	26.7
Female	359	73.3
Age (years)		
14-25	112	22.9
26-40	170	34.7
41-55	128	26.1
56-70	63	12.9
71-90	17	3.5
Mean ± SD: 40.29 years±15.84 years		
Education		
Illiterate	211	43.1
Literate	279	56.9
Occupation		
House wife	317	64.7
Self-employed	35	7.1
Laborer	36	7.3
Business	20	4.1
Rickshaw puller / CNG driver	18	3.7
Weaving worker	14	2.9
Service	11	2.2
Student	18	3.7
Others	21	4.3
Family type		
Nuclear family	360	73.5
Joint/Extended family	130	26.5

Among the total 490 respondents 359 (73.3%) were female, Mean age ± SD was 40.29 ± 15.84 years, 279 (56.9%) were literates, 317 (64.7%) were housewives and 360 (80.8%) were from nuclear families (Table I)

Table II: Distribution of the respondents by monthly income

Monthly income (Taka)	Frequency	Percent	Statistics
5,000-20,000	453	92.4	Mean=10812.30
20,001-40,000	29	5.9	Median=8000.0
40001-100,000	8	1.6	Mode=5000.0
Total	**490**	**100.0**	SD ±10039.635 Minimum=5,000 Maximum=100,000

Table II opines respondents' monthly income. Among the respondents 453 (92.4%) had monthly income 5,000-20,000 taka, 29 (5.9%) had taka 20,001-40,000 and 8 (1.6%) had 40001-100,000. Mean monthly income was 10812.30 taka with standard deviation ±10039.63 taka. The minimum and maximum were 5,000 taka and 100,000 taka respectively.

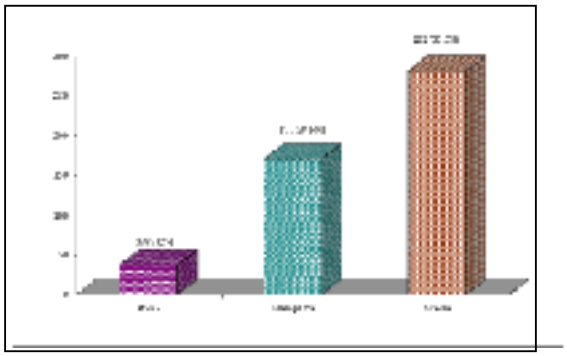

Figure 1: Distribution of the respondents by house type

Regarding house type it was seen that 282 (57.3%) respondents resided in kancha houses, 171 (34.9%) in semi-pucca houses and the rest 37 (7.6%) resided in pucca houses (Figure 1).

Table III: Practice of hand washing by the respondents

Time of hand washing (Practice)	Frequency	Percent
Before eating	476	97.3%
After coming from washroom	435	89.0%
Before preparing food	301	61.6%
After cleaning stool urine of children	304	62.2%
After coming home from outside	124	25.4%
After holding coins	15	3.1%
After playing	19	3.9%
After coming in contact with pets	154	31.5%
After coming in contact with sick person	91	18.6%

* Multiple responses

Table III opines respondents' practices on hand washing. Among them 476 (97.3%) said that they wash their hands 'before eating', 435 (89.0%) said 'after coming from washroom', 304 (62.2%) said 'After cleaning stool urine of children', 301 (61.6%) mentioned 'before preparing food', 124 (25.4%) mentioned 'after coming home from outside' 154 (31.5%) said 'after coming in contact with pets' 91 (18.6%) mentioned of 'after coming in contact with sick person', 19 (3.9%) said 'after playing and 15 (3.1%) mentioned of 'after holding coins'. Multiple responses existed.

Table IV: Distribution of the respondents by material used for hand washing

Material used for hand washing	Frequency	Percent
Soap and water	408	83.3
Only water	38	7.8
Ash and water	25	5.1
Liquid soap	15	3.1
Hand sanitizer	1	.2
Mud and water	3	.6
Total	**490**	**100.0**

Majority (83.3%) of the respondent used soap and water for hand washing. Only water was used by 38 (7.8%), and ash and water by 25 (5.1%) respondents. Fifteen (3.1%) respondents used sanitizer for hand cleaning (Table IV).

