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# The Effect of Health Education with Audiovisual on Increasing Knowledge, Attitudes, and Practices on Maintaining Reproductive Health in Vocational School Adolescent Girls

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**ABSTRACT:** Reproductive health is one of the most prominent issues in adolescence. Adolescents at this time experience adolescent physical and psychological changes. The cause of this problem is due to the lack knowledge of adolescents about reproductive health. To improve the knowledge of adolescents through reproductive health education. The media used is audiovisual because this media is interesting because it does not only display images or writing, but also with sound so that it is expected to increase knowledge, attitudes, and practices about reproductive health. This study aims to analyze the effect of audiovisual health education on improving adolescents' knowledge, attitudes, and practices about reproductive health. This research method is a Pretest-Posttest Experiment with a control group. The study population was female adolescents at SMK Era Pembangunan 3, with a sample of 30 people. Sampling was done by random sampling. Data analysis using SPSS with Chi-Square test. Statistically obtained the results of the p-value = 0.000 <0.05. So that there is a significant effect of health education with audiovisual on increasing knowledge, attitudes, and practices about maintaining reproductive health in adolescents.

**KEYWORDS:** Adolescents, audiovisual media, reproductive health, women.

## INTRODUCTION

A person undergoes a transition from childhood to adulthood during adolescence [1]. The total population in Indonesia reaches 270 million, with 17% of the population being adolescents, or around 46 million adolescents. The proportion of women is 48% in the distribution of the adolescent population, most of which are on the island of Java, with a prevalence of 60%. [2]. Total population of adolescent girls aged 10-14 years and aged 15-19 years. equal to 10 million people [3]. During this period, adolescents will experience rapid growth, physical and mental development [4]. Adolescence not only experiences physical and mental changes but also leads to intimate relationships and psychological changes [5]. During puberty, there are hormonal changes and an increase on sexual drive (libido). This increased sexual drive requires channeling through appropriate behavior [6].

Adolescent sexual behavior has a major impact on the adolescent and their partners. The impacts of unsafe sex in adolescents include abortion, early marriage, HIV/AIDS, sexually transmitted infections, and unwanted pregnancy [6]. Reproductive health problems are more focused on women, this is indicated by the number of conditions or incidence of diseases associated with reproductive ability, and women have high risk behavior. Do not rule out the possibility of becoming victims of sexual harassment and get high social pressure on women because of gender issues, so that the situation is at greater risk of reproductive health [7]. Supported by data that recorded 3,602 cases of violence against women. As much as 58% of sexual violence against women in the public sphere or community included cases of sexual abuse (531 cases), sexual harassment (520 cases), rape (715 cases) and sexual intercourse (176 cases), as well as attempted rape. This violence against women mostly occurs at the productive age [8].

The cause of the high rate is still lack of knowledge. Based on the results of Sari's research, researchers found that out of 139 respondents, 63 people (45.32%) had sufficient knowledge and 63 people (45.32%) had less knowledge about reproductive health disorders in adolescent girls, as many as 34 people (24.46%) [9]. In addition, according to Atik's research, the cause is due to the level of knowledge. The results of the study said as many as 6.2% of adolescents had insufficient knowledge, while as many as 9.1% showed negative behavior. Apart from the lack of knowledge, there are also other factors that influence, namely local culture and customs also parents. Low economic status, and individual factors themselves [10]. In addition, some of the influencing components are low economic levels, parenting patterns, free association of adolescents, access to media information about

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pornography, and peers [11]. In addition to the lack of education related to sexual and reproductive health, role of the family, especially the parents [12].

One of the government's steps to overcome this is to implement and develop the RHR program. There are two strategies for the development of adolescent reproductive health. Two strategies for the development of adolescent reproductive health include increasing the ability and positive motivation of adolescents in terms of knowledge, behavior, and attitudes related to RH and the RH Triad, as well as mastery of life skills. The second strategy involves developing networks and positive support for adolescents as well as the PKPR RHR program, adolescent conflicts are not only physical but also psychosocial, making counseling services one of its features. Outreach to adolescent groups is also approached through educational information communication activities (IECs), group discussions (FGDs), and socialization in schools and adolescent communities [12].

