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PREDICTORS OF EMPLOYEE PERFORMANCE AND COMPETENCE AMONG TUBERCULOSIS PROGRAM IMPLEMENTERS IN TANGERANG SELATAN HEALTH OFFICE

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Abstract

This study examines the relationships among work motivation, work tenure, work culture, work competence, and employee performance among tuberculosis (TB) program implementers across 35 community health centers (Puskesmas) under the Tangerang Selatan City Health Office. A quantitative explanatory design was used with 140 respondents selected through saturated sampling. Data were collected using a 39-item questionnaire with a four-point Likert scale and analyzed using partial least squares structural equation modeling (PLS-SEM) in SmartPLS 4. The measurement model demonstrated acceptable reliability and validity. Of the tested structural relationships, only work motivation was positively associated with work competence. Work tenure and work culture were not significantly associated with competence; none of the four predictors showed a significant direct relationship with employee performance, and work competence did not mediate the relationships between motivation, tenure, culture, and performance. The model explained 8.4% of the variance in competence and 3.7% in performance, indicating limited explanatory value for individual-level factors in this service context. The findings suggest that motivation may be used as an entry point for competence development, but performance improvement should also address organizational and service-system conditions, including workload, supervision, resources, coordination, and continuity of care. Because performance was self-reported and a separate full-collinearity assessment of common method bias was not available, these limitations should be considered when interpreting the results

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INTRODUCTION

Employee performance is a central indicator of organizational effectiveness because it reflects how employees translate assigned responsibilities into service outcomes. In public health organizations, however, performance cannot be understood solely in terms of individual capability. Health-worker performance is embedded in a broader system involving workload, leadership, resources, supervision, teamwork, professional development, and service-delivery arrangements. Recent evidence indicates that workforce development and performance emerge from the interaction between individual motivation and organizational conditions rather than from isolated employee characteristics (Endalamaw et al., 2024; Larsman et al., 2024; Fernandes et al., 2025).

The Tangerang Selatan City Health Office reported generally favorable performance in 2025, although several indicators remained below their predetermined targets. For example, the tuberculosis treatment-success rate was targeted at 90% and reached 86%, equivalent to 95.56% of the target. Although this achievement was relatively strong, the remaining gap provides a practical basis for examining the human-resource and organizational conditions surrounding TB program implementation. The present study therefore focuses on TB program implementers rather than assuming that program outcomes are a direct reflection of individual employee characteristics.

TB program implementers operate in a demanding environment that requires technical knowledge, practical skills, professional attitudes, cross-unit coordination, accurate reporting, adherence to standard operating procedures (SOPs), and continuity of patient follow-up. These demands create a theoretical tension in predicting performance. Motivation may stimulate effort and learning; tenure may provide accumulated experience; and work culture may shape discipline, communication, and shared norms. Nevertheless, these individual resources may not translate into higher performance when employees face workload pressures, limited organizational support, inadequate resources, weak coordination, or changing program requirements. Evidence from primary healthcare systems likewise indicates that leadership, teamwork, training, the work environment, and organizational support are important conditions for workforce development and performance (Endalamaw et al., 2024; Liu et al., 2025; Ghasemi & Shakerian, 2025).

Work competence is theoretically relevant because knowledge, skills, and attitudes should enable employees to perform their assigned responsibilities effectively. However, competence should not be equated with performance. Competence must be activated through opportunities to apply skills, adequate resources, supportive supervision, and effective work processes. Recent evidence on competency-based training and health-worker performance indicates that capability development can improve practice, but the transfer of competence into observable performance depends on contextual and organizational conditions (Sultan et al., 2025; Hasmin & Nurung, 2026). This distinction is particularly important when interpreting a non-significant competence–performance relationship in the present study.

Previous empirical studies have reported positive associations among motivation, competence, culture, and performance, but the strength and direction of these relationships vary across organizational settings. Research involving public-sector and healthcare workers suggests that motivation can be related to performance, while other evidence points to a stronger role for organizational support, workload, incentives, leadership, and work-system conditions (Holtan et al., 2024; Opoku & Boateng, 2024; Fernandes et al., 2025). Work tenure is similarly theoretically ambiguous: accumulated experience may increase familiarity with tasks, yet years of service do not necessarily indicate current competence when procedures, technologies, and policy requirements evolve. Likewise, a work culture emphasizing discipline and SOP compliance may standardize behavior without necessarily generating new knowledge or skills.

