Featured Article

Promoting workplace retention during global crises: An international survey of the preventive role of psychological support among victims of social discrimination in long-term care facilities

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ABSTRACT

This international cross-sectional survey examined the potential role of organizational psychological support in mitigating the association between experiencing social discrimination against long-term care (LTC) facilities' healthcare professionals (HCPs) and their intention to stay in the current workplace during the COVID-19 pandemic. Participants included a convenience sample of 2,143 HCPs (nurses [21.5 %], nurse aids or residential care workers [40.1 %], social workers [12.1 %], and others [26.4 %]) working at 223 LTC facilities in 13 countries/regions. About 37.5 % of the participants reported experiencing social discrimination, and the percentage ranged from 15.3 % to 77.9 % across countries/regions. Controlling for socio-demographic and work-related variables, experiencing social discrimination was significantly associated with a lower intention to stay, whereas receiving psychological support showed a statistically significant positive association (p-value=0.015 and <0.001, respectively). The interaction term between social discrimination and psychological support showed a statistically significant positive association with the intention to stay, indicating a moderating role of the psychological support.

Introduction

Promoting healthcare professionals' (HCPs) retention at the workplace is essential to ensure high-quality care. This is particularly important during global healthcare crises, such as the COVID-19 pandemic, and in high-risk settings, such as long-term care (LTC) facilities for older people. The literature shows that the COVID-19 pandemic has globally threatened healthcare professionals' work retention-related concepts (e.g., actual turnover, high intention to leave, or low intention to stay).[1] For instance, a systematic review of nurses' intention to leave during the pandemic revealed that about one-third of nurses intended to leave the job.[2] Factors commonly reported to be associated with HCPs' retention during the COVID-19 pandemic included fear of infection, job stress, anxiety, high workload, burnout, compassion fatigue, and poor working conditions.[1,2]

Discrimination is the unfair or prejudicial treatment of people and groups based on their characteristics.[3] Discrimination against HCPs during the COVID-19 pandemic was reported worldwide and included bullying, threatening and rude gestures, verbal abuse, and harassment.[4] For instance, some HCPs were reportedly denied access to public transport, insulted in the street, evicted from rented apartments, and subjected to physical assaults.[5] Some HCPs also reported facing mistrust and disrespect from politicians, hospital leaders, and the public.[6] The evidence shows that discriminatory and hateful acts against HCPs negatively impact their clinical performance, work satisfaction, mental health, psychological well-being, and quality of life.[7,8] These conditions could potentially drive HCPs to leave their jobs and/or the profession.[7] Nevertheless, the association between discrimination against HCPs and their turnover intention was rarely examined, particularly in LTC facilities.

Providing adequate psychological support for HCPs has been a fundamental recommendation since the onset of the COVID-19 pandemic. Research shows that HCPs' perception of psychological support during the pandemic was associated with lower burnout, anxiety, and stress.[9-11] Several interventions were presented to help HCPs respond to the COVID-19 pandemic-related stress.[12] Most of these interventions aimed at promoting positive emotions, improving sleep, maintaining teamwork efficacy, and improving well-being, as well as preventing or reducing burnout, stress, depression, and post-traumatic stress disorder.[12,13] Among other positive impacts, psychological support for HCPs during the pandemic increased their workplace engagement[14,15] and decreased their work-related strains and burnout.[16,17]

During the COVID-19 pandemic, LTC residential facilities for older people have been identified as high-risk settings.[18,19] For instance, the prevalence rate of COVID-19 infection was up to 85.4 % and 62.6 % among residents and staff, respectively.[20] Among staff, increased workload and shortage, high burnout and emotional burden and exhaustion, fears of infection, stress, anxiety, depression, and moral distress were prevalent.[21,22] Despite the devastating impact of the pandemic on LTC staff, research is scarce on discrimination against them and its relationship with their turnover intention. Therefore, the current study sought to examine the intention to stay in the current workplace among LTC staff worldwide and how this intention was related to experiencing social discrimination and receiving psychological support during the COVID-19 pandemic. Specifically, the present study aimed to address the following three research questions:

- What was the association between LTC staff's experience of social discrimination during the COVID-19 pandemic and their intention to stay in the current workplace?

- What was the association between receiving psychological support and the intention to stay in the current workplace among LTC staff during the COVID-19 pandemic?
- Could psychological support moderate the association between experiencing social discrimination and the intention to stay in the current workplace among LTC staff during the COVID-19 pandemic?

