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Caring culture in interprofessional collaboration in hospitals: A scoping review

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Abstract

Background: Interprofessional Collaboration (IPC) is essential for managing the complexity of hospital care, yet its effectiveness depends on organizational culture and the quality of interprofessional relationships. Prior literature has largely examined communication, leadership, or caring separately, leaving the structural role of caring culture in IPC insufficiently mapped.

Purpose: To map evidence on the role of caring culture in hospital IPC and identify its facilitators, barriers, and implications.

Method: This scoping review followed the Arksey and O'Malley framework, Levac's refinements, and PRISMA-ScR guidance. PubMed/MEDLINE, Scopus, CINAHL, Google Scholar, and Portal Garuda/SINTA were searched for publications from 2021–2025. Of 1,240 initial records, 320 titles/abstracts were screened, 80 full texts assessed, and 55 articles charted through structured extraction and thematic synthesis.

Results: Seven theme clusters emerged, led by effective communication/SBAR (21.8%), organizational culture, trust, and collaborative leadership (18.2%), and specific clinical settings and other themes (16.4%). Regional variation, professional hierarchy, resource constraints, and inconsistent outcomes were also reported. The novelty lies in mapping caring culture as a structural enabler linking organizational context, communication, and IPC practice.

Conclusion: Caring culture may support IPC, but the relationship cannot yet be interpreted causally and requires empirical testing.

Keywords: Caring Culture; Hospital; Interprofessional Collaboration; Scoping Review.

INTRODUCTION

Patient safety remains a global issue that demands cross-professional coordination. The World Health Organization (World Health Organization, 2023) estimates that approximately one in ten patients experiences harm while receiving healthcare services, more than three million deaths occur each year due to unsafe care, and more than half of that harm is preventable. These data indicate that safety does not depend solely on individual competence, but also on system design, communication, and the ability of health workers to function as a single team. This is the rationale for treating IPC as a system-level concern in this review, rather than as a matter of individual interpersonal skill. Maeda & Socha-Dietrich

(2021) similarly positions patient-centered communication and interprofessional collaboration as cross-professional competencies required by future health workers, reinforcing the policy relevance of mapping how such collaboration is culturally supported. The Joint Commission's (2024) sentinel event report affirms the same point by reading safety incidents as a system problem rather than an individual failure. Its count of 1,411 reviewed events in 2023 is voluntarily reported and therefore not an epidemiological estimate; it is cited here only as contextual evidence that collaboration failures are formally tracked as a patient-safety priority, not as a generalizable incidence figure. In line with this

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system-level framing, the World Health Organization's Global Patient Safety Action Plan 2021-2030 explicitly calls for strengthening teamwork and communication competencies as a strategic objective for eliminating avoidable harm (World Health Organization, 2021).

Interprofessional Collaboration (IPC) refers to the process in which health workers from different professional backgrounds work together with patients, families, and communities to produce coordinated care (World Health Organization, 2010). Synthesized evidence shows that facilitators of IPC include open communication, role clarity, trust, leadership, and organizational support, while barriers include professional hierarchy, workflow fragmentation, identity conflict, time constraints, and resource limitations (Gleeson et al., 2023; McLaney et al., 2022; Schot et al., 2020; Wei et al., 2022). A Cochrane systematic review of IPC interventions similarly concluded that collaborative-practice interventions can improve healthcare processes and outcomes, but that the evidence base remains heterogeneous in design and outcome measurement (Reeves et al., 2017), while a review of IPC competency frameworks noted that most existing models emphasize procedural and communication competencies without a corresponding relational or values-based competency domain (Vaseghi et al., 2022). Accordingly, the use of communication tools such as Situation, Background, Assessment, Recommendation (SBAR) is necessary, but not sufficient when applied within an environment that is not psychologically safe or that does not respect the contributions of other professions.

