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A Qualitative Phenomenological Study of Perinatal Loss Experiences in Indonesia: A Trauma-Informed Care Perspective

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ABSTRACT

Introduction: Perinatal loss is a profound health event that extends beyond medical complications and encompasses emotional, social, and spiritual consequences for the women and their families. This study aimed to explore the experiences of women, their partners, and healthcare providers. In many setting, care following perinatal loss remains primarily biomedical, with limited attention to psychosocial and bereavement needs. This study aimed to explore how women, their partners and healthcare professionals' experience and engage with perinatal loss in Indonesia and to provide recommendations for more holistic and responsive maternal healthcare services.

Methods: A qualitative phenomenological design was conducted between June and September 2025 in Yogyakarta and Central Java, Indonesia. A total of 27 participants were recruited, including 11 women who experienced perinatal loss, 7 husbands, and 9 healthcare providers (midwives and general practitioners). Data were collected through in-depth interviews and focus group discussions and analysed thematically using Braun and Clarke's six-step approach, guided by Trauma-Informed Care principles. Ethical approval was secured from the Health Research Ethics Committee of Universitas 'Aisyiyah Yogyakarta.

Results: The analysis identified four overarching themes: pregnancy journey and risks, healthcare services experiences, spiritual coping and grief after perinatal loss and bereavement care and institutional support. Participants described delayed risk recognition, inconsistent referral pathways and communication that priorities clinical information over emotional support. Mothers reported prolonged grief, guilt and spiritual searching, while fathers often experienced hidden distress and emotional suppression. Healthcare providers acknowledged emotional burden, limited training and the absence of structured bereavement protocols.

Conclusion: Perinatal loss care in Indonesia requires strengthening through trauma-informed approaches that integrate emotional, spiritual and social dimensions alongside clinical management. Developing consistent bereavement protocols and providing equitable psychosocial support for mothers and fathers are essential to improve family wellbeing and system responsiveness.

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INTRODUCTION

Perinatal loss, which includes miscarriage and stillbirth, is a traumatic experience with profound physical, emotional, and social consequences for mothers and their partners. Globally, about 10-15% of pregnancies end in miscarriage, while stillbirth accounts for nearly two million cases annually (1). The psychological effects on mothers include grief, anxiety, stress, and depression, which may be prolonged into the postpartum period and beyond (2).

Fathers also experience significant emotional distress after miscarriage. However, their responses are often delayed and less openly expressed than those of women (3). In Indonesia, miscarriage is frequently perceived as a private experience, leaving both mothers and fathers with limited access to adequate psychosocial support (4). Recent studies have highlighted that healthcare providers also face substantial emotional burdens when caring for couples who have experienced perinatal loss. Psychosocial interventions delivered by midwives and nurses have identified strategies shown to reduce grief, anxiety, depression, and PTSD among bereaved parents (5).

Previous studies on perinatal loss have primarily examined its psychological impact on mothers, including anxiety, sadness, and depression (6, 7), as well as its obstetric implications for future pregnancies and maternal-fetal attachment (8). Research also shows that strong support systems can foster emotional recovery and post-traumatic growth among parents and healthcare workers (9). Social support consistently emerges as a protective factor for maternal mental health, reducing the risk of postpartum depression (10), while also shaping the husband's role as an emotional companion (11) and contributing to the emotional strain experienced by midwives and nurses (12,13). Taken together, this body of work highlights the need for structured and compassionate support for families experiencing perinatal loss.

Despite this evidence, clinical care for perinatal loss often prioritizes physical recovery, leaving psychological and social needs insufficiently addressed. Adequate support after miscarriage has been shown to reduce post-loss health problems (14), and a majority of women in prior studies identified social support as central to coping with grief (15). Such support may come from family, peers, or healthcare professionals(10); however, many mothers hesitate to seek help due to stigma or limited support networks (16).

Self-care is increasingly recognized as important for mothers, partners, and healthcare providers in managing the impact of loss. Yet, no evidence-based self-care model is currently available, particularly one that positions healthcare providers as facilitators. Existing research also highlights ongoing challenges faced by providers, including limited training and inadequate emotional support for their own wellbeing (17).

