



Nurses' perceptions of corporate social responsibility and associated factors in the hospitals of Golestan province, Iran

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Abstract

Background: Nurses' perceptions of corporate social responsibility (CSR) in Iranian hospitals remain underexplored, particularly where formal CSR education is limited for academic nurses. Nurses' understanding of CSR-as conceptualized by Carroll's pyramid encompassing economic, legal, ethical, and philanthropic responsibilities-is crucial as they translate organizational commitments into patient care quality and safety. This study examined nurses' perceptions of CSR and the associated factors.

Methods: This cross-sectional study was conducted in 2025 among 309 nurses from 12 hospitals affiliated with Golestan University of Medical Sciences, Iran. Participants were selected using stratified proportional sampling by hospital size with convenience sampling within strata. Organizational-level CSR was assessed using Carroll's CSR questionnaire (20 items; Cronbach's $\alpha=0.89$; four dimensions; 5-point Likert scale, score range: 20-100). Associations between CSR scores and demographic factors (Age, gender, marital status, education, and ethnicity) and occupational factors (Work experience, clinical unit, and job title) were analyzed using SPSS version 26.0. Group differences were examined using one-way ANOVA, and multiple linear regression was used to identify factors independently associated with total CSR scores.

Results: The mean total CSR score was 72.39 ± 13.22 (Economic: 17.32 ± 3.67 ; legal: 18.68 ± 3.56 ; ethical: 18.35 ± 3.74 ; philanthropic: 18.04 ± 4.37). Significant associations were found with marital status ($p=0.024$, higher in single nurses), clinical unit ($p=0.006$, lowest in orthopedic, highest in dialysis/management units), and a weak negative correlation with age ($r= -0.132$, $p=0.020$) and work experience ($r=-0.116$, $p=0.041$). Multiple linear regression showed that marital status was independently associated with CSR scores ($\beta = 0.120$, $p = 0.032$). Compared with nurses in internal-surgical units, those working in orthopedic ($\beta = -0.223$, $p < 0.001$), emergency ($\beta = -0.135$, $p = 0.040$), and neonatal units ($\beta = -0.113$, $p = 0.037$) had significantly lower CSR scores. The model explained 12.1% of variance (adjusted $R^2 = 0.121$).

Conclusion: Nurses in hospitals demonstrated generally positive perceptions of corporate social responsibility. These perceptions were influenced more strongly by workplace factors-particularly the type of clinical unit-than by personal demographic characteristics. Improving organizational conditions and promoting ethical leadership may further enhance CSR awareness, professional performance, and the quality of patient care.

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Highlights

What is current knowledge?

Existing evidence highlights the importance of nurses' perceptions of corporate social responsibility (CSR) for patient care quality and safety. CSR is commonly framed using Carroll's pyramid model (Economic, legal, ethical, and philanthropic responsibilities). Moreover, formal CSR education for academic nurses in Iran is limited, indicating a knowledge gap in this context.

What is new here?

This study provides new empirical data by measuring nurses' CSR perceptions in Iranian hospitals, showing an overall positive view. It identifies key associated factors such as marital status and clinical unit type (e.g., orthopedic, dialysis/management) which had significant associations, while age and work experience showed weak negative correlations. Importantly, workplace factors-especially the clinical unit- showed stronger associations on CSR perceptions than individual demographics, offering new insights into the determinants of CSR awareness among nurses.

Introduction

Within an organizational context, corporate social responsibility (CSR) refers to an organization's commitment to financial sustainability, legal compliance, ethical integrity, and social value creation. CSR is commonly framed through Carroll's pyramid, which defines it as a multidimensional construct encompassing economic, legal, ethical, and philanthropic responsibilities (1). Although CSR originated in for-profit organizations, its framework has increasingly been applied to healthcare organizations, including hospitals, where ethical accountability and social value creation are central to organizational missions (2).

Within hospital healthcare systems, nurses play a pivotal role in patient safety (3). As frontline providers, nurses interact extensively with patients, families, and communities and are continuously exposed to organizational values, ethical standards, leadership behaviors, and socially responsible or irresponsible practices that shape care delivery (2,4-6). Consequently, nurses are well positioned to observe and interpret how hospitals fulfill their social obligations. According to the Global Corporate Sustainability 2025 report, healthcare organizations are increasingly integrating CSR within sustainability strategies (7).