Despite growing research on health-worker motivation and performance, evidence remains context-dependent, and fewer studies jointly test motivation, tenure, and work culture as predictors of both competence and performance among TB program implementers in local primary-care settings. This study addresses that gap by examining

personnel across 35 Puskesmas within the Tangerang Selatan City Health Office. Its contribution is not to assume that individual HR characteristics necessarily improve performance, but to test the proposed relationships and interpret unsupported paths in light of the organizational and service-system context. The findings therefore help identify the limits of an individual-level explanatory model in a regulated, resource-dependent public-health program.

Hypothesis Development

Work motivation refers to the psychological energy that directs employees toward work goals and sustains their effort. In health services, motivation may encourage employees to seek information, participate in training, comply with procedures, and invest effort in developing job-related capabilities. Recent evidence indicates that health-worker motivation is influenced by both intrinsic and institutional factors, including professional development, organizational support, incentives, autonomy, and opportunities for knowledge sharing (Madebo et al., 2025; Assele et al., 2025). On this basis, work motivation is expected to be positively associated with work competence.

H1: Work motivation has a positive effect on work competence.

Work tenure reflects accumulated exposure to work routines and organizational experience. Longer tenure may facilitate practical knowledge and familiarity with established procedures; however, tenure does not necessarily imply continuous competence development. In dynamic health programs, changes in treatment guidelines, reporting requirements, digital technologies, and policy priorities require ongoing learning. Recent evidence from primary health services suggests that years of service may be associated with work-related attitudes and satisfaction, but its effects remain context-dependent rather than automatic (Liu et al., 2025). Accordingly, the relationship between tenure and competence requires empirical examination.

H2: Work tenure has a positive effect on work competence.

Work culture provides shared norms that can support discipline, communication, learning, and adherence to organizational expectations. However, cultural values may contribute to competence only when they are reinforced by leadership, coaching, learning opportunities, and institutional systems. Recent evidence suggests that organizational culture and team leadership can strengthen collaboration, while primary-healthcare research emphasizes supportive leadership and work environments as important mechanisms for developing competent and motivated workforces (Meng et al., 2025; Endalamaw et al., 2024).

H3: Work culture has a positive effect on work competence.

Competence is generally expected to enhance performance because employees with relevant knowledge, skills, and attitudes should be better equipped to complete their duties. In healthcare, however, performance is also shaped by workload, organizational support, leadership, teamwork, resources, and service processes. Competency-based education can facilitate the transfer of learning into practice, but contextual support remains necessary for capability to become observable performance (Sultan et al., 2025; Hasmin & Nurung, 2026).

H4: Work competence has a positive effect on employee performance.

Work motivation may influence performance by increasing effort, persistence, and goal orientation. Evidence from healthcare and public-sector settings supports this expectation,

although recent research also indicates that organizational resources and incentives can determine whether motivation is translated into actual job performance (Ghasemi & Shakerian, 2025; Lamba et al., 2025).

H5: Work motivation has a positive effect on employee performance.

Work tenure may enhance performance through accumulated experience, familiarity with procedures, and practical problem-solving. Nevertheless, longer tenure can also represent repeated exposure to routines without corresponding professional development when learning opportunities and role requirements remain unchanged. The present study therefore treats tenure as a contextual predictor rather than assuming that length of service automatically improves performance.

H6: Work tenure has a positive effect on employee performance.

Work culture may influence performance by shaping discipline, communication, collaboration, and shared expectations. Yet culture alone may be insufficient when performance depends on resources, workload, supervision, coordination, and external service conditions. Recent evidence on multidisciplinary teamwork suggests that culture and leadership can influence collaborative behavior, while broader primary-care research highlights system-level barriers to workforce performance (Meng et al., 2025; Endalamaw et al., 2024).

H7: Work culture has a positive effect on employee performance.

Work competence was initially proposed as a mediating mechanism through which motivation, tenure, and work culture might influence employee performance. This mediation argument assumes that an antecedent contributes to competence and that competence subsequently contributes to performance. Because mediation requires empirical support for the indirect pathway, the indirect effects are tested directly. The final interpretation therefore does not assume a mediating role when the data do not support it.

H8: Work competence mediates the effect of work motivation on employee performance.
H9: Work competence mediates the effect of work tenure on employee performance.
H10: Work competence mediates the effect of work culture on employee performance.