Grounded in these gaps, this study explores how women, partners, and healthcare providers understand and navigate perinatal loss. Using a qualitative approach, it examines their experiences of support and self-care within the healthcare system, providing foundational insights for developing a context-appropriate, evidence-based self-care model.

METHOD

This study adopted a qualitative phenomenological design to explore the lived experiences of women, their partners, and healthcare providers following perinatal loss. Although this study draws on phenomenology to foreground participants' lived experiences, Braun and Clarke's thematic analysis was selected as a flexible analytic method suitable for identifying patterned meanings across accounts. This pragmatic combination allows phenomenological depth in data generation while enabling systematic theme development.

Population and Sample/Informants

This research included 27 participants: 11 women who had experienced perinatal loss within the last six months, 7 partners, and 9 healthcare providers (7 midwives and 2 general practitioners). Participants were recruited through midwives and obstetrics units in 5 hospitals using purposive criteria designed to capture maximum variation in gestational age, type of loss and parental background. Recruitment continued until thematic saturation was reached, indicated by repeated patterns with no emergence of new insights across interviews. This sample size aligns with phenomenological traditions that prioritise the depth of lived experiences rather than representativeness.

Research Location

The study was conducted in Yogyakarta, and Central Java across five hospitals, selected to reflect variations in hospital type and service context.

Instrumentation or Tools

A semi-structured interview guide was developed to explore experiences of pregnancy and loss, emotional responses, social support, self-care and future needs.

Data Collection Procedures

Data collection consisted of online in-depth interviews with mothers and partners and face-to-face focus group discussion (FGD) with healthcare providers. Online interviews were selected to ensure participant comfort and privacy while accommodating mothers who preferred discussing their loss from home. Interviews lasted between 45-90 minutes, while FGD lasted approximately 90-120 minutes and were conducted by researchers trained in qualitative interviewing and bereavement-sensitive communication. The research team adopted a constructivist epistemological stance, acknowledging that meaning is co-constructed between participant and interviewer. Reflexive memos were written after each interview to identify positionality, assumptions, and emotional reactions that could influence interpretation. A distress protocol was implemented during the in-depth interviews with women and their partners. The protocol included pausing interviews, offering grounding techniques, and providing referral information for psychological support when needed.

Data Analysis

All sessions were recorded with participants' consent, transcribed verbatim, and analysed using Braun and Clarke's thematic analysis beginning with repeated reading of transcripts and line-by-line initial coding. Codes were then grouped into conceptual categories and refined into themes through iterative discussion among researchers. This combined method reflects modern qualitative practice, valuing lived experience while using thematic analysis to make sense of the patterns that connect participants' stories. Reflexivity was maintained by documenting analytic decisions, intercoder comparisons, and regular team debriefs. Trauma-Informed Care principles (safety, trustworthiness, empowerment, peer support, and collaboration) guided theme interpretation, ensuring analytic alignment with the study's conceptual frame.

Ethical Approval

This study was approved by the Health Research Ethics Committee of Aisyiyah Yogyakarta University (Approval Number: No.4689/KEP-UNISA/VII/2025). All participants provided informed consent prior to participating in the study. The confidentiality of all participants was strictly maintained throughout the research process. All digital files were stored in encrypted password-protected folders, accessible only to the research team. Identifiers were removed during transcription, and pseudonyms were assigned to maintain anonymity. Online interviews were conducted using secure platforms with end-to-end encryption to ensure confidentiality

RESULTS

The findings describe participants' experiences across pregnancy, healthcare encounters, emotional responses, and expectations for future care. Four overarching themes were identified from the data

Table 1. Description of the respondents

Mothers' identity								Husband info
Code	**Age**	**Parity**	**Education**	**Religion**	**Cause of perinatal loss**	**Gestational age**	**Duration since loss**	**Code/Age/ Employment**
P1	33	P2A1	Bachelor	Islam	Blighted Ovum	11 weeks	2 Mos	Pr1/35/ Self employed
P2	32	P1A1	Bachelor	Islam	Ab incipient	12 weeks	4 Mos	-
P3	39	P2A1	Bachelor	Islam	Abortus	12 weeks	3 Mos	-