Methods

This was a cross-sectional, multi-site, international survey.[23] The data used in the current paper is part of a larger dataset used to examine LTC facilities' response to the COVID-19 pandemic. There is no redundancy or duplication between the current paper and other publications using the same dataset.[24,25] Reporting of the current paper followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement guidelines.[26]

Settings, participants, and sampling

The survey was conducted in LTC facilities in 13 countries: Brazil, Egypt, England, Hong Kong, Indonesia, Japan, Norway, Portugal, Saudi Arabia, South Korea, Spain, Thailand, and Turkey. For the purpose of the current study, LTC facilities were defined as designed institutions that provide formal (from paid staff) accommodation and health or social LTC services for older people.[23] A convenience sampling approach was used to select LTC facilities. Direct care staff working at participating facilities (i.e., healthcare professionals who provide daily direct care to the facility's residents) were invited to participate in the study. The inclusion criteria of staff were: (i) working at the facility during the calendar year 2020, (ii) available at the time of data collection, and (iii) agreeing to participate in the study; categories of included professionals were decided based on the country and facility regulations. In the current study, the convenience sampling approach was used to select LTC and study participants for three reasons: (i) lack of LTC facilities' sampling framework (e.g. national database, etc.) in many of the participating countries/regions, (ii) lack of funding to support researchers' commuting to geographically distant LTC facilities, and (iii) to allow researchers to include LTC facilities with which they already have connections.[23] The latter was particularly critical during the COVID-19 pandemic, where the increased workload could cause LTC facilities' managers and staff to decline participation in research activities, especially when unfamiliar with the researchers. Considering the challenges of data collection during the pandemic, the research team strived to include at least ten LTC facilities and at least 100 staff members from each participating country/region, and no formal sample size calculation was performed in advance.

Measurements

Intention to stay. Intention to stay in the current workplace was evaluated by asking participants to select the response that best reflects their opinion regarding the statement, "*I intend to stay in this facility for the next 12 months.*"[27] Responses were elicited on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree); higher scores indicate a higher intention to stay.

Experience of social discrimination. Following a literature review,[4–8] seven discrimination events were listed in the questionnaire: (i) feeling rejected by the community, (ii) experiencing physical or verbal assaults or attacks, (iii) being asked not to leave home, (iv) being asked not to use public transportation, (v) receiving threatening or hate messages, (vi) being asked to leave their job, and (vii) experiencing any of these events by a household member because of the participant's job. Participants were asked whether they had experienced any of the seven discrimination events during the pandemic, and selecting multiple items was allowed. Each item was responded to with either "yes" or "no." Based on their responses, participants were dichotomized into two groups: yes (i.e., those who experienced any social discrimination event) and no (those who did not experience any social discrimination event).

Perceived psychological support. The question "How do you evaluate the psychological support you received from the facility during the COVID-19 pandemic?" was used to assess the psychological support provided to participants. Response options included "lots of support," "minimal support," and "no support," and the results were dichotomized into yes (i.e., receiving lots or minimal support) and no (i.e., receiving no support).

Demographic and work-related data. Demographic data included age (in years) and gender. Work-related data included professional background (e.g., nurse, social worker, etc.), years of experience, and interest in working with older people. The latter was assessed using a single item (i.e., *To what extent do you feel motivated/enjoying/interested in working with older people?*), and responses were elicited on a 1 (not at all interested) to 5 (extremely interested) Likert scale.

Data collection

Data were collected from April to October 2021 using an online survey created on SurveyMonkey®; the design of the online survey was described elsewhere.[23] The survey was developed in English, and its content validity was assured by a panel of researchers and practitioners from different countries. Due to the lack of time and resources, the validation process took place through online discussions with experts, and no pilot or feasibility studies were conducted. The survey was then translated into each participating country's local language by a professional translation company, which adopts three stages of translation: translation by a target language native translator, proofreading by an original language native translator, and a quality check by a translation manager. Further, at least one research collaborator in each participating country confirmed the semantic, idiomatic, experiential, and conceptual equivalence between the English and translated versions of the questionnaires and made modifications if needed.[23] Researchers in each country selected LTC facilities and distributed the survey URL to eligible participants. To increase the response rate, paper copies of the survey were made available on request, and periodic reminders were sent to the study participants. If paper copies of the questionnaires were used, the data were entered into the online form by the researchers. The procedure of administrating the questionnaires in each country/region and the interval of the periodic reminder were decided by the local research team and was tailored to the specific conditions and capabilities of each locale. For instance, in cases where online data collection was implemented, the URL was distributed either through the facility's intranet network or by the facility managers via platforms such as WhatsApp. Similarly, paper-based questionnaires were either directly handed to the participants by the researchers or distributed through the facility managers. It is noteworthy that the data collection was primarily planned to be accomplished within one month; however, it was extended to six months due to feasibility issues.

