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THE RIGHT TO HEALTH FROM PATIENTS' PERSPECTIVE – THE APPLICATION OF PHOTOVOICE METHOD IN THE CONTEXT OF HEALTH PROTECTION[**]

Health is not merely the lack of disease or infirmity, but a state of full physical, mental and social well-being. Holistic approach to health includes a subjective component and the right to health should not be observed solely from the standpoint of medical and legal experts, but from patients' perspective as well. Participatory action research methods, such as photovoice, can draw attention and contribute to resolving the problems in various fields of life, including health, from the aspect of those affected by them. Photovoice is based upon the co-creation of knowledge throughout a democratic research process in which the participants make photographs as visual representations of the issues constituting the research topic, discuss them and accompany them with brief texts. This material is subject to qualitative content analysis to identify key problems and make suggestions for improvements. The author explains why patients' viewpoint should be considered when estimating the respect of the right to health, discusses the capacities of photovoice to contribute to participation of patients in health policies creation and analyses examples of photovoice research related to health protection.

Keywords: *health, human rights, participation, decision-making process, photovoice, participation.*

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1. Holistic approach to health – why patients' perspective matters

Health is crucial for a person's ability to function effectively, and it represents essential prerequisite for dignified life and personal development (Trgovčić, 2018: 75, 82) as well as for partaking in social, political and economic life (Borić, 2021: 165). A holistic and comprehensive definition of health was established almost 80 years ago in the Constitution of World Health Organisation (hereinafter: WHO) (WHO, 1946; OHCHR, WHO, 2008). The Preamble of this document describes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). According to this definition, health comprises two components: "lack of disease", which is grounded on objective assessment (medical examinations, laboratory tests etc.) and well-being, which is based on individual's subjective evaluation (Langevin, 2024: 13). This definition represents an effort to draw attention to the patient and change previous concept of diagnostic tests that used to be primarily focused on disease (*Ibid.*).

Restricting health solely to a biomedical construct weakens the possibility to integrate all the processes that have an impact on health and to address the causes of illness (Durch, Bailey, Stoto, 1997). Like Syme (1996) highlighted almost 30 years ago, the attention of medical experts should not be focused solely on the disease, but also on the quality of life (Syme, 1996: 467). In other words, traditional biologic, epidemiologic or other measures remain relevant indicators of population's health, whereas a more extensive concept of health provides an opportunity to consider other relevant factors (Durch, Bailey, Stoto, 1997) (political, economic, social, cultural, environmental, behavioural and biological) that can either promote or harm one's health (WHO, 1986). Since holistic approach to health includes a subjective component as well, the respect and promotion of the right to health cannot be studied only from the standpoint of medical and legal experts, but from patients' perspective as well[1]. This view implies that the respect of the right to health and patients' rights, as one of its aspects, should dwell upon the partnership between health care providers and patients (Ivanović, Petrović, 2022).

[1] Another perspective, which is not in the focus of this paper but should not be neglected, would be the perspective of caregivers, particularly informal caregivers (see: Batrićević, 2022), whose voice can also provide valuable information about various topics related to health.

2. The right to health as one of fundamental human rights

The Preamble of WHO Constitution proclaims that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions" (WHO, 1946). The right to health is one of collective rights derived from international solidarity (Trgovčić, 2018: 82) and it is recognised as one of fundamental human rights in several international instruments including:

1) Universal Declaration of Human Rights (1948) (Article 25(1))[2], 2) International Covenant on Economic, Social and Cultural Rights (1966) (Article 12)[3], 3) International Convention on the Elimination of All Forms of Racial Discrimination (1966) (Article 5(e) iv)[4], 4) Convention on the Elimination of All Forms of Discrimination against Women (1979) (Articles 11(1) (f), 12 and 14(2)(b))[5], 5) Convention on the Rights of the Child (1989) (Article 24)[6], 6) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990) (Articles 28, 43 (e) and 45 (c)[7], 7) Convention on the Rights of Persons with Disabilities (2006) (Article 25)[8], 8) European Social Charter (1961) (Article 11)[9], 9) Revised European Social Charter (1996) (Article 11)[10], 10) African Charter on Human and Peoples' Rights (1981) (Article

[2] United Nations (General Assembly) (1948) Universal Declaration of Human Rights Resolution 217A (III), https://www.refworld.org/legal/resolution/unga/1948/en/11563, accessed on 23.05.2025.

[3] United Nations (General Assembly) (1966) International Covenant on Civil and Political Rights. Treaty Series, 999, 171, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights, accessed on 22.05.2025.

