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Tell Me—Show Me: Using Combined Focus Group and Photovoice Methods to Gain Understanding of Health Issues in Rural Guatemala

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Abstract

As health researchers, our training is more literary than visual. We are only beginning to learn about the value of photography as a qualitative data collection method. In this article we describe a project utilizing focus groups and photovoice, sequentially, to gather information about health-related conditions in rural Guatemala. In the first phase, the perceptions of a group of comadronas (birth attendants) were elicited using traditional focus group methodology. In the second phase, conducted several months later, the photovoice method was utilized. During this phase, the same participants viewed and responded to photographs taken during the intervening period by some of the phase-one participants. The findings from this two-phase approach support those from other studies that suggest that photovoice provides more in-depth data and the potential for bringing out additional information that might not emerge during traditional interviews or focus group discussions.

Keywords

focus groups; Guatemala; international health; lived experience; midwifery; photography; photovoice; poverty

One of the most challenging problems in conducting health-related research in developing countries is that of accessing populations that might be the most vulnerable to the many health risks that exist in these regions. This vulnerability is compounded in countries where many, especially rural peoples, live in conditions of extreme poverty. Paul Farmer, author of *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (2005), described the "indisputable association" between poverty and disease, and what he saw as the mandate of medicine to devote itself to populations struggling against poverty. He said that health professionals must "observe, judge, act" (p. 141) rather than be overcome by a paralysis because of the magnitude of the challenge. Although rich in natural resources, Guatemala is one of the poorest countries in Central America, and one that has some of the worst health statistics in the region (World Health Organization [WHO], 2006). Many of the most disadvantaged groups in Guatemala are isolated geographically, linguistically, and socially, a situation that makes health assessment in these areas challenging. Without assessment, designing effective interventions for improving health is difficult, at best.

Over the past 25 years or so, there has been an increasing realization that community-based rather than the community-placed interventions are likely to be more effective in developing solutions to health problems everywhere in the world (Minkler & Wallerstein, 2003). The mandate to observe, judge, and act described by Farmer (2005, p. 141) requires that researchers develop creative methods for collecting health data in areas that are not readily accessible to research teams. Modern, relatively inexpensive and user-friendly technology offers researchers possibilities for data collection that were not available as recently as two decades ago. We describe a project in which a two-phase combination of related qualitative data collection methods—focus groups and photovoice—were utilized to gather information about health-related conditions in several small villages in rural Guatemala. The primary aim of this descriptive qualitative study was to explore the nature of health concerns and conditions as perceived by the study participants, a group of *comadronas* (traditional

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birth attendants) who live and work in rural highland villages in Guatemala. The second aim was to assess the photo elicitation method (photovoice) as to its utility in this setting. The third was to evaluate the nature of the data that emerged from each phase of the study.

In the first phase of the study, the "tell me" component, the perceptions of the comadronas were elicited using traditional focus group methodology. In the second phase, the "show me" component, conducted several months later with the same participants, a photo elicitation method called *photovoice* was utilized. In this phase the stimulus to the group discussion was a series of photographs taken during the intervening period by some of the phase-one participants.

The theoretical underpinnings for this study were provided by the fields of anthropology, education, and the community-based participatory research orientation. In the introduction to the classic book, *Visual Anthropology: Photography as a Research Method* (Collier & Collier, 1986), Edward Hall wrote about the difficulty in "grasping the notion that two individuals from different cultures viewing an identical scene, are not necessarily seeing the same thing" (p. xiv). Brazilian educator Paulo Freire (1970) emphasized the importance of providing people with the opportunity to speak from their own experiences, of helping them to see connections among these experiences, and to discover, through the sharing of these experiences, the root causes for some of their problems. Freire saw visual images as a way of helping people think critically about their lives. Minkler and Wallerstein (2003) described the participatory community orientation as "methods and techniques for helping communities identify their strengths and the problems or concerns they wish to explore" (p. 26).

As health researchers, our training is literary rather than visual. We are only beginning to learn about the value of visual information as a qualitative data collection method. The "tell me—show me" designation here emphasizes the contrast between the literary method whereby we asked participants to verbally inform, and the visual method whereby the participants used their photographic images to inform about their lived experiences. The intent of this article is to focus on the second and third purposes of this study, the methodology, and specifically on the types of data that emerged from this sequential approach. It is not our intention to extensively report the extrapolated data, which will be presented in another article.