However, studies from Iran and other low- and middle-income countries suggest that nursing education does not yet fully integrate social responsibility and community-oriented content, and that further efforts are needed to strengthen nurses' preparation in this area (8-10).

In hospital settings, CSR is reflected in transparent governance, equitable human resource policies, compliance with healthcare regulations, ethical clinical practice, patient- and community-centered approaches, environmental stewardship, and participation in community health initiatives (11,12). Socially responsible hospitals have been associated with stronger ethical climates, organizational trust, professional commitment (13,14) collaboration, better care outcomes, and greater patient satisfaction (15). Conversely, inadequate internal CSR may be associated with reduced job performance among nurses, while burnout remains a particularly prevalent concern in low- and middle-income countries such as Iran (16-19).

At the macro-social level, CSR is closely linked to sustainable health systems and the pursuit of equitable access to healthcare (20). Healthcare organizations are increasingly recognized as socially responsible institutions whose obligations extend beyond clinical care to include equitable access, protecting vulnerable populations, and strengthening community resilience (21,22). Hospitals can therefore be regarded as ethical stewards of public goods, the social determinants of health, and the well-being of their workforce (23,24). Measuring CSR across hospital settings is necessary to evaluate alignment with these broader societal responsibilities (23,25).

Nurses' perceptions of CSR are particularly important, as nurses constitute the largest hospital workforce and operationalize organizational policies at the clinical level. Employees' perceptions of CSR influence organizational identification, work behaviors, and employee commitment (26-28). Within the nursing profession, perceived CSR is a multifaceted construct closely associated with professional values, ethical practice, and accountability (8,10).

Although CSR has received growing attention in healthcare sector, relatively few studies have examined nurses' perceptions of hospital CSR (29), and evidence from Iran remains limited (8). Some studies have reported associations between CSR perceptions and variables such as marital status, work experience, and clinical unit (30,31). Moreover, many of these studies have been conducted with small samples or within limited settings, thereby restricting the generalizability of their findings (32).

In Iran, nurses' responses in CSR research primarily reflect perceptions of organizational responsibility rather than individual moral accountability. Formal CSR-focused educational programs are scarce, and CSR-related content is largely addressed indirectly through ethics education, professional codes, and accreditation standards. Given the central role of nurses in translating organizational values into everyday clinical practice, understanding their perceptions of hospital CSR is critical for strengthening ethical climates, workforce sustainability, and quality of care. Therefore, this study aimed to assess nurses' perceptions of corporate social responsibility and examine their associations with selected demographic and occupational characteristics.

Methods

This cross-sectional study was conducted on nurses working in hospitals affiliated with Golestan University of Medical Sciences, Iran, in 2025.

The sample size was calculated using the results of Hassanian et al. (2017) (30), who reported a Pearson correlation coefficient of 0.184. Using G*Power version 3.1.9.4 ($\alpha=0.05$, power=0.90), the required sample size was estimated at 293 nurses. Considering a 20% expected dropout rate, the target sample size was set at 352 participants (293 + 20% dropout).

Sampling was performed using stratified proportional sampling by hospital size, with convenience sampling within each stratum. Of the 352 nurses initially targeted, 309 participated, yielding a response rate of 87.78% (309/352) from 12 hospitals affiliated with Golestan University of Medical Sciences across Golestan Province (Table 1)

Inclusion criteria were willingness to participate and at least one year of clinical experience, whereas failure to answer more than 10% of the questions was considered an exclusion criterion.

Data collection instruments consisted of two parts. The first part included a demographic information form covering variables such as age, gender, ethnicity, marital status, educational level, work experience

in years, clinical unit, and job title. The second part was the Corporate Social Responsibility questionnaire developed by Carroll (1991), based on his corporate social responsibility framework (1). This questionnaire assesses corporate social responsibility at the organizational level rather than individual moral or professional responsibility and is based on Carroll's four-dimensional social responsibility model (2,8,32). It consists of 20 items designed to assess four main dimensions: economic, legal, ethical, and philanthropic (Social) responsibilities. Each dimension comprises five items (Items 1-5: economic, 6-10: legal, 11-15: ethical, and 16-20: philanthropic). Respondents rated each item on a five-point Likert scale ranging from 1 (Very low) to 5 (Very high). The total CSR score is obtained by summing all 20 items (Range: 20-100), with higher scores indicating a higher perceived level of corporate social responsibility at the organizational level (34,35).