Statistical analysis

Collected data were managed and analyzed centrally by the principal investigator (the first author of the current paper). Following the examination of descriptive statistics, a multilevel regression analysis was used to examine the association between participants' experience of social discrimination and receiving psychological support and their intention to stay in the current workplace, controlling for their socio-demographic and work-related variables. A 3-level

Table 1
Characteristics of the study sample (n = 2143).

	Mean ± SD or n (%) [†]	Missing, n (%)
Age (in years)	41.99 ± 11.75	153 (7.14 %)
Gender		22 (1.03 %)
Female	1730 (81.53 %)	
Male	391 (18.43 %)	
Professional background		19 (0.89 %)
Nurse	457 (21.52 %)	
Nurse aid or resident care worker	852 (40.11 %)	
Social worker	257 (12.10 %)	
Others [¶]	558 (26.37 %)	
Years of experience (in years)	10.97 ± 8.67	52 (2.43 %)
Interest in working with older people (range, 1−5) [‡]	3.85 ± 0.91	22 (1.03 %)
Intention to stay (range, 1−5) [§]	4.14 ± 0.98	42 (2.0 %)
Experience of social discrimination during the pandemic		50 (2.33 %)
Yes	784 (37.46 %)	
No	1309 (62.54 %)	
Receiving psychological support from the facility during the pandemic		102 (4.76 %)
Yes	1741 (85.30 %)	
No	300 (14.70 %)	

[†] Valid percentage (i.e., missing data did not account for the calculation).
[‡] Higher scores indicate higher interest in working with older people.
[§] Higher scores indicate a higher intention to stay in the current workplace.
[¶] Include support worker, assistant, auxiliary worker, physiotherapist, health worker, occupational therapist, service worker, caregiver, technician, etc.
Abbreviation: SD, Standard deviation.

regression analysis was used to account for the hierarchical nature of the data where LTC staff are nested in facilities, and facilities are nested in countries.[28] The extent of the variability of the study outcome (i.e., intention to stay) across countries and facilities was examined by estimating an unconditional generalized mixed model with random intercepts. The proportion of variance among countries was 0.067 (Wald Z = 2.209; p = 0.027), suggesting that 6.7 % of the outcome variability lies between countries. The proportion of variance among facilities was 0.043 (Wald Z = 3.127; p = 0.002), suggesting that 4.3 % of the outcome variability lies between facilities. These results justified building a 3-level regression model.[28] The possible moderating effect of psychological support was tested by including an interaction term of experiencing social discrimination and receiving psychological support in the regression model. Multicollinearity between explanatory variables was examined, and none were excluded due to multicollinearity. All analyses were conducted using SPSS version 28. No missing data replacement was conducted for the current analyses; that is, the number of cases with missing data was reported for each variable, and all analyses were performed only on cases with valid data. All p-values were two-tailed, and the alpha significance level was 0.05.

Ethical considerations

The current study was approved by the Research Ethics Committee of the Graduate School of Medicine, The University of Tokyo (number: 2020329NI) and other Research Ethics Committees in participating countries.[24] The cover letter of the survey explained the study purpose, provided assurance regarding the voluntary and confidential nature of the response, and stated that the completion and submission of the survey would be regarded as consent to participate.

Results

A total of 2143 staff members (response rate = 26.7 %) working at 223 LTC facilities in 13 countries participated in the study. Most (81.5 %) participants were female, 21.5 % were nurses, and 40.1 % were nurse aids or residential care workers (Table 1). The mean score of the intention to stay (possible range, 1−5) was 4.14 (standard deviation = 0.98). Approximately 15 % of the study participants did not

receive any psychological support from their facilities during the pandemic, and 37.5 % reported experiencing at least one social discrimination event (Fig. 1). The most frequently reported social discrimination events were being asked not to leave home (n = 520; 25 %) and not to use public transportation (n = 390; 18.7 %), and these results were consistent across countries/regions and professional backgrounds (Fig. 2).