Background

The Research Setting

The Republic of Guatemala in Central America is a country of about 14 million people, most of whom are either indigenous Mayan people, or *Ladinos*, who are of mixed Hispanic Mayan descent. Besides Spanish, spoken by approximately 60% of the population, there are 24 indigenous languages, the principal ones being Kiche, Kaqchikel, Q'eqchi, and Mam. Guatemala is a country of beautiful mountain ranges and fertile coastal plains, with many natural resources. Its people produce a variety of valuable products including rubber, and foodstuffs such as coffee, sugar, fruits, and vegetables, about one third of which is exported to the United States (Central Intelligence Agency, 2008). Guatemala is connected to the United States in other ways, both historically, and through current immigration patterns. It is estimated that close to one million Guatemalans currently reside in the United States (Pew Hispanic Center, 2009).

Many of the health problems in Guatemala are clearly related to poverty, and are most evident among the indigenous people living in rural areas such as those described in this study. According to the WHO Report (2006), the annual per capita income in Guatemala is $2,130 U.S., and about 56% of the population live on less than $2 U.S. per day. About 25% of adult men and 33% of adult women have no formal education. The infant mortality rate is 33.4 per 1,000 live births, and the maternal mortality rate is 149 per 100,000 (Pan American Health Association, 2007). About 24% of children under the age of 14 years are involved in child labor. Child marriages are common, especially in rural areas, where as many as 40% of the girls are married before the age of 18 and 20% before the age of 16 (United Nations International Children's Emergency Fund, 2007). The roots of poverty and oppression in Guatemala can be traced back to events following the demise of the Mayan civilization, which flourished in the region for many centuries prior to the arrival of the Spaniards in the 16th century. With the Spaniards came the Roman Catholic religion, the Spanish language, and the beginning of centuries of oppression of the indigenous Mayans. The Ladino sector, a result of intermarriage between the conquering Spanish with the indigenous Mayans, soon established political and economic dominance, which has persisted to the present day. Guatemala's recent history has been marked by a prolonged and devastating civil war that began in 1958 and ended in 1996. The conflict essentially pitted the Ladino-led government and military against the indigenous peoples, and resulted in the deaths of at least 200,000 people, many of whom came from the poorest rural areas (American Association for the Advancement of Science, 1999). The United States officially and unofficially supported the Ladino-dominated government led by an unelected military officer (Schlesinger & Kinzer, 2005). These events remain in the collective memory of many in these regions and explain, to some degree, the residual feelings of helplessness that exist among the people, as well as the sometimes evident undercurrent of

suspicion about the intentions of those who come from the United States.

Comadronas and Health Research

Comadronas are generally older women who have become recognized for their knowledge and experience in caring for pregnant women, delivering babies, and caring for the neonate and the mother post delivery. Many learn their basic skills from an older female relative, and few have had more than minimal schooling. Most comadronas have little or no formal health training.

A literature search of studies conducted among comadronas in Guatemala since 1995 revealed that the research focus has been on traditional midwifery activities, with an emphasis on their role in caring for pregnant women, assisting in childbirth, and caring for mothers and newborns (Goldman & Glei, 2003; Hinojosa, 2004; Lang & Elkin, 1997; Rööst, Johnsdotter, Lijestrand, & Essén, 2004). Although these traditional birth attendants have been described as "respected sources of authoritative knowledge" (Foster, Anderson, Houston, & Doe-Simkins, 2004, p. 222), to our knowledge, no research has explored their perspectives about more general health concerns. After becoming familiar with Guatemalan village life, and with the role of these traditional birth attendants, we became increasingly aware that midwives have a depth and breadth of knowledge that has not been extensively tapped by investigators. Because they are often perceived as health authorities within their villages, and because they are frequently the first persons contacted when health professionals are attempting to address local health concerns, understanding the broader health-related perspectives of comadronas might be important for successful interventions not directly related to childbirth.

Focus Groups and Photography as Research Methods

Verbal-elicitation focus group. Qualitative researchers strive to discover the perspectives and priorities of study participants. One way of eliciting this information is to conduct a focus group, which is a guided conversation in which the participants interact among themselves and with the researcher. The participants talk and listen in a permissive environment, with the researcher serving as a guide and facilitator. The focus group is the most common group discussion method—its roots having originated with social scientists in the 1920s, when the method was used primarily to develop survey instruments (Finch & Lewis, 2003). More recently, the method has been used in market and political research, and currently is a popular qualitative interview strategy for the social and behavioral sciences (Green & Kreuter, 1999).