RESEARCH METHODS

Research Design and Participants

A quantitative explanatory design was employed to examine the proposed relationships among work motivation, work tenure, work culture, work competence, and employee performance. The study was conducted among TB program implementers assigned to 35 Puskesmas within the working area of the Tangerang Selatan City Health Office. The population comprised personnel involved in TB program implementation whose responsibilities included program management and service delivery. A total of 140 respondents participated, with saturated sampling used to include all eligible members of the population.

Instrument and Data Collection

Primary data were collected through questionnaires distributed directly to the respondents. The instrument used a four-point Likert scale: 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. The even-numbered response format was intentionally adopted without a neutral midpoint, requiring respondents to indicate a direction of agreement or

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disagreement. Recent methodological research treats the inclusion of a neutral category as a measurement-design decision rather than a universal requirement and directly examines the implications of four- versus five-category response formats (Kankaraš & Capecchi, 2025). The four-point format was retained because the approved instrument was designed to obtain a more directional assessment of work-related statements.

Nevertheless, removing the neutral option may place greater forced-choice pressure on respondents who genuinely hold an intermediate or uncertain position. This potential trade-off is therefore acknowledged as a methodological limitation rather than overlooked. The four-point scale should consequently be understood as a deliberate measurement choice that balances directional discrimination against respondent comfort.

Following instrument testing and refinement, 39 statements were retained: 8 items measuring work motivation, 10 measuring work tenure, 5 measuring work culture, 8 measuring work competence, and 8 measuring employee performance. Employee performance was assessed through self-reported perceptions. The results therefore represent perceived performance rather than independently verified outcomes, such as officer-level TB treatment-success rates. This measurement approach introduces potential social-desirability and common-method concerns and limits direct comparison with objective program indicators.

Table 1 Variable Operationalization

Construct	Dimensions / indicators from thesis	Item mapping	Example indicator / statement focus
Work Motivation (X1)	Herzberg: Achievement; Recognition; Responsibility; Advancement; The Work Itself	1–2; 3; 4–5; 6; 7–8	Achievement of targets; recognition; responsibility; career development; the work itself.
Work Tenure (X2)	Foster: Duration of employment; Work experience; Understanding of work; Work ability and skills; Organizational commitment	9–10; 11–12; 13–14; 15–17; 18	Length of service; accumulated experience; understanding of duties; work ability/skills; organizational commitment.
Work Culture (X3)	Wangko et al. (2026): Work discipline; Teamwork; Work communication; Compliance with procedures; responsibility/professional attitude	19; 20; 21; 22; 23	Punctuality; teamwork; communication; SOP compliance; responsible/professional behavior.
Work Competence (Z)	Sutrisno (2022): Knowledge; Understanding; Skill; Interest; Attitude	24–25; 26–27; 28–29; 30; 31	Health regulations and TB procedures; program/process understanding; planning and technical execution; interest in innovation; openness to positive change and competence development.
Employee Performance (Y)	Mangkunegara (2020): Work quality; Work quantity; Timeliness; Responsibility; Teamwork; Initiative	32–33; 34; 35–36; 37; 39; 38	Report accuracy; workload completion; timely reporting; responsibility; cooperation; initiative.

The matrix follows the operational definitions and item allocation in the approved thesis. The 39-item questionnaire was retained without changing the item allocation; the matrix is provided to make the measurement structure transparent for journal review.

The operationalization table summarizes the dimensions and representative indicators used in the 39-item instrument. The wording of the individual items was retained from the

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approved research instrument, while the table was added to make the measurement structure more transparent for journal evaluation.

Data Analysis

The data were analyzed using Structural Equation Modeling–Partial Least Squares (SEM-PLS) with SmartPLS 4. The measurement model was assessed for convergent validity using outer loadings and average variance extracted (AVE), internal consistency using Cronbach's alpha and composite reliability, and discriminant validity using the Fornell–Larcker criterion and the heterotrait–monotrait ratio (HTMT). The structural model was evaluated using path coefficients and bootstrapping at the 5% significance level. R^2 was used to assess explanatory power, f^2 to assess effect size, and inner VIF to assess potential multicollinearity. Specific indirect effects were examined to evaluate mediation. The use of HTMT is consistent with established PLS-SEM practice (Henseler et al., 2015), while prediction-oriented assessment can complement explanatory evaluation when examining the predictive value of PLS path models (Shmueli et al., 2019).

