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Analysis of Childbirth Preparation Among Pregnant Women Using the Maternal and Child Health Handbook

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ABSTRACT

Introduction: The Maternal Mortality Ratio (MMR) is a key indicator of public health and maternal healthcare quality. In Indonesia, the MMR declined to 144 per 100,000 live births in 2025, achieving the national strategic target of 183 per 100,000 live births. However, further reductions are needed to meet the 2030 Sustainable Development Goals (SDGs) target of 70 per 100,000 live births. The updated 2024 Maternal and Child Health Handbook supports pregnancy monitoring and birth preparedness. This study aimed to examine birth preparedness among pregnant women through the use of the Maternal and Child Health Handbook. **Methods:** This study employed a qualitative research method with a phenomenological approach. The study was conducted in the Candimulyo Village area, Madiun Regency, in March 2026. The study informants consisted of 12 pregnant women in their second and third trimesters who were attending prenatal check-ups. Data collection was conducted through in-depth interviews, followed by analysis involving data categorization, data presentation, and drawing conclusions. **Results:** The study results indicate that the majority of pregnant women make effective use of the Maternal and Child Health Handbook when reviewing birth preparations. **Conclusions:** The conclusion of this study is that the better a mother utilizes the Maternal and Child Health Handbook, the more effective her efforts to prepare for childbirth will be. It is recommended to seek support from healthcare professionals (midwives) and family members when preparing for childbirth by utilizing the Maternal and Child Health Handbook.

Keywords: Birth preparedness; Maternal and Child Health Handbook; pregnant women; maternal health; pregnancy

1. INTRODUCTION

The Maternal Mortality Ratio (MMR) is a key indicator for assessing the level of public health and the quality of maternal health services. According to 2025 SUPAS data, the maternal mortality rate in Indonesia has dropped drastically to 144 per 100,000 live births.[1] This means that Indonesia's maternal mortality rate has surpassed the 2025 strategic plan target of 183 per 100,000 live births. However, Indonesia continues its efforts to reduce the maternal mortality rate in order to achieve the 2030 Sustainable Development Goals (SDGs) target of 70 per 100,000 live births.[2]

Efforts to improve maternal and child health depend not only on the services provided by healthcare professionals but also require the active involvement of mothers and their families in monitoring health status throughout pregnancy, childbirth, the postpartum period, and the child's growth and development. One of the tools developed by the Ministry of Health of the Republic of Indonesia to support these efforts is the Maternal and Child

Health (MCH) Handbook. This book serves as a record-keeping tool for health services and an educational resource for mothers and families regarding pregnancy, childbirth, newborn care, immunization, and nutrition, as well as for monitoring a child's growth and development up to the age of six.[3]

The Maternal and Child Health (MCH) handbook can serve as a guide for mothers and their families in monitoring the health of the mother and baby. By making optimal use of the Maternal and Child Health (MCH) Handbook, it is expected that pregnant women will improve their knowledge regarding danger signs during pregnancy and be better prepared for childbirth. Birth preparation is a crucial aspect of ensuring a safe and comfortable childbirth experience. Birth preparedness encompasses not only physical and psychological readiness but also knowledge of the signs of labor, the choice of birth companion and birth attendant, delivery costs, health insurance coverage, the selection of the place of birthing, the availability of necessary documents and potential blood donors for emergencies, transportation arrangements, the display of the Birth Planning and Complication Prevention (*Program Perencanaan Persalinan dan Pencegahan Komplikasi* or P4K) sticker, and even planning for the contraceptive method to be used.[4]

To date, there are still pregnant women who have not made optimal preparations for childbirth. The causes include, among others, a lack of knowledge, low levels of education, parity, a lack of family support—particularly from the husband—and socioeconomic conditions. A lack of birth preparedness can lead to delays in recognizing emergencies, resulting in a failure to receive adequate healthcare, which ultimately increases the risk of morbidity and mortality for both mothers and infants.[5]

Birth preparations can be monitored using the Maternal and Child Health (MCH) handbook. The Maternal and Child Health (MCH) handbook serves as a source of information and an effective communication tool between pregnant women and healthcare workers. Every pregnant woman gets 1 (one) MCH handbook. Possession of the Maternal and Child Health (MCH) Handbook does not necessarily translate into its use as a source of information; consequently, its educational benefits have not been fully realized. In practice, the utilization of the Maternal and Child Health (MCH) Handbook remains suboptimal. Some pregnant women only bring their Maternal and Child Health (MCH) handbook to antenatal check-ups without reading or understanding the information contained within it. This situation results in some pregnant women still lacking knowledge regarding birth preparedness, despite possessing the Maternal and Child Health (MCH) Handbook.[6]