Focus groups conducted in international settings have considerable cross-cultural challenges. Academic researchers have their own subculture, which is different in many ways from that of the participants, even when the two groups share a common language. Conducting focus groups in an international setting presents major challenges related to culture in general, and to language in particular. The sociocultural context of the study should influence each step, from development of the discussion guide to data collection and analysis. Researchers must decide not only the language in which to conduct the group discussions, and sometimes on the particular dialect, but also on the selection of appropriate translators, assuring translation accuracy and preserving cultural nuances and subtle meanings.

Photo elicitation (photovoice). Although photographs have been used in research for many years, by both physical scientists (such as astronomers) and social scientists (especially anthropologists), their purpose was primarily to support findings collected in other ways (Collier, 1957). Photovoice, however, is a special photographic technique whereby cameras are provided to study participants who are then asked to use the camera to record their real-life experiences. It is a participatory, qualitative, action-oriented method with three main goals: (a) to enable people to record and reflect on the community strengths and concerns, (b) to promote critical dialogue and increase understanding about important community issues, and (c) to reach policy makers (Wang, 2003). As a data collection method, the idea of providing research subjects with cameras is relatively new. Although photovoice is becoming an increasingly common method for collecting data for a variety of purposes, both scholarly and commercial, articles describing the method for collecting health-related data in remote international settings are scarce. The first published health-related project using the photovoice method in an international setting was conducted in Yunan, China, by Wang, Burris, and Xiang (1996), with a focus on women's reproductive health and development. Subsequently, photovoice has been used in a study of Ugandan nurses reflecting on their practice (Fournier, Mill, Kipp, & Walusimbi, 2007) and a study of leisure experiences of older women with AIDS (Gosselink & Myllykangas, 2007). More recently, a sociological study of farmer groups in rural Mozambique was conducted using photovoice methodology (Gotschi, Delve, & Freyer, 2009).

The poor in Guatemala are among the most disadvantaged and historically oppressed populations in the world. A common result of this oppression is what has been described as "learned helplessness," or "dependency thinking" (Carlson, Engebretson, & Chamberlain, 2006, p. 837). According to Freire (1970), self-depreciation is

"characteristic of the oppressed, which derives from their internalization of the opinion that oppressors hold of them" (p. 49). He described this overcoming process as *conscientização*, or consciousness raising. The photovoice method has been found by some researchers to have the unexpected benefit of empowerment, allowing participant photographers to express themselves in creative ways and sometimes revealing a sophisticated understanding of the social determinants of their heath and well-being (Ornelas et al., 2009). One consequence of this empowerment is a greater degree of community participation in problem solving. Information can be gained directly from the photographs, making it a particularly appropriate method for illiterate or semiliterate groups. Of course, it is important to be cognizant of the problems inherent in simply viewing photographs and gathering conclusions from them without benefit of the photographer's perspective.

Methods

Phase One

Sample and setting. The study setting was a small health clinic located in a rural area in the central highlands region of Guatemala. The clinic had been in operation for several years and was familiar to all of the participants; they had previously received health services for themselves and/or family members at this facility. The study participants consisted of a convenience sample of 15 working comadronas from 11 villages in the region. Their ages ranged from 27 to 81 years, and their years of experience as comadronas ranged from 2 to 68. All were fluent Spanish speakers, and all but two spoke Spanish at home; the two exceptions were Kekchi speakers.

Procedures. The institutional review board of the university approved the study. The research team for phase one of the study was composed of a female nurse researcher who had basic competence in Spanish and was experienced in conducting focus groups, a bilingual translator from the United States, and two local bilingual research assistants with previous experience working as health clinic assistants. The principle investigator served as the focus group facilitator. Study participants were recruited with the assistance of the district health ministry nurse, who had regular contact with them in their home villages. Information about the study was disseminated during the month of September, 2005. The inclusion criteria were that the participants be practicing comadronas in the villages where they lived and that they be able to speak and understand spoken Spanish. The informed consent document was translated into Spanish by a native speaker who was a member of the research team. It was then reviewed by the health ministry nurse and the two local research assistants for translation accuracy, literacy level, and meaning. The ministry nurse reviewed the consent document verbally with the participants as a group and individually prior to the initiation of the first focus group. At the beginning of the focus group session, the principle investigator again reviewed the consent document verbally, provided opportunities for questions, and distributed copies for signatures. Only eight of the 15 participants were able to sign their names, and the remainder indicated their consent by marking an "X" on the form. The consents were witnessed by one of the research team members and the principal investigator. Incentives included a variety of items that the comodronas often requested to help them in their work, such as latex gloves, umbilical clamps, and adhesive bandages. Because of the prolonged travel times to and from the session, lunch and snacks for participants and accompanying children were provided.

