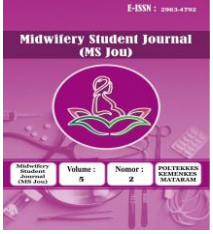
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Motivational Video And Testimonial Education: Knowledge And Long-Acting Contraceptive Choice

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ABSTRACT

Background: Limited knowledge and misconceptions may discourage informed consideration of long-acting contraceptive methods (LACMs). Objective: To compare motivational video and testimonial (VMT) education with ABPK-KB flipchart counseling in relation to contraceptive knowledge and post-education method choice. Methods: A quasi-experimental pretest–posttest comparison involved 30 women of reproductive age in Babakan Timur, Mataram, in 2025 (15 per group), selected purposively without random allocation. Knowledge was assessed before and after education, and method choice was recorded afterward. Wilcoxon and Mann–Whitney tests were reported for knowledge; Pearson's chi-square was calculated for the choice frequencies. Results: Mean knowledge scores increased from 58.3 to 87.0 in the VMT group and from 55.3 to 70.0 in the flipchart group (within-group $p = .001$ for both groups; reported between-group $p < .001$). After education, 60.0% versus 20.0% selected LACMs (Pearson $\chi^2(1) = 5.00$, $p = .025$, calculated from reported counts). Conclusion: VMT education was associated with larger immediate knowledge gains and more frequent post-education LACM choice. Actual initiation or continued use was not measured.

Keywords: long-acting contraception; motivational video; testimonials; contraceptive knowledge; contraceptive choice

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INTRODUCTION

Access to accurate information is central to informed contraceptive decision-making. Although family-planning services offer a range of highly effective methods, women may hesitate to choose long-acting options because of limited knowledge, perceived side effects, circulating myths, and concerns about the insertion procedure. Long-acting contraceptive methods (LACMs), referred to in Indonesia as metode kontrasepsi jangka panjang (MKJP), include intrauterine devices, implants, and permanent methods. Educational approaches should help clients consider the effectiveness, benefits, limitations, and suitability of available methods while respecting individual preferences (Shintya & Monde, 2021; Utami & Sari, 2022).

Indonesia continues to face challenges in achieving balanced use of family-planning options. The source study reported that injectable contraceptives (35.3%) and pills (13.2%) were more frequently used in 2023 than implants (10.5%), intrauterine devices (8.9%), female sterilization (4.1%), and male sterilization (0.2%). In Babakan Timur, Babakan Urban Village, Mataram City, West Nusa Tenggara, local service figures cited by the investigators listed 90.16% of users with non-LACMs and 8.72% with LACMs. Because these two figures total 98.88%, the remaining 1.12% and the register reporting year cannot be identified from the available manuscript materials. These contextual figures should therefore not be regarded as a complete method distribution.

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A preliminary assessment conducted in December 2024 at a community health post in Babakan Timur further identified substantial information gaps. Eight of ten women interviewed were unfamiliar with LACMs, and six used injectable contraception. Participants reportedly expressed concerns and misconceptions regarding long-acting methods. Such findings highlight the need for clear counseling that not only explains method characteristics but also addresses fears and allows women to evaluate choices in accordance with their reproductive intentions.

Conventional counseling aids such as the ABPK-KB flipchart can organize explanations of contraceptive methods. However, communication based solely on printed material may not fully respond to questions about lived experience, side effects, and the practical process of using a method. Audiovisual education may provide an additional channel for presenting practical information through spoken explanation, pictures, and relatable experiences. Health educators have also reported the usefulness of interactive audiovisual materials in different teaching settings (Arsyad et al., 2021). An Indonesian study reported improvement in women's knowledge of intrauterine devices after an audiovisual educational intervention (Marizi et al., 2019).

Evidence from other settings also supports the potential of video-assisted counseling, although effectiveness varies by outcome and population. Burapasikarin et al. (2020) found higher postpartum uptake of long-acting reversible contraception after educational video exposure in a randomized trial. Ingersoll (2021) reported gains in adolescents' knowledge after an online video intervention, and Vayngortin et al. (2020) evaluated educational video counseling among adolescents attending emergency care. Recent studies in Australia found substantial immediate improvement in contraceptive knowledge and preference after tailored videos; however, changes in stated preferences did not consistently translate into later uptake (Mazza et al., 2022, 2024, 2025).

Testimonial-based educational materials add a further dimension by presenting personal experiences and possible reasons for choosing a treatment or preventive method. Experimental evidence indicates that narrative testimonials and other decision-support approaches can help people feel more prepared for preference-sensitive choices (Korger et al., 2021). In contraceptive counseling, this approach should be balanced and should not pressure clients toward a specific method. Rather, it should complement accurate information and shared decision-making (Borrero et al., 2024).