[4] United Nations (General Assembly) (1965) International Convention on the Elimination of All Forms of Racial Discrimination. Treaty Series, 660, 195, https://www.ohchr.org/en/instruments-mechanisms /instruments/international-convention-elimination-all-forms-racial, accessed on 22.05.2025.

[5] United Nations (General Assembly) (1979). Convention on the Elimination of All Forms of Discrimination Against Women, Treaty Series, 1249, 13, https://www.un.org/womenwatch/daw/cedaw/cedaw.htm, accessed on 22.05.2025.

[6] United Nations (General Assembly) (1989) Convention on the Rights of the Child. Treaty Series, 1577, 3, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child, accessed on 22.05.2025.

[7] United Nations (General Assembly) (1990) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, A/RES/45/158, https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_45_158.pdf, accessed on 22.05.2025.

[8] United Nations (General Assembly) (2006) Convention on the Rights of Persons with Disabilities, A/RES/61/106, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities, accessed on 22.05.2025.

[9] Council of Europe (1961) European Social Charter, European Treaty Series, No. 35, https://rm.coe.int/168006b642, accessed on 22.05.2025.

[10] Council of Europe (1996) European Social Charter (Revised), European Treaty Series – No. 163, https://rm.coe.int/168007cf93, accessed on 22.05.2025.

16)[11] and 11) Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988) (Article 10)[12] (See also: Borić, 2021: 173-175).

International Covenant on Economic, Social and Cultural Rights (1966) (hereinafter: ICESCR) regulates the right to health in the most extensive manner (Dimitrijević et al., 2024: 320). ICESCR proclaims that the States Parties should "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12 Paragraph 1) and obliges them to take several steps to facilitate complete realization of this right (Article 12 Paragraph 2). When interpreting the term "the highest attainable standard of health" one should take into consideration both – individual biological factors as well as social and economic preconditions and state's available resources that can be utilized to achieve it (Dimitrijević et al., 2024: 321).

The most relevant interpretation of the right to the highest attainable standard of health from Article 12 of ICESCR was given by the body in charge of monitoring the application of ICESCR – Commission for Economic, Social and Cultural Rights (hereinafter: CESCR) in its General Comment No. 14[13], which, despite its authority, is not legally binding (Bjegović-Mikanović et al., 2015: 30-31). It explains that, as defined in Article 12 ICESCR, the right to health should not be understood as the absence of illness, but as the right of every individual to be provided by the healthcare system the opportunity to live his/her life with dignity, i.e., in the state of physical, mental and social wellbeing. (Petrović, Pokuševski, 2023: 192). Accordingly, the right to health contains the entitlement to be the user of various types of assistance and services (Dimitrijević et al., 2024: 321).

The right to health is labelled as an inclusive right, expanding beyond the access to health care and including a variety of circumstances that contribute to a healthy life (OHCHR, WHO, 2008: 3; Trgovčić, 2018: 76). In that sense, the right to health is not related solely to the right to health protection, since it depends on other socio-economic factors (Petrović, Pokuševski, 2023: 192) referred to as "underlying determinants of health" (OHCHR, WHO, 2008: 3). It is a complex right, comprised of numerous rights and freedoms not explicitly mentioned in Article 12 of ICESCR (Petrović, Pokuševski,

[11] African Union (1981) *African Charter on Human and Peoples' Rights*. African Union, https://www.refworld.org/legal/agreements/oau/1981/en/17306, accessed on 23.05.2025.

[12] Organization of American States (OAS) (1988) Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, "Protocol of San Salvador", https://www.oas.org/juridico/english/treaties/a-52.html

[13] CESCR (2000) General Comment No. 14: The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4. https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf, accessed on 23.05.2025.

2023: 192). According to CESCR these include: safe food and drinking water, appropriate sanitation, adequate housing and nutrition, healthy environment and working conditions, education and information related to health, and gender equality (OHCHR, WHO, 2008: 3; Borić, 2021: 170).

CESCR General Comment No. 14 recognises that, similarly to other economic and social rights, the right to health is considered a precondition for the implementation of other human rights (CESCR, 2000; Dimitrijević et al., 2024: 320) such as the right to: life, human dignity, labour, privacy, education etc. (Petrović, Pokuševski, 2023: 191). Since human rights are "interdependent, indivisible and interrelated"[14] (see also: Stanila, 2024), the infringement of the right to health may emerge as an obstacle for the enjoyment of some other human rights, such as, for example the right to education or the right to work and contrarywise (OHCHR, WHO, 2008: 6).