Caring culture in this study is understood as a pattern of shared values that places empathy, respect for dignity, attention to the needs of patients and staff, and mutually trusting relationships as the foundation of organizational behavior. This concept is rooted in Human Caring theory, which emphasizes the quality of human relationships in care (Watson, 2008), but its application is not limited to nurse-patient interaction. Work environment, managerial competence, leadership support, and nurse-physician relationships have been reported to be associated with caring behavior (Arsat et al., 2022), while IPC can serve as a mechanism linking the work environment with job satisfaction and nurse-perceived safety outcomes (Labrague et al., 2022). These findings direct caring

culture away from an individual concept toward a relational and organizational attribute.

Because this review synthesizes several related but distinct constructs, operational boundaries are stated explicitly. *Caring culture* is treated as the shared, organization-level pattern of values and norms (empathy, respect, trust, attentiveness to patients and staff) described above; *caring behavior* refers to the observable, individual-level enactment of that culture (e.g., a specific act of attentiveness or responsiveness by a clinician); and *Human Caring* denotes the specific theoretical framework (Watson, 2008) from which both constructs are conceptually derived. Interprofessional Collaboration (IPC), in turn, is treated as a team-level process outcome (coordinated, joint decision-making across professions) that is conceptually distinct from, but hypothesized to be enabled by, caring culture. These four constructs are related because caring culture is proposed as the organizational condition, caring behavior as its individual manifestation, and Human Caring theory as their shared theoretical anchor, together forming the relational climate in which IPC processes such as communication and shared decision-making occur; they are nonetheless analytically separable, and studies were retained for synthesis only where the text linked at least one caring-related construct to an IPC-related process or outcome, rather than merely mentioning both terms independently.

Previous research reveals three tendencies. First, hospital communication studies emphasize the need for communication structure, mutually respectful relationships, and the opportunity to voice clinical concerns (Gleeson et al., 2023). Second, studies on IPC implementation in Indonesian teaching hospitals show that the factors influencing collaboration are distinctive to each institution and are related to systems, culture, and interprofessional relationships (Djagaruddin et al., 2023; Effendy, 2021). Third, caring studies more often assess patient or nurse perceptions and the influence of the work environment, but have not yet consistently linked these to the architecture of IPC. In Greece, for example, both patients and nurses rated caring behavior relatively highly, but differences in rating variation indicate that caring is not always perceived uniformly (Alikari et al., 2023).

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The conceptual gap lies in the fact that the mechanism explaining how caring values operate between organizational context and the IPC process has not yet been mapped. Some syntheses state that there are benefits to collaboration, but evidence regarding patient-centered outcomes remains uneven (Bouton et al., 2023), and a meta-analysis in Ethiopia showed an IPC proportion of 52.73% with very high heterogeneity (Moloro et al., 2025). Therefore, the claim that caring directly improves safety or satisfaction cannot yet be made without taking into account study design, country context, organizational characteristics, and the potential for publication bias.

This positioning departs from existing syntheses in identifiable ways. Reeves et al.'s (2017) Cochrane review evaluated the effectiveness of IPC interventions on care processes and outcomes but did not examine the organizational-cultural conditions under which those interventions succeed or fail. Wei et al.'s (2022) meta-review catalogued IPC facilitators and barriers across individual, team, organizational, and system levels but treated culture as one barrier category among several rather than as an integrating construct. Schot et al. (2020) reviewed how healthcare professionals actively contribute to interprofessional collaboration but did so from a professional-boundary-work perspective rather than a caring or relational-values perspective. None of these reviews specifically traces how caring values are theorized to translate into IPC processes at the hospital level. The novelty of this study therefore lies in positioning caring culture as a structural enabling factor of IPC, rather than merely as a personal trait of nurses or one barrier among many. The mapping is directed toward the conceptual relationship between organizational context, internalization of caring values, communication and coordination processes, and reported outcomes. This model is intended as a conceptual proposition to be tested, not as a causal model that has already been verified.

This study aims to map and synthesize evidence regarding the role of caring culture in the implementation of IPC in hospitals; to identify supporting factors, barriers, and contextual variation; and to formulate a conceptual model that can serve as a basis for empirical testing. Scientifically, the results of this study clarify the point of intersection between the literature on caring, organizational culture, and interprofessional collaboration. Practically, this mapping can be used by

hospital management to design staff orientation, standardized communication, support for health worker well-being, and evaluation of collaborative behavior. In terms of policy, the results can support the development of IPC standards that regulate not only procedures, but also relational climate, protection for voicing clinical concerns, and interprofessional respect.