Mothers' identity								Husband info
Code	Age	Parity	Education	Religion	Cause of perinatal loss	Gestational age	Duration since loss	Code/Age/ Employment
P4	37	P2A0Ah1	High school	Islam	IUFD	32 weeks	2 Mos	Pr4/ 36/ Self-employed
P5	31	P3A1Ah2	Bachelor	Islam	IUFD	28 weeks	3 Mos	Pr5/ 33/ Self-employed
P6	35	P1A2	Bachelor	Islam	Abortus	12 weeks	3 Mos	Pr6/ 37/ Govt employee
P7	38	P3A2Ah1	Bachelor	Islam	IUFD	28 weeks	4 Mos	Pr7/40/ Self-employed
P8	33	P1A0	Bachelor	Islam	Blighted Ovum	12 weeks	4 Mos	-
P9	28	P1A1	Bachelor	Catholic	Foetal death	10 weeks	2 weeks	Pr9/ 31/ Teacher
P10	29	P1A2	Junior high school	Islam	Blighted Ovum	11 weeks	2 weeks	Pr10/ 39/ Self-employed
P11	25	P1A0	Bachelor	Islam	Blighted Ovum	11 weeks	2 weeks	-

Source: Primary Data, 2025
P: Participant
Pr: Partner

Table 2. Characteristics of Medical and Healthcare Personnels

Respondent	Age	Education	Length of Service (years)	Placement
M1	46	Bachelor	18	Delivery room
M2	35	Bachelor	9	Inpatient
M3	33	Bachelor	9	Inpatient
M4	34	Bachelor	10	Inpatient
M5	30	Bachelor	8	Inpatient
M6	37	Bachelor	14	Emergency room
M7	35	Bachelor	12	Delivery room
MD1	28	Medical doctor	1	Emergency room
MD2	27	Medical doctor	2	Inpatient

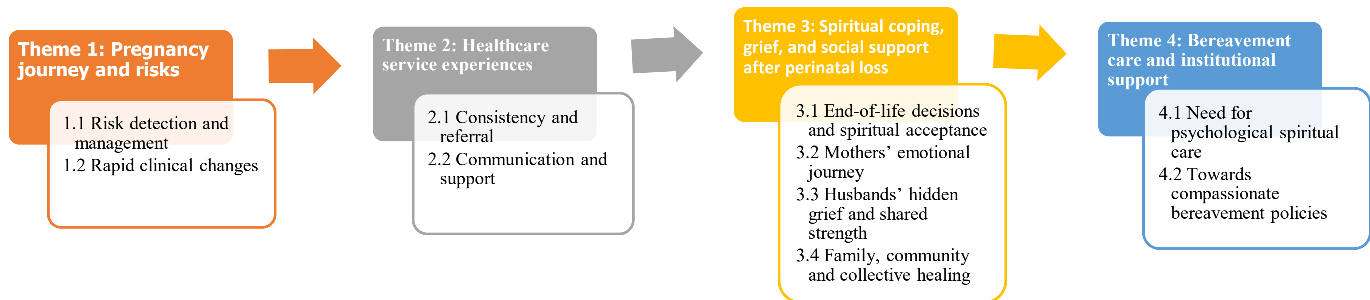
Source: Primary Data, 2025
M: Midwifery
MD: Medical Dokter

Table 3. Thematic Coding Process in Perinatal Loss Study

Data (Quotation)	Initial Code	Category	Subtheme	Theme
"I once had severe preeclampsia…" (P4)	Unrecorded risk history; delayed preventive therapy	Inconsistent documentation	Risk detection	Pregnancy journey and risks
"I was still hoping to hold on…" (P2)	Hope vs sudden miscarriage	Abrupt clinical change	Rapid clinical changes	Pregnancy journey and risks
"The clinic where I had my check-up was closed..." (P8)	Conflicting SOPs between facilities	Service inconsistency	Consistency referral	Healthcare service experiences
"The doctor's answers were flat…" (P5, husband of P5)	Lack of empathetic communication	Communication gap	Communication and support	Healthcare service experiences