Because all constructs were measured using the same questionnaire source, common method bias (CMB) is a relevant methodological concern. A full-collinearity VIF approach has been proposed for examining potential common-method contamination in PLS-SEM (Kock, 2015). The available output reports structural inner VIF values ranging from 1.002 to 1.092, which indicate no problematic multicollinearity among the structural predictors. These values are not equivalent to a dedicated full-collinearity CMB assessment and therefore cannot establish that CMB has been ruled out. The study consequently acknowledges CMB as a limitation and does not claim that a formal CMB test was completed.

RESULTS AND DISCUSSION

Descriptive Findings

The 140 respondents represented TB program implementers from 35 Puskesmas. Descriptive statistics indicated generally favorable perceptions across the constructs. Mean scores for work motivation ranged from 2.91 to 2.94, while work-tenure indicators ranged from 2.77 to 2.98. For work culture, discipline recorded a mean of 3.03, whereas adherence to standard operating procedures (SOPs) recorded the highest mean at 3.29. For work competence, knowledge had the highest mean at 2.94 and attitude the lowest at 2.77. For employee performance, teamwork recorded the lowest mean at 2.79, while initiative had the highest mean at 2.98.

These descriptive statistics should not be interpreted as evidence of causal relationships. High mean scores indicate how respondents perceived the constructs, whereas statistical significance in SEM-PLS concerns the strength and uncertainty of relationships among constructs. This distinction is particularly important because most structural relationships in the present model were not statistically significant. Accordingly, managerial recommendations based on descriptive means are presented as exploratory areas for attention rather than as causal conclusions derived from the SEM-PLS model.

Tabel 2 Measurement Model Evaluation

Construct	Cronbach's Alpha	Composite Reliability	AVE
Work Motivation (X1)	0.869	0.897	0.526
Work Tenure (X2)	0.934	0.941	0.620

Construct	Cronbach's Alpha	Composite Reliability	AVE
Work Culture (X3)	0.796	0.846	0.525
Work Competence (Z)	0.946	0.955	0.728
Employee Performance (Y)	0.888	0.905	0.546

Cronbach's alpha and composite reliability exceeded 0.70 for all constructs. AVE values ranged from 0.525 to 0.728, exceeding the commonly used 0.50 threshold and supporting convergent validity. HTMT values were reported as ranging from 0.089 to 0.240, below the commonly used 0.90 threshold. The square roots of AVE were 0.725 for work motivation, 0.787 for work tenure, 0.725 for work culture, 0.853 for work competence, and 0.739 for employee performance; the diagonal values exceeded the corresponding inter-construct correlations. Taken together, the reported results support acceptable reliability and validity for the measurement model.

Tabel 3 Structural Model Evaluation

Relationship	β	t	p	Decision
Work Motivation → Work Competence	0.226	2.765	0.006	H1 supported
Work Tenure → Work Competence	-0.119	1.220	0.223	H2 not supported
Work Culture → Work Competence	-0.142	1.115	0.265	H3 not supported
Work Competence → Employee Performance	-0.088	0.885	0.376	H4 not supported
Work Motivation → Employee Performance	0.143	1.226	0.220	H5 not supported
Work Tenure → Employee Performance	0.072	0.367	0.714	H6 not supported
Work Culture → Employee Performance	-0.089	0.598	0.550	H7 not supported

Bootstrapping identified only one statistically significant structural relationship: work motivation was positively associated with work competence (β = 0.226; p = 0.006). This result should not be interpreted as evidence that motivation directly improves employee performance. Rather, it suggests that motivation is more closely associated with the capability-development stage of work. This interpretation is consistent with recent health-workforce research indicating that motivation is shaped by training opportunities, professional development, knowledge sharing, incentives, and institutional support (Madebo et al., 2025; Assele et al., 2025).

Work tenure did not significantly predict work competence (β = −0.119; p = 0.223). Although the coefficient was negative, the relationship was not statistically significant; therefore, longer tenure cannot be interpreted as a determinant of higher competence in this setting. Experience may increase familiarity with established routines, but competence in TB program implementation requires continuous updating as treatment guidance, reporting requirements, digital systems, and program priorities evolve. Tenure may consequently become less informative when it is not accompanied by structured training, supervision, and opportunities to apply new knowledge. This interpretation is consistent with broader evidence emphasizing continuous workforce development rather than seniority alone (Endalamaw et al., 2024; Sultan et al., 2025).

