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ARTIKEL

ENHANCING DIGITAL HEALTH LITERACY THROUGH ARTIFICIAL INTELLIGENCE-BASED AUDIOVISUAL EDUCATION AMONG ADULTS AT RISK OF DIABETES MELLITUS

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Abstract

Digital health literacy is important for enabling communities to access, evaluate, and use reliable health information for diabetes prevention. This community service activity aimed to improve diabetes prevention knowledge and perceived eHealth literacy among adults at risk of diabetes mellitus in Pedungan, South Denpasar, Bali. A participatory community empowerment approach was implemented over four weeks through five stages: socialization and needs assessment, training and education, AI-based audiovisual education, mentoring and evaluation, and sustainability development. Fifty participants completed pre- and post-intervention assessments using a 31-item diabetes knowledge questionnaire and the 8-item eHealth Literacy Scale (eHEALS). Data were analyzed using descriptive statistics and the Wilcoxon signed-rank test. Mean diabetes knowledge scores increased from 25.74 ± 6.35 to 28.62 ± 1.05 ($p = 0.001$), while mean eHealth literacy scores increased from 28.48 ± 6.15 to 31.42 ± 4.69 ($p < 0.001$). The relative increases were 11.19% for diabetes knowledge and 10.32% for eHealth literacy, both below the predefined program target of 20%. The activity demonstrated statistically significant short-term improvements in diabetes knowledge and perceived eHealth literacy. However, because the evaluation used a one-group pretest–posttest design without a control group, the observed changes should not be interpreted as evidence of a causal intervention

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effect. Future programs should use baseline-stratified tailored content, repeated mentoring, practical digital-information verification exercises, and longer controlled follow-up to assess whether these improvements are sustained and translated into preventive behaviors.
***Keywords**: digital health literacy; diabetes prevention; artificial intelligence; audiovisual education; community empowerment*

1. INTRODUCTION

Diabetes mellitus is a major public health challenge that requires prevention strategies extending beyond clinical care to community-level health promotion. Digital technologies increasingly provide opportunities to deliver diabetes education and self-management support beyond conventional face-to-face encounters. Digitally enhanced diabetes self-management education, social-media-delivered education, and smartphone-based coaching have been evaluated as approaches to extend access to diabetes-related information and support self-management (Wilson-Anumudu et al., 2021; Leong et al., 2022; Pamungkas et al., 2022).

Digital health literacy is particularly relevant because access to online information does not automatically mean that individuals can identify credible information, interpret it correctly, and apply it to health decisions. The eHealth Literacy Scale (eHEALS) was developed to assess perceived ability to seek, find, understand, and appraise health information from electronic sources (Norman & Skinner, 2006). Measurement research has emphasized the importance of validated eHealth literacy instruments, while systematic-review evidence indicates that digital interventions can improve health-literacy-related skills among people living with chronic diseases (Lee et al., 2021; Verweel et al., 2023).

Audiovisual education is relevant to community-based diabetes prevention because video can combine narration, demonstrations, visual cues, and repeated access. A systematic review of diabetes patient education found that videos have been used across a range of outcomes, including health literacy, self-efficacy, physical activity, medication adherence, and glycemic outcomes, although the evidence and intervention characteristics vary across studies (Hoe et al., 2024). Experimental studies have also reported benefits of audiovisual or web-based diabetes education for knowledge and related outcomes (Sari et al., 2022; Cenčič et al., 2024).

In the target community, preliminary observations and discussions with community representatives identified limitations in identifying credible digital health information, distinguishing evidence-based information from misinformation, and accessing engaging educational materials. The community service program therefore integrated diabetes prevention education, digital health literacy training, and AI-based audiovisual materials that could be accessed through smartphones, QR codes, messaging applications, and community learning sessions. In this intervention, AI was specifically used to generate visual illustrations for the educational materials and to assist video production and editing; it was not presented as a diagnostic or clinical decision-making system. This community-oriented approach is consistent with evidence supporting culturally responsive and health-literacy-adapted diabetes education (Rismayanti et al., 2023; Shahina et al., 2023; Panagiotidis et al., 2025).