Utilizing the Maternal and Child Health (MCH) handbook serves as an effective educational strategy for enhancing mothers' preparedness for the childbirth process.[7] The 2024 edition of the Maternal and Child Health (MCH) handbook includes, among other things, more comprehensive information on birth preparation to help mothers be better prepared for childbirth. A study has shown a link between the use of the Maternal and Child Health (MCH) handbook and the level of knowledge among pregnant women regarding birth preparedness; it was found that those who utilized the handbook optimally possessed a better level of knowledge about preparing for childbirth compared to those who made less use of it.[8]

However, several research findings indicate various factors that influence birth preparedness. Based on those results, research is needed on the use of the Maternal and Child Health (MCH) Handbook in birth preparation to determine the extent to which pregnant women utilize it as a source of information and to examine its relationship with preparedness for childbirth. The research findings are expected to serve as a basis for healthcare professionals—particularly midwives—to enhance education for pregnant women by optimizing the use of the Maternal and Child Health (MCH) Handbook, thereby better preparing them for childbirth.

2. METHODS

2.1 Research Design

This study use a qualitative design with a phenomenological approach to explore in depth the experiences of informants regarding birth preparedness among pregnant women, utilizing the 2024 edition of the Maternal and Child Health (MCH) handbook. The research was conducted at Candimulyo Village, Madiun Regency, in March 2026. This research location was chosen because a review of documentation revealed several cases of maternal referrals resulting from a lack of information regarding birth preparedness, which led to delays in decision-making.

2.2 Population

An informant is an individual or subject being studied, or a person who provides information in a

research study. The key informants for this study consisted of 12 pregnant women in their second and third trimesters attending prenatal check-ups, while additional informants included midwives and the companions accompanying the pregnant women during these visits. The method used for selecting informants was purposive sampling, with inclusion criteria consisting of pregnant women in their second and third trimesters.

2.3 Data Collection

The researchers used instruments consisting of the Maternal and Child Health (MCH) handbook, interview guidelines, and writing materials. A set of 10 questions regarding birth preparedness has been compiled, based on the 2024 edition of the Maternal and Child Health (MCH) handbook. Data collection techniques using in-depth interviews.

2.4 Data Analysis

The data that has been collected is then analyzed by categorizing the data, presenting the data, and drawing conclusions. In the initial stage, researchers collected general information about the characteristics of informants. Next, the researcher inquired about the extent of the mother's preparation for childbirth in accordance with the guidelines in the Maternal and Child Health (MCH) handbook, covering ten components: knowledge of the estimated time of birth; companions for prenatal check-ups and the birthn companoin; savings for childbirth costs; health insurance coverage; the place of birth and the birth attendant; availability of necessary documents; preparation of blood donors; transportation; the display of the Birth Planning and Complication Prevention (P4K) sticker; and contraceptive method planning. The interview results were analyzed to determine the extent of the mother's preparation for childbirth.

2.5 Ethical Practices

The researchers have obtained ethical approval from the research ethics committee of Universitas Muhammadiyah Madiun (ethical approval no: 141.1/A.3-III/LPPM/2026). The research objectives and methods was submitted before data collection was carried out. The informant has completed the consent form for an interview regarding birth preparedness. The informant's name is written using initials to protect the mother's privacy.

3. RESULTS

In this chapter, the researcher presents the research findings obtained after conducting in-depth interviews with both key and additional informants. The interview was conducted while the key informant was attending a prenatal check-up.

Informant Characteristics

The key informants in this study consisted of 12 pregnant women in their second and third trimesters attending prenatal check-ups, while additional informants included midwives and the women's companions. Additional informants included the midwife who examined the pregnant woman and the mother's companion, who helped provide supplementary information. The characteristics of the informants are described in the Table 1.

