Voice Campaigns in Brazil: Effective Practices in Health Education

***Rodrigo Dornelas, †Emilse Aparecida Merlin Servilha, ‡Susana Pimentel Pinto Giannini, and §Leslie Piccolotto Ferreira,** *†‡§*Brazil*

Summary: Objectives. The aim of this study was to identify the health education practices used during Voice Campaigns in Brazil between 2005 and 2013.

Study Design. This was a descriptive retrospective research study.

Methods. We analyzed materials from 28 Voice Campaigns carried out between 2005 and 2013. The document analysis technique was used, and the campaigns were categorized as dialogic and unidirectional. The *SPSS* version 22.0 software was used for statistical analysis.

Results. The southeast region of the country had the highest number of campaigns; however, there were more institutions involved in the south region. A total of 19 different strategies were used, involving nearly 10 million participants in total. There were 2.8-fold more unidirectional campaigns than dialogic campaigns. The trend analysis showed a significant increase in the number of campaigns over the years (average increase of 1.58 dialog campaigns/year and 4.13 unidirectional campaigns/year).

Conclusions. The activities in the Voice Campaign, associated with dialog, followed the precepts of health education; however, these campaigns must be systematized according to the needs of the population to develop strong and efficient strategies.

Key Words: Voice–Health–Voice Campaign–Voice disorders–Health education.

INTRODUCTION

Health education currently promotes actions that aim to make individuals more active and autonomous in taking care of themselves, thus stimulating the development of healthy habits. Therefore, it is necessary to apply an educational model that must be contextualized and based on the daily events and lifestyles of individuals and communities.[1,2] Following the Health Reform movement that occurred in Brazil in the 1980s, educational practices began to prioritize the dialog process with individuals.[3] The population became involved in the development of health education practices, with both supporting and guiding roles. Thus, health education became a health promotion tool to encourage autonomy of the population and their responsibility in the health-disease process.[4]

On the other hand, there is a unidirectional model, in which health professionals educate the population about health, disregarding that popular knowledge is important in the education process.[5] In addition, this model does not consider family, work, or the region where the individual lives and works.

In Brazil, the Voice Campaign promoted by the Brazilian Society of Speech-Language Pathology and Audiology (SBFa) is a health action movement organized by autonomous institutions in partnership with government agencies and supported by private entities. The Voice Campaign takes place annually on World Voice Day (April 16th), and its activities aim to raise awareness about the importance of taking care of the voice. The Voice Campaign is gradually reaching its goal of making people understand the importance of their voice and be aware of strategies to keep it healthy.[6] The purpose of this study was to identify the health education practices used during Voice Campaigns conducted in Brazil from 2005 to 2013.

MATERIALS AND METHODS

This descriptive retrospective research complies with the Resolution 466/2012 of the Ministry of Health. The project was approved by the Research Ethics Committee of the Pontifical Catholic University of Sao Paulo (PUC-SP) (CAAE No. 25780014.0.0000.5482).

Material selection

The SBFa's Voice Department stores all the Voice Campaigns submitted by the organizers throughout the country every year to organize the Best Voice Campaign Award. In 2005, the SBFa began to receive digital files of the campaigns. The material analyzed in the present study was obtained from this database, which is available upon the institution's authorization. The materials from the Voice Campaigns conducted between 2005 and 2013 were analyzed. However, since 2012, the SBFa award was divided into three categories: Health Services, Educational Institution, and Business Company, and the top three winners for each category were selected.

Each campaign represents a document submitted for analysis. A "document" means all the printed promotional material that was made available to the public and the descriptions of the activities performed during the Voice Campaign. This information was included in the applications to the SBFa's Best Voice Campaign Award.

Accepted for publication March 15, 2016.

From the *Federal University of Sergipe, Brazil; †Pontifical Catholic University of Campinas, Brazil; ‡Municipality of Sao Paulo, Rehabilitation Division of Communication Disorders, Derdic / Pontifical Catholic University of Sao Paulo, Brazil; and the §Pontifical Catholic University of Sao Paulo, Brazil.

Address correspondence and reprint requests to Rodrigo Dornelas, Departamento de Fonoaudiologiam, UFS, Street Laudelino Freire, 184, 2nd floor, Centro, Lagarto, Sergipe 49400-000, Brazil. E-mail: rodrigodornela@uol.com.br

Journal of Voice, Vol. 31, No. 1, pp. 116.e7–116.e12
0892-1997

http://dx.doi.org/10.1016/j.jvoice.2016.03.008

Data analysis

Data were analyzed using the document analysis technique. All 20 documents related to Voice Campaigns were read to associate information and to organize the schemes and theoretical frameworks, according to current literature on health campaigns.[7] To provide scientific rigor during the document analysis,[7] the materials were organized and categorized as follows: documents that complied with the purpose of the study were selected after exhaustive reading of the material; samples were representative and could be categorized according to the purpose of the study; the classification and organization of the materials were standardized; and finally, the suitability of the selected documents to reach the proposed objective was determined.