The program also builds on the implementation team's previous work in digital and audiovisual diabetes education, including development of the M-DFEET mobile application, evaluation of its effect on diabetic-foot prevention behaviors, development of the MANIS application, and community audiovisual diabetes self-management education (Agustini et al., 2022; Suniyadewi et al., 2024; Harimahardika et al., 2025; Agustini et al., 2025b). These activities provide a practical foundation for a continuing and structured community-service roadmap: earlier work focused on digital tools for diabetes self-management and diabetic-foot prevention, whereas the present program extends this trajectory to community-level digital health literacy and prevention. The progression also supports future integration of mobile applications, audiovisual education, mentoring, and community health-cadre involvement within a sustained digital diabetes-prevention strategy.

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2. METHODS

Design and setting. A community-based one-group pretest–posttest evaluation was conducted as part of a participatory community empowerment program in Pedungan, South Denpasar, Bali, Indonesia, in 2026. The intervention was delivered over four weeks. The target group comprised adults identified by the program team as being at risk of diabetes mellitus. The program was implemented collaboratively by lecturers, students, community representatives, and local health cadres.

Participants and data collection. Fifty community members participated in the program and completed the evaluation instruments. The analysis retained all 50 participant records supplied by the program team; no observations were excluded as accidental duplicates. Baseline and post-intervention data were collected using a 31-item diabetes knowledge questionnaire and the 8-item eHealth Literacy Scale (eHEALS). The diabetes knowledge score ranged from 0 to 31, with higher scores indicating greater knowledge. The eHEALS score ranged from 8 to 40, with higher scores indicating greater perceived eHealth literacy (Norman & Skinner, 2006). The Indonesian version of eHEALS has demonstrated acceptable validity and reliability (Wijaya & Kloping, 2021).

Implementation stages. The intervention was delivered over four weeks and consisted of five sequential stages: (1) socialization and needs assessment, including coordination with community stakeholders, participant recruitment, baseline assessment, and identification of preferred communication channels; (2) training and education on diabetes risk factors, early signs, complications, healthy nutrition, physical activity, screening, and digital health information skills; (3) AI-based audiovisual education, including educational videos incorporating AI-generated visual illustrations and AI-assisted video production/editing, disseminated through smartphones, QR codes, messaging applications, and community sessions; (4) mentoring and evaluation through guided use of the materials and post-intervention assessment; and (5) sustainability development through continued access to digital materials and involvement of community health cadres. The implementation structure is shown in Figure 1.

Evaluation and analysis. Descriptive statistics were used to summarize participant characteristics and pre- and post-intervention scores. Pre- and post-intervention measurements were paired within participants. The Wilcoxon signed-rank test was used to compare pre- and post-intervention measurements because the paired outcome data were analyzed using a non-parametric approach. Statistical significance was set at $p < 0.05$. Relative percentage change was calculated as (post-intervention mean − pre-intervention mean) / pre-intervention mean × 100. The analysis was performed on all 50 paired participant records.

Ethical considerations. Participation was voluntary. Participants received information about the purpose and procedures of the activity and provided informed participation before completing the questionnaires. Results were reported in aggregate form without identifying individual participants. The manuscript reports the available program-level ethical information and does not introduce an approval number that was not documented in the source materials.



Figure 1. Community Service Implementation Flow
[Source: Authors' documentation, 2026]

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3. RESULTS AND DISCUSSION

3.1 Results

Fifty participants completed the community service evaluation. Participants were predominantly male (80.0%) and had completed senior high school (62.0%). Most participants had a smartphone (90.0%), used the internet every day (72.0%), had previously searched for diabetes information online (72.0%), and had previously received health information through digital media (90.0%). Age data were available for 49 participants, with a mean age of 49.98 ± 5.04 years and a range of 40–61 years. Education data were missing for two participants and smartphone-ownership data were missing for two participants.

Table 1: Characteristics of participants (N = 50)

Characteristic	n / mean ± SD	%
Age, years, mean ± SD (n = 49)	49.98 ± 5.04	
Age range, years	40–61	
Gender	n	%
Male	40	80.0
Female	10	20.0
Education	n	%
Elementary school	3	6.0
Junior high school	4	8.0
Senior high school	31	62.0
Diploma	4	8.0
Bachelor	6	12.0
Missing	2	4.0
Smartphone ownership	n	%
Yes	45	90.0
No	3	6.0
Missing	2	4.0
Internet use	n	%
Every day	36	72.0
Often	6	12.0
Sometimes	3	6.0
Rarely	1	2.0
Never	4	8.0
Previously searched for diabetes information	n	%
Yes	36	72.0
No	14	28.0
Previously received health information through digital media	n	%
Yes	45	90.0
No	5	10.0