Previous studies have demonstrated favorable psychometric properties for this instrument. Exploratory factor analysis supported a four-factor structure (KMO = 0.923; Bartlett's test of sphericity, $p < 0.0001$), explaining 74% of the total variance (36). The instrument also showed acceptable internal consistency, with a reported Cronbach's alpha of 0.813. In another study, an even higher Cronbach's alpha of 0.92 was reported (37).

Data collection was conducted face-to-face following official approval from Golestan University of Medical Sciences. Questionnaires were distributed during work shifts by the researcher and trained research assistants. The research assistant team (Postgraduate and senior undergraduate nursing students) received standardized training through two orientation sessions covering study objectives, questionnaire content, interviewing skills, and ethical principles. Although formal inter-rater reliability testing was not conducted, procedural consistency was ensured through scripted procedures and regular coordination meetings to address challenges and minimize variation. Participants completed questionnaires independently, with clarifications provided when needed. Potential sources of bias (e.g., self-report, convenience sampling within strata) were minimized through standardized training and scripted procedures.

Data analysis was conducted using SPSS version 26. Descriptive statistics (Mean, standard deviation, frequency, and percentage) were used to summarize demographic variables and CSR scores. Inferential analyses-including Pearson correlation, independent t test, and one-way ANOVA-were used to examine unadjusted associations between CSR and demographic or occupational variables. Pearson's correlation coefficients were calculated to assess linear relationships between age, work experience, and total CSR scores. A multiple linear regression analysis was conducted to identify factors independently associated with total Corporate Social Responsibility (CSR) scores. The assumptions of parametric tests were assessed prior to analysis. Homogeneity of variances was evaluated using Levene's test. Given the relatively large sample size, parametric tests were considered robust to minor deviations from normality. A p-value < 0.05 was considered statistically significant.

Table 1. Frequency distribution of nurses in selected hospitals of Golestan province

City	Hospital name	No. of Participants (n)	Percentage (%)
Gorgan	5 th Azar	46	14.9
	Sayyad Shirazi	14	4.5
Gonbad	Shohada	23	7.4
	Motahari	42	13.6
	Payambar Azam	34	11.0
Kordkuy	Amir Al-Momenin	31	10.0
Kalaleh	Rasoul Akram	19	6.1
Bandar Turkman	Imam Khomeini	27	8.7
Minoodasht	Fatemeh Zahra	18	5.8
Agh Qala	Alejalil	20	6.5
Bandar Gaz	Shohada	16	5.2
Ali Abad	Baqiyatallah Azam	19	6.1
Total	12 Hospitals	309	100

Results

A total of 309 nurses participated in the study, of whom 76.1% were female. The mean age of participants was 34.45 ± 7.85 years (Range 22–56), and the mean work experience was 10.22 ± 7.46 years. Most participants were married (71.5%) and held a bachelor's degree (93.5%). Regarding ethnicity, 57.0% were Fars, 35.9% Turkmen, 5.2% Sistani, and 1.9% belonged to other ethnic groups. Nurses were predominantly employed in specialized care units (38.2%) and internal-surgical units (26.2%), with the remainder working in emergency, women's, psychiatric, orthopedic, pediatric, dialysis, neonatal, infectious disease, and management units.

The distribution of participants across the selected hospitals is presented in Table 1.

The mean total CSR score among nurses was 72.39 ± 13.22 , while the dimension-specific scores are presented in Table 2.

Pearson's correlation analysis revealed a weak but statistically significant negative relationship between age and total CSR scores ($r = -0.132$, $p = 0.020$). Similarly, work experience was weakly and negatively associated with total CSR scores ($r = -0.116$, $p = 0.041$).

Associations between CSR scores and demographic as well as occupational characteristics are presented in Table 3. No significant differences in total CSR scores were observed according to gender, education level, job title, or ethnicity.

Marital status was significantly associated with total CSR scores, with single nurses reporting higher scores than married nurses.

Significant differences in total CSR scores were also found across clinical units.

Descriptively, nurses working in orthopedic units had the lowest total CSR scores, whereas higher mean scores were observed among nurses in dialysis and management units.