RESEARCH METHOD

This study uses a scoping review design based on the framework of Arksey and O'Malley (2005), the refinement by Levac et al. (2010), the JBI guidelines (Peters et al., 2020), and PRISMA-ScR reporting (Tricco et al., 2018). The review questions were formulated using the Population-Concept-Context (PCC) framework: Population consisting of health workers and interprofessional teams; Concept consisting of caring culture, caring behavior, and IPC practice; Context consisting of hospitals or inpatient services. The main question is: how is caring culture positioned, applied, and reported in the implementation of IPC in hospitals, and what factors support or hinder it?

The search was conducted in March–April 2026 for publications issued from January 1, 2021 to December 31, 2025 through PubMed/MEDLINE, Scopus, CINAHL via EBSCOhost, Google Scholar, and Portal Garuda/SINTA. The restriction to 2025 was used so that all publication years were complete and could be verified. The final search across all five sources was completed on 30 April 2026. This scoping review's protocol was not registered in a public repository such as the Open Science Framework (OSF); the absence of prospective registration is acknowledged as a transparency limitation in the Discussion. Terms were developed from the concepts of caring, IPC, and the hospital context. Table 1 presents the full adaptation of the search string according to the syntax of each database. Because Google Scholar and Portal Garuda/SINTA do not support exportable, fully reproducible search strings, records from these two sources were screened by relevance ranking to a fixed depth of the first 10 results pages per source rather than to exhaustion; the strings for these two sources in Table 1 therefore represent a transparent reconstruction of the terms and combinations actually used, rather than an exported machine-readable query, and this reconstruction is stated as a reproducibility limitation.

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Table 1. Database-Specific Search String Adaptation

Database	String/Search Strategy
PubMed/Medline	((("caring culture"[Title/Abstract] OR "caring behavior"[Title/Abstract] OR "nursing caring"[Title/Abstract] OR "human caring"[Title/Abstract]) AND ("interprofessional collaboration"[Title/Abstract] OR "interprofessional practice"[Title/Abstract] OR "interdisciplinary collaboration"[Title/Abstract]) AND (hospital*[Title/Abstract] OR inpatient*[Title/Abstract])) AND ("2021/01/01"[Date - Publication] : "2025/12/31"[Date - Publication]))
Scopus	TITLE-ABS-KEY(("caring culture" OR "caring behavior" OR "human caring") AND ("interprofessional collaboration" OR "interprofessional practice" OR "interdisciplinary collaboration") AND (hospital* OR inpatient*)) AND PUBYEAR > 2020 AND PUBYEAR < 2026
CINAHL/EBSCOhost	(TI ("caring culture" OR "caring behavior" OR "human caring") OR AB ("caring culture" OR "caring behavior" OR "human caring")) AND (TI ("interprofessional collaboration" OR "interprofessional practice") OR AB ("interprofessional collaboration" OR "interprofessional practice")) AND (TI (hospital* OR inpatient*) OR AB (hospital* OR inpatient*)); limiter 2021–2025, English/Indonesian, full text, peer reviewed
Google Scholar	allintitle/keyword combinations: ("caring culture" OR "caring behavior") ("interprofessional collaboration" OR IPC) (hospital OR inpatient), 2021–2025; screened by relevance and duplicate status
Portal Garuda/Sinta	("budaya caring" OR "perilaku caring") AND ("kolaborasi interprofesional" OR "interprofessional collaboration") AND ("rumah sakit" OR "rawat inap"), tahun 2021–2025

Inclusion criteria comprised: (1) publications discussing caring culture/behavior or caring theory in relation to interprofessional collaboration; (2) hospital, inpatient, ICU, palliative care, or hospital clinical unit contexts; (3) published in 2021–2025; (4) full text in Indonesian or English; and (5) quantitative, qualitative, mixed-methods, systematic review, scoping review, or relevant theoretical study designs. Exclusion criteria included editorials, opinion pieces, letters to the editor, protocols without results, conference abstracts without full text, publications outside the hospital context, and articles that did not link caring with collaborative processes or environments. Full-text availability was applied as a formal inclusion criterion (criterion 4 above); consequently, potentially relevant records available only as abstracts were not retrievable and could not be assessed, which introduces a possible availability bias toward more accessible, typically higher-visibility publications, as noted in the Limitations. For records identified through Portal Garuda/SINTA, formal peer-review status was not itself an inclusion requirement, since SINTA indexes journals across a range of accreditation tiers; instead, methodological quality was addressed uniformly for all included records, regardless of source, through the JBI critical appraisal step described below.