3. Participation as an important aspect of the right to health

CESCR General Comment No. 14 underlines that the respect of the right to health can be pursued through many complementary approaches, including the creation of health policies, the implementation of WHO health programmes, as well as through relevant legal instruments (CESCR, 2000). In the context of the right to health, human rights-based approach proposes that essential human rights principles and standards should be implemented within all health services and health system policies (WHO, 2023), with the aim to develop the capacity of responsible entities to fulfil their duties as well as to empower rights-owners to successfully claim their rights[15]. The way in which international human rights standards will be implemented in the national legal framework depends on legislator's readiness to take into consideration the actual needs of citizens as well as to maintain an equilibrium between the interests of various social groups (Kolaković-Bojović, 2022: 64).

At this point, it should be emphasized that one of the entitlements that constitute the right to health is the right of the entire population to participate in health-related decision making at both national as well as community level (OHCHR, WHO, 2008: 4).

[14] World Conference on Human Rights (1993) Vienna Declaration and Programme of Action, A/CONF.157/23, https://www.ohchr.org/en/instruments-mechanisms/instruments/vienna-declaration-and-programme-action, accessed on 24.05.2025.

[15] See also: A human rights based approach to health, Department of Ethics, Equity, Trade and Human Rights (ETH) Information, Evidence and Research (IER), Human Rights and Economic and Social Issues Section & Millennium Development Goals Section, https://www.ohchr.org/sites/default/files/Documents/ Issues/ESCR/Health/HRBA_ HealthInformationSheet.pdf, accessed on 24.05.2025.

Human rights principles of participation and inclusion suggest that all individuals and peoples have the right to "active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized" (UNSDG, 2003). This implies that the general population should be involved with and actively participate in the creation of the abovementioned legal or strategic documents (such as health policies and programmes). Accordingly, national health systems are expected to provide appropriate arrangements in order to guarantee the participation in the design of health policies (OHCHR, WHO, 2008: 27). Correspondingly, a European policy framework Health 2020 claims that human rights standards and values (including participation, equality, non-discrimination, transparency and accountability) should guide health policymaking and permeate all phases of health programming development (WHO, 2013: 41).

In terms of health, social participation is understood as the involvement of the population in the making of decisions that have an impact on their health status (Francés, La Parra-Casado, 2019: 1). It can be performed either through institutional networks and procedures or via other, non-institutionalised methods (Ganuza, Francés, 2008: 481 according to Francés, La Parra-Casado, 2019: 1). The Alma-Ata Declaration (1978)[16] proclaims that the highest grade of community or individual self-reliance and participation throughout the process of planning, organising, operating and controlling primary health care, is a precondition for health protection and promotion (Francés, La Parra-Casado, 2019: 1).

Participation means that individuals or groups are involved with and have an impact on 1) making decisions influencing their health status and health-care services, 2) implementing those decisions, 3) evaluating and monitoring and 4) defining the problems in this field (Francés, La Parra-Casado, 2019: 1). Social participation in health is the process of collective reflection, allowing individuals or groups to generate relevant information in the sphere of health, and reflect on it with the aim to make decisions through participatory mechanisms, in collaboration with institutions, and to be involved in the planning and implementation of these decisions (Francés et al., 2016: 4 according to Francés, La Parra-Casado, 2019: 1).

The Ottawa Charter for Health Promotion (1986) links health promotion (as a process that enables people to gain control over and improve their health) to the empowerment of communities (WHO, 1986). It stresses that health promotion can be achieved

[16] World Health Organization (WHO) & United Nations Children's Fund (UNICEF) (1978) Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12September 1978. Geneva: World Health Organization, https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2, accessed on 25.05.2025.

through real and effective community action in "setting priorities, making decisions, planning strategies and implementing them to achieve better health" (WHO, 1986). The Charter sees the empowerment of communities as the process in which their members take control of their own future, based on community resources, self-help and social support enhancement and the development of systems flexible enough for public participation in health-related issues (WHO, 1986).

Social participation in the area of health has multiple advantages: 1) providing a more meaningful life where a person becomes the agent of his/her own destiny through making health status related decisions 2) improving community and social connections via spaces designed for social interaction and promoting participatory processes 3) developing a feeling of control over person's living conditions as the consequences of his/her own decisions; and 4) allowing individuals to do the things they enjoy, depending on the decisions they made (Francés, La Parra-Casado, 2019: 3). The holistic and positive concept of health (particularly mental and social), as defined in the WHO Constitution Preamble, and genuine health equity cannot be accomplished without inclusive social participation processes (*Ibid.*).