Multiple linear regression analysis showed that marital status and clinical unit were significant predictors of total CSR scores (Table 4). Higher CSR scores were observed among single nurses, whereas lower scores were found among nurses working in orthopedic, emergency, and neonatal units compared with internal-surgical units. Other demographic and occupational variables were not significantly associated with CSR scores. The model explained 12.1% of the variance in total CSR scores.

Table 2. Scores for corporate social responsibility and its four dimensions among nurses (N = 309)

Variable	Mean $\pm$ SD
Total CSR	72.39 ± 13.22
Economic responsibility	17.32 ± 3.67
Legal responsibility	18.68 ± 3.56
Ethical responsibility	18.35 ± 3.74
Philanthropic responsibility	18.04 ± 4.37

SD: Standard Deviation. Higher scores indicate higher social responsibility.

Table 3. Mean total CSR scores by demographic characteristics among nurses (N = 309)

Variables		N (%)	Total CSR Mean $\pm$ SD	P-value
Gender	Male	74 (23.9)	71.03 ± 13.64	0.383
	Female	235 (76.1)	72.81 ± 13.08	
Marital status	Single	83 (26.9)	74.43 ± 12.52	0.024
	Married	221 (71.5)	71.00 ± 13.42	
	Divorced/Widowed	5 (1.6)	74.20 ± 11.35	
Education level	Bachelor	289 (93.5)	72.21 ± 13.13	0.341
	Master and PhD	20 (6.4)	75.00 ± 14.53	
Job title	Nurse	262 (84.8)	71.98 ± 13.33	0.274
	Head Nurse	27 (8.7%)	72.41 ± 10.82	
	Supervisor	12 (3.9)	79.17 ± 10.14	
	Staff	8 (2.6)	75.63 ± 19.27	
Ethnicity	Fars	176 (57.0)	71.65 ± 14.35	0.186
	Turkmen	111 (35.9)	73.38 ± 11.36	
	Sistani	16 (5.2)	76.56 ± 11.53	
	Others	6 (1.9)	64.67 ± 12.31	
Clinical unit	Emergency	36 (11.7)	69.17 ± 15.90	0.006
	Internal-Surgical	81 (26.2)	74.35 ± 12.10	
	Women's unit	22 (7.1)	74.59 ± 10.10	
	Psychiatric	10 (3.2)	66.90 ± 8.01	
	Specialized care units	118 (38.2)	72.43 ± 12.97	
	Orthopedic	12 (3.9)	60.08 ± 15.14	
	Dialysis	5 (1.6)	78.80 ± 13.37	
	Neonatal	4 (1.3)	62.00 ± 19.53	
	Pediatric	3 (1.0)	75.67 ± 1.53	
	Infectious disease	5 (1.6)	77.40 ± 16.62	
	Management	13 (4.2)	78.62 ± 9.70	

SD: Standard Deviation.

The significance level was set at $p < 0.05$.

P-values from independent t-test for gender and from one-way ANOVA for other categorical variables.

For the PhD group (N = 1), only the raw CSR score was available; SD is not reported.

Table 4. Multiple linear regression analysis of factors associated with total CSR scores among nurses (N=309)

Variable	Category	B (Unstandardized)	SE	β (Standardized)	P-value	95% CI for B
Constant	—	75.842	4.891	—	< 0.001	66.214 - 85.470
Age (Years)	Continuous	-0.184	0.112	-0.109	0.101	-0.404 - 0.036
Work experience (Years)	Continuous	-0.087	0.118	-0.049	0.462	-0.319 - 0.145
Gender	Male (Ref)	—	—	—	—	—
	Female	1.847	1.611	0.064	0.252	-1.322 - 5.016
Marital status	Married (Ref)	—	—	—	—	—
	Single	3.281	1.528	0.120	0.032	0.275 - 6.287
	Divorced/Widowed	2.954	5.036	0.030	0.558	-6.957 - 12.865
Education level	Bachelor (Ref)	—	—	—	—	—
	Master's/PhD	2.108	2.780	0.041	0.449	-3.362 - 7.578
Job title	Nurse (Ref)	—	—	—	—	—
	Head nurse	0.542	2.396	0.013	0.821	-4.175 - 5.259
	Supervisor	5.891	3.496	0.094	0.093	-0.986 - 12.768
	Staff	3.128	4.219	0.041	0.459	-5.175 - 11.431
Ethnicity	Fars (Ref)	—	—	—	—	—
	Turkmen	1.624	1.399	0.064	0.246	-1.126 - 4.374
	Sistani	4.563	2.898	0.082	0.116	-1.142 - 10.268
	Others	-6.891	4.889	-0.077	0.160	-16.509 - 2.727
Clinical unit	Internal-Surgical (Ref)	—	—	—	—	—
	Emergency	-5.124	2.489	-0.135	0.040	-10.019 - -0.229
	Women's unit	0.238	2.956	0.005	0.936	-5.577 - 6.053
	Psychiatric	-7.446	4.037	-0.107	0.066	-15.392 - 0.500
	Specialized care	-1.892	1.844	-0.075	0.306	-5.519 - 1.735
	Orthopedic	-14.283	3.927	-0.223	<0.001	-22.011 - -6.555
	Dialysis	4.451	5.318	0.045	0.403	-6.009 - 14.911
	Neonatal	-12.362	5.897	-0.113	0.037	-23.965 - -0.759
	Pediatric	1.324	6.718	0.011	0.844	-11.897 - 14.545
	Infectious disease	3.051	5.312	0.031	0.566	-7.397 - 13.499
	Management	4.287	3.557	0.071	0.229	-2.709 - 11.283