[Source: Community service evaluation data, 2026]

Table 2: Pre- and post-intervention scores for diabetes knowledge and eHealth literacy (N = 50)

Outcome	Pre mean ± SD	Post mean ± SD	Mean change	Relative change	Wilcoxon statistic	p
Diabetes knowledge (0–31)	25.74 ± 6.35	28.62 ± 1.05	+2.88	11.19%	44.5	0.001
eHealth literacy (8–40)	28.48 ± 6.15	31.42 ± 4.69	+2.94	10.32%	128.5	<0.001

[Source: Community service evaluation data, 2026]

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As shown in Table 2, diabetes knowledge increased from a mean of 25.74 ± 6.35 before the intervention to 28.62 ± 1.05 after the intervention. The mean increase was 2.88 points, corresponding to an 11.19% relative increase, and the Wilcoxon signed-rank test indicated a statistically significant change ($p = 0.001$). Perceived eHealth literacy increased from 28.48 ± 6.15 to 31.42 ± 4.69, with a mean increase of 2.94 points and a 10.32% relative increase ($p < 0.001$). Both outcomes therefore showed statistically significant short-term pre–post changes, although neither reached the predefined program target of at least 20% improvement. Statistical significance should be interpreted alongside the single-group design and the absence of a control condition.

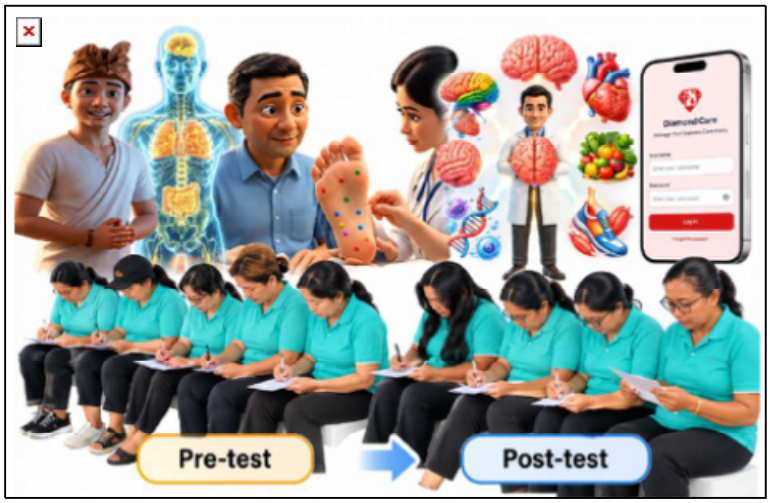


Figure 2. Community Services Documentation
[Source: Authors' documentation, 2026]

3.2 Discussion

The observed improvement in diabetes knowledge is consistent with evidence that structured digital education can support diabetes-related learning and self-management. Previous studies have evaluated digitally enhanced diabetes self-management education, social-media-delivered education, and smartphone-based coaching and reported improvements in selected diabetes-related outcomes (Wilson-Anumudu et al., 2021; Leong et al., 2022; Pamungkas et al., 2022). In the present activity, the audiovisual format provided concise prevention information that participants could access through commonly used digital devices.

The improvement in perceived eHealth literacy is also consistent with systematic-review evidence that digital interventions can improve health-literacy-related skills among people living with chronic diseases (Verweel et al., 2023). In this program, digital literacy training was integrated with diabetes education, including guidance on accessing and evaluating online health information. The increase in eHEALS therefore reflects a measurable change in participants' perceived ability to engage with electronic health information, rather than a direct measure of objective information-verification performance. For future implementation, this component could be strengthened through a simple verification routine in which participants identify the information source, check the publication or update date, compare claims with authoritative health sources, and discuss uncertain information with health professionals or community health cadres before applying it. Such hands-on activities would help connect perceived digital literacy with observable verification practices.

Audiovisual delivery may be particularly useful in community settings because video can combine concise explanations with visual illustrations, demonstrations, and materials that can be revisited after a group session. In the present program, AI-generated illustrations were incorporated into the educational videos and AI-assisted tools were used in video production

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and editing. These features may have enhanced comprehension by making prevention concepts more concrete and allowing participants to revisit the same visual information through smartphones or other accessible digital channels. However, the present one-group evaluation did not isolate the effects of individual audiovisual components, so these features should be regarded as plausible educational mechanisms rather than independently demonstrated causal factors. The systematic review by Hoe et al. (2024) identified video as a frequently used format in diabetes education and reported outcomes including health literacy and self-efficacy.