Data collection. The entire focus group session was audiotaped. At the beginning of the session, the facilitator explained that the researchers considered them to be experts about the health in their villages. They were reminded that there were no right or wrong answers. Using an interview guide the group facilitator posed semistructured questions. The translator directed the questions in Spanish to the participants and was assisted during the session by the health ministry nurse in revising vocabulary or sentence structure as necessary to assure mutual understanding. Participants were asked to respond in turn to each question posed. The facilitator took notes in English throughout the session. Ambiguous responses were clarified with the assistance of the translator, who validated the response with the participant by back translating from English to Spanish.

Using the funnel approach (from general to specific), the participants were asked to respond to four questions. The first addressed the general health status of the people in their respective villages. The participants were asked to prioritize the conditions that they perceived to be most prevalent and problematic, as well as any resources that promoted health. The second question related to the overall health of women and children in the villages. The third addressed issues related to pregnancy and childbirth. The closing question asked them to describe, in a sentence or two, what they would like others to know about health in their villages. Throughout the session they were encouraged to consider and relate not only problems, but also what they perceived to be strengths and resources in their villages.

At the end of the session, in preparation for phase two of the study, six participants were selected to participate in the photovoice component. The selection of these participants was based on recommendations from the health ministry nurse concerning their ability to use a camera.

They were instructed on the use of the 35 mm disposable cameras provided, and asked to take photographs that they believed depicted or represented some aspect of health in their communities, either positive or negative. They were instructed to obtain written consent when photographing individuals who could be identified. A consent document with instructions for its use was provided. The participants were instructed to refrain from photographing if they perceived that there was a potential for physical or psychological harm to themselves, to other individuals, or to their communities. They were informed that the photos would be used in an educational setting to help others understand life in their villages. They were given the opportunity to ask questions and voice concerns about the project. The local research assistants were instructed to collect the cameras at the end of one month, to develop the film, to send a copy of each photo to the researchers, and to save a copy of each for phase two, planned for 4 months later (February, 2006). Provision was made for each participant to receive a copy of each of their photos. Each photographer was given a second camera to take photos for her own enjoyment. The cost of developing these personal photos was covered by research funds.

Phase Two

Sample and setting. This phase of the study was conducted approximately 4 months after phase one was completed. Eleven of the original 15 participants, including all of the participant photographers, returned for this session, which was held in the same locale as the first.

Procedures. For this second phase the research team consisted of the primary investigator who conducted the first focus group; the coinvestigator, who is both a nurse with previous experience as a visiting health care provider at this clinic and an experienced qualitative researcher; a bilingual translator from the United States; and the same two local research assistants who participated earlier. The informed consent procedure utilized was identical to that used in phase one. This time, rather than using semistructured questions from an interview guide, the photographs were used as stimuli for the guided group discussion. After a photographer displayed her photo and explained the scene or subject and how it related to health in her village, each of the other participants was invited to comment or to respond to questions such as, "Is this a concern in your village?" "Is there anything you would like to say about this photo?" "Does the photo make you think of anything else that you would like us to know?" The entire session was again audiotaped.

Data analysis. The audiotaped data from both phases were transcribed verbatim into Spanish, and then translated back into English by the bilingual research assistant, who also served as an assistant to the group facilitator during the focus group sessions. To assure accuracy, the English transcripts were compared with the researchers' detailed field notes made during the focus group sessions. Data were analyzed by content analysis to identify themes and commonalities contained within the participants' voiced responses concerning village health. Each transcript was read and key words and phrases were highlighted. Preliminary codes were identified. Analysis progressed with the rereading of transcripts and the identification of themes and patterns, including commonalities as well as differences.

Findings

Phase One

Because the primary purpose of this article is to address methodology, this discussion has minimal emphasis on the iteration of specific themes. The focus will be on a more general comparison of the similarities and differences in the kinds of data that emerged during each phase.