The motivational video and testimonial (VMT) method evaluated in the present study combines an explanatory motivational segment with accounts from contraceptive users. The study's distinctive feature was to compare this combined audiovisual approach against the routinely used ABPK-KB flipchart in a community where local uptake of LACMs was low. The aim was to assess differences in knowledge improvement and in post-education selection of LACMs among women of reproductive age in Babakan Timur in 2025.

METHODS

This quasi-experimental study used two nonrandomized groups with pretest and posttest assessments in Babakan Timur, Babakan Urban Village, Mataram City, Indonesia, during 2025. The study population comprised couples of reproductive age in the community, while the participants analyzed were 30 women of reproductive age recruited purposively. Fifteen participated in VMT education and fifteen in flipchart counseling. Eligibility was described in the available manuscript only in terms of women of reproductive age from the study setting; additional inclusion or exclusion criteria were not specified. Group assignment was not randomized, and the allocation procedure beyond the recorded 15:15 distribution was not documented. These omissions limit evaluation of selection bias.

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The intervention group received LACM education through motivational video content and testimonials from contraceptive users; the comparison group received counseling on the same topic with the ABPK-KB flipchart. Knowledge was assessed before and after the educational encounter, while post-education method choice was recorded as LACM or another method using a separate questionnaire. The educational content and mode of delivery are known, but the video length, counseling duration, number of sessions, and exact interval to posttesting were not specified in the available records. Knowledge scores were reported numerically and as good, moderate, or poor categories. The original documentation did not supply the item count, theoretical score range, category cutoffs, or instrument validity and reliability statistics; these should not be inferred from the observed scores.

Descriptive results are presented as frequencies, percentages, means, and standard deviations. Wilcoxon signed-rank tests were reported for within-group knowledge differences; a Mann–Whitney U test was reported for the between-group knowledge comparison. The statistical source did not identify whether that comparison used posttest scores or individual change scores, so the between-group p-value is presented as reported without assigning it to either contrast. For the 2 × 2 post-education choice counts (9 vs 3 women selecting LACMs), an uncorrected Pearson chi-square statistic was independently calculated as $\chi^2(1) = 5.00$, $p = .025$; this figure should be cross-checked with the primary statistical output. Two-sided significance was set at $p < .05$. Ethical review status, research permission, and participant informed-consent procedures could not be verified from the available manuscript materials; no ethics approval number is asserted.

RESULTS

A total of 30 women participated, with 15 assigned to the intervention group and 15 to the flipchart control group. Their characteristics are summarized in Table 1. The majority in both groups were aged 20–35 years, had secondary education, did not have paid employment, and were multiparous.

Table 1. Participant characteristics by study group (n = 30)

Characteristic	VMT group n (%)	Flipchart group n (%)
Age <20 or >35 years	6 (40.0)	7 (46.7)
Age 20–35 years	9 (60.0)	8 (53.3)
Primary education or less	2 (13.3)	1 (6.7)
Secondary education	11 (73.3)	13 (86.7)
Higher education	2 (13.3)	1 (6.7)
Employed	6 (40.0)	5 (33.3)
Not employed	9 (60.0)	10 (66.7)
Primiparous	4 (26.7)	2 (13.3)
Multiparous	10 (66.7)	13 (86.7)
Grand multiparous	1 (6.7)	0 (0.0)

Knowledge improved in both groups, although post-education scores favored VMT. The proportion categorized as having good knowledge increased from 2 of 15 (13.3%) to 14 of 15 (93.3%) in the VMT group and from 1 of 15 (6.7%) to 5 of 15 (33.3%) in controls (Table 2). The category labels are retained as reported; their numerical thresholds were not documented in the supplied source material.

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Table 2. Knowledge categories before and after education

Knowledge category	VMT pretest n (%)	VMT posttest n (%)	Control pretest n (%)	Control posttest n (%)
Good	2 (13.3)	14 (93.3)	1 (6.7)	5 (33.3)
Moderate	5 (33.3)	1 (6.7)	4 (26.7)	8 (53.3)
Poor	8 (53.3)	0 (0.0)	10 (66.7)	2 (13.3)

After education, 9 of 15 women (60.0%) in the VMT group selected an LACM, compared with 3 of 15 (20.0%) in the flipchart group (Table 3). This was a self-reported post-education choice, not verified initiation, correct use, or continuation.

Table 3. Post-intervention contraceptive choice

Post-education choice	VMT group n (%)	Flipchart group n (%)
Long-acting method (LACM)	9 (60.0)	3 (20.0)
Other contraceptive method	6 (40.0)	12 (80.0)

Mean knowledge increased from 58.3 (SD 9.9) to 87.0 (SD 5.9) in the VMT group (a 28.7-point increase) and from 55.3 (SD 13.0) to 70.0 (SD 11.6) in controls (a 14.7-point increase). The reported Wilcoxon p-value was .001 within each group, and the reported between-group Mann–Whitney p-value was < .001 (Table 4).