The unit of analysis was not human respondents, but rather the 55 articles that met the criteria. Two authors, NF and M, conducted title/abstract and full-text screening and eligibility assessment independently of one another; disagreements were resolved through discussion and consensus, with Risnah, as supervising and corresponding author, acting as the third-party arbiter for any disagreement the two screeners could not resolve between themselves. Historical records did not retain each screener's individual decisions in a format that would allow reconstruction of Cohen's kappa; therefore, the kappa value is not reported, and this condition is stated as a methodological limitation. The research instruments consisted of: (1) a search log for each database; (2) an inclusion–exclusion screening sheet; (3) a JBI-based data extraction form containing author, year, country, design, setting, caring concept, IPC components, and findings; (4) a JBI appraisal checklist appropriate to the design; and (5) a thematic codebook to maintain coding consistency.

Records were imported into Mendeley for deduplication, then screened based on title and abstract. Articles that passed were assessed in full text. Critical appraisal used JBI tools appropriate to the study design. A score of less than 50% was not used as an automatic exclusion threshold because critical appraisal in a scoping review is optional and the main purpose of the study is to map the breadth

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of evidence. Appraisal results were used to contextualize the strengths, limitations, and caution required in interpretation. Where appraisal indicated notable methodological weakness in a study still meeting the inclusion threshold, this is flagged in the narrative synthesis below rather than used to exclude the study.

Data were processed through six stages: cleaning of bibliographic data; structured extraction; open coding; grouping of codes into categories; determination of the dominant theme for each article; and critical narrative synthesis. NVivo 12 was used to assist in organizing the codes, while frequencies and

percentages were calculated descriptively. Percentages were not treated as effect measures, and no meta-analysis was conducted. Regional comparison was carried out narratively by selecting representative studies from Asia, Europe, and Africa.

This study used public data and did not involve interaction with human subjects, personal data, or clinical intervention, and therefore did not require human subjects research ethics approval. The principle of academic integrity was maintained through citation, reporting of the selection process, explanation of limitations, and declaration of conflicts of interest.