During phase one, the majority of the participants described the health situation in their villages primarily in terms of discrete symptoms or syndromes. The symptoms were usually presented as single entities, such as diarrhea or headaches, which they did not associate with any particular illness. The syndromes were ascribed to specific illnesses, diseases, or conditions such as *grippe* (flu). Only two of the participants mentioned or alluded to root causes for health problems; both of these were younger participants. Only one participant mentioned lack of access to clean and adequate water as a significant problem, although once mentioned, all of the respondents agreed that water was indeed a problem.

During a break the researchers noted that the children were given coffee to drink, even though juice was available. When we asked about this, we were told that the children liked to drink coffee, and often drank more than two cups a day. One mother said, "They will drink coffee with bread, one cup in the morning, and one in the afternoon." Another stated that the children liked to drink coffee at noon and at bedtime. Some of the women reported that the children did drink milk when funds were available.

In summary, phase one findings provided a validation of what we had previously known about general health issues. In addition, there were discussions about anemia, coffee consumption among children, and in general, more distal causal explanations for disease. These distal explanations were provided by the younger participants and a more concrete listing of proximal causes was offered by the older participants. It was our impression that the older respondents seemed more accepting of the conditions in their villages and generally projected less passion and

concern than the younger ones. For example, the oldest participant, who each time her turn came to speak, folded her hands in a prayer-like manner, stated, "Thanks be to God, no problems."

Phase Two

In phase two, each of the six participant photographers discussed her photos, one by one, and the rest of the participants were encouraged to comment on each. As this second phase proceeded, some new themes began to emerge. Although the first phase produced specific and concrete ideas and concerns, such as specific illnesses and environmental problems, the second phase elicited, for the most part, a "peeling back" of health issues. Deeper and more abstract concerns were revealed. For instance, issues related to work emerged as the photographs depicting women gathering wood and making *comales* (clay platters) were displayed (Figure 1). Another photograph stimulated a discussion about children's work and the young age (6 or 7 years) at which children begin to carry heavy loads such as wood and milk (Figure 2). A photograph depicting a grandmother with her two grandchildren introduced a discussion about aging and the elderly, which in turn initiated a discussion of grandparents raising grandchildren (in one instance because of the alcoholism of the mother). Yet another photograph introduced the subject of mental illness and developmental disabilities. One photo showed a grandmother caring for two developmentally disabled children. Several photographs reflected very starkly the challenges the villagers faced each day in meeting their most basic hygiene and sanitation needs. For example, a close-up photo of a very dirty concrete toilet sitting outside one of the homes had a particular powerful impact for the researchers. We were told, "We don't use these because we can't clean them." Another showed a basin of water with a dipper, which was the water supply for all needs for that day, including cooking, bathing, and drinking. Another scene showed a water hole outside a house with a chicken and a pig nearby. Each photograph, in turn, stimulated an "unpacking" of the elements. Most of the participants, whether photographers or not, did not limit their responses to the details presented in the photographs, but expanded on the photographic representations, bringing in other examples and additional issues.

The participant photographers displayed pride in their photos. Most smiled broadly when their turn came, and thoughtfully explained their reasons for taking each photo and the meaning each had for them. The other participants displayed active engagement in the discussion, nodding their heads in agreement with the perspectives of the photographers and frequently adding their own comments about a particular problem as it applied to their own villages. It appeared at times that the participants were considering some issues for the first time, or at least articulating them for the first time. For example, their discussion about children's work led to a question about age-appropriate work, and whether heavy loads could be harmful to young children. This question stimulated many thoughtful comments.

Figure 1. Making comales

Figure 2. Children's work

Discussion

The primary purpose of this study was to increase our understanding of the health-related concerns in Guatemalan villages as perceived by traditional birth attendants. The information gained affirmed much of what was already known about village conditions, but was validated by these women, who were valued health resource persons in their respective villages. They provided interesting insights based on their own experiences. For example, the older

participant mentioned earlier who said, "Thanks be to God, no problems," might reflect beliefs about "normalcy" observed in some cultures, whereby conditions that are very common (for example, parasitic worms in children) are not viewed as illness, but as a normal part of life (Skolnik, 2007). In addition, the participants offered new information about the ways health and illnesses were perceived in terms of causality.