Participatory processes in the spheres relevant to the right to health influence health equity at the level of health-professionals, health-facilities as well as at the level of health system and policy (Brown et al., 2014: 8). Among participatory processes, participatory diagnosis plays a particularly important role as a tool that enables the researchers to identify key issues and needs, their severity, the population affected by a certain problem, the urgency to find a solution, to produce knowledge and act in accordance with reality, to gain information necessary for intervention planning as well as to facilitate the participation of the community in the decision-making process (Canales, 2019: 479). There are a multitude of techniques that can be applied to establish participatory diagnosis, including participatory community-based surveys (Schultz et al., 1998), deliberative surveys or deliberative polling (Mansbridge, 2010), situational flow-grams, focus groups (see also: Đurić, 2007; Conde et al., 2024), SWOT analyses and photovoice method (Brown et al., 2014: 9).

4. Photovoice as one of participatory action research methods

Photovoice is defined as a research method aimed at identifying, representing and enhancing a particular community through a special photographic technique comprised of entrusting the cameras to research participants and encouraging them to document their reality, share their knowledge and act as potential drivers of change (Wang,

Burris, 1997: 369; Wang, 2006: 148). By taking part in a photovoice research, "participants document the reality of their lives" (Wang et al., 1998: 75). Photovoice participants "use their images to express or make known their experiences" (Lorenz, 2010a: 212). Not only does photovoice method enable participants to document their reality, but it also enhances them to take part in group discussions about their photographs and to present them in public (Wang, Redwood-Jones, 2001 according to Baker, Wang, 2006).

Photovoice belongs to participatory action research that differs from other types of qualitative research applied in social sciences and humanities, it the terms of both – methods implemented and research goals (Petrović, 2008: 237-238; Batrićević, 2021: 24, Conde et al., 2024). The theoretical foundations of photovoice method dwell in the approach to education based upon critical consciousness (Freire, 1970 according to Baker, Wang, 2006: 1406; Wang, Burris: 1997: 370), feminist theory (Wang, Burris: 1997: 370), and a community-based principles applied on documentary photography and health improvement (Wang, Morrel-Samuels, et al., 2004 according to Baker, Wang, 2006: 1406). Such concept allows individuals from diverse social and economic positions to express their problems, opinions, needs and concerns through a powerful means – the visual image (Wang & Burris, 1997: 372; Baker, Wang, 2006: 1406).

The concept and application of photovoice method was designed by Caroline Wang and Marry Ann Burris, who initially named it *photo novella* (Wang, Burris, 1994: 171; Coemans et al., 2019: 38; Batrićević, 2021: 23-24), but soon replaced it with the term photovoice, as defined above (Wang, Burris, 1997: 369; Wang, 2006: 148). In the term photovoice, "voice" is an acronym that stands for "Voicing Our Individual and Collective Experience" to remind the participants to be aware not only of their own experiences but of those belonging to other participants as well (Palibroda et al., 2009: 6). Photovoice method is regarded as citizen science (Buyx et al., 2017 according to Conde et al., 2024). Citizen science is often used as alternative expression for participatory research and patient-led research, referring to the research involving volunteers who are not professional researchers, but who contribute to it in various ways (Buyx et al., 2017: 378).

When implementing photovoice method, researchers are guided by three main goals: 1) to give participants a chance to document and present positive and negative aspects of their community, 2) to encourage critical thinking and exchange of ideas within group discussions about the participants' photographs and 3) to draw attention to participants' problems (Wang, Burris, 1997: 370; Wang, 2006: 148; Batrićević, 2021: 24) and influence decision-making processes (Suprapto et al., 2020: 675; Batrićević, 2021: 24).

Photovoice is particularly suitable for research involving persons who find verbal (oral or written) expression difficult for various reasons, as well as for persons who belong to vulnerable or marginalized groups (Batrićević, 2021: 26; Đurić, Paraušić-

Marinković, 2025: 73) such as homeless persons (Wang, 2003), persons with mental impairments (Fleming et al., 2009), persons with health issues (Lorenz, 2010a, Lorenz, 2010b), migrants (Del Vecchio et al., 2017; Lögdberg et al., 2020), refugees (Adinia, Chandra, 2019; Humpage et al., 2019), persons in the process of immigration detention and deportation (Turnbull, 2019), indigenous people (Lewis et al., 2012; Anderson et al., 2023), people who inject drugs (Drainoni et al., 2019), persons recovering from problem substance use (Smith et al., 2023), persons with alcohol addiction (Fuente et al., 2021), juveniles under risk of delinquency (Hsiao et al., 2020), elderly persons[17] (Novek et al., 2012; Ronzi et al., 2016; Mysyuk, Huisman, 2020) etc.