Table V: Distribution of the respondents by duration of hand washing

Duration of hand washing	Frequency	Percent
Less than 10 seconds	86	17.6
10–20 seconds	238	48.6
More than 20 seconds	166	33.9
Total	**490**	**100.0**

Duration of hand washing by the respondents is shown in (Table V) Majority (48.6%) mentioned of 10-20 seconds and 86 (17.6%) mentioned Less than 10 seconds. About one third (166) said that they wash their hands for a period of more than 20 seconds.

Table VI: Distribution of the respondents by sources of water for washing food items and cooking n=490

Attribute	Frequency	Percent
Source of water for washing food items		
Tube well	438	89.4
Pond	2	0.4
River	1	0.2
Supply water	5	1.0
Filter water	44	9.0
Source of water for cooking		
Tube well	424	86.5
Pond	4	0.8
Supply water	6	1.2
Filter water	51	10.4
Well	5	1.0

For washing of food items 438 (89.4%) respondents mentioned of tube well water and 44 (9.0%) mentioned filter water. Five (1.0%) said that they used supply water, 2 (0.4%) used pond water and one (0.2%) used pond water. For cooking majority (86.5%) of the respondents used tube well water. Filter water was used by 51 (10.4%), supply water by 6 (1.2%), well water by 5 (1.0%) and pond water by 4 (0.8%) respondents (Table VI).

Table VII: Distribution of the respondents by frequency of consuming meat, fish, and egg; vegetables, fruits and milk n=490

Attribute	Frequency	Percent
Frequency of consuming meat, fish, and egg		
Daily	134	27.3
Every alternate day	69	14.1
Twice a week	86	17.6
Once a week	64	13.1
Occasionally	134	27.3
Do not consume meat, fish, egg	3	0.6
Frequency of consuming vegetables		
Daily	381	77.8
Every alternate day	56	11.4
Twice a week	22	4.5
Once a week	12	2.4
Occasionally	16	3.3
Do not consume vegetables	3	0.6
Frequency of con fruits suming		
Daily	40	8.2
Every alternate day	19	3.9
Twice a week	37	7.6
Once a week	53	10.8
Occasionally	289	59.0
Do not consume fruits	52	10.6
Frequency of consuming milk		
Daily	163	33.3
Every alternate day	17	3.5
Twice a week	26	5.3
Once a we ek	29	5.9
Occasionally	196	40.0
Do not consume milk	59	12.0

About frequency of consuming meat, fish, and egg 134 (27.3%) respondents mentioned of consuming daily, 69 (14.1%) on alternate days, 86 (17.6%) twice a week, 64 (13.1%) once a week, another 134 (27.3%) mentioned occasionally and 3 (0.6%) said of not consuming meat, fish and egg. About frequency of consuming vegetables 381 (77.8%) respondents mentioned of consuming daily, 56 (11.4%) on alternate days, 22 (4.5%) twice a week, 12 (2.4%) once a week, 16 (3.3%) mentioned occasionally and 3 (0.6%) said of not consuming vegetables. About frequency of consuming fruits 40 (8.2%) respondents mentioned of consuming daily, 19 (3.9%) on alternate days, 37 (7.7%) twice a week, 53 (10.8%) once a week, 289 (59.0%) mentioned occasionally and 52 (10.6%) said of not consuming fruits. About frequency of consuming milk 163 (33.3%) respondents mentioned of consuming daily, 17 (3.5%) on alternate days, 26 (5.3%) twice a week, 29 (5.9%) once a week, 196 (40.0%) mentioned occasionally and 59 (12.0%) said of not consuming milk (Table VII).