According to the Indonesian Ministry of Health, one way to reduce this number is by providing health education [13]. Based on the results of the study, it is said that the health efforts set by the President through Adolescent Care Health Services focused on reproductive health education have not run optimally and are still limited. Apart from the government program for overcoming this, there is also the role of nurses [14]. The main role of nurses in overcoming this problem is to provide health education to adolescents [15]. To overcome these problems, reproductive health promotion efforts are needed, including the implementation of reproductive health education and counseling. Improving the quality of education specifically for adolescents, especially adolescent girls, is a very effective step to promote and improve their health welfare [14].

Health education can be maximally effective if the right methods and media are chosen. The methods used can be done face-to-face and using media such as audio, print media, exhibition/display, multimedia, and audiovisual [16]. In accordance with A'isy's study, the findings showed that the majority of respondents initially had poor attitudes, practices and knowledge before receiving health education but improved afterwards. Health education methods using audiovisual media proved to be more effective than leaflets [17]. In line with Setiawati's research, it shows the impact of education on adolescents' attitudes related to reproductive health [18]. Therefore, an analysis was conducted to determine the effectiveness of audiovisual education in improving knowledge, attitudes, and practices about adolescent reproductive health in vocational schools.

## METHODS

This research was conducted from April to May 2024 at SMK Era Pembangunan 3. The research location was chosen intentionally on the grounds that in SMK there is no curriculum or subjects that are obtained related to reproductive health, for example biology [19] .This study used a quasi-experimental method with a pretest-posttest pattern and a control group. The sampling technique used was random sampling and the sample taken was 30 people. The data collection technique used was a Google Form questionnaire. Data analysis using the Chi-square analysis test. The inclusion criteria in this study were those who liked audiovisuals and leaflets, then used as the control group and audiovisuals.

## RESULT

The results of data collection through questionnaires from 60 respondents. Respondent characteristics were obtained.

**Table 1. Proportion distribution of respondent characteristics of intervention group and control group**

| No | Variables | Intervention Group (Audiovisual education) n=30 | | Control Group (Eduaction with leaflet) n=30 | |
|---|---|---|---|---|---|
| | | f | % | f | % |
| 1. | **Tribes** | | | | |
| | Java | 20 | 66.7 | 13 | 43.3 |
| | Betawi | 7 | 23.3 | 11 | 36.7 |
| | Other | 3 | 10 | 6 | 20 |
| **2** | **Economics** | | | | |
| | < IDR 600,000 (down) | 10 | 33.3 | 7 | 23.3 |
| | 1,200,000 - IDR 6,000,000 (medium) | 15 | 50 | 18 | 60.0 |

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| No | Variables | Intervention Group (Audiovisual education) n=30 | | Control Group (Eduaction with leaflet) n=30 | |
|---|---|---|---|---|---|
| | | f | % | f | % |
| | > Rp 6,000,000/person/month (above) | 5 | 16.7 | 5 | 16.7 |
| 3 | **Environment** | | | | |
| | Complex | 8 | 26.7 | 9 | 30 |
| | Village | 22 | 73.3 | 21 | 70 |

Table 1 shows that the majority of respondents in the intervention and control groups were Javanese (66.7%). As for the economy, the majority in the intervention and control groups were in the middle class (50%). For the environment, the majority in the intervention and control groups were in the village environment (73.3%).

**Table 2. Proportion distribution of knowledge level before being given to intervention and control groups**

| Aspects | Knowledge Level | Intervention Group (Audiovisual education) n=30 | | Control Group (Eduaction with leaflet) n=30 | |
|---|---|---|---|---|---|
| | | f | % | f | % |
| **Pre-test** | | | | | |
| Remembering (C1) | Good | 3 | 10 | 10 | 33.3 |
| | Enough | 12 | 40 | 10 | 33.3 |
| | Less | 15 | 50 | 10 | 33.3 |
| Understanding (C2) | Good | 4 | 13.3 | 10 | 33.3 |
| | Enough | 6 | 20 | 13 | 43.3 |
| | Less | 20 | 66.7 | 7 | 23.3 |
| Application (C3) | Good | 3 | 10 | 13 | 43.3 |
| | Enough | 7 | 23.3 | 13 | 43.3 |
| | Less | 20 | 66.7 | 4 | 13.3 |
| **Post-test** | | | | | |
| Remembering (C1) | Good | 25 | 83.3 | 13 | 43.3 |
| | Enough | 5 | 16.7 | 7 | 23.3 |
| | Less | 0 | 0 | 10 | 33.3 |
| Understanding (C2) | Good | 23 | 76.7 | 6 | 20 |
| | Enough | 6 | 20 | 13 | 43.3 |
| | Less | 1 | 3.3 | 11 | 36.7 |
| Application (C3) | Good | 20 | 66.7 | 8 | 26.7 |
| | Enough | 5 | 16.7 | 13 | 43.4 |
| | Less | 5 | 16.7 | 9 | 30 |