The regression analysis (Table 2) showed that controlling for socio-demographic characteristics (i.e., age and gender) and work-related variables (i.e., professional background, years of experience, and interest in working with older people), experiencing social discrimination was significantly associated with a lower intention to stay (estimate [95 % confidence interval]: −0.144 [−0.259, −0.028]; p = 0.015), whereas receiving psychological support showed a statistically significant positive association (0.281 [0.164, 0.399]; p < 0.001). The interaction term between social discrimination and psychological support showed a statistically significant positive association with the intention to stay (0.230 [0.004, 0.456]; p = 0.046), suggesting a moderating effect of the psychological support on the association between experiencing social discrimination and the intention to stay in the current workplace.

Discussion

The intention to stay in the current workplace is a strong and possibly the best predictor of turnover.[29] The current study revealed that HCPs who experienced social discrimination during the COVID-19 pandemic were less likely to intend to stay in their current workplace. In contrast, HCPs who received psychological support from their facilities during the pandemic were more likely to intend to stay. The results also showed that psychological support could moderate the association between experiencing social discrimination and the intention to stay. These results provide insights into the challenges HCPs face during global health crises and underscore the importance of psychological support as a potential strategy to retain and support HCPs during times of crisis. The results can also inform targeted interventions to promote inclusivity and equality and prevent stigmatization and discrimination against HCPs.

The negative association between social discrimination against HCPs and their intention to stay can be explained through various theories and mechanisms. The job embeddedness theory suggests
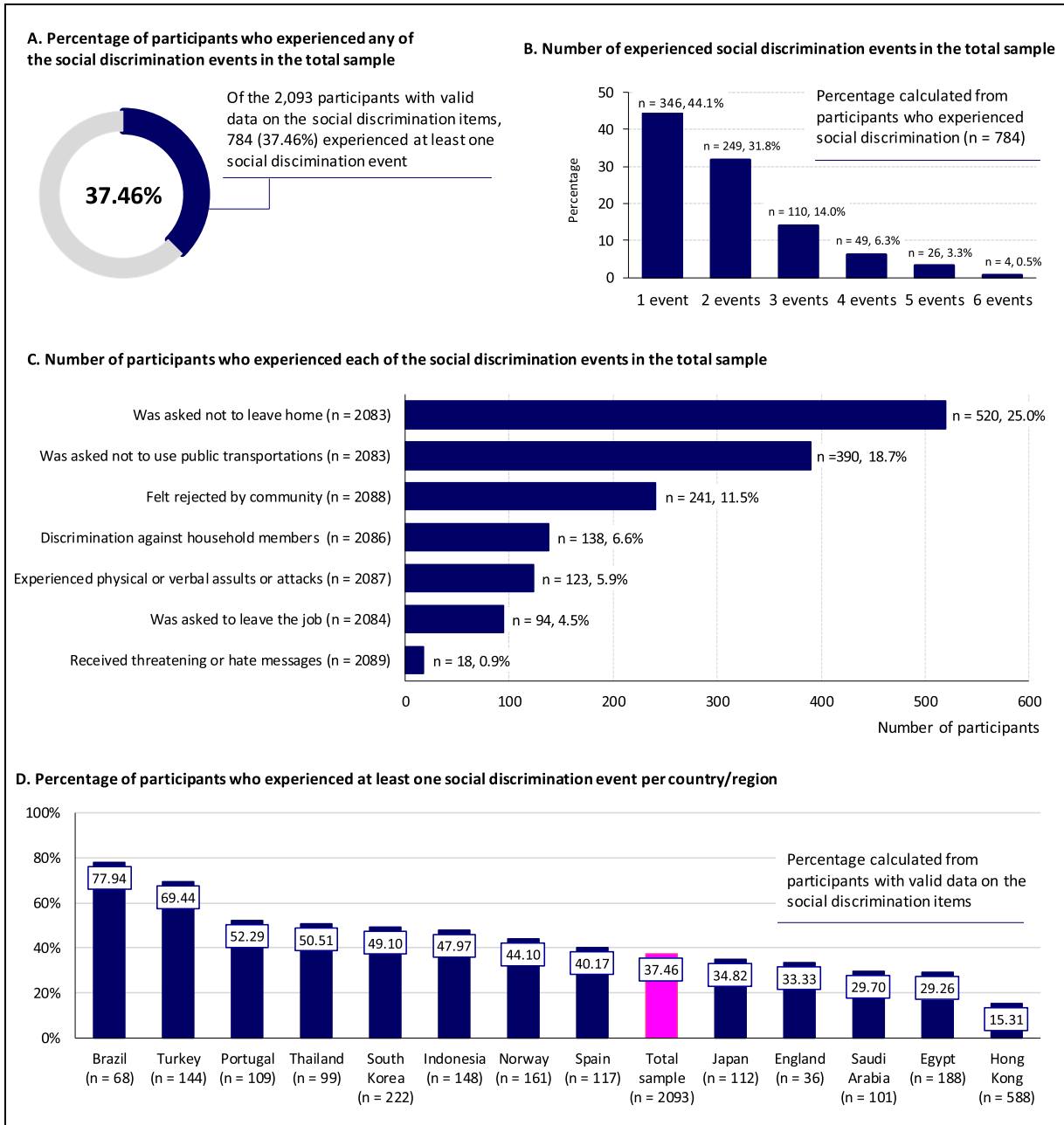
A. Percentage of participants who experienced any of the social discrimination events in the total sample