Research Procedure Diagram

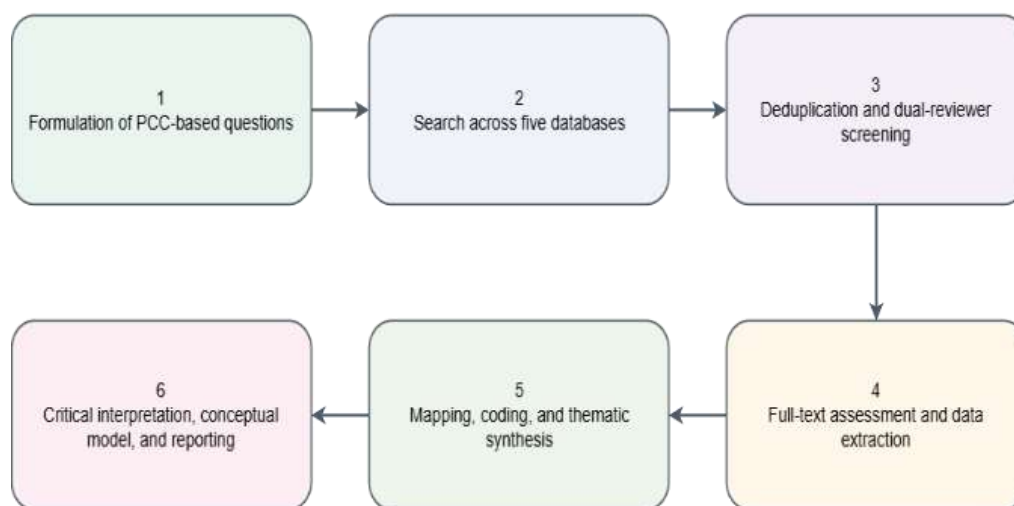


Figure 1. Research Procedure Diagram

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RESEARCH RESULTS

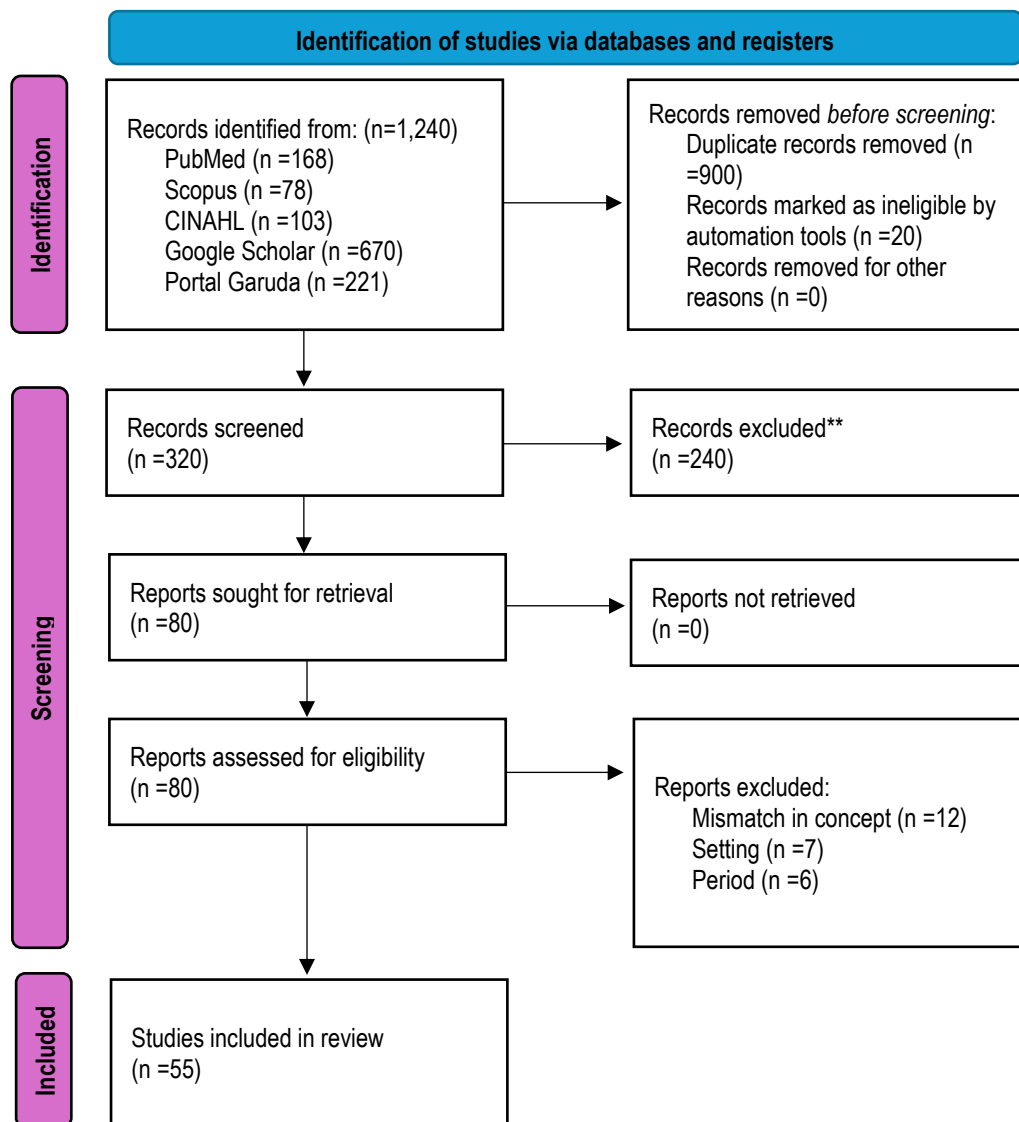


Figure 2. PRISMA-ScR Selection Flowchart

A total of 1,240 records were identified in the initial stage across the five sources. After deduplication and initial screening, 920 records were excluded (duplicates and records clearly irrelevant on title alone), leaving 320 titles and abstracts for detailed screening; of these, 240 were excluded for irrelevance to the topic, setting, or study design. The remaining 80 articles were assessed in full text, of which 25 were excluded (mismatch in concept, setting, period, or language, or inaccessible full text), leaving 55 articles included in the mapping.