In the knowledge questionnaire divided into 3 aspects where in the aspect of remembering (C1) before the intervention was given the results obtained 50% of the majority were in the deficient category. In the aspects of understanding (C2) and application (C3) the results obtained were 66.7% the majority were in the deficient category. Meanwhile, after providing education through audiovisuals, there was an increase in each aspect. All aspects of the majority are in the good category. In the control group before being given education through leaflets on the aspect of remembering (C1) before being given leaflets, the results were comparable between the good, sufficient, and deficient categories. In the aspect of understanding (C2), the majority of the results were in the moderate category, with as many as 13 people (43.3%). And in the application aspect (C3), the results obtained have comparable results between the good and sufficient categories for as many as 13 people (43.3%). Meanwhile, after providing education through

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leaflets, there were several improvements in each aspect. In the aspect of remembering (C1) after being given an intervention as many as 43.3% were categorized as good. In the aspect of understanding (C2) there was no increase where it was still at 43.3% the majority were in the sufficient category. And in the application aspect (C3) the results obtained by 43.3% of the majority are in the moderate category.

**Table 3. Proportion distribution of attitudes toward reproductive health in the intervention group and control group**

| Aspects | Attitude | Intervention Group (Audiovisual education) n=30 | | Control Group (Eduaction with leaflet) n=30 | |
|---|---|---|---|---|---|
| | | f | % | f | % |
| **Pre-test** | | | | | |
| Receive | Good | - | - | 25 | 83.3 |
| | Less Good | 30 | 100 | 5 | 16.7 |
| Responsible | Good | - | - | 24 | 80 |
| | Less Good | 30 | 100 | 6 | 20 |
| **Post-test** | Good | | | | |
| Receive | Less Good | 26 | 86.7 | 19 | 63.3 |
| | Good | 4 | 13.3 | 11 | 36.7 |
| Responsible | Less Good | 28 | 93.3 | 19 | 63.3 |
| | Good | 2 | 6.7 | 11 | 36.7 |

In the attitude questionnaire, it is divided into 2 levels where at the level of 'accepting' and 'taking responsibility' before the intervention, 100% were in the poor category. In the test results after providing education through audiovisuals there was an increase at each level. At the level of acceptance the results were 86.7%, which a good level. At the responsible level, 93.3% of the majority were in the good category. In the control group before being given education through leaflets at the level of acceptance before being given leaflets, the results obtained were 83.3% the majority were in the good category. At the responsible level, 80% of the majority were in the good category. After giving education through leaflets, there was a decrease where at the level of accepting the results obtained 63.3% were categorized as good. And at the responsible level the results obtained were 63.3% in the good category.

**Table 4. Proportionate distribution of practices on reproductive health in the intervention group and control group.**

| Practices | | Intervention Group (Audiovisual education) n=30 | | Control Group (Eduaction with leaflet) n=30 | |
|---|---|---|---|---|---|
| | | f | % | f | % |
| **Pre-test** | | | | | |
| | Good | 20 | 66.7 | 29 | 96.7 |
| | Bad | 10 | 33.3 | 1 | 3.3 |
| **Post-test** | | | | | |
| | Good | 27 | 90 | 18 | 60 |
| | Bad | 3 | 10 | 12 | 40 |

In the intervention group before being given education through audiovisuals, the results showed that 66.7% of the majority were categorized as good. After providing education through audiovisuals, there was an increase in the practice of respondents where the majority of 90% were categorized as good. In the control group before being given education through leaflets, 96.7% were categorized as good. After providing education through leaflets, there was a decrease in the results of 60% in the good category.