Photovoice research usually consist of nine steps (Wang, 2006: 149; Palibroda et al., 2009: 26; Batrićević, 2021: 25-26). However, the photovoice method is very flexible and highly adaptable to various circumstances and conditions, which gives the researcher a certain amount of freedom regarding organisation and realisation of research (Wang and Burris, 1997; Đurić, Paraušić-Marinković, 2025). The initial step includes the selection of target group of decision-makers to whom the research problem should be presented. The second step refers to the selection of participants. A consensus has not been reached yet about the ideal number of photovoice research participants. Wang suggests that there should be between 7 and 10 participants (Wang, 1999; Wang, 2006; Đurić, Paraušić-Marinković, 2025), but there are photovoice projects with a smaller or larger sample – for example, ranging between 6 and 22 participants (Suprapto, 2020: 679). Next step includes the meeting(s) with the participants to explain to them the essence of photovoice as well as the basics of photography techniques and ethics (Wang, 2006: 149; Batrićević, 2021: 25-26).

Another important step in the photovoice research refers to providing four types of consents:1) consent of the participants to participate in the photovoice research, 2) statement of the participants confirming that they are willing to allow the researcher to publish the photographs they made in a research article or book as well as on a public exhibition, 3) consent of third parties (i.e. persons that the participants photograph for the purpose of the research) to be photographed and 4) consent of the persons photographed for the public display of their photographs (Palibroda, 2009: 47-51; Latz, 2017 according to Đurić, Paraušić-Marinković, 2025). It is very important to correctly obtain written consent of subjects of the photograph, because this procedure prevents the violation of their right to privacy (Palibroda et al., 2009: 34).

[17] One of the topics related to the rights of elderly persons that would be suitable for a photovoice research could be the accessibility of cultural and social activities in urban and rural areas, an issue that was highlighted by the author of this paper in 2023 (Batrićević, 2023).

The next step is a group discussion in which the participants are expected to define the topics for their future photographs together with the photovoice facilitator (Wang, 2006: 149; Batrićević, 2021: 25-26). There is also a possibility to give the participants a journal in which they can write down their ideas about the research topic and draft the photographs they would like to make in order to express these ideas (Palibroda et al., 2009). After defining key topics for photographing, the participants are provided with photo equipment and given instructions for its appropriate use (*Ibid.*). In the time when mobile phones are equipped with fine cameras allowing their users to create high-quality images rather easily, it seems that this step can be skipped, unless the participants for some reason prefer or have to use analogue or digital cameras.

The participants are typically given a one-week term to make photographs for each topic, and then, on weekly meetings, they present and discuss their photographs with other participants (Wang, 2006: 149; Batrićević, 2021: 25-26). The discussions are of key importance for the photovoice research, since they allow the photographers to "unpack the story behind their photographs" (Wang, 2022: 207). They are most commonly organized in the form of a focus-group interview, although in some cases they may have the shape of an in-depth interview (Đurić, Paraušić-Marinković, 2025: 79). While some authors prefer a more structured approach to the discussion and tend to use a set of particular questions about the photographs (Wang, 1999 according to Palibroda et al., 2009), others consider such approach constricting and suggest a less structured technique, allowing the participants to interpret and analyse their photographs in a less controlled discussion (McIntyre, 2003 according to Palibroda et al., 2009).

The final step is a photography exhibition, where participants' photographs and narratives are presented to the community (Wang, Pies, 2004: 99; Palibroda et al., 2009: 4; Lorenz, 2010a: 213; Wang, 2006: 149; Batrićević, 2021: 25-26;). Gallery exhibition does not have to be the only way to share participants' photographs with the community, since printed or e-books and online galleries are also suitable (Wang, 2006: 149).

Data collection and analysis are considered to be the significant steps in "moving photovoice from project to research" (Palibroda et al., 2009: 53). In photovoice research, the collection of data is an ongoing process that includes several activities: taking photographs, taking part in group discussions that are being recorded, journaling, feedback from the exhibition's visitors and debriefing (*Ibid*.). For that reason, the evidence gathered through the application of photovoice method is complex, comprising visual data (photographs taken by the participants), participant's narratives (transcripts of recorded discussions and brief texts that accompany participants' photographs) as well as contextual data (such as socio-demographic data or information about participants' community) (Đurić, Paraušić-Marinković, 2025: 80-81). Data generated through the application of

photovoice method is predominantly qualitative, but in some cases, depending on the sample size and the number of photographs submitted, it can also be quantified (Đurić, Paraušić-Marinković, 2025: 82).