Based on the design groupings available in the extraction sheet, the sources consisted of 18 systematic/scoping reviews (32.7%), 12 qualitative studies (21.8%), 11 quantitative/cross-sectional studies (20.0%), 2 mixed-methods studies (3.6%), and 12 theoretical studies or narrative reviews (21.8%). The diversity of designs broadened the scope of the mapping, but limited direct comparison because the units of analysis, instruments, and outcomes were not homogeneous.

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Table 2. Distribution of Dominant Themes in the Reviewed Articles (n = 55)

Dominant Themes	Results (n/%)
Effective Communication and SBAR	12/21.8
Organizational Culture, Trust, and Collaborative Leadership	10/18.2
Caring Culture and Patient Experience/Satisfaction	8/14.5
Human Caring Theory in Collaborative Practice	7/12.7
IPC Barriers: Hierarchy, Professional Ego, and Role Conflict	5/9.1
Systems Approach, Work Stress, and Staff Well-Being	4/7.3
Specific Clinical Settings and Other Themes	9/16.4

Table 2 presents descriptive frequencies only; these figures are strictly a denominator-of-55 count of how many included articles were assigned each dominant theme, and the percentage therefore indicates the density of literature attention that theme received within this specific corpus, not the strength of its influence, the magnitude of any effect, or its prevalence in the wider literature. The analytical meaning of each theme, interpreted narratively rather than embedded in the frequency table itself, is as follows: Effective communication and SBAR functions as an operational coordination instrument whose value depends on a climate of trust and the opportunity to speak up. Organizational culture, trust, and collaborative leadership operate as a structural enabling factor shaping psychological safety and interprofessional relationships. Caring culture and patient experience/satisfaction represent a relational dimension manifested in attention, presence, appreciation, and responsiveness to needs. Human Caring theory in collaborative practice provides the humanistic foundation for extending caring from nurse-patient relations to team relations. IPC barriers such as hierarchy, professional ego, and role conflict act as a contextual force that can reduce openness, learning, and shared decision-making. The systems approach to work stress and staff well-being indicates that organizational caring needs to include support for health workers themselves. Finally, specific clinical settings and other themes affirm variation in IPC needs across ICU, palliative care, geriatrics, transitional care, and other units.

Standardized communication was the theme that appeared most frequently. However, the qualitative literature places communication structure alongside trust, understanding of roles, interpersonal

relationships, and organizational support (Gleeson et al., 2023). This means that SBAR can help the completeness of information exchange, but does not automatically change power relations or encourage health workers to voice clinical doubts. The hospital collaborative competency framework also emphasizes communication, team values, role clarity, team functioning, and conflict resolution as an interrelated set of competencies (McLaney et al., 2022).

In the Asian context, a study of an Indonesian teaching hospital reported that IPC implementation was influenced by institution-specific factors, including organizational culture, understanding of roles, communication, and system support (Djaharuddin et al., 2023). An IPE meta-analysis showed that interprofessional education can improve collaborative attitudes and mutual respect, but variation in design and outcomes limits conclusions regarding long-term changes in clinical practice (Saragih et al., 2024); this evidence is educational rather than hospital-practice-based and is treated as contextual background rather than direct hospital evidence. In Malaysia, work environment and nurse-physician relationships were reported to be associated with caring behavior, while staff and resource limitations could weaken its manifestation (Arsat et al., 2022).