Tabel 1. Informant characteristics

Informant	Age (Years)	Paritas	Pregnancy Age (Weeks)*
Key Informant			
Mrs. L	20	1	29
Mrs. R	24	1	26
Mrs. E	27	2	34
Mrs. So	22	1	36
Mrs. B	25	1	34
Mrs. Am	30	2	38
Mrs. I	27	2	37
Mrs. C	21	1	28
Mrs. Su	28	2	27
Mrs. An	32	2	38
Mrs. D	25	1	34
Mrs. G	22	1	32
Additional Informants			
Midwifery	58		
Mrs. Am's Husband	31		
Mrs. B's Husband	25		
Mrs. D's Husband	26		

Based on the table above, it is evident that the age range of all key informants falls within the productive age group of 20–32 years. Additional informants are individuals close to the mother who are knowledgeable about her personal situation and the progress of her pregnancy. Supported by information from the midwife, who conducts examinations and provides education in

accordance with the guidelines in the Maternal and Child Health (MCH) handbook. Of the study participants, 58% (7 pregnant women) were primiparas (first pregnancy), and 42% (5 pregnant women) were in their second pregnancy. In accordance with the inclusion criteria, the pregnant women serving as informants were in their second and third trimesters. The gestational age range of the mothers in this study was 26–38 weeks, comprising 83% (10 pregnant women) in the third trimester and 17% (2 pregnant women) in the second trimester.

Birth Preparation

The results of the data analysis regarding birth preparedness consist of 10 items based on the 2024 edition of the Maternal and Child Health (MCH) handbook. The study results showed that 80% of pregnant women in their second and third trimesters in Candimulyo Village, Madiun Regency, had adequately prepared for childbirth in accordance with the guidelines in the Maternal and Child Health (MCH) handbook, which served as their source of information. The data analysis is outlined as follows:

1. Knowledge about estimated time of birth

In-depth interview results indicate that all pregnant women were aware of their estimated time of birth. This is in accordance with the results of the informant interview below:

"(*while opening the Maternal and Child Health (MCH) handbook)... Yes I'm, the estimated date is July 1, 2026...*" (Mrs. R)

"...My due date is April 6th—it's very close now—but I've been having frequent contractions, so it looks like the baby might arrive early; my first child was also born two days ahead of schedule..." (Mrs. Am)

"... The midwife said the estimated date is June 16th..." (Mrs. C)

Statement from the additional informant:

"*... All pregnant women have been informed of their estimated time of birth, and it has been recorded in their Maternal and Child Health (MCH) handbook...*" (Midwife)

Based on the interview results above, it is evident that all pregnant women undergoing prenatal check-ups are aware of their estimated time of birth.

2. Companion during prenatal check-ups and the birthing

A total of 83% (10) of pregnant women stated that their husbands accompanied them to their prenatal check-ups. There were times when my husband was away from home and I would set out on my own, though occasionally I was accompanied by a close family member, such as an older sibling or my mother. 17% (two) of the pregnant women stated that they were never accompanied by their husbands; one of them said she went alone because her husband was working out of town and she was a newcomer with no family in the area, meanwhile another person was accompanied by her mother because her husband was working and she felt more comfortable having her mother with her (as it was her first pregnancy).

The results of in-depth interviews stated that all pregnant women (100%) would be accompanied by their husbands during childbirth. This is in accordance with the results of the informant interview below:

"... Usually, my husband takes me to my check-ups, and he will also accompany me during birthing..." (Mrs. L)

"... Sometimes my husband drops me off, but if he's working, I go on my own; I live nearby, so I can ride my motorbike there myself..., my husband will accompany me during birthing; he is taking time off work for it..." (Mrs. S)

"...My husband is away on an out-of-town work assignment—an official duty—so I usually go on my own; he will take leave when it is time for me to give birth..." (Mrs. C)

Statement from the additional informant:

"… I'm the one who takes her to every check-up; I've already taken time off work because she's been complaining about strong contractions. With our first child, the birthing happened a week early, so this one might come early too..." (Mrs. An's husband)

3. Saving for childbirth costs

In-depth interview results revealed that 75% (9) of the pregnant women had already prepared funds for birthing, while 12% (3) had not done so due to financial constraints. She started saving as soon as she found out she was pregnant, and she already had a substantial amount of savings. This is in accordance with the results of the informant interview below:

"... Yes, InsyaAllah, it's enough for the birthing; I've also started buying baby supplies bit by bit..." (Mrs. An)

"... I've been saving up since the beginning of the pregnancy; if I run short, my family will lend me the money..." (Mrs. I)