In the context of photovoice, data analysis refers to the process of exploration, examination and comparison of data collected throughout the research process, allowing the researcher and co-researchers to define general themes and patterns as well as to see how individual experiences are related to others' experiences (Palibroda, 2009: 4-5). Wang and Burris (1997) suggest that when photovoice is used for needs assessment, the following three-steps process should be conducted with the participants as a foundation for data analysis: 1) the selection of photographs that most truthfully depict the needs and assets of a particular community; 2) contextualization, i.e. explanation of the meaning of the photographs and 3) coding, i.e. the identification of emerging themes, issues and theories (Wang, Burris, 1997: 380; Palibroda et al., 2009: 55). Despite their complexity and diversity, data gathered through the application of photovoice method can be analysed in the same way as other qualitative data – through coding, re-analysis, and interpretation of themes and categories (Hergenrather et al., 2009 according to Đurić, Paraušić-Marinković, 2025: 82). Namely, it is agreed that content analysis (whether qualitative or quantitative) as a method can be used on various types of data, including textual, visual and audio materials (Manić, 2017: 34). This refers to the data gathered through the application of photovoice method: textual (transcripts from discussions, narratives and captions that accompany participants' photographs as well as participants' journals provided that they have them and that they agree with their use for the purpose of the research, feedback from exhibition if it is in written form etc.), audio recordings of group discussions and, finally, visual – participants' photographs (Palibroda et al., 2009).

5. How can photovoice make a difference in the field of health-related public policies?

WHO defines health policy as a series of decisions, plans, and actions carried out in order to reach given health care goals within a society (Moutselos, Maglogiannis, 2020; O'Brien et al., 2020). Health policy shapes decisions and choices related to the development and use of health technologies, establishment and financing of health services, lists of freely available medicines etc. (Buse et al., 2012 according to O'Brien et al., 2020). For that reason, it is of crucial importance for full enjoyment of the right to health that health policy truly corresponds with the needs of health care system users. Therefore, a European policy framework Health 2020 (WHO, 2013) accentuates the role of cross-society engagement in the process of planning, development, implementation

and monitoring of health policy, insisting on the involvement of health professionals as well as on the empowerment of people, citizens, consumers and patients (WHO, 2013: 10). This is in accordance with the principle of participation as an aspect of the right to health. Nevertheless, it can be discussed what would be the most suitable way(s) to involve citizens as actual or potential patients in the process of health policy design and implementation?

To be considered effective and sustainable, public policies should be created on the grounds of factual knowledge (actual or asserted), gained either through observation or via experimentation, to support conclusion, referred to as evidence (Oxman et al., 2009 according to WHO, 2021: 6). Two approaches to the implementation of evidence into healthcare practice can be distinguished: evidence-based and evidence-informed (Kumah et al., 2022) and similar distinction can be noted when it comes to health policy. The evidence-based policymaking was recognized by the European Commission in 2001, when the importance of the role that scientific and other experts have in decisions' preparing and monitoring was highlighted (Kolaković-Bojović, 2022: 67). Although there is no doubt that evidence-based policymaking has the capacity to effectively addresses relevant issues and needs as well as to define goals achievable through appropriate activities, in accurate deadlines, supported by adequate resources, and accompanied by risk assessment (*Ibid.*), more recently, the emphasis is placed on the evidence-informed decision and policy-making, especially in the field of health policy and practice (WHO, 2021: 6; Kumah et al., 2022).

Evidence-informed decision-making claims that decisions should be made on the grounds of the best available evidence obtained from research, but also taking into account other relevant factors such as context, public opinion, fairness, probability of implementation, affordability and sustainability and acceptability to stakeholders (Rehfuess, et al., 2019 according to WHO, 2021: 6). Systematic and transparent, in line with principles of equity, accountability and equality (Stewart et al., 2019 according to WHO, 2021: 6), this approach applies structured and replicable methods, to "identify, appraise and make use of evidence across decision-making processes" (Partridge et al., 2020 according to WHO, 2021: 6).