Work culture likewise showed no significant effect on work competence (β = −0.142; p = 0.265). This finding does not imply that culture is unimportant. Instead, the measured cultural dimensions did not provide evidence that general shared norms directly account for differences in competence. In a highly regulated public-health setting, discipline and SOP compliance may standardize behavior without necessarily generating new knowledge or

skills. Cultural influences may require more proximal mechanisms, such as coaching, leadership, feedback, teamwork, and access to learning resources. Recent evidence on hospital culture and multidisciplinary collaboration similarly suggests that culture operates through organizational and leadership processes rather than as an isolated determinant (Meng et al., 2025).

Work competence did not significantly predict employee performance (β = −0.088; p = 0.376). This finding is important because it challenges the assumption that individual capability automatically translates into measurable service performance. TB program implementation is a multi-actor process involving patient adherence, family support, continuity of treatment, reporting systems, availability of medicines and diagnostics, workload, coordination across units, and supervisory arrangements. Consequently, even competent employees may be unable to generate higher measured performance when system-level constraints limit opportunities to apply their capabilities. Recent health-workforce research likewise emphasizes that infrastructure, workload, organizational support, and governance conditions shape the extent to which individual capability is converted into service outcomes (Endalamaw et al., 2024; Fernandes et al., 2025).

Work motivation had a positive but statistically non-significant direct association with employee performance (β = 0.143; p = 0.220). The contrast between the significant motivation–competence relationship and the non-significant motivation–performance relationship suggests that motivation may contribute to learning or capability formation, while performance remains dependent on the organizational conditions in which those capabilities are deployed. Evidence from primary healthcare similarly indicates that motivation is intertwined with incentives, supervision, working conditions, and institutional support rather than operating independently (Ghasemi & Shakerian, 2025; Madebo et al., 2025).

Work tenure (β = 0.072; p = 0.714) and work culture (β = −0.089; p = 0.550) also showed no significant direct effects on employee performance. Taken together, these results indicate that the three individual-level predictors examined in this study do not adequately capture the determinants of performance in this setting. The findings should not be interpreted as evidence that tenure or culture are universally irrelevant. Rather, they suggest that their effects may depend on organizational resources, leadership, workload, supervision, teamwork, and broader service-system conditions. This contextual interpretation is particularly relevant in decentralized public-health organizations, where employees operate within standardized but resource-dependent systems.

Table 4 Mediation Analysis

Indirect relationship	B	t	p	Conclusion
Work Tenure → Competence → Performance	0.010	0.537	0.591	Not significant
Work Motivation → Competence → Performance	-0.020	0.760	0.447	Not significant
Work Culture → Competence → Performance	0.012	0.527	0.598	Not significant

None of the specific indirect effects reached statistical significance. Work competence therefore cannot be established as a significant mediating mechanism linking work motivation, work tenure, or work culture to employee performance in the present model. The absence of mediation is theoretically informative because the proposed individual-level pathway is interrupted by the lack of a significant competence–performance relationship. The findings therefore support a more cautious interpretation: competence development

and performance production may be conceptually related, but the tested mediation pathway was not empirically supported in this setting.

Tabel 5 Explanatory Power, Effect Size, and Collinearity

Endogenous construct	R^2	Adjusted R^2
Employee Performance	0.037	0.008
Work Competence	0.084	0.064

The model explained only 3.7% of the variance in employee performance and 8.4% of the variance in work competence. These low R^2 values represent a substantive limitation in explanatory power and indicate that most of the variation in the endogenous constructs lies outside the variables examined. In this sense, the structural model appears under-specified for explaining performance in the complex TB service environment. The small f^2 values reinforce this interpretation, with the largest effect being the effect of motivation on competence ($f^2 = 0.056$).

The low explanatory power should not be interpreted as evidence that motivation, tenure, culture, or competence have no organizational relevance. Instead, it suggests that performance may be more strongly shaped by factors located closer to the service-delivery system. Potential contextual variables include leadership, perceived organizational support, workload, staffing, resource availability, supervision quality, access to training, teamwork, digital reporting systems, patient adherence, continuity of care, and inter-unit coordination. Recent reviews and empirical studies similarly indicate that health-worker outcomes reflect interactions between individual motivation and broader organizational and system conditions (Endalamaw et al., 2024; Larsman et al., 2024; Liu et al., 2025; Fernandes et al., 2025).