37.46%

Of the 2,093 participants with valid data on the social discrimination items, 784 (37.46%) experienced at least one social discimination event

B. Number of experienced social discrimination events in the total sample

Percentage calculated from participants who experienced social discrimination (n = 784)

n = 346, 44.1%
n = 249, 31.8%
n = 110, 14.0%
n = 49, 6.3%
n = 26, 3.3%
n = 4, 0.5%

1 event 2 events 3 events 4 events 5 events 6 events

C. Number of participants who experienced each of the social discrimination events in the total sample

Was asked not to leave home (n = 2083) — n = 520, 25.0%
Was asked not to use public transportations (n = 2083) — n =390, 18.7%
Felt rejected by community (n = 2088) — n = 241, 11.5%
Discrimination against household members (n = 2086) — n = 138, 6.6%
Experienced physical or verbal assults or attacks (n = 2087) — n = 123, 5.9%
Was asked to leave the job (n = 2084) — n = 94, 4.5%
Received threatening or hate messages (n = 2089) — n = 18, 0.9%

Number of participants

D. Percentage of participants who experienced at least one social discrimination event per country/region

Percentage calculated from participants with valid data on the social discrimination items

Brazil (n = 68) — 77.94
Turkey (n = 144) — 69.44
Portugal (n = 109) — 52.29
Thailand (n = 99) — 50.51
South Korea (n = 222) — 49.10
Indonesia (n = 148) — 47.97
Norway (n = 161) — 44.10
Spain (n = 117) — 40.17
Total sample (n = 2093) — 37.46
Japan (n = 112) — 34.82
England (n = 36) — 33.33
Saudi Arabia (n = 101) — 29.70
Egypt (n = 188) — 29.26
Hong Kong (n = 588) — 15.31

Fig. 1. Experience of social discrimination in the total sample.

that employees' connections and links to their organization and community influence their intention to stay or leave.[30] Social discrimination can weaken these connections and reduce an individual's sense of belongingness and attachment to the workplace. The job demands-resources model suggests that job demands and resources influence employee well-being and work-related outcomes.[31] We believe that discrimination creates additional job demands on HCPs, such as emotional stress, psychological strain, and reduced job autonomy, and reduces the availability of psychological resources, such as support and recognition from colleagues and supervisors. The social exchange theory explains how individuals make relationship decisions based on a cost-benefit analysis.[32] Discrimination can reduce the benefits that HCPs perceive they are getting from their job, such as feeling valued and respected. The social identity theory posits that individuals derive part of their self-concept from group memberships, such as their profession.[33] Discrimination may negatively impact HCPs' professional identity, causing them to disengage from their professional roles and consider leaving. Furthermore, discrimination against HCPs may be perceived as a breach of the psychological contract (i.e., the unwritten, intangible expectations and obligations)[34] between HCPs and the community, as HCPs may expect appreciation and support because of their efforts as the frontline fighters against the pandemic.