The second purpose was to explore the utility of this type of study in gathering health data in this rather remote and relatively inaccessible setting. This research approach seemed particularly appropriate and feasible in this population for the following reasons: the participants were in a position in their respective village to be well informed about many types of health problems; they belonged to a population that has traditionally had little power, and often little opportunity to be participants in identifying problems and creating their own solutions; their villages are not readily accessible to research teams; the groundwork had been laid by previous contact; and the local health authorities were supportive and encouraging. Much of the time these comadronas were informed by outsiders about what ought to be important, such as vaccinations, pregnancy, and childbirth concerns. The photovoice project gave them creative control and the freedom to tell us—and later to show us—other issues that concerned them. In addition, it provided a stimulus for a broader discussion and to introduce new questions, thus offering the potential for new approaches for solving problems that concerned them. These findings reflect similar observations by others about the empowerment benefit of photography and visual stimuli (Freire, 1970).

Our third purpose was to compare the data that emerged from the two approaches. The overall project findings validated for us some of the reported experiences of other photovoice researchers and provided us with some additional insights from our unique experience in Guatemala. Although the two-phase method utilized here has not been reported in the literature, other researchers have suggested that photo elicitation might provide richer data, both quantitatively and qualitatively, than the strictly literary approach as utilized in traditional group discussions. We believe that the comparison of the two data sets graphically represented in Figure 3 supports this hypothesis. The inner circle includes examples of the data provided in the verbal elicitation phase. The next circle includes the major types of data collected during the photo elicitation phase. The outermost circle contains ideas for future research that emerged from each of the two phases.

The findings from this two-phase study suggest that the use of photovoice methodology not only provides a "thicker description" (Geertz, 1973) of health-related conditions described by the participants in the first interview, but also adds additional information that did not emerge earlier. Although this was not an ethnographic study, we think that Geertz's ideas from the discipline of anthropology apply to our study findings. According to Geertz, this thicker description is a consequence of understanding that "actions are comments on more than themselves," and that "small facts speak to large issues" (p. 23). In group discussions, as conducted in a traditional focus group, actions and situations are verbally reported and must be imagined by the listener. Photographs show the action and show or suggest the context, leading the viewer to think about what it is the subjects are doing and more importantly, why they are doing it. This might be one of the reasons we found the data from phase two to be richer, more reflective, and more contemplative. The photographs introduced new ideas and stimulated researchers to wonder about ways to study some of the issues that emerged; for example, child labor and its health implications, aging and elder care, mental illness, and developmental disabilities. In addition, we wondered how men might perceive health in their villages and how their photos might compare to those taken by women.

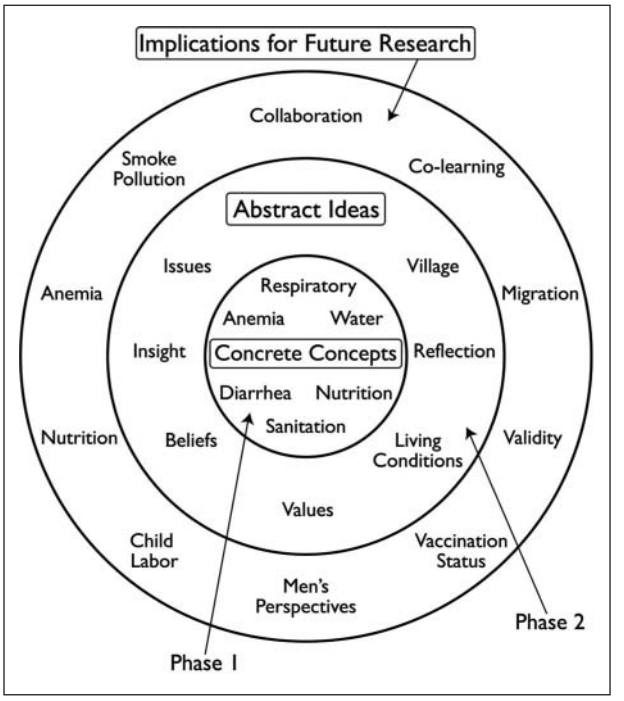

Figure 3. Comparison of data sets

Limitations

We noted several limitations in connection with the study. One was the presence of the health ministry nurse during both group sessions. Because she was considered