It was necessary to select the documents that would be part of the research *corpus* to perform the empirical analytical analysis. The materials were classified and categorized according to the proposed interaction between professionals and the population. Then, the analysis was conducted by comparing the documents provided by the organizers of the campaigns with the different dimensions of this interaction, to identify consonances and limitations in the materials produced during the Voice Campaigns.

The document analysis was performed in two stages. In the first stage, during the longitudinal characterization of Voice Campaigns, the documents were arranged according to the following variables: year, location, the region in Brazil where it was conducted, and the estimated population coverage. In the second stage, called the systematization of the health education practices performed in Voice Campaigns, the materials were categorized according to the interaction between professionals and the population. The campaigns were divided into two groups. The first group was dialogic, in which the population is part of the campaigns' construction process, which was subdivided into activities that involve doing and dialog, and activities that involve dialog. The second group was unidirectional, in which the professional is responsible for the knowledge and provides guidelines on vocal aspects. This group included activities in which the professional's voice prevails, activities in which the professionals have full command, and activities using long-distance communications. It is noteworthy that the same campaign could include information to be analyzed in more than one of these categories.

Health Education practices presented in Voice Campaigns were organized into five categories:

(1) *Activities involving doing and dialog*—including interactive games, talks, preparation of materials and workshops, and voice competitions. Because the participants had to perform, create, move, or make sounds, they were more active/participative in the teaching-learning relationship of the educational activities.
(2) *Activities involving dialog*—including talks in the waiting room, video conferences, tutoring sessions, and vocal orientations with or without the use of folders. These activities stimulate dialog and interaction between professionals and the population.
(3) *Activities in which the professional's voice prevailed*—including plays, lectures, and the training of speech-language pathology students on vocal care to disseminate to the public. These activities usually have a larger audience and provide general informative content, keeping the physical distance between the professional and the public.
(4) *Activities in which the professional had full command*—including speech-language or medical screenings or assessments.
(5) *Long-distance communications*—including the distribution of printed material, such as bookmarks, gifts, folders, and informative booklets, as well as the use of advertising banners, billboards, interviews in print, digital and broadcast media, and e-mail correspondence.

The results were arranged into a matrix, registering the common elements among the practices that characterized them, as well the challenges in addressing the public policies related to health promotion in Brazil. A descriptive analysis was performed by using absolute and relative frequencies, and central tendency and dispersion measures. The distribution of campaigns by region according to the years was presented in charts with error bars, plotting mean values and their respective confidence intervals (95%).

For trend analysis, scatter plots of the total number of dialogic and unidirectional campaigns and the years evaluated were designed to determine the most appropriate function to the model. The linear regression ($y = \beta 0 + \beta 1x$) was used, considering $P < 0.05$, the coefficient of determination (r^2), and the homoscedasticity by residue analysis. The number of campaigns was selected as the dependent variable (y), and the year was selected as the independent variable (x). To avoid collinearity, the variable year was transformed into the year centralized (x—as the midpoint of the historical series); thus, the equation was given by $y = \beta 0 + \beta 1$ (year 2009). Statistical significance was set at $P < 0.05$. Data were entered into *Excel* (Microsoft Office 2010 XP) and analyzed using Statistical Package for the Social Sciences (*SPSS*) for Windows, Version 22.0 (IMB - Armonk, NY, USA.).

RESULTS

The characteristics of the voice campaigns according to year, region, and population coverage are shown in Table 1. The distribution of campaigns according to the groups and subgroups are shown in Table 2. It is noteworthy that there were 2.8-fold more unidirectional campaigns than dialogic campaigns. Within the subgroups, the long-distance communication campaign was the most frequently used, with an annual average of 10.8 (standard deviation = 6.3), median of 9, minimum of 3, and maximum of 22 campaigns.

As shown in Table 3, the Southeast region of the country held the highest number of campaigns, both dialogic and unidirectional. However, a greater number of institutions were involved in the South region of the country, which had the highest average of campaigns by institutions (mean = 8.0, standard deviation = 1.4) (Figure 1).

According to the trend analysis (Table 4), the number of campaigns increased over the years. For dialogic campaigns, there