However, relevant data (on the grounds of which public policies are supposed to be created) do not always come in the shape that policymakers find useful (McBride et al., 2008: 150-154 according to Brownson et al., 2009: 1580). Besides, academic quality research does not always manage to reach the policymakers (Feldman et al., 2001: 312-321 according to Brownson et al., 2009: 1580). Therefore, combining traditional academic research methods with more flexible and socially engaged ones, could contribute

to bridging the gap between policymakers, on the one hand and public policy beneficiaries, on the other. This particularly refers to a field closely intertwined with health policy known as health care quality improvement, i.e., "a process of approaching systemic problems in healthcare" (Puri et al., 2023). In this area, "methodological approaches that transcend traditional techniques to comprehensively evaluate health care quality and needs for improvement" (Balbale et al., 2016: 1382) are being increasingly applied.

Participatory visual methods, such as photovoice, are progressively applied in various contexts to involve individuals and communities with research and advocacy in the fields of health, illness and health care and improve health policy and practice by placing real lives of patients and community members in the focus of policy-making processes (Berland, 2007: 2533 according to Lorenz, Kolb, 2009: 263). By adding a new, multi-dimensional visual type of data to traditional forms of verbal and written research material, a more detailed understanding of the layers and depths of research subject is provided **(**Đurić, Paraušić Marinković, 2024: 3). Also, the application of participatory visual methods has the potential to deliver a more direct insight into participants' life experiences, and their observations in comparison to the methods that rely solely on the data collected and controlled by the researcher (Rich et al., 2000: 156 according to Lorenz, Kolb, 2009: 264).

Since they are directly involved in the healthcare system, both – patients and providers have the capacity to provide valuable insights into healthcare process (Balbale et al., 2016: 1382). However, the views of the providers and those of the patients may differ when it comes to the issues such as patients' information needs and values, the character of patient-staff interactions and some other topics (Bolderston, 2008: 112-115 according to Balbale et al., 2016: 1382).

An important characteristic of participatory visual research such as photovoice is the fact that, instead of passive, the participants play an active role throughout the entire research process, shaping its path and methods (Balbale et al., 2016: 1382), starting from the definition of research problem, topics for photographing and discussion to the selection of photos for public exhibition and narratives that follow them. This makes the participants feel truly engaged and enhances their interest in the research (Balbale et al., 2016: 1382), among other, because it gives them the opportunity to share their feelings and experiences with others (Baker, Wang, 2006: 1409)

The application of photovoice in health care settings is beneficial on several levels, since it enhances the partnership between participants and researchers, by giving the participants a voice, and empowering them to make a positive change (Jagosh et al., 2012: 312 according to Balbale et al., 2016: 1382-1383) and to be involved with health im-

provement (Catalani, Minkler, 2010 according to Balbale et al., 2014). Participatory visual methods such as photovoice have the potential to generate plenty of useful data that can be used to create healthcare interventions adjusted to participants' needs (according to Balbale et al., 2014). This is of particular importance when it comes to improving health promotion practice with vulnerable populations, since photovoice method has the capacity to transmit the message from groups whose voices may otherwise remain unheard (Lorenz, Bush, 2022: 279).

6. Application of photovoice method in the context of health protection and promotion – examples of good practice

Photovoice method was implemented for the first time in research about the health of women in Yunnan Province in rural China (Wang, Burris, 1994; Wang, 2022: 205). Since then, photovoice has been applied in various social contexts and for several aims, and its role in the process of health policy-making and healthcare improvement is becoming increasingly significant. There are numerous examples of the implementation of photovoice method in the context of health protection and promotion, and, for the purpose of this paper three of them are presented.

6.1. Visual metaphors of living with brain injury – a photovoice project with brain injury survivors

In Framingham, MA in 2006, a photovoice project was implemented by Professor Lorenz and two co-facilitators, involving 8 brain injury survivors, members of a brain injury survivor support group, as a part of their extra-curricular activity (Lorenz, 2010a: 213). The participants were between 40 and 50 years old, they had a recognized disability from brain injury and were considered high-functioning at the time of project implementation – some of them were volunteering while some had part-time employment (*Ibid.*). The most prevalent motive for joining this project was participants' wish to additionally enhance their personal healing process after brain injury (*Ibid.*).

The main goal of the project was to gain an insight into brain injury survivors' life experiences of illness, healing and health care from their own perspective, with the intention to include these insights in the process of creating policies and practices that are more focused on patients (Lorenz, 2010a: 210). The reason why photovoice method was applied here lays in its flexibility, creativity and adaptability, which is of particular importance when research participants are facing various cognitive challenges (Lorenz, 2010a: 210).