"... Not yet; I'd like to save up, but the money always gets used up on daily expenses. However, I plan to use BPJS for the delivery—I already have coverage..." (Mrs. B)

Statement from the additional informant:

"*... I already have savings; even though I'll be using company-provided insurance later, I'm still setting aside funds just in case they're needed at any point...*" (Mrs. An's husband)

4. Health insurance coverage

Interview results revealed that 58.3% (7) of the pregnant women already possessed health coverage for childbirth; specifically, six utilized coverage from the Social Security Agency (BPJS), while one held private insurance through her husband's employer. There are 33.3% (4 individuals) of pregnant women who do not yet have health insurance coverage; 8.3% (1 individual) are in the process of obtaining BPJS coverage, while the others are still in the planning stage. This is in accordance with the results of the informant interview below:

"*... I've been using BPJS since my first child...*" (Mrs. E)

"*... Yes, as it happens, my first child was delivered via sectio caesarea (SC) using BPJS, so it's likely this one will be a SC too...*" (Mrs. Am)

"*... It is being processed but isn't finished yet...*" (Mrs. S)

"*... Not yet; my husband plans to handle it. He said it would become active within two weeks, so we'll just take care of it closer to the due date...*" (Mrs. G)

Statement from the additional informant:

"*... For second pregnancies, most women already have BPJS coverage; it is usually those pregnant for the first time who don't have it yet. They tend to arrange it only as the birth date approaches to minimize monthly premium payments, since the coverage becomes active and usable just two weeks after registration. I have advised those without coverage to get it sorted out immediately, because you never know when it might be needed—for instance, in the event of an emergency—so it is ready to use...*" (Midwife)

5. Place and birth attendant

Interview results revealed that 66.7% (8) of the pregnant women planned to give birth at a community health center, 16.7% (2) planned to have their birthing assisted by a midwife at a private practice, and 16.7% (2) planned to birthing at a hospital due to a history of previous SC. This is in accordance with the results of the informant interview below:

"*... I've been using BPJS since my first child...*" (Mrs. E)

"*... I'd really like to be assisted by the midwife here, but she said that if I want to use BPJS coverage, I have to go to the community health center (Puskesmas)...*" (Mrs. C)

"*... Yes, as it happens, my first child was born via SC using BPJS, so it's likely this one will be a SC at the hospital too...*" (Mrs. Am)

"*... I'd like to stay right here (at the midwife's practice) and be assisted by the midwife...*" (Mrs. L)

Statement from the additional informant:

"*... Actually, many people want to give birth here, but current BPJS regulations dictate that care must be provided at community health centers (Puskesmas), and the majority of patients are BPJS members...*" (Midwife)

"*... Actually, many people want to give birth here, but because the current policy allows BPJS patients to be treated at community health centers (Puskesmas), and most of our patients are BPJS participants...*" (Midwife)

6. Availability of required documents

Interview results revealed that 83% (10) of the pregnant women already possessed and had prepared the necessary important documents, such as their identity card (KTP) and Family Cards (KK), while the remaining 17% (2) held ID cards but were still listed on their parents' Family Cards. This is in accordance with the results of the informant interview below:

"*... The identity card and family card are all complete...*" (Mrs. E)

"*... I have the identity card, but the status hasn't been updated, and I am still listed on my parents' family card..., Yes, it will be taken care of later...*" (Mrs. C)

"*... Don't have my own family card yet; I'm still listed under my parents'...*" (Mrs. L)

Statement from the additional informant:

"*... The family card (KK) and identity card (KTP) have all been replaced with new ones...*" (Mrs. R's husband)

7. Blood donor preparation

Interview results revealed that 75% (9) of the pregnant women had arranged for blood donors; the majority were husbands with the same blood type, while others were close family members such as parents and siblings. Meanwhile, 16.7% (2 pregnant women) stated they did not yet have a potential blood donor, and 8.3% (1 pregnant women) planning a hospital SC intended to follow the hospital's established procedures. This is in accordance with the results of the informant interview below:

"... My blood type is the same as my mother's, so perhaps she is the one ready to be the donor..." (Mrs. R)

"... My husband has a different blood type than I do; it's my father who has the matching type, so he might be the one to donate blood if it's needed..." (Mrs. B)

*"... Insyaallah, my husband is ready since we share the same blood type, though ideally, a transfusion won't be necessary. *Bismillah*—may everything go smoothly..."* (Mrs. I)