The mechanisms and theories proposed above may also help explain the positive association between receiving psychological support and the intention to stay among HCPs and the buffering effect of psychological support on the relationship between discrimination and intention to stay. According to the job demands-resources model, psychological support, as a job resource, can counteract the negative impact of social discrimination, high workload, job stress, and anxiety experienced during the COVID-19 pandemic as job demands.[31] According to the social exchange theory[32] and the organizational
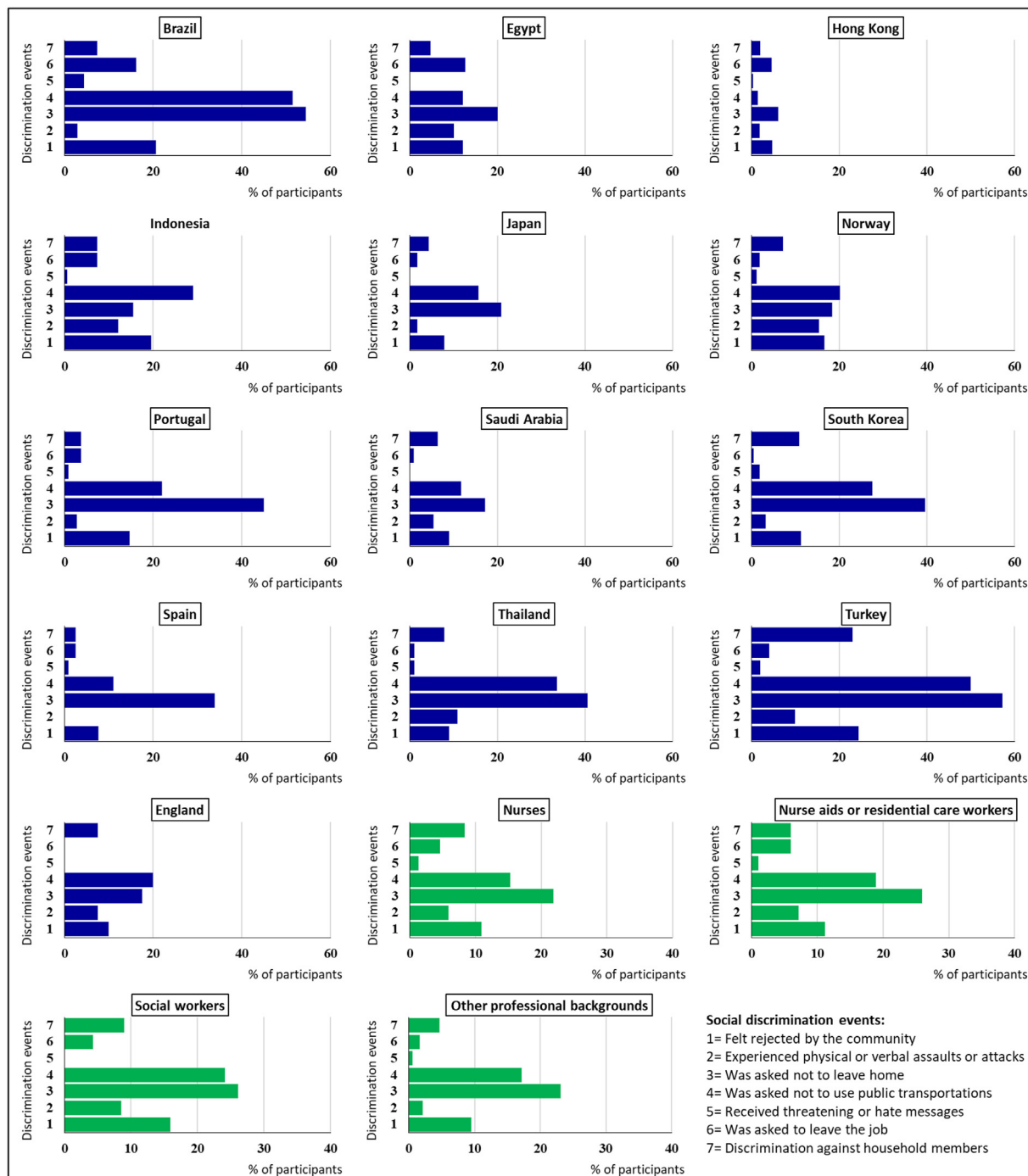
Fig. 2. Experience of social discrimination by country (in blue) and professional background (in green).

support theory,[35] psychological support to HCPs can provide them with benefits, such as feeling valued, cared for, appreciated, and supported. As a result, HCPs are more likely to reciprocate this support through increased commitment and loyalty and reduced turnover intention. Psychological support can help HCPs develop resilience and cope with challenges posed by discrimination, relieving its harmful effects on their job attitudes. Furthermore, psychological support can help HCPs communicate more effectively with their colleagues and supervisor, which can help resolve conflicts and improve job satisfaction,[36] both of which can increase the intention to stay. A study by Hebles et al.[37] found that psychological safety (i.e., how safe healthcare employees perceive the interactions with their colleagues

are) mediates the relationship between cognitive stress and turnover intention. Yeh et al.[38] also proved the mediating effects of psychological demands and social support on the relationship between workplace violence and turnover intention.

Clinical implications

Results of the current study hold significant implications for enhancing workplace retention among healthcare professionals, particularly during global crises. At the country level, policymakers and regulatory bodies must enact and enforce laws protecting HCPs from discrimination. Government agencies can also invest in public

Table 2
Multi-level regression analysis of the intention to stay (n = 1832).