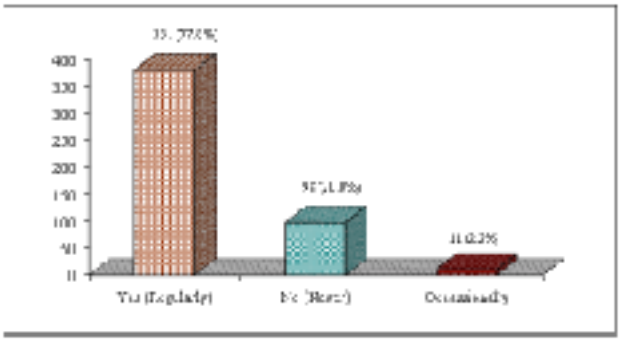

Figure 2: Distribution of the respondents by extra salt consumption

Majority [381 (77.8%)] of the respondents mentioned that they consumed extra table salt daily. One fifth [98 (20.0%)] never consume it and the rest 11 (2.2%) consume it occasionally (Figure 2).

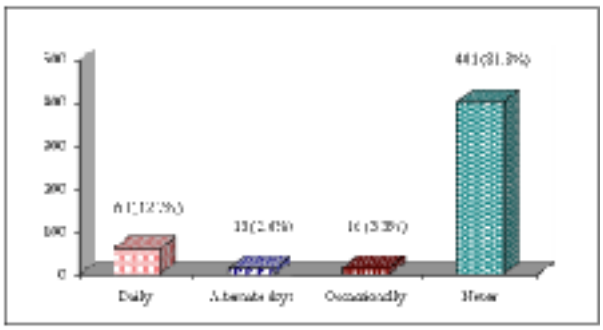

Figure 3: Distribution of the respondents by playing / doing exercises n=490

Regarding playing / doing exercises it was seen that majority [401 (81.8%)] respondents never took part in playing of doing exercises. However, 60 (12.2) mentioned of playing / doing exercises daily, 12 (2.6%) on alternate days and the rest mentioned occasionally (Figure 3). ‘

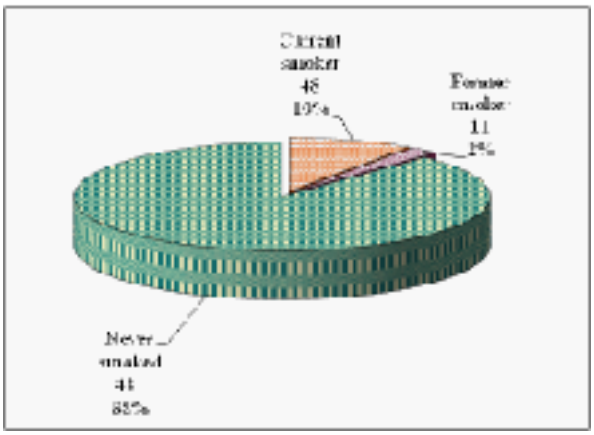

Figure 4: Distribution of the respondents by smoking status n=490

Figure 4 reveals that 431 (88.0%) never smoked, 11 (2.2%) were former smokers and 48 (9.8%) were current smokers.

Table VIII: Distribution of the respondents by watching television

Pattern of watching TV	Frequency	Percent
Daily more than 3 hours	31	6.3
Daily 2 -3 hours	54	11.0
Daily 1 -2 hours	114	23.3
Daily less than 1 hour	61	12.4
Occasionally	32	6.5
Do not watch television	198	40.4
Total	**490**	**100. 0**

Among the respondents 198 (40.4%) mentioned that they do not watch television. Watching television daily 1-2 hours was mentioned by 114 (23.3%), daily less than 1 hour by 61 (12.4%), daily 2-3 hours by 54 (11.0%) and daily more than 3 hours by 31 (6.3%) respondents. Thirty (6.5%) respondents mentioned that they watch television occasionally (Table VIII).