Data (Quotation)	Initial Code	Category	Subtheme	Theme
"We offered a pacemaker, but we refused it…" (P4, husband of P4)	Refusing end-of-life care	Difficult parental choice	End-of-life management	Spiritual coping, grief, and social support after perinatal loss
"I had such guilt because I still did heavy work and carried my child. It took 2–3 months before I could accept." (P9)	Guilt; need for validation	Mother's grief	Mothers' emotional journey	Spiritual coping, grief, and social support after perinatal loss
"My husband started strong…" (P9, husband of P9)	Suppressed grief; gendered coping	Father's hidden grief	Husbands' hidden grief and shared strength	Spiritual coping, grief, and social support after perinatal loss
"The lack of pre-procedure preparation increased trauma." (P3)	Lack of pre-procedure preparation; increased trauma	Insufficient information	Towards compassionate bereavement policies	Emotional support and bereavement care policies

Source: Primary Data, 2025



Picture 1. Themes and Subthemes from Thematic Analysis
Source: Primary Data, 2025

Theme 1: Pregnancy journey and risks

Subtheme 1.1: Risk detection and management

The pregnancy journey of mothers who experienced loss revealed uncertainty from the detection of risk up to the sudden onset of clinical changes. Unrecorded medical histories or delayed management often triggered anxiety, as expressed by a mother with preeclampsia:

> *"I once had severe preeclampsia, but at the health centre it wasn't written in the maternal health book (KIA), and aspirin was only given when I was four months pregnant."* (P4).

From the provider's perspective, healthcare workers also acknowledged that delayed detection still frequently occurred, as expressed in the FGD:

> *"Preeclampsia cases are often detected late, sometimes patients are only referred when swelling has already appeared."* (M2).

The statement was strengthened by a participant who experienced an Intra Uterine Foetal Death (IUFD)

> *"At the midwife the heartbeat could not be found… I was referred to the health centre and then to the hospital; the doctor said the baby had been dead inside for 2-3 days."* (P7)

Such conditions often led to emergencies, when initial symptoms such as spotting suddenly progressed into bleeding or miscarriage.

> *"I was still hoping to hold on… but the next day my stomach suddenly hurt, and then clots came out right away."* (P2).

Subtheme 1.2: Rapid clinical changes

Pregnancy loss was often preceded by sudden clinical deterioration, shifting within hours from mild complaints to critical emergencies.

"In the afternoon I was given medicine, that night I had severe cramps and vomiting, tissue came out, curettage was done the next day." (P9).

"She was short of breath… the preeclampsia-related fluid had reached the lungs, so the planned surgery was brought forward to the morning." (Pr4, husband of P4).

For others, miscarriage occurred abruptly:

"On Thursday it was just a slight spotting… by Sunday night the pain became stronger and clots were expelled; by the next morning only tissue resembling the placenta remained." (P6).

Even with attempts to maintain the pregnancy, some faced inevitable loss:

"After being given misoprostol, I had cramps and heavy bleeding; when I was about to undergo curettage I was nervous, but it turned out the procedure had to be performed immediately." (P1).

Theme 2: Healthcare service experiences

Subtheme 2.1: Consistency and referral

Families often faced confusion due to different protocols across facilities.

"*At the clinic I was told to take aspirin three times a day, at the health centre only once, so I was confused*." (P4).

Her husband added:

"*We were referred from the health centre to the hospital, and were immediately treated by a specialist doctor.*" (Pr4 Husband of P4).

Providers acknowledged the same issue:

"*In the field, differences in protocols between facilities make patients confused*." (M5).

Subtheme 2.2: Communication and support

Communication often focused on medical risks, leaving families emotionally unsupported.

"*The answers were flat… so I had to look for information myself.*" (Pr5, husband of P5).

"The substitute doctor seemed in a hurry; when I asked about restrictions, the answer was brief before leaving." (P10)

In contrast, another appreciated small gestures and the care provided by healthcare providers:

"*The nurse hugged my wife, the doctor explained the risks clearly.*" (Pr4, husband of P4).