an authority figure by the comadronas, her presence might have had an inhibitory effect on the expressive freedom of the participants. Another limitation was that the participants who were selected as photographers were among the younger participants. Their selection was based on the recommendation of the ministry nurse, who felt that the younger women would be able to use the cameras more competently than the older women, who had little or no experience with modern technologies. A third limitation was that the use of the photovoice method stops short of action (López, Eng, Randall-David, & Robinson, 2005), and does not necessarily engage participants in taking steps to address the needs and concerns that were reflected in the photographs or that emerged from discussions about the photographs. The many needs of people living in poverty and in settings where they have little power, political and otherwise, often seem overwhelming both to those attempting to help and to those who need help. However, it is hoped that the findings from this study will be useful in future efforts to improve health and well-being in these villages. We believe that the consciousness raising described by Freire (1970), which was demonstrated by the comadronas during the data collection activities, was in and of itself a positive outcome. As mentioned earlier, some of the issues that were articulated through the group discussion process seemed not to have been a part of their conscious awareness previously. The group discussions and sharing of photographs served an important purpose, we believe, in that these activities seemed to increase solidarity among the participants.

Ethical Considerations

The ethical concerns related to qualitative data collection methods such as focus groups have been explored in several studies. In a recent article by Karnieli-Miller, Strier, and Pessach (2009), the authors explored the power relations inherent in qualitative research and described the "developmental nature of the power relations through different stages" (p. 280) of a qualitative study. We believe this was exemplified in our study in the following way. Although we envisioned the relationship between ourselves and the participants as an equal partnership, that of coresearcher and coparticipant, we were well aware that there were many instances when the relationship was not, and could not be, equal. For example, during the first phase, we controlled the setting, and to some extent, the progression of the group discussions in terms of time and content. With the beginning of the photography phase, however, it was the participant photographers who assumed a more powerful role, and because their photos became the central focus, they retained this power during the second phase. This fluctuating power relationship is likely to be present in all or most qualitative research studies. We agree that confronting power issues and concerns at the outset, and remaining aware that the primary obligation of researchers is to the participants and their welfare, should be central to qualitative designs.

Using photography as a data collection method presents particular ethical considerations that are different in some essential ways from methods that collect only verbal data. One of the best known critiques of photography, and of photographers in particular, is Susan Sontag's essay *On Photography* (1977). Sontag described photography as "a tool of power" (p. 8) in the negative sense, stating that the photograph can be "used" by the photographer to project unreality as well as reality. But Sontag was not thinking about the photovoice method, whereby the value of the photographs lies in the possibility of providing people having little power with a reflective tool to gain insight or to share visually some aspect of their world that might be otherwise inaccessible to others. In the comodronas' case, the photograph can be a "tool of power" in a positive sense. The subjects or scenes depicted are not objectified as a journalist photographer might do, but are subjective, the content being controlled by the photographer, who is experiencing each day the reality depicted, rather than simply taking a picture to display in another setting. It is true, however, that researchers have an opportunity to use the photographs in ways that were criticized by Sontag, perhaps giving photographs meanings that might not be intended by the photographer. Indeed we do this, as colearners in the research process. Our ethical obligation is to recognize this and to make clear to others the difference between our meanings and those expressed or implied by the photographers. It is imperative that researchers using photographs be ever vigilant about the potential power in the photographs we view and analyze, and that we use the data in ways that preserve the dignity of the people we are studying. If utilized in this way, photographs have the potential for improving the lives of the photographers and their communities through bringing both visual and verbal messages to those who might be in a position to help them build on their resources as well as bring about needed change to better their lives.

Conclusions

Several conclusions can be drawn regarding the methodology utilized in this study. Of particular note, photographs can be viewed as tools to enrich and extend existing interview methodologies by providing information that cannot always be obtained through direct analysis. Harper (2002) contended that this additional data might have a physical

basis, explaining that "the parts of the brain that process visual information are evolutionarily older than the parts that process verbal information" and thus, "images may evoke deeper elements of human consciousness than do words" (p. 1). Essentially, the photographs can function as "starting and reference points" for discussions about both the familiar and the unknown (Collier & Collier, 1986, p. 3). We saw this phenomenon on several occasions, the most notable being the discussion of children's work. Also, it is not necessarily the obvious subject matter depicted that has importance, but sometimes why the photographer chose to film that activity, scene, object, or individual rather than another. Each photographer and each viewer may attach a personal meaning to the image. The particular meanings might vary according to the level of knowledge of the subject matter depicted, or according to personal experiences that might be unrelated to the subject matter. Finally, the colearning phenomenon described as integral to this method and to participatory research in general was clearly evident. The dialogue was for the most part between equals. The researchers were both teachers and learners, as were the participants.

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