In the European context, a study of six hospitals in Greece found relatively high caring ratings from both patients and nurses, but the variation in patient scores was greater than that of nurses, indicating that caring perceptions need to be read from more than one party (Alikari et al., 2023). A study on complex patient transitions in Switzerland showed that system fragmentation can limit collaboration even though health workers recognize its benefits (Geese &

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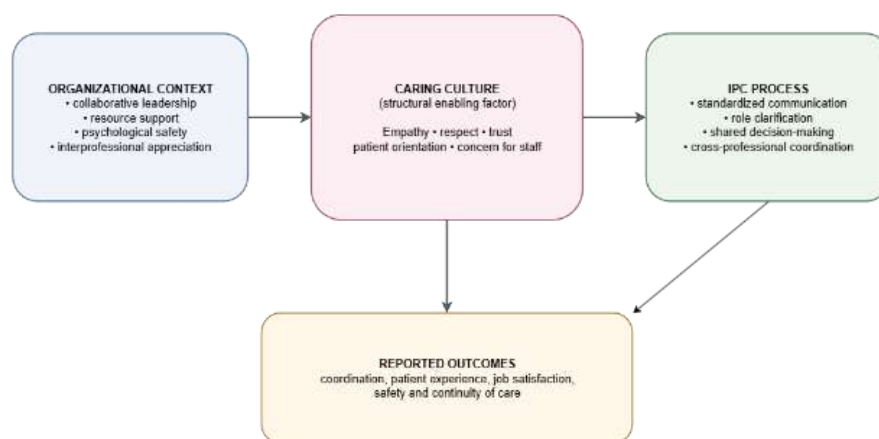
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Schmitt, 2023). In the African context, a meta-analysis in Ethiopia reported an IPC proportion of 52.73% with I^2 heterogeneity of 91.5%, indicating differences between hospitals and limiting the generalization of a single summary figure (Moloro et al., 2025), a pattern consistent with an earlier northwest Ethiopian cross-sectional study that likewise reported wide facility-to-facility variation in collaboration levels among nurses and physicians (Degu et al., 2023). A South African study also demonstrated the need for competencies and collaborative structures tailored to specific multidisciplinary services (Hlongwa & Rispel, 2021).

Not all of the literature shows uniform outcomes. A systematic review on primary care states that evidence for the effect of IPC on patient-centered outcomes remains fragmented and dependent on the type of intervention and indicators used (Bouton et al., 2023); because this evidence originates from primary care rather than hospital settings, it is treated here as

contextual background on IPC-outcome heterogeneity in general, not as direct evidence about hospital caring culture, and conclusions drawn later in this review are restricted to the hospital/inpatient scope specified in the PCC framework. Similarly, the IPE meta-analysis discussed above (Saragih et al., 2024) speaks to interprofessional education outcomes rather than to hospital IPC practice directly, and is likewise cited as contextual, indirect evidence rather than direct hospital evidence. The discrepancy between health worker and patient perceptions of caring also suggests the possibility of self-assessment bias (Alikari et al., 2023). In addition, the high heterogeneity in the quantitative evidence (Moloro et al., 2025) and the dominance of cross-sectional designs require the use of terms such as "associated with," "reported," or "potentially," rather than "proven to cause."

Conceptual Model of Synthesis Results



This model is the result of conceptual mapping and has not been tested as causal relationships.

Figure 3. A Conceptual Model of a Culture of Caring as a Structural Enabler of IPC

The model in Figure 3 summarizes the pattern of relationships in the literature: organizational context shapes opportunities for the internalization of caring culture; caring culture supports the IPC process; and this process is associated with both organizational and patient outcomes. This model is the result of conceptual synthesis, not the result of mediation or causal testing.

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DISCUSSION

The mapping results broaden the understanding of caring from individual behavior toward an organizational characteristic. Values of empathy, respect, trust, patient orientation, and concern for staff can create relational conditions that facilitate information exchange, role clarification, and shared decision-making. This interpretation is consistent with Human Caring, which positions human relationships at the core of care (Watson, 2008), but this study adapts it to the team and organizational level. Accordingly, caring does not replace IPC protocols; caring provides the ethical and psychological context needed for protocols to be used openly and meaningfully.

