Qualitative Methods Without Borders: Adapting Photovoice: From a U.S. to South African Setting

Our experiences of health and well-being are fundamentally influenced by the cultural contexts from which we make meaning. These frameworks inform the beliefs and actions of [health researchers], policy-makers and practitioners as much as the people they serve. For this reason, [health researchers, policy-makers and practitioners] must seek not only to understand the values they attribute to others, but also to critically examine their own cultures—their perceptions, daily practices and processes of decision-making and their effects on people who may or may not share the same values and priorities.

—David Napier, World Health Organization

Culture, or patterns of ideas, norms, and behaviors shared by a particular group (Centers for Disease Control and Prevention, 2015), is widely known to affect health. Culture shapes how people define and perceive their health, illness, and mortality; approach prevention and treatment; and value health and medical knowledge (Thomas et al., 2004). Understanding culture is ultimately essential to providing high-quality health care and developing effective health policies and interventions. Thus, cultural competence, awareness, and sensitivity trainings abound to help health care providers understand their patients’ needs (Centers for Disease Control and Prevention, 2015). Similarly, a large body of research shows that evidence-based interventions that are effective in one setting must be adapted culturally to be effective in a new setting or with a new population (Barrera et al., 2013, 2017). Numerous frameworks, like intervention mapping (Kok et al., 2016), Precede-Proceed (Crosby & Noar, 2011), and ADAPT-IT (Wingood & DiClemente, 2008), among others, exist to guide the cultural adaptation of a health program from one setting to another to improve reach, engagement, effectiveness, and sustainability (Barrera et al., 2013, 2017).

The importance of understanding culture is one of the reasons that qualitative methods are essential in health research, given that these methods unearth experience and meaning (Napier, 2017). As Wilson et al. (2016) so aptly stated in their review of the use and value of qualitative methods in the study of HIV, these methods play an important role in exploring cultural meanings of HIV, sexuality, and relationships—and help to translate these meanings into helpful interventions. Qualitative data show us that people’s health experiences take place in very specific cultural spaces and are best understood in those spaces (Assumpta Aneas & Paz Sandín, 2009).

Although researchers recognize that qualitative methods are well-suited to capture culture, we less frequently reflect on how the way in which we develop, use, and implement qualitative methods is also a culture-laden task. Like health care practices and interventions, qualitative methods require cultural adaptation (Castleden & Garvin, 2008; Kamanda et al., 2013; Mark & Boulton, 2017). In this editorial, we describe the process of translating and adapting an HIV Photovoice study implemented in the Midwest U.S. (by MT) for use in a completely different cultural setting, urban South Africa (by MT and BVW) with a group of adolescents living with HIV (ALHIV). We outline the steps taken and the lessons learned to initiate a discussion on adapting qualitative methods and contributing to formal adaptation guidelines for researchers.

Photovoice is a community-based participatory research method (CBPR) in which participants take and discuss photos to identify, express, share, and advocate their experiences and ideas (Wang & Burris, 1994, 1997). CBPR is a collaborative approach to research that involves the research participants and stakeholders in research planning, implementation, and dissemination (Cornwall & Jewkes, 1995). CBPR benefits both researchers (e.g., they gain information, data) and participants, who generally gain via new skills or benefit from the translation of their input into action (Cornwall & Jewkes, 1995). Although flexibility is noted as one of the strengths of this approach, few descriptions of CBPR adaptations to community needs and context exist (Castleden & Garvin, 2008; Chang et al., 2013; Mark & Boulton, 2017). Likewise, CBPR developed from a Western scientific premise and has been mostly implemented in the United States and Canada (Kamanda et al., 2013; Simonds & Christopher, 2013). Despite their potential, there is no assurance or automatic way that CBPR or qualitative methods are inclusive and effective in generating meaning.
across different groups. Accordingly, we enacted the following process to translate the method from one setting and population group to another.

1. **Acknowledge researcher’s values and assumptions underlying decision to use specific methods**: BVW and MT both value community input into health policies and interventions. We wanted to use a method that allowed adolescents aged 10–19 years to express themselves freely. Based on BVW’s existing research with youth, we assumed that youth also wanted a larger voice in explaining their lives with HIV and a broader platform to share their ideas. We believed that photos could help accomplish this. BVW and MT also value the translation of research into practice in a timely manner. We assumed that Photovoice would provide tangible points of discussion (i.e., photos) and that these photos could transport participants’ experiences to the larger public. Acknowledging our assumptions about the method helped us to identify points of clarification for discussion with stakeholders as we introduced the method to potential community partners.