"Dr. O delivered information clearly and firmly; it helped me feel confident to proceed." (P11)

A provider admitted:

"We usually focus on clinical explanations, but sometimes forget to provide psychological support." (MD1).

Mothers described the sense of being unheard

"I felt no one was really listening," (P2)

"*it was like talking to a wall,*" (P3)

"during curettage I wished someone would say comforting words, not just instructions," (P1)

"when the clots came out, no one reassured me; it felt so lonely." (P6)

Theme 3: Spiritual coping, grief, and social support after perinatal loss

Subtheme 3.1: End-of-life decisions and spiritual acceptance

The end-of-life stage was the most difficult moment for families, when they were faced with choosing whether to continue or stop medical interventions.

"*We were offered a pacemaker (in the NICU), but we refused because the condition was already critical. My wife asked not to continue, all the equipment was already attached, so we accepted it."*." (Pr4, husband of P4).

"I was offered to see, but I couldn't; only my husband saw. We buried the baby and gave a name." (P7)

Parents performed religious and ritual acts to find solace

"Even though I had a feeling, I still had to… there was nothing else to count on. For me now, it's more about drawing closer to Allah." (P3).

"We gave the baby a name and buried it; my child said, 'I won't have a sibling after all.'" (P10)

"We named the baby 'Syawal' and buried it together with the grandparents." (P11)

"In Islam, there's a hadith that a child who dies young can give intercession to the parents." (Pr4, husband of P4)

Healthcare providers recognized the ethical challenge:

"Families are often confused in making end-of-life decisions, we need guidance for sensitive communication." (MD2).

Subtheme 3.2: Mothers' emotional journey

For mothers, the loss extended far beyond the medical event, it brought guilt, emptiness, and the challenge of finding peace.

"I felt like a failure… only felt relieved after the doctor explained in detail." (P5)

"I was just starting to feel happy about being pregnant, then suddenly had to undergo curettage, it was so hard." (P9)

"I still can't heal… every time I see the photo I cry." (P4)

"I couldn't sleep the whole night, thinking about how to tell my family." (P7)

Spiritual surrender became a way to cope:

"Even though I had a feeling, I still had to accept… now it's more about drawing closer to Allah." (P3)

Subtheme 3.3: Husbands' hidden grief and shared strength

Husbands often concealed their pain to appear strong, yet their internal struggle was equally profound.

"As a man it's hard to cry… I cry alone, not in front of my wife." (Pr5 husband of P5).

"*I had to be strong in front of my wife… I prayed that it would all be over soon.*" (Pr7, husband of P7)

"*At home I acted strong, but I was also sad; talking with fellow teachers who had gone through the same thing helped a lot*." (Pr9, husband of P9))

Yet the burden was heavy but the mother shared how her husband became her anchor:

"I kept crying, my husband stayed quiet, trying to be strong, so we took turns strengthening each other." (P6).

"It feels like I have three personalities: one sad, one being a strong husband, and one explaining to the children and parents." (Pr4 husband of P4).

Providers admitted this gap:

"The focus is usually only on the mother, even though the husband also needs space to express grief." (M3).

Subtheme 3.4: Family, community, and collective healing

Support from extended family, friends, and communities was crucial in helping parents heal through shared presence and ritual.

"I sell food at the canteen, meet many people, and it helps me forget a little." (P4).

"My mother, sister, and relatives took care of the burial; my husband stayed with me in the hospital." (P7)

"My mom stayed with me, it really helped." (P2).

Husbands also found strength through communities:

"Friends from my car and bike community kept me company, until I decided to focus on the children." (Pr5 husband of P5).

Others emphasized shared rituals also with the neighbours that also found to give strength to the mother:

"Every Thursday evening or Friday I take my wife to the grave, whenever she misses (our baby), I take her." (Pr4 husband of P4).

"*Neighbours and relatives gave their support; there was a prayer service at the family cemetery*." (P10)

"Many prayed for us, it made me feel less alone." (P3).