The magnitude of improvement remained below the predefined 20% target. Diabetes knowledge increased by 11.19%, while perceived eHealth literacy increased by 10.32%. This result should be interpreted as evidence of measurable short-term pre–post improvement rather than complete achievement of the program target. The relatively high baseline diabetes knowledge score also suggests a possible ceiling effect because the mean baseline score was already 25.74 of a possible 31 points. Future activities may therefore benefit from stratifying participants according to baseline knowledge and perceived digital literacy needs before intervention delivery. Participants with lower baseline scores could receive more foundational and guided content, whereas those with higher baseline scores could receive more advanced activities focused on evaluating online claims and applying information to prevention decisions. Increasing the duration or frequency of mentoring and providing more hands-on practice in evaluating digital health information may also improve the practical impact of the program.

The program also builds on the team's previous diabetes-focused digital and audiovisual work. The M-DFEET application was developed and validated for early diabetic-foot self-assessment, and a subsequent study reported improved diabetic-foot prevention behaviors among Indonesian patients using the application (Agustini et al., 2022; Suniyadewi et al., 2024). The team has also developed the MANIS application and reported community audiovisual diabetes self-management education (Harimahardika et al., 2025; Agustini et al., 2025b). The current program extends this trajectory by applying digital education at the community level and by making digital health literacy an explicit outcome. Taken together, these activities can be viewed as components of a structured community-service roadmap that progresses from development of digital self-management tools to audiovisual education, and then to broader community digital-health-literacy promotion. Future programs can build on this roadmap by integrating the applications and audiovisual materials with standardized mentoring, cadre training, baseline-stratified educational pathways, and longer-term outcome evaluation.

Several limitations should be considered. First, the one-group pretest–posttest design did not include a control group, so the observed changes cannot be attributed exclusively to the intervention; maturation, repeated testing, external information exposure, and other contextual factors may also have contributed. Second, eHEALS is a self-reported measure of perceived eHealth literacy and does not directly assess objective ability to verify online information. Third, follow-up was limited to the immediate post-intervention period, preventing assessment of retention and sustained behavior change. Fourth, the evaluation focused on knowledge and perceived eHealth literacy rather than objective clinical outcomes. Fifth, the present evaluation did not compare the relative contribution of individual audiovisual components, such as AI-generated illustrations or video-editing features. Finally, the program involved 50 community participants from one local setting, which limits generalizability. Future evaluations should use larger samples, longer follow-up, baseline-stratified intervention pathways, practical measures of digital-information verification, and, where feasible, a comparison group and behavioral or clinical indicators.

4. CONCLUSION

The community service program involving 50 adults at risk of diabetes mellitus demonstrated statistically significant short-term pre–post improvements in diabetes knowledge and perceived eHealth literacy following a four-week program integrating AI-based audiovisual education with training, mentoring, and community empowerment. Diabetes knowledge increased by 11.19%, while eHealth literacy increased by 10.32%; both changes were below the

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predefined 20% program target. Because the evaluation used a one-group pretest–posttest design without a control group, these findings indicate measurable short-term change but do not establish a causal intervention effect. Future programs should stratify participants according to baseline knowledge and digital-literacy needs, provide tailored content and repeated mentoring, incorporate practical digital-information verification exercises, and use controlled longer-term follow-up to determine whether improvements are sustained and translated into preventive health behaviors.

STATEMENTS

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Generative AI Use Statement

ChatGPT (OpenAI) was used to assist with manuscript organization and English-language editing. The authors reviewed, verified, and approved the final manuscript and remain responsible for the accuracy, interpretation, and integrity of the reported content.

Author Contributions

Ni Luh Putu Inca Buntari Agustini: conceptualization, project leadership, methodology, data interpretation, manuscript preparation, and critical review of the manuscript. I Gede Putu Darma Suyasa, Ni Luh Dwi Indrayani, Israfil, I Wayan Edi Sanjana, Ida Ayu Manik Damayanti, Putu Rima Sintyadewi, Portia Zoleta Vitug, Nadia Tresna Wulansari, I Kadek Ermanto, and Ni Kadek Dwi Intari: program implementation, educational content development, and evaluation.

Conflict of Interest

The authors declare no conflict of interest.

Data Availability

The anonymized evaluation data underlying the reported results are available from the corresponding author upon reasonable request, subject to applicable institutional and participant confidentiality requirements.

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