2. **Develop a collaborative team to implement the methods**: Our team included researchers, field workers, and providers serving youth living with HIV. MT is a visual CBPR public health researcher from the United States, with 10 years of experience using Photovoice to study HIV in urban and nonmetropolitan areas in the United States. BVW is a social psychologist with experience studying the social and behavioral aspects of HIV and health in South Africa. BVW is from South Africa and has extensive experience (e.g., 16 years) collaborating with local health systems and welfare agencies that serve populations affected by and infected with HIV. He has also conducted many years of research with vulnerable youth affected by gang violence, HIV, and poverty in South Africa. We decided to do research together because we believed our values were similar and our expertise was complimentary. MT has experience with the method and BVW has experience with the context, setting, and population. Our team also included two field researchers and HIV service providers. Both field workers are from South Africa and have previous experience working with local agencies and interviewing local, at-risk youth. One is also a certified counselor. BVW organized and led several meetings with three local HIV clinics to discuss the project and the methods. It was important to meet with both the nurses who worked with adolescents on a regular basis and the medical staff who ran the clinic, to secure project understanding and support, and obtain project feedback, on multiple levels.

3. **Discuss and adapt methods**: MT presented the way she uses Photovoice by outlining the underlying theory (e.g., CBPR, empowerment of participants), assumptions, session content, data collection, and data analysis to the overall project team. The team (MT, BVW, field workers, medical providers) decided to make a number of small changes to the process to enhance success in the South African “township” setting. (e.g., an underdeveloped racially segregated urban area that was reserved for non-Whites: Indians, Africans, and Coloureds until the end of Apartheid in 1994.) These included, for example, giving cellphones (with cameras) instead of traditional cameras to participants. The team suggested that cellphones were preferable to cameras because phones are a highly desired commodity among South African youth, and phones are less visible than cameras. Thus, they carry less risk of robbery by gangs in the community. We also adapted existing Photovoice sessions to include an introductory session for participants’ parents in addition to participants because the team suggested that parents would want to understand and approve the process. Providers suggested that these introductory sessions coincide with the appointment days when youth collect their medication from the health clinic to facilitate youth’s attendance. Photovoice typically includes a public exhibit to share participants’ ideas with service providers and policy makers. Upon discussing the logistics of an exhibit, the team expressed concern that a public exhibit might not be appropriate for these particular South African youth, given the high levels of HIV stigma and discrimination in communities, and the innate desire of adolescents to fit in rather than stand out. We decided to postpone exhibition plans until we had piloted the project with a smaller group of youth. This concept, of course, proved one of our assumptions (i.e., that these youth were in supportive environments where they could advocate for themselves via photos) as incorrect.

4. **Train to sustain use of methods across settings**: MT conducted a daylong training for BVW and his research team about how to conduct Photovoice. The small trainee group and MT developed and implemented our own Photovoice study on the meaning of public health. This allowed the group to experience Photovoice firsthand. Then, MT went through each step of the Photovoice process from participant training, to interviewing, to data analysis. We also practiced data analysis with sample data. This kind of comprehensive training equipped the team with the skills and information to conduct the methods independently once MT left.

5. **Pilot-test the methods on a small-scale**: We conducted a pilot Photovoice project with 10 ALHIV aged 10–19 years. Youth discussed and shared images and shared their thoughts on the overall Photovoice process to inform revisions or additions to the protocol. Overall, the method worked well. Youth took photos, said they liked taking them, and were able to use them to discuss difficult aspects of living with HIV like shame, identity loss and reformation, and relationships. The major challenge was among the youngest participants (i.e., under
age 12). They were unsure of what to photograph and came back with few pictures. To help resolve this, we added more discussion to the initial project session about what kind of pictures youth could take. This way youth left session one with ideas. We also gave specific instructions to youth about how many pictures to take (five)—which we explained visually with a “high five” gesture. Some of the youth were excited about the prospect of exhibiting their pictures. However, most youth and their parents did not want youths’ identity linked to their photos. The health providers were eager to have photo exhibit as part of World AIDS day awareness campaign at their health facility. Thus, we will work with our clinic partners and youth to plan an appropriate exhibit for this event.

We propose our experiences as a starting point to further the discussion about adapting methods to different cultural settings (Castleden & Garvin, 2008; Chang et al., 2013; Kamanda et al., 2013; Mark & Boulton, 2017). Qualitative methods are well-suited to capture issues of culture and meaning, but we spend far too little time reflecting on the cultural aspects of choosing, developing, and implementing those methods. Such thought can result in improved application of methods, stronger research teams, and richer data.

Michelle Teti
University of Missouri, Columbia, MO, USA

Brian van Wyk
University of the Western Cape, Bellville, South Africa

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