Statement from the additional informant:

"... I'm ready; my blood type matches my wife's, so hopefully it's a match—though, of course, I hope nothing bad happens..." (Mrs. R's husband)

8. Transportation

Interview results revealed that 83% (10) of the pregnant women had arranged for a transportation should the need arise, while 17% (2) had not yet planned for the necessary transportation. The vehicle prepared does not necessarily have to be privately owned; it can also be borrowed from parents, relatives, or neighbors who have agreed to lend their vehicle. This is in accordance with the results of the informant interview below:

"... We do have a vehicle at home—a car—but it belongs to my father; I can borrow it whenever needed..." (Mrs.S)

" ... I'm borrowing it from a neighbor; I've already asked for permission, so I can use the car when it's time to give birth..." (Mrs. I)

"... does not yet own a means of transportation..." (Mrs. Am)

Statement from the additional informant:

"... Most patients already have their own cars; if they don't own one, they usually borrow from parents or relatives. As for those who don't have a vehicle, it's not a problem—the midwife can lend them one...." (Midwifery)

9. Knowledge regarding the P4K sticker

Interview results revealed that 50% (6) of the pregnant women were informed about P4K and had displayed the P4K sticker at the front of their homes, while the other 50% (6) were informed about P4K but had not displayed the sticker, keeping it inside their Maternal and Child Health (MCH) books instead. This is in accordance with the results of the informant interview below:

"... Yes, the one stuck on the front wall of the house, right?..." (Mrs. D)

"... I'm already aware of that information, and the sticker has been put up in front of the house; I hope the birthing goes smoothly..." (Mrs. G)

Statement from the additional informant:

"... The sticker has not yet been affixed; it is still kept inside the MCH (Maternal and Child Health) handbook..." (Mrs. R)

10. Contraceptive method planning

Interview results revealed that 58.3% (7) of the pregnant women had planned a postpartum contraceptive method, while 41.7% (5) had not. Pregnant women who have previously used contraception already have options; however, first-time expectant mothers require further information regarding contraceptive methods. This is in accordance with the results of the informant interview below:

"... I'm planning to use an IUD; from what I've gathered, it's the contraceptive with the lowest risk, but the thought of it scares me..." (Mrs. B)

"... The plan is to get the 3-month contraceptive injection—the same one as before; it works well for me, and I haven't had any issues..." (Mrs. I)

"... I don't have any plans yet; I'll think about it after I give birth—I'm still considering it..." (Mrs. G)

Statement from the additional informant:

"... On average, mothers who have previously used contraception already have a family planning plan in mind; if they experienced no issues with their previous method, they usually opt to use the same one again. However, among first-time pregnant mothers, there are some who do not yet have a clear idea of what to choose..." (Midwife)

4. DISCUSSION

Based on the research findings, all key informants fell within the productive age range of 20 to 32 years. The age range of 20 to 35 is the safest time for a woman to conceive, give birth, and breastfeed, as the reproductive organs are functioning optimally. At this age, a woman is considered ready—anatomically, physiologically, and psychologically.[9]

Parity refers to the number of pregnancies a woman has carried to the age of viability—that is, the stage at which the fetus is capable of surviving outside the womb. Mothers who have been pregnant before have better experience in preparing for childbirth.[10] First-time pregnant mothers require more information regarding childbirth preparation; therefore, the Maternal and Child Health (MCH) handbook serves as an information

resource that can assist them in preparing for birthing. According to the information in the Maternal and Child Health (MCH) handbook, to ensure a smooth birthing process, birth preparations must be made well in advance—specifically, starting in the second trimester.[4] As the birthing date approaches, it is expected that preparations will be more comprehensive and thorough.