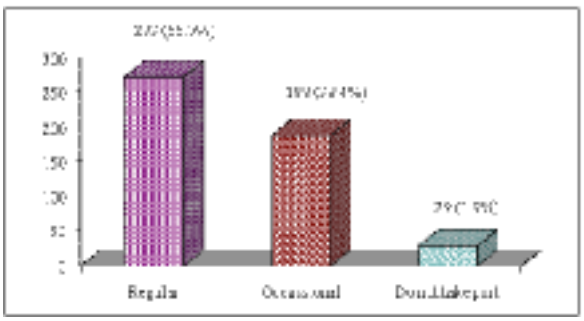

Figure 5: Distribution of the respondents by taking part in religious activities n=490

Majority [272 (55.7%)] of the respondents mentioned that they took part in religious activities daily, 188 (38.4%) mentioned occasionally and the rest 29 (5.9%) said that they do not take part in religious activities (Figure 5).

Discussion

The study was conducted to assess healthy lifestyle practice among a selected rural community of Sirajganj district. A total of 490 respondents having age from 14 to 90 years were interviewed face-to-face using a semi-structured questionnaire. Mean age was found 40.29 years with standard deviation ±15.840 years. Majority (73.3%) were female and the rest 26.7% were male. Among Bangladeshi population male constitute 50.6% and female 49.4%.[5] Finding of the study does not correspond with the national figure due to the fact that data collection was done during 10 am to 1 pm in a working day and majority of male members in the families were out of home for their work. Nearly half (43.1%) of the respondents were illiterate and 56.9% had education. Literacy rate, adult total (% of people ages 15 and above) in Bangladesh was reported at 73.91 % in 2018 according to the World Bank collection of development indicators, compiled from officially recognized sources.[6] About occupation it was found that 64.7% were housewives. It was due to the fact that at the time of data collection mainly housewives could be attended. About three fourth (73.5%) came from nuclear families. Nowadays, "family" refers to nuclear family and existence of extended family is very rare in Bangladesh. From 1990s, the rate of breaking down of extended families to nuclear families has been increasing.[7] Mean monthly income was 10812.30 taka with standard deviation ±10039.635 taka. It is slightly higher than mean income as shown in the data as per 'Bangladesh Household Income and Expenditure Survey: Household Income per Month' which shows 8,795.000 BDT.[8]

Regarding practice on time of hand washing 97.3% said that they wash their hands 'before eating', 89.0% said 'after coming from washroom', 62.2% said 'After cleaning stool urine of children', 61.6% mentioned 'before preparing food', 25.4% mentioned 'after coming home from outside' 31.5% said 'after coming in contact with pets' and 18.6% mentioned of 'after coming in contact with sick person', 3.9% said 'after playing and 3.1% mentioned of 'after holding coins'. Poor hand washing practice was seen 'after coming home from outside', after coming in contact with pets', 'after coming in contact with sick person', 'after playing' and 'after holding coins'. Only 3.1% wash hand after holding coins. In a study it was seen that currency notes collected from fish sellers, meat sellers, vegetable sellers, food vendors, office workers, students, bus conductors, beggars and shop keepers with 42.85%-85.71% Escherichia coli, 28.57% - 92.85%, Klebsiella, 9.09%-53.84% Staphylococcus aureus,, 0% - 42.85% Salmonella sp, 0%-28.57% Vibrio cholerae, 0% - 25% Bacillus sp and, 0%-28.57% Pseudomonas sp. respectively.[9] Majority (83.3%) of the respondent used soap and water for hand washing. Only water was used by 7.8%, and ash and water by 5.1% respondents. Bilqis Hoque in her study found 41% of rural women washed their hands using only water. However, most women rubbed their hands on the ground, or used soil, and rinsed them with water during post-defecation hand washing. Most women claimed that they could not afford to buy soap.[10]

In another study Amal K Halder found that 51% respondents demonstrated washing both hands with soap after defecation, in structured observation, only 33% of caregivers of children and 14% of all persons observed washed both hands with soap after defecation.[11] Regarding duration of hand washing majority (48.6%) mentioned of 10-20 seconds. Ideally it should be at least 20 seconds.[12]