1. Estimates of covariance parameters of the null model					
	Estimate	**SE**	**Wald Z**	**p-value**	**95 % CI**
Residual	0.842	0.027	31.181	<0.001	(0.790, 0.896)
Intercept (Country)	0.063	0.028	2.209	0.027	(0.026, 0.153)
Intercept (Country*Facility)	0.040	0.013	3.127	0.002	(0.021, 0.075)
2. Full model					
2.1. Estimates of covariance parameters					
	Estimate	**SE**	**Wald Z**	**p-value**	**95 % CI**
Residual	0.714	0.025	28.859	<0.001	(0.667, 0.764)
Intercept (Country)	0.037	0.018	2.063	0.039	(0.014, 0.096)
Intercept (Country*Facility)	0.038	0.013	3.024	0.002	(0.020, 0.073)
2.2. Estimates of fixed effects[†]					
	Estimate	**SE**	**t**	**p-value**	**95 % CI**
Experiencing social discrimination: Yes	−0.144	0.059	−2.439	0.015	(−0.259, −0.028)
Receiving psychological support: Yes	0.281	0.060	4.690	<0.001	(0.164, 0.399)
Social discrimination*Psychological support	0.230	0.115	1.994	0.046	(0.004, 0.456)
R^2 at the participants' level	0.152				
R^2 at the country's level	0.410				
R^2 at the facility's level	0.047				

[†] Adjusted for age, gender, professional background, years of experience, and interest in working with older people.
Abbreviations: CI, Confidence interval; SE, Standard error.

awareness campaigns to highlight the detrimental impact of social discrimination on frontline fighters. Collaborating with professional associations and advocacy groups can strengthen these efforts and create a united front against discrimination. At the organizational level, psychological support represents a cost-effective intervention, especially important for resource-constrained low and middle-income countries. LTC facilities may benefit from implementing policies and practices that foster a supportive work environment and provide HCPs with access to resources that can enhance their psychological well-being. For instance, Shanafelt et al.[39] proposed a set of actions to be taken before (e.g., establishing a professional well-being program), during (e.g., regular stress and stressors evaluation), and after (e.g., honoring the dedication and memorializing the sacrifice of HCPs) crises to increase organizational resilience and cohesion and HCPs' well-being and coping.

Research implications

The current study offers potential avenues for future research. The present study only assessed the psychological support received from participants' facilities, overlooking support from other sources, such as friends and family. Future studies could consider support from multiple networks. Additionally, the current research solely focused on participants' intention to stay in their current workplace, overlooking their intention to remain in the profession. The latter could be addressed in future research. The association between social discrimination and the intention to stay may be influenced by several factors, such as the severity and frequency of the discrimination and the individual's coping mechanisms. Likewise, the relationship between psychological support and the intention to stay may be influenced by factors such as the frequency of support and the individual's needs. Future research can gain insights into the underlying mechanisms through which these factors are related, enabling the development of targeted and effective strategies for HCPs' well-being, enhancing their resilience during healthcare crises, and promoting their retention.

Strengths and limitations

To the best of our knowledge, this study represents the first examination of discrimination against LTC staff during the COVID-19 pandemic. The countries included in the current study are diverse regarding economic statuses, healthcare systems, and demographic characteristics.[24] Including healthcare professionals from various backgrounds adds further credibility to the current results. Considering the challenges posed by data collection during the pandemic, such as the lockdown of many LTC facilities, the inability of many researchers to enter LTC, and the high workload on LTC staff, the relatively high number of participants in the current study also adds to the credibility to the results. Furthermore, this research examined multiple forms of discrimination, providing a comprehensive exploration of healthcare professionals' experiences that, to our knowledge, have not been previously undertaken.

Certain limitations of the current study merit mention. Due to the cross-sectional nature of the study design, the results provide only evidence of association, and neither causality nor the direction of association could be confirmed. The low response rate, coupled with the non-probability sampling, limits the generalizability of the results. Due to time and resource limitations, no pilot or feasibility studies were conducted, and the psychometric properties of the data collection instruments could not be confirmed. The time limitation also hindered following a forward and backward translation approach, and translating the questionnaires relied mainly on the forward translation and verification by linguists and researchers. At the beginning of the data collection, participants were asked whether they had any difficulties understanding or answering any of the questions, and no difficulties were reported. The survey did not explicitly define psychological support or collect detailed data on the received psychological support; therefore, the term psychological support might have been interpreted differently across the study participants. Although a mixed-mode design (collecting data using both online and paper-based questionnaires) was implemented to increase the response rate, we failed to document the response mode for each response.[40] Therefore, we could not examine mode-related errors, such as mode selection bias and mode measurement bias.[41]