Birth Preparation

1. Knowledge about estimated time of birth

Interview results indicate that all pregnant women undergoing prenatal check-ups are aware of their estimated time of birth. The Estimated Due Date (EDD) can help the mother, her family, and healthcare professionals plan for the pregnancy and birth.[11] Information regarding the estimated due date is recorded from the beginning of pregnancy and serves as a reference for monitoring fetal growth and development, as well as for preparing for birth. Therefore, pregnant women are advised to know and understand their estimated due date (EDD) and to utilize the Maternal and Child Health (MCH) handbook as a source of information regarding birth preparation and the signs of labor—both normal and those requiring immediate attention.[12]

2. Companion during prenatal check-ups and the birthing

The interview results indicate that the husband has developed an awareness of fulfilling his roles as both a husband and a father. A birth companion is someone who provides physical, emotional, and psychological support to the mother during pregnancy and childbirth. The research results indicate that all mothers plan to be accompanied by their husbands during the birthing process. The presence of a support person can boost self-confidence, helping the mother feel safer and more comfortable facing the labor process. A birth companion is a form of mother-friendly care.[13]

3. Saving for childbirth costs

The informants' statements align with the purpose of maternity savings—namely, to plan for childbirth expenses and prepare for potential unexpected costs—even though they already possess health insurance coverage. Pregnant women who have birth savings will be calmer during pregnancy and childbirth compared to those who do not have birth savings.[14]

4. Health insurance coverage

One important component of birth preparedness is health insurance coverage, as it helps mothers and their families access safe and timely healthcare services without being hindered by costs.[15] The Maternal and Child Health (MCH) handbook explains that having health insurance coverage is part of birth preparedness, as it helps ensure access to quality healthcare services, reduces financial barriers, accelerates care in the event of complications, and supports the safety of both mother and baby.

5. Place and birth attendant

The currently high number of deliveries at community health centers (*Puskesmas*) is linked to the increase in BPJS Kesehatan enrollment. BPJS participants receive maternity services in accordance with applicable regulations.[16] Community Health Centers (*Puskesmas*) are primary healthcare facilities capable of handling low-risk deliveries within the BPJS Kesehatan referral system. Thus, BPJS Kesehatan membership contributes to increased utilization of childbirth services at community health centers (*Puskesmas*).

6. Availability of required documents

The Maternal and Child Health (MCH) handbook explains that having necessary documents—such as the Family Card (KK) and Identity Card (KTP)—ready is part of birth preparation, as it facilitates the administrative process of handling paperwork after the baby is born.[17]

7. Blood donor preparation

According to the Maternal and Child Health (MCH) handbook, arranging for blood donors is part of birth preparedness—as well as the Birth Planning and Complication Prevention (P4K) program—aimed at anticipating postpartum hemorrhage so that blood for transfusion can be obtained immediately.[18] Prospective blood donors can be family members or other individuals who meet the requirements to serve as donors.

8. Transportation

Vehicle preparation is a key component of the birth preparedness and complication readiness (P4K) plan, as it helps ensure the mother can quickly access medical assistance if needed.[19]

9. Knowledge regarding the P4K sticker

Affixing the P4K sticker is an effort to assist pregnant women, their families, and healthcare workers in preparing for a more planned childbirth. This sticker should be affixed to the home after being filled out together with a healthcare worker. The benefits of the P4K sticker include facilitating monitoring by health workers,

enhancing preparedness for complications, and reducing delays in treatment.[20]

10. Contraceptive method planning

The selection of a contraceptive method should be made through counseling with a healthcare professional, taking into account the mother's health status, lactation status, contraceptive goals, and the partner's consent. Thus, the chosen method can be safe, effective, and suited to postpartum needs.[21] In the Maternal and Child Health (MCH) handbook, contraceptive planning is part of postpartum preparation, enabling the mother and her family to plan for the use of postpartum family planning methods aimed at preventing a pregnancy too soon after childbirth.

5. CONCLUSION

Based on the results of the study, it can be concluded that 80% of pregnant women in the second and third trimesters in Candimulyo Village, Madiun Regency, had adequately prepared for childbirth in accordance with the guidelines provided in the Maternal and Child Health (MCH) Handbook as a source of information. The factors influencing childbirth preparedness included maternal age, parity, and gestational age. As maternal age increases, women tend to become more mature and better prepared to face childbirth. Mothers who have previous childbirth experience are generally more prepared physically, psychologically, and in terms of all the necessary requirements for labor and delivery. Furthermore, the more advanced the gestational age, the greater the mother's readiness to face childbirth.

Ethical Approval

This research has received approval from the Research Ethics Committee of the Institute for Research and Community Service (LPPM) at Universitas Muhammadiyah Madiun, under assignment letter number 141.1/A.3-III/LPPM/2026.

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Competing Interests

All the authors declare that there are no conflicts of interest.

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Underlying Data

Derived data supporting the findings of this study are available from the corresponding author on request.

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