Regarding consumption of different types of food items it was seen that 27.3% consume meat, fish, and egg occasionally and another 27.3% consume daily. Proportion of vegetable consumption was higher (77.8% consumed daily). About fruits and milk consumption it was seen that 59.0% consumed fruits occasionally and 40.0% consumed milk occasionally. As vegetables are relatively cheaper in comparison to meat, fish, milk and fruits, proportion of regular consumer of vegetable is higher (77.8%). More than three fourth (77.8%) of the respondents mentioned that they consumed extra table salt daily. High dietary salt intake is an important risk factor of hypertension and other non-communicable diseases (NCD). Therefore it has been identified as an indicator of global monitoring framework for NCD control.[13] In a study about extra salt intake in Bangladesh it was seen that sixty-nine percent (94% in rural and 44% in urban areas) were habituated to take extra salt during their meals.[14]

Regarding playing /doing exercises it was seen that majority (81.8%) respondents never took part in playing of doing exercises. In a study it was seen that the overall country wide prevalence of low physical activity (PA) was 34.5%.[15]

Majority (88.0%) of the respondents never smoked, 2.2% were former smokers and 9.8% were current smokers. Only 11.8% were smokeless tobacco consumers. These figures are less than national survey on tobacco consumption. Global adult tobacco survey Bangladesh fact sheet 2017 shows that 35.3% of Bangladeshi adult irrespective of sex use tobacco in any form.[16]

About recreation about 60% respondents watch television. Televisions are available in most of the houses now a day and it is the most important source of recreation in rural Bangladesh.

Majority (55.7%) of the respondents mentioned that they took part in religious activities daily, 38.4% mentioned occasionally and 5.9% said that they do not take part in religious activities.

The World Health Organization (WHO) discerns four dimensions of health, namely physical, social, mental, and spiritual health. More than 3000 empirical studies have examined relationships between religion and health, including more than 1200 in the 20th century.[17]

It is important for healthcare to include the cultural and spiritual needs of the patient. Healthcare professionals should be empowered with the knowledge and skills to respond to the needs of patients and their families at an intensely stressful time.[18]

Conclusion

Living a healthy lifestyle can help prevent chronic diseases and long-term illnesses. Physical fitness is not the sole basis of

being healthy; being healthy means being mentally and emotionally fit. Healthy lifestyle is to eat health and nutritious food, regular workouts, proper sleep, quit smoke and alcohol and staying happy and positive. Being healthy should be part of our overall lifestyle. Maintaining a healthy lifestyle is not much difficult, nor does it require a lot of work. Just keeping doing what we do and apply the tips of staying healthy can ensure us a healthy life.

Acknowledgement

We are grateful to the people of Jugnidaha, Nalua, Barabil and Tetierkanda villages of Shahjadpur upazila in Sirajganj district for their hospitality and kind cooperation during data collection without which conduction of this study was quite impossible.

Referrences

1. Centre for Research and Information.Healthcare Services for All: the Bangladesh Story [Internet]. Dhaka, Bangladesh: CRI; [2014]. Available at https:// cri. org. bd/ 2014/11/02/healthcare-services-for-all-the-bangladesh-story/

2. Action Against Hunger.WASH BASELINE Knowledge, Attitude and Practice Survey Report Gogrial West County, Warrap state South Sudan [Internet]. USA: Action Against Hunger; [2012]. Available from: https:// www. act iona gainsthunger.org/sites/default/files/publications/WASH_Baseline_Knowledge_Attitude_and_Practice_Survey_Report-_Gogrial_West_County_South_Sudan_05.2012_0.pdf

3. Icddr,b, WaterAid Bangladesh, Policy Support Unit (PSU). Bangladesh National Hygiene Baseline Survey [Internet]. Dhaka Bangladesh: icddr,b,wateraid,psu; [2014]. Available from: https:// www. psb. gov. bd/ policies/ bnhbs.pdf

4. Kigaru DMD, Loechl C, Moleah T et al. Nutrition knowledge, attitude and practices among urban primary school children in Nairobi City, Kenya: a KAP study. BMC Nutr 1, 44 (2015). https://doi.org/10.1186/s40795-015-0040-8

5. Countrymeters. Bangladesh Population [Internet]. Countrymeters;[2019]. Available from: https:// country meters. info/en/Bangladesh.