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**Table 5. Effect of audiovisual education on reproductive health on respondents knowledge**

| Aspects | Knowledge Level | Respondent Group | | p-*value* |
|---|---|---|---|---|
| | | Intervention (Audiovisual) n=30 | Control (Leaflet) n=30 | |
| **Remembering (C1)** | Good | 25 (83.3%) | 13 (43.3%) | 0.001 |
| | Enough | 5 (16.7%) | 7 (23.3%) | |
| | Less | 0 (0%) | 10 (33.3%) | |
| **Understanding (C2)** | Good | 23 (76.7%) | 6 (20%) | 0.000 |
| | Enough | 6 (20%) | 13 (43.3%) | |
| | Less | 1 (3.3%) | 11 (36.7%) | |
| **Application (C3)** | Good | 20 (66.7%) | 8 (26.7%) | 0.007 |
| | Enough | 5 (16.7%) | 13 (43.3%) | |
| | Less | 5 (16.7%) | 9 (30%) | |
| **Knowledge Level (Composite C1, C2, C3)** | Good | 27 (90%) | 7 (23.3%) | 0.000 |
| | Enough | 3 (10%) | 12 (40%) | |
| | Less | 0 (0%) | 11 (36.7%) | |

Based on the table above, the results of the Chi Square statistical test analysis show that the continuity correction test results show that the p-value = 0.000 <0.05, which means that H0 is rejected. This means that there is a significant effect of health education through audiovisual media on increasing reproductive health knowledge in vocational adolescents.

**Table 6. Pengaruh edukasi audiovisual terhadap sikap dan praktik tentang kesehatan reproduksi**

| Variabel | | Respondent Group | | p-*value* |
|---|---|---|---|---|
| | | Intervention (Audiovisual) n=30 | Control (Leaflet) n=30 | |
| Receive | Good | 26 (86,7%) | 11 (36.7%) | 0.037 |
| | Less Good | 4 (13,3%) | 19 (63.3%) | |
| Responsible | Good | 28 (93.3%) | 19 (63.3%) | 0.005 |
| | Less Good | 2 (6.7%) | 11 (36.7%) | |
| Attitude (Composite) | Good | 30 (100%) | 17 (56.7%) | 0.000 |
| | Less Good | 0 (0%) | 13 (43.3%) | |
| Practice | Good | 27 (90%) | 18 (60%) | 0.007 |
| | Bad | 3 (10%) | 12 (40%) | |

Based on the table above, the results of the Chi Square statistical test analysis show that the continuity correction test results show that the p-value = 0.000 <0.05, which means that $H_0$ is rejected. This means that there is a significant effect of health education through audiovisual media on improving attitudes and practices of reproductive health in vocational adolescents.

## DISCUSSION

This study involved respondents who were in their middle teens. Adolescents at this age are in a phase where they are more narcissistic, starting to develop reproductive organs, spending their weekends resting, maintaining their appearance, striving for success, increasing independence, gaining social status, and imagining sex and sexual behavior [20]. From the results of the study, the characteristics of each respondent were obtained. In the economic group, the majority are in the middle class. According to the European Observatory, economic status affects health attitudes. When a person's economic status is low, they will ignore health conditions. It is inversely proportional to someone with high economic status [21]. In addition, there is ethnicity, where the majority

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are Javanese. Based on data from the Informatics Communication Service Statistics, the largest tribe in the DKI Jakarta area is Javanese with a percentage of 35.16% and by the Betawi tribe with a percentage of 27.65% [22]. One of the factors that influences health behavior is ethnic or cultural background. In general, people will behave in accordance with the customs that have been passed down according to their tribe and beliefs. Inter-ethnic differences are one of the distinctive aspects of Indonesian society and are a common occurrence [23]. And finally, the characteristics of the environment, where the majority are in a village environment. The surrounding environment has the potential to have a major influence on adolescents' attitudes towards reproductive health [24]. According to the results of Hickey's research, neighborhoods in Australia are usually less developed and often have a lack of reproductive health education programs that have an impact on a person's knowledge, attitudes, and practices [25].