A provider reflected:
"Patients often rely on family or neighbours because formal services rarely provide psychosocial support." (M5).

Theme 4: Bereavement care and institutional support
Subtheme 4.1: Need for psychological and spiritual care

Both mothers and fathers emphasized the importance of emotional and psychological support during hospitalization.

"Fathers also need space to talk, not just to look strong." (Pr5, husband of P5)
"It would be good if there were psychological counselling sessions before being discharged from the hospital." (P9)
"I tried short meditation and dialogue with my family to stay grounded and not get lost in it." (Pr9, husband of P9)

Subtheme 4.2: Towards compassionate bereavement policies

Families called for clearer, more empathetic communication and formal guidance in loss situations.
"I asked, 'Will it be under general anaesthesia, Doctor?'… the answer was brief, so I got more scared." (P3)
"I cried in the consultation room, the doctor gave me time, handed me tissues, and said I could contact a psychologist if needed." (P6)
"The answers were flat… so I had to look for information myself." (P2)
Healthcare providers acknowledged this need:
"We need SOPs for bereavement support, including psychological counselling." (M7)
Participants also emphasized clarity and guidance:
"Clear and firm explanations from the doctor made me confident in my decision; this should be a standard." (P11)
"Husbands also need to be told what to do; some kind of guide for us." (Pr9, husband of P9)

DISCUSSION

The purpose of this study was to explore the experience of perinatal loss from the perspectives of mothers, fathers, and healthcare providers, and to generate service recommendations grounded in Trauma-Informed Care (TIC). By examining risk detection, healthcare services, critical decision-making, emotional grief, and families' expectations, this discussion applies the TIC framework: safety, trustworthiness, peer support, collaboration, empowerment, and choice, as the analytical lens.

The four overarching themes emerged from the data and providing insights into the medical, psychological, and social challenges families face while highlighting the areas within midwifery and maternal healthcare services in Indonesia that require further strengthening. The findings reveal delayed risk detection, inconsistent provision of care, and late recognition of pregnancy, which undermined safety and trust in early antenatal and neonatal care. Such uncertainty left mothers and families feeling unsafe at a particularly vulnerable time. Within the TIC framework, these results underscore the importance of systematic risk screening and consistent communication to ensure both psychological and clinical support.

Isobel (2023) emphasizes that maternity care should be trauma-sensitive, incorporating shared care planning and anticipation of potential complications, to avoid reinforcing feelings of unpreparedness or deepening perinatal trauma (18). In line with this, WHO (2017) recommends the first antenatal visit as early as possible in the first trimester to enable timely risk detection and follow-up, thereby enhancing safety and maternal confidence in the health system (19). Similarly, United States Preventive Services Task Force (USPSTF) guidelines advise initiating low-dose aspirin (81 mg/day) from 12 weeks' gestation for mothers at high risk of preeclampsia, reinforcing the importance of early and consistent intervention as a foundation for safety and trust in TIC (20).

The study also shows that families were often confused by hospital SOPs and by communication styles described as "flat," both of which undermine trustworthiness in TIC. Prior research highlights that inconsistent practices and non-mother-centred communication are associated with negative experiences and reduced adherence.

(21,22). By contrast, what mothers value most includes clear, consistent information and emotional support, not just biomedical explanations (23). Thus, establishing a "one source of truth" in education (standardized written materials across facilities) and embedding empathetic communication practices (e.g., teach-back, emotional validation) are not only ethical but also effective strategies to strengthen engagement and adherence. Participants' accounts of inconsistent communication and varying levels of emotional support indicate gaps in continuity of care across facilities. These variations align with global evidence showing that fragmented systems can undermine trust and psychological safety

The findings also reveal the tensions families face in making end-of-life decisions (e.g., continuation versus withdrawal of resuscitation), which demand trauma-sensitive communication, shared decision-making, and decision aids. Evidence indicates that families benefit from repeated explanations and explicit goal setting, practices that reduce distress and strengthen decision-making cohesion (24). Decision-making aids have been shown to improve the quality of clinical decision-making across contexts and could be adapted for neonatal resuscitation discussions (25). Structured family conferences that outline agenda, options, consequences, and values clarification represent a concrete way to implement collaboration and transparency in TIC.