6. Trading economics. Bangladesh - Literacy Rate, Adult Total (% Of People Ages 15 And Above) [Internet]. Trading economics [2019]. Available from: https:// tradingeconomics. com/bangladesh/literacy-rate-adult-total-percent-of-people-ages-15-and-above-wb-data.html.

7. Rezvi MR. Why extended family breaking down in Bangladesh [Internet]. Dhaka Bangladesh:Daily sun; [2018]. Available from: https://www.daily-sun.com/post/339513/Why-extended-family-breaking-down-in-Bangladesh

8. Bangladesh Household Income and Expenditure Survey: Household Income per Month. https:// www. ceicdata. com/en/bangladesh/household-income-and-expenditure-survey-household-income-per-month

9. Ahmed MSU, Parveen S, Ahmed U, Nasreen T, Feroza B. Evaluation of the Microbial Contamination of Bangladesh Paper Currency Notes (Taka) in Circulation. Available at: https://www.researchgate.net/ publication/228362455

10. Hoque B. Handwashing Practices and Challenges in Bangladesh. ?International Journal of Environmental Health Research 13 Suppl 1(1): S81-7· July 2003. DOI: 10.1080/ 0960312031000102831. Source: Pub Med

11. Halder AK, Tronchet C, Akhter S, Bhuiya A, Johnston R, Luby SP. Observed hand cleanliness and other measures of hand washing behavior in rural Bangladesh. BMC Public Health 2010, 10:545. Available at http:// www. biomed central.com/1471-2458/10/545.

12. World Health Organization. Hand Hygiene: Why, How & When [Internet]. Geneva: WHO; [2009]. Available from: https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf

13. World Health Organization. Non communicable Diseases Global Monitoring Framework: Indicator Definitions and Specifications. Available at: http://www.who. int/ nmh/ ncd-tools/ indicators / GMF_ Indicator_ Definitions_ Version_ NOV 2014. pdf. Accessed March 2, 2016.

14. Zaman MM, Choudhury SR, Ahmed J, Khandaker RK, Rouf MA, Malik A. Salt Intake in an Adult Population of Bangladesh. Glob Heart. 2017; 12(3):265-266. doi:10.1016/j.gheart.2016.05.005.

15. Moniruzzaman M, Zaman MM, Islam MS, Ahsan HAMN. Physical activity levels in Bangladeshi adults: Results from STEPS survey 2010, Public Health 137:131-138· April 2016 with?834 Reads. DOI: 10. 1016/ j.puhe. 2016. 02.028.

16. Bangladesh Bureau of Statistics. Global adult tobacco survey Bangladesh 2017 [Internet]. Dhaka: BBS; [2018]. Available from: http:// bbs. portal. gov. bd/ sites/ default/files/files/bbs.portal.gov.bd/page/57def76a_aa3c_46e3_9f80_53732eb94a83/Preliminary%20Report%20on%20GATS%20Bangladesh%202017.pdf

17. Koenig, Harold G.; McCullough, Michael E.; Larson, David B. (2001). Handbook of Religion and Health (1st ed.). New York: Oxford University Press. ISBN 978-0-19-511866-7. OCLC 468554547

18. Swihart DL, Martin RL. Cultural Religious Competence in Clinical Practice. [Updated 2020 Mar 27]. In: Stat Pearls [Internet]. Treasure Island (FL): Stat Pearls Publishing; 2020 Jan-. Available from: https:// www. ncbi. nlm. nih. gov/books/NBK493216/