Table 4. Descriptive knowledge scores and reported statistical tests

Statistic	VMT pre	VMT post	Control pre	Control post
Minimum score	45	70	35	50
Maximum score	80	95	80	85
Mean score	58.3	87.0	55.3	70.0
Standard deviation	9.9	5.9	13.0	11.6

Observed mean pretest–posttest differences were +28.7 points (VMT) and +14.7 points (control). The original analysis reported Wilcoxon p = .001 in each group and Mann–Whitney p < .001 between groups; it did not establish whether the latter test compared posttest values or change scores.

DISCUSSION

The VMT group showed a larger immediate improvement in knowledge and a higher proportion of post-education LACM choices than the flipchart group. A plausible explanation is that video can demonstrate contraceptive procedures visually, while user testimonials can make practical experiences more tangible. These formats may address concerns that are difficult to communicate through printed material alone. However, this nonrandomized study cannot establish that VMT itself caused the observed differences.

Baseline characteristics were generally comparable in broad categories, but only 15 participants were included in each group. Age, educational background, employment, and parity may shape contraceptive information needs and preferences, and no adjusted comparison was available. These considerations are compatible with prior work on counseling, reproductive decision-making, and partner-related factors (Henniwati, 2020; Mahardany et al., 2023; Mariati, 2018; Utami & Sari, 2022).

Both educational formats were followed by improved knowledge. The larger observed gain with VMT may reflect the combined use of consistent audiovisual explanation and relatable narratives, rather than the inadequacy of conventional counseling. Because knowledge categories

were not linked to verified scoring cutoffs and baseline equivalence was not formally established, this interpretation should be regarded as tentative.

Audiovisual materials can repeat complex information in a consistent, accessible format and visually illustrate the steps involved in contraception. Marizi et al. (2019) and more recent Indonesian studies reported improved IUD-related knowledge after audiovisual education (Herrin, 2026; Lubis et al., 2026; Nasution et al., 2026). Ingersoll (2021) similarly reported improved LACM knowledge after video-based education among younger women, while Burapasikarin et al. (2020) examined subsequent postpartum LARC use in a randomized trial. Because the designs and outcomes differ, these findings support plausibility rather than direct equivalence.

Testimonials may help women interpret technical information through concrete experiences with insertion, side effects, satisfaction, and discontinuation. In experiments involving preference-sensitive decisions, Korger et al. (2021) found that patient narratives or decision strategies could improve decision preparedness. Such narratives should remain balanced and should not create pressure to select a particular method. Individual preferences and informed decision-making remain central to respectful contraceptive counseling (Borrero et al., 2024).

Post-education LACM choice was more frequent in the VMT group (60.0% vs 20.0%). Pearson's chi-square derived from the displayed frequencies yielded $p = .025$, as reported in Table 3. Given the small groups, nonrandom allocation, and a single immediate choice measure, this finding should not be interpreted as evidence of actual contraceptive uptake.

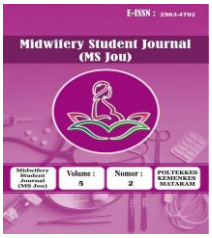
Evidence on video-based contraceptive education also distinguishes stated preference from subsequent use. Mazza et al. (2022, 2024, 2025) documented improvements in knowledge and LARC preference, but increases in preference did not consistently become increased uptake at follow-up. A trial involving women with systemic lupus erythematosus likewise examined knowledge, attitudes, and method use after video education (Kittichaovanun et al., 2026). Service availability, clinical assessment, partner considerations, and access to trained providers may influence whether informed preference becomes actual adoption.

The principal limitations were purposive recruitment, nonrandom group allocation, small group sizes, no adjusted analyses, and measurement of immediate choice rather than contraceptive uptake. Important procedural details (eligibility rules, allocation mechanism, educational duration, testing interval, knowledge-score cutoffs, instrument validation, and ethics/consent documentation) were unavailable in the supplied records. In addition, the contrast tested by the reported between-group Mann–Whitney procedure and the original p-value for the 2 × 2 choice analysis need verification from primary statistical outputs.

Further studies should specify the primary outcome, document intervention and instrument procedures, and use larger samples with random allocation or baseline-adjusted analyses. Research should follow actual method initiation and continuation, alongside women's experience of informed and voluntary choice. In current practice, VMT can be considered as an adjunct to person-centered counseling, rather than a substitute for individualized assessment or comprehensive contraceptive options.

CONCLUSION

Among 30 women of reproductive age in Babakan Timur, VMT education was associated with larger immediate knowledge gains and a higher proportion of reported post-education LACM choices than flipchart counseling. The study did not assess confirmed initiation or continuation of contraception. These preliminary findings support exploring audiovisual testimonials as a



complement to person-centered family-planning counseling, with further validation in larger studies.

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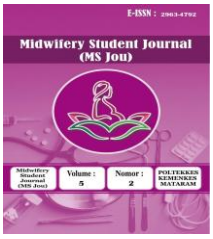
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