DISCUSSION AND MANAGERIAL IMPLICATIONS

The principal empirical finding is deliberately narrow: work motivation is significantly associated with work competence, whereas the other tested structural pathways are not statistically supported. The most direct managerial implication of this result is to use motivation as an entry point for competence development through regular TB training, coaching, performance feedback, professional-development opportunities, and appropriate recognition. These recommendations should not be interpreted as evidence that motivation-focused interventions will automatically improve employee performance.

A second group of recommendations is derived from descriptive rather than causal findings. The attitude dimension of work competence recorded the lowest mean (2.77), while teamwork recorded the lowest employee-performance mean (2.79), and communication within the work-culture construct had a mean of 2.780. These areas may warrant exploratory managerial attention through teamwork activities, cross-program coordination, case discussions, reflective supervision, communication forums, and opportunities to strengthen adaptability and continuous learning. Because the corresponding structural relationships were not statistically significant, these recommendations should be understood as secondary exploratory implications rather than causal effects established by the SEM-PLS model.

More broadly, the Health Office should avoid relying exclusively on motivation, tenure, culture, or competence as stand-alone levers for improving performance. The low R^2

indicates that performance improvement should also address the broader work system surrounding TB implementation, including leadership, workload allocation, resource availability, supervisory quality, coordination, reporting processes, and continuity of care. This systemic orientation is consistent with evidence showing that health-worker performance depends on organizational resources and governance conditions as well as individual attributes (Endalamaw et al., 2024; Fernandes et al., 2025; Ghasemi & Shakerian, 2025).

Future research should expand the model by incorporating contextual variables that are more proximal to service delivery and, where possible, objective indicators of employee or program performance. Longitudinal and mixed-method designs could also help explain why employees who report adequate competence do not necessarily demonstrate higher performance and whether changes in organizational conditions alter these relationships over time.

STUDY LIMITATIONS

Several limitations should be considered. First, the cross-sectional design does not establish temporal order and cannot show how motivation, competence, and performance change over time. Second, performance was measured through self-reported perceptions rather than objective, officer-level TB program outcomes, creating potential social-desirability and common-method concerns. Third, the four-point forced-choice scale may have constrained respondents who genuinely held neutral or uncertain views. Fourth, the available SmartPLS output includes structural inner VIF values but no separate full-collinearity CMB assessment; therefore, CMB has not been statistically ruled out in this study. Fifth, the model explains only 3.7% of the variance in performance and 8.4% in competence, suggesting that relevant explanatory variables were not included. Future research should incorporate organizational and service-system factors, use objective TB indicators where feasible, and consider longitudinal or mixed-method designs.

CONCLUSION

The analysis identified a positive and statistically significant relationship between work motivation and work competence. Work tenure and work culture were not significantly related to competence. Work competence, motivation, tenure, and work culture did not show statistically significant direct relationships with employee performance, and the indirect effects through competence were also not significant. Given the cross-sectional survey design, these findings are interpreted as relationships within the tested model rather than definitive causal effects.

For practice, motivation may be used as an entry point for competence development through training, coaching, feedback, and professional-development opportunities. However, the model does not support treating motivation as a stand-alone intervention for improving performance. Descriptive scores suggest that attitude, teamwork, and communication may warrant exploratory attention, while the low R^2 indicates that performance improvement should also address organizational and service-system conditions.

Future research should incorporate contextual variables such as leadership, perceived organizational support, workload, work environment, job satisfaction,

organizational commitment, organizational climate, supervision quality, training access, resource availability, teamwork, patient adherence, continuity of care, and service-system effectiveness. Where feasible, future studies should also use objective performance indicators and adopt longitudinal or mixed-method approaches to clarify the mechanisms underlying employee performance in public-health program implementation.

Statement on the Use of Artificial Intelligence.

AI was used in the preparation of this manuscript. The authors used artificial intelligence tools solely to assist with language improvement, grammar checking, and editing for clarity and readability. The authors remain fully responsible for the accuracy, originality, integrity, and academic content of the manuscript. All AI-assisted content was reviewed and verified by the authors before submission.

Conflicts of interest

The authors declare no conflict of interest.

Author contributions

Conceptualization, Suherman, Subarto, and Mukrodi; data collection, Suherman; data validation, Suherman; formal analysis, Suherman and Subarto; writing—original draft preparation, Suherman; writing—review and editing, Subarto and Mukrodi; visualization, Suherman. All authors have read and approved the final version of the manuscript.

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