The study also underscores profound grief among mothers; characterized by guilt and intrusive memories and emotional suppression among fathers, who often act as "pillars" for their wives. This highlights the importance of peer support and emotional validation as core elements of TIC. Structured perinatal bereavement interventions have been linked to reductions in depressive symptoms and complicated grief, alongside improved functioning (26). For fathers, the risk of PTSD and unrecognized grief is often overlooked, despite its significant prevalence and the need for specific support (27). Training in empathetic communication for healthcare professionals and obstetric teams that acknowledges fathers' dual identity as both partners and bereaved parents has been associated with more meaningful interactions and greater family satisfaction (28).

When mapped to TIC pillars, these findings lead to several operational recommendations: 1) Safety and trustworthiness: preconception/prenatal risk screening; early ANC visits; standardized aspirin orders for high-risk pregnancies, 2) Collaboration and empowerment: consistent educational materials across facilities; open ANC notes; clear policies on care, 3) Peer support: referral pathways to psychological and bereavement counselling; structured father-mother support groups.

These interventions align with health system quality agendas; clinical reliability, person-centeredness, and continuity, which are essential to reducing quality gaps in middle-income countries (19,29). Thus, TIC should not be viewed as a "soft addition," but rather as a core framework for clinical quality and patient safety, firmly rooted in evidence.

CONCLUSION

This study concludes that perinatal loss is not solely a clinical issue, but a multidimensional experience that involves emotional, social, and spiritual dynamics. Thematic analysis across four themes: pregnancy journey and risks, healthcare service experiences, spiritual coping, grief, and Bereavement care and institutional support; demonstrates how mothers, partners, and healthcare providers navigate uncertainty, fragmented care, and prolonged grief.

Recommendations emerging from these findings emphasize the need for: 1) early and consistent risk detection with standardized interventions; 2) trauma-informed communication and care planning that ensures safety, trust, and empowerment; 3) hospital policies that strengthen family access, support, and shared decision-making; 4) structured bereavement care and referral systems for both mothers and fathers; and 5) integration of trauma-informed care principles into maternal and neonatal health policies at the system level.

A major strength of this study lies in its triangulation of perspectives, capturing experiences from mothers, fathers, and healthcare providers, which provides a comprehensive and nuanced understanding of perinatal loss. The application of Trauma-Informed Care (TIC) as an analytical framework also adds theoretical and practical value, especially in the context of Indonesia's maternal health system. However, the study has limitations. The relatively small sample size and focus on three hospitals in Yogyakarta limit the generalizability of findings to other regions. As a qualitative study, the results cannot be extrapolated quantitatively, and recall bias may have influenced

participants' narratives. Future studies should consider larger, multi-site mixed-methods designs to validate and expand these insights.

AUTHOR CONTRIBUTION STATEMENT

Evi Wahyuntari (EW), Cesa Septiana Pratiwi (CSP) and Ellyda Rizki Wijhati (ERW) conceived and designed the study. CSP, EW and ERW also conducted the in-depth interviews, while Oktavianus Wahyu Prihantoro Putro (OWPP) served as the facilitator of the focus group discussion (FGD). Data analysis was carried out collaboratively by CSP and EW, ensuring triangulation and credibility of the findings. The initial draft of the manuscript was written by CSP and EW, with further refinement contributed by all authors. All authors have read and approved the final version of the manuscript.

Legend: EW = Evi Wahyuntari; ERW = Ellyda Rizki Wijhati; CSP = Cesa Septiana Pratiwi; OWPP = Oktavianus Wahyu Prihantoro Putro.

CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest that could have influenced the results of this study. The entire research and writing process was conducted independently without intervention from any party.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

While developing this manuscript, the authors utilized generative AI tools, such as Grammarly, to assist with language refinement and academic editing. All content was then carefully reviewed, validated, and revised by the authors to maintain accuracy, ensure originality, and uphold academic integrity.

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