Conclusions

The current international survey provided evidence of the negative association between experiencing social discrimination and the intention to stay among HCPs in LTC facilities. The survey also

revealed the vital role of psychological support in moderating this negative association. Investing in protecting HCPs from discrimination at both country and organizational levels would enhance their work retention, particularly during healthcare crises. Potentially helpful efforts include enacting anti-discrimination laws, running awareness campaigns, and creating supportive work environments. Future research needs to delve into the complex relationships between social discrimination, psychological support, and HCPs' retention.

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During the preparation of this work the author used *ChatGPT 3.5* to improve the clarity of the language. After using this tool/service, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

Declaration of competing interest

None

CRediT authorship contribution statement

Sameh Eltaybani: Writing – original draft, Writing – review & editing, Supervision, Project administration, Methodology, Validation, Formal analysis, Resources, Data curation, Visualization, Funding acquisition, Conceptualization. **Ayumi Igarashi:** Writing – review & editing, Methodology. **Ayse Cal:** Writing – review & editing, Methodology. **Claudia K.Y. Lai:** Writing – review & editing, Methodology. **Cristina Carrasco:** Writing – review & editing, Methodology. **Dianis Wulan Sari:** Writing – review & editing, Methodology. **Eunhee Cho:** Writing – review & editing, Methodology. **Gørill Haugan:** Writing – review & editing, Methodology. **Jorge D. Bravo:** Writing – review & editing, Methodology. **Nesreen A. Abouzeid:** Writing – review & editing, Methodology. **Patrick Alexander Wachholz:** Writing – review & editing, Methodology. **Sang-arun Isaramalai:** Writing – review & editing, Methodology. **Shaimaa Samir Dawood:** Writing – review & editing, Methodology. **Yannis Pappas:** Writing – review & editing, Methodology. **Abeer Abd El Galeel Abd-El-Moneam:** Writing – review & editing, Methodology. **Ana Beatriz Rodríguez:** Writing – review & editing, Methodology. **Bader A. Alqahtani:** Writing – review & editing, Methodology. **Catarina Lino Neto Pereira:** Writing – review & editing, Methodology. **Cathrine Ragna Solheim Jenssen:** Writing – review & editing, Methodology. **Doris S.F. YU:** Writing – review & editing, Methodology. **Felismina Rosa P. Mendes:** Writing – review & editing, Methodology. **Gurch Randhawa:** Writing – review & editing, Methodology. **Hanaa Abou El-soued Hussein Ahmed:** Writing – review & editing, Methodology. **Haruno Suzuki:** Writing – review & editing, Methodology. **Ilknur Aydin-Avci:** Writing – review & editing, Methodology. **Imam Waluyo:** Writing – review & editing, Methodology. **Irma Nurbaeti:** Writing – review & editing, Methodology. **Jitka Vseteckova:** Writing – review & editing, Methodology. **Joanna Kathryn Horne:** Writing – review & editing, Methodology. **Justina Yat Wa Liu:** Writing – review & editing, Methodology. **Kari Ingstad:** Writing – review & editing, Methodology. **Kosuke Kashiwabara:** Writing – review & editing, Supervision. **Louise Grant:** Writing – review & editing, Methodology. **Maha Mohammed Abd-El-Moniem:** Writing – review & editing, Methodology. **Mariko Sakka:** Writing – review & editing, Methodology. **Mohamed Ezzelregal Abdelgawad:** Writing – review & editing, Methodology. **Muhammad Arsyad Subu:** Writing – review & editing, Methodology. **Nichola Kentzer:** Writing – review & editing, Methodology. **Noura A. Almadani:** Writing – review & editing, Methodology. **Pablo Tomas-Carus:** Writing – review & editing, Methodology. **Renata Cunha Matheus Rodrigues-Garcia:** Writing – review & editing, Methodology. **Retno Indarwati:** Writing – review & editing, Methodology. **Sonthaya Maneerat:** Writing – review & editing, Methodology. **Wai Tong Chien:** Writing – review & editing, Methodology. **Yuko Amamiya:** Writing – review & editing, Methodology. **Yuri Wanderley Cavalcanti:** Writing – review & editing, Methodology. **Noriko Yamamoto-Mitani:** Writing – review & editing, Supervision, Project administration, Methodology, Conceptualization.

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