Reference categories: Male (Gender), Married (Marital status), Bachelor (Education level), Nurse (Job title), Fars (Ethnicity), Internal-Surgical (Clinical unit). All categorical coefficients are relative to these baseline levels. Reference categories have B=0; other parameters marked as "—".

Continuous variables (Age, Work experience): Change per 1-year increase.

Model statistics: Adjusted R²=0.121; F-test p<0.001.

B = Unstandardized Coefficient; SE = Standard Error; β = Standardized Coefficient; CI = Confidence Interval.

Discussion

Nurses in Golestan Province perceived hospitals as demonstrating a generally high level of corporate social responsibility (CSR). The relatively elevated mean total CSR score (72.39 ± 13.22) and consistently high scores across its four dimensions suggest a generally favorable perception of CSR among nurses. This is consistent with Carroll's theoretical model, which conceptualizes CSR as a multidimensional construct encompassing economic, legal, ethical, and philanthropic obligations (1). This interpretation is supported by evidence from healthcare settings indicating that CSR-related organizational practices have been associated with better employee psychological well-being and lower burnout through supportive work environments and ethical organizational climates (38). Consistent with this framework, previous research has emphasized that ethical and philanthropic responsibilities represent higher-level expressions of CSR that go beyond basic economic and legal obligations, particularly in healthcare-related industries (39).

Previous Iranian nursing research has generally emphasized the ethical and philanthropic dimensions of social responsibility. (8,30).

In the current study, there were no significant differences in CSR by gender, education level, job title, or ethnicity. Such stability of CSR may indicate that it is based primarily on shared professional values, ethical norms, and the general moral foundation of nursing rather than on personal demographic factors. Previous Iranian and international

evidence support this view, suggesting that CSR is rooted in the ethical foundations of nursing codes, the development of professional identity, and expectations associated with clinical roles (30,31). The American Nurses Association (ANA) emphasizes that all nurses, regardless of their specific roles or practice settings, hold a shared professional responsibility to promote ethical practice environments and uphold social justice (6). In addition, ethics education—mostly incorporated into nursing curricula—may further enhance such uniformity by strengthening moral sensitivity and ethical reasoning across different groups of nurses (40,41).

However, marital status was significantly related to total CSR scores in the current study, with single nurses reporting higher scores than married nurses.

Iranian studies have also indicated that married nurses experience family burden and an increase in emotional and domestic workload which may narrow their scope of extra occupational ethical or socially directed activities (30,43). Research on work–family conflict likewise indicates that increased domestic responsibilities are associated with higher levels of burnout and reduced compassion satisfaction among nurses, potentially undermining their professional well-being (19). This finding contrasts with the results reported by Hassanian et al. (2017), who found that married nurses demonstrated higher levels of social responsibility compared with their single counterparts (30). This discrepancy could reflect cultural or contextual differences across occupational environments.