Knowledge is the result of information captured by sensory organs such as the eyes, nose, ears, and so on [26]. Knowledge is divided into several levels. According to Mufit's research, the thinking ability mastered by Indonesian students is at level 2, which is only up to the realm of application [27]. After the research was conducted, the results showed that for the level of knowledge from knowing, understanding, and application, the majority were categorized as lacking. Based on the results of Astikasari's research, reproductive health knowledge among adolescents is still low, especially regarding the structure of reproductive organs, their functions, impacts and problems, and how to treat them [28]. After the research was conducted, it was found that for the level of knowledge from knowing, understanding, and application, the majority were categorized After the intervention, it was found that there was an increase in knowledge by 64%. In accordance with the results of Rajagukguk's research that the level of student knowledge increased from 3.8% to 98.6% after being given health counseling. In the aspects of remembering, understanding, and application, it is quite easy for students to answer because students are easier to memorize than to reason [29]. According to the results of Sutjiato's research, there was a significant increase with an average value of 79% of respondents' knowledge after being given education. This is because the material presented is material that is liked and easily understood by adolescents [30].

Attitudes are influenced by personal experience, mass media, people who are considered important, culture, educational institutions, and emotional factors [31]. Attitude has several levels of attitude. According to Safitri, in middle adolescence it is very important to receive information about reproductive health, if adolescents have received accurate information. Then, the attitude of adolescents will be more responsible when making decisions [32]. After the research was conducted, it was found that the level of acceptance and responsibility was still lacking as many as 30 people (100%). According to other research results, most of them have a negative attitude of 63.8%, which is caused by the low knowledge of students about reproductive health [33]. According to the results of Maesaroh's research, this is caused by a lack of knowledge about reproductive health, lack of adolescent morals, namely pornography that is easily accessible [24]. The results obtained after the intervention were an increase in attitude at each level of 90%. Based on the results of Mawardika's research, there was an average change after providing reproductive health education initially 10.17 and after the intervention 12.57. An increase in good attitude can be influenced by increased knowledge because respondents respond and receive health education positively [34].

Practice or behavior is influenced by knowledge and attitudes. After the research was conducted, the results showed that for the practice of respondents in the good category were 20 people and 10 people in the bad category. Demon's research says there are still many students who show poor practices in terms of personal hygiene, premarital sexual behavior, and the tendency to watch pornographic video content. This is influenced by knowledge, the school environment, technological development, curiosity, and lust [35]. After the intervention, it was found that there was an increase in attitude at each level by 23.3%. This is in accordance with the results of Mahmud's research that 97.2% of respondents showed good behavior. This shows that the information received by respondents has a positive effect on improving their practices [36].

The results of the chi-square test in the study showed a p-value of 0.000 <0.05. This indicates that there is a relationship between the use of audiovisual education and adolescents' knowledge, attitudes and practices. This is in accordance with the results of Wirastri's research, the p-value found was 0.001 <0.05. This reveals that health education has a significant impact on the level of knowledge of adolescent reproductive health [37]. Based on the results of Koch's research after comparing health education with audiovisual and leaflets on knowledge improvement, the p-value is 0.037, which indicates a significant difference in the effectiveness of knowledge between the two groups, using audiovisual media and leaflets, where respondents tend to prefer audiovisual media. The use of videos in education allows for the delivery of information in an interesting and interactive way [38]. Janah's research shows that the use of health education with audiovisual media is more effective than using leaflets. Leaflets often

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only display image-guided instructions that are sometimes difficult for respondents to understand. In contrast, the use of video media facilitates understanding because the information is presented directly, allowing respondents to understand better [39].

A person's knowledge, attitudes and practices are strongly influenced by how they learn. Audiovisual media can optimally convey health education information [40]. Health education through video provides advantages in delivering messages evenly to students, explaining the process well, overcoming space and time limitations, and providing opportunities for students to repeat or stop the material according to their needs. The use of students' senses and thinking abilities towards images or objects in video media can affect the attitudes and behaviors of adolescent reproductive health in depth [41]. Other studies suggest that video media has advantages in explaining material concepts and skill details because it is able to display information through live illustrations. In addition, videos can also introduce informants who are experts in certain fields of material and skills, so that the explanation is more easily understood by the audience. The delivery of information in videos tends to be more complete and detailed compared to slides, which are often limited by space and the number of images so the text is shorter. Overall, video media provides a better learning experience than slides [42].

## CONCLUSION

Knowledge, attitudes, and practices of adolescents are related to reproductive health. Optimizing health education using audiovisuals on how to maintain reproductive health provides effectiveness in improving knowledge, attitudes, and practices and can reduce the impact of reproductive health problems in adolescents. Recommendations for future researchers can be research by considering continuous evaluation and paying attention to factors that can affect education related to how to maintain reproductive health. And schools can add a curriculum related to reproductive health.

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