This framework also explains why technical communication interventions can produce different outcomes. When staff feel safe voicing uncertainty, SBAR can function as a tool for coordination and the prevention of information loss. Conversely, in a hierarchical culture, the same format can turn into one-way documentation. Findings from an IPC meta-review show that facilitators and barriers exist at the individual, team, organizational, and system levels (Wei et al., 2022). Therefore, evaluation of IPC needs to measure not only compliance with communication forms, but also the quality of dialogue, clarity of responsibility, staff experience, and patient involvement.

The regional comparison shows that organizational structure and professional norms influence the way caring and IPC are translated into practice. Of the 55 included articles, 21 were set in Asian countries, 17 in European countries, 15 in African countries, and 2 elsewhere or not country-specific; the studies discussed narratively below were selected as representative because they most directly addressed the review's caring-IPC question within their region and reported sufficient methodological detail for comparison, not because they are necessarily typical of all literature from that region. The Asian literature largely highlights hierarchy, role clarity, management support, and the need for local cultural adaptation. The European literature more often discusses patient experience, cross-service fragmentation, and formal team mechanisms. The African literature emphasizes resource limitations, professional distribution, and variation between facilities. These differences do not indicate that one

region is more collaborative than another, nor that the cited studies represent all literature from that continent; rather, they affirm that caring culture must be operationalized according to context and cannot be reduced to a universal intervention package.

LIMITATION

The search was restricted to five sources, the Indonesian and English languages, and the 2021–2025 period, so relevant publications outside these boundaries may not have been identified. Google Scholar and Portal Garuda/SINTA have indexing consistency that differs from bibliographic databases. Classifying a single dominant theme per article simplifies the interconnections between themes. Critical appraisal was used for context, not to weight estimates, and no meta-analysis was conducted. The reviewers' independent decisions were not retained, so inter-reviewer reliability cannot be calculated retrospectively. The use of publications available in full text also carries the potential for publication and availability bias; studies with positive results may be more easily published than neutral or negative results. Therefore, the resulting conceptual model should be regarded as a working hypothesis.

IMPLICATIONS

For hospital practice, the findings support developing collaborative behavior standards that incorporate empathetic communication, respect for roles, the right to voice clinical concerns, blame-free response, and evaluation of staff well-being; SBAR training should be paired with conflict simulation, debriefing, and cross-professional decision-making exercises rather than delivered as a stand-alone communication drill. For education, IPE curricula should assess behavioral change transferred into the workplace, not only attitudes measured immediately after training (Saragih et al., 2024). For hospital policy, these practice- and education-level actions can be operationalized through staff orientation content, team performance assessment criteria, patient safety incident audits, and speak-up mechanisms; the broader question of how hospital regulation should formalize accountability and protection for health workers who raise clinical concerns is carried forward as a future research direction in the Conclusion below, rather than elaborated here, to avoid duplicating that discussion.

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CONCLUSION

This scoping review provides a contribution in the form of a conceptual mapping of the relationship between caring culture and Interprofessional Collaboration in hospitals. The literature indicates that caring can be positioned as a structural enabling factor that links leadership, organizational support, mutual trust, standardized communication, and interprofessional coordination; however, the heterogeneity of designs, variation in regional context, measurement limitations, and potential synthesis bias do not permit the drawing of causal conclusions. The novelty of this study lies in a model that broadens caring from an individual relationship into a relational-organizational characteristic of IPC. Hospitals are advised to integrate caring behavior, psychological safety, and evaluation of staff and patient experience into IPC policy, while future research needs to test the model through longitudinal, mixed-methods, or multicenter intervention studies, as well as examine policy and legal aspects regarding accountability, speak-up protection, and the distribution of authority in collaborative clinical decisions.

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AUTHOR CONTRIBUTIONS

Nilam Fauziah: conceptualization, literature search, independent title/abstract and full-text screening, data extraction, thematic synthesis, visualization, and manuscript preparation (original draft). Musdalifah: independent title/abstract and full-text screening, data extraction verification, and manuscript review and editing. Risnah: supervision, arbitration of unresolved screening disagreements, methodological oversight, and manuscript review and editing, as corresponding author. Widya Amraeni: data extraction support, quality-appraisal cross-checking, and manuscript review and editing. All authors read and approved the final manuscript.

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