Significant differences were also identified among clinical units. Nurses practicing in orthopedic units self-reported lower CSR scores, while nurses working in dialysis and managerial units had higher scores. Such differences may be partly accounted for by variations in the intensity of patient care, patient turnover, the need for emotional labor, and opportunities for continued therapeutic communication. High workload clinical settings may limit time opportunities for ethical reflection and contribute to moral distress among nurses, potentially influencing their perceptions of CSR (17,44,45). In contrast, care in many dialysis units is typically long-term in nature, which may facilitate sustained patient relationships and create greater opportunities for empathy, advocacy, and ethical commitment (18,46,47). Differences in the ethical climate, leadership support, and team collaboration—some of the documented contributors to the practice of social responsibility—could also explain these differences at a unit level. The findings are also consistent with previous research emphasizing age and work experience as key drivers of responsibility-related behaviors (30). The observed weak negative association between age/work experience and total CSR contrasts with Hassanian et al., who found higher social responsibility among older/more experienced nurses (30).

The high scores on ethics and philanthropy in this study further align with Iranian concept analyses that describe CSR as multidimensional, spiritually grounded, and shaped over time through reflective professional development (8). International literature similarly frames nurses' CSR as extending beyond direct patient care to include responsibilities toward communities, vulnerable populations, and broader health systems (1,2,6).

The findings indicate that variations in nurses' CSR are primarily related to workplace conditions, especially the nature of clinical units, rather than demographic characteristics. Although organizational factors were not measured directly, differences across units suggest that workload intensity, patient turnover, emotional labor, and opportunities for sustained communication might influence CSR levels. Practical strategies such as maintaining appropriate nurse–patient ratios, managing workload, strengthening leadership support, fostering collaborative team environments, and reinforcing ethics education and reflective practice may help support CSR in hospital settings and contribute to a more supportive work environment.

Several limitations should be considered: the cross-sectional design prevented causal inferences; data were self-reported and might have been subject to response bias; the study focused on hospitals affiliated with Golestan University of Medical Sciences. This could limit generalizability of findings. Moreover, organizational culture, moral distress, emotional labor, and leadership style were not measured.

Therefore, future studies using longitudinal or mixed-methods designs could provide deeper insight into CSR in nursing by comparing regions or health systems, testing interventions to improve ethical climate and workload, and exploring nurses' experiences through qualitative methods.

Overall, these findings suggest that nurses' perceptions of CSR are influenced mainly by organizational and workplace factors, highlighting the importance of supportive work environments for enhancing CSR in hospital settings.

Conclusion

Overall, nurses in hospitals affiliated with Golestan University of Medical Sciences demonstrated generally positive perceptions of corporate social responsibility (CSR), with relatively high scores across economic, legal, ethical, and philanthropic dimensions. The findings suggest that marital status and clinical unit were significant factors associated with CSR perceptions, while age and work experience showed weak negative correlations with CSR scores; however, the relatively low explained variance indicates that additional organizational and individual factors likely contributed to these perceptions.

From a practical perspective, these findings suggest the potential value of unit-sensitive strategies to strengthen CSR and its integration into daily nursing practice, especially in clinical settings where CSR scores appeared lower.

Incorporating structured CSR education into continuing professional development programs, along with managerial strategies that promote an ethical climate and social accountability, may enhance

staff engagement and improve care quality. Future research should use longitudinal and multi-center designs to clarify causal relationships, include organizational-level determinants such as leadership and institutional policies, and examine the impact of CSR perceptions on patient outcomes, staff well-being, and organizational performance.

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Ethical Statement

Ethical approval for this study was obtained from the Ethics and Research Committee of Golestan University of Medical Sciences (IR.GOUMS.REC.1404.002). All participants were fully informed about the study objectives and procedures, and written informed consent was obtained prior to participation. Participation was voluntary, and participants were free to withdraw at any time without penalty. Confidentiality and anonymity were strictly maintained by assigning numerical codes to questionnaires, and all collected data were securely stored and accessible only to the research team. The guidelines for research involving the use of human subjects strictly adhered to the Helsinki Declaration.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

F.M. conceived the main idea, designed the statistical model and computational framework, and approved the final manuscript. M.A., M.A.K., M.M. collected the data and approved the final manuscript. F.M., M.A. designed the study, performed the data analysis, interpreted the results, and critically revised the manuscript. F.M. and M.A., A.M. drafted the manuscript. H.F. contributed to the overall study conception and approved the final manuscript.

Data Availability Statement

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Use of Artificial Intelligence

ChatGPT (OpenAI) was used solely to improve the readability and language quality of the manuscript.

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