Participants used disposable cameras to take photographs representing their answers to several questions about their coping with the experience of brain injury (Lorenz, 2010a: 214). They were given their printed photographs at group meetings, where they had a chance to discuss their photographs and read the captions they wrote as at-home assignments and exchange their feelings and opinions with others (Lorenz, 2010a: 215). Both participants as well as co-facilitators took part in the discussions, listening to photographers' explanations, asking questions and sharing their viewpoints (Riessman, 2007 according to Lorenz, 2010a: 219). Before organizing the public exhibition, the participants were asked to identify and develop, as a group, themes or categories and sort their photographs within them (Lorenz, 2010a: 216).

Several outreach activities continued for three years after the project (Lorenz, 2010b: 863), comprising: photography exhibitions, conferences and conference presentations, a video with participants, a training for photovoice facilitators, an evening programme promoting brain injury awareness among US veterans, posting participants' photographs and captions and photovoice guidelines on relevant websites and a new photovoice project including some of the co-facilitators and participants (serving as mentors) from the original one (Lorenz, 2010a: 213).

The project appeared to be highly beneficial and transformative for the participants, since it helped them to "see themselves and be seen as experts" (Lorenz, 2010a: 221), allowing at the same time raising of awareness and empathy of the audiences (*Ibid.*). When health-policy impact is concerned, just like in the case of other participatory action research projects, it remains uncertain to what extent the participants managed to influence relevant decision-makers (*Ibid*). Nevertheless, the project's indirect impact on health policy can be derived from the fact that it inspired future photovoice projects in that field (*Ibid.*).

6.2. Application of photovoice method to study the experience of chronic pain in older adults

Another example of the use of photovoice method with the purpose to provide a more detailed insight into specific health issues, assess the needs of persons affected, and make an effort to influence health policy, is a study conducted by Baker and Wang (the results of which were published in 2006) about the experience of chronic pain in older adults (Baker, Wang, 2006). The aim of the research was to explore various psycho-social factors related to chronic pain among 27 clinic and non-clinic patients of the average age of 65, 13 of which completed all phases of the research (Baker, Wang, 2006: 1406-1408).

In the first phase of the research, the participants used disposable cameras to photograph the objects that served as visual representation of their chronic pain experience (Baker, Wang, 2006: 1406). After taking the pictures, the participants would bring their cameras to the research office for photo processing and labelling and then, the processed photographs would be given to their authors so that they could select four, write titles and brief narratives for each and return them to the researchers (Baker, Wang, 2006: 1408). So, although the researchers intended to use the photovoice method in its original form, the physical limitations of the participants including transportation problems and a small number of those that were clinic-based, it was not possible to organise group sessions or public photography exhibitions (Baker, Wang, 2006: 1409)

After completing the first task, each participant was provided with another disposable camera with the instruction to photograph the objects symbolizing how their lives would be like without chronic pain (*Ibid*). Again, they would return the cameras to the office, choose four photos, write captions and narratives and return them to the researchers (*Ibid.*). At the end, the participants would fill in an exit interview survey including demographic questions as well as a series of open-ended questions related to their participation, photographic experience, pain experience etc. (*Ibid.*). Some of the open-ended questions addressed patients' reason for, feelings about and expectations from participating in the study (Baker, Wang, 2006: 1409). As key motives for participation the willingness to learn more about the factors causing chronic pain, the chance to share their feelings with others and the wish to help others were mentioned (*Ibid*.).

This study provided additional forms of analytical information that can be used by researchers, health care providers and evaluators (Baker, Wang, 2006: 1412). It also enabled the patients to conduct their own needs' assessment and share with others their experiences of chronic pain (*Ibid.*). The modification of the original photovoice method was absolutely reasonable and, in the opinion of the author of this paper, it did not harm the essence of this flexible and adaptable research method.

6.3. Investigating recovery from problem substance use by applying digital photovoice

Research conducted in 2019 and 2020 with 7 users of harm reduction drug service in the Southwest of England was aimed at exploring the process of their recovery from problem substance use through the implementation of photovoice method (Smith et al., 2022:1380). The participants used digital cameras to photograph "people, places and things meaningful to them in their recovery" (*Ibid.*).

Participants' photographs and descriptions were used as inspiration for discussion throughout in-depth interviews and allowed the researchers to gain valuable findings about the experience of recovery, such as, for example, the relation between social capital

and recovery results (Smith et al., 2022:1378). In that way, the research provided "a vivid picture of an individual's experience of the recovery process" and allowed the public to understand them more accurately (Smith et al., 2022:1379). At the same time, it encouraged the users of harm reduction drug service to share their experiences and discuss about the way in which these services could be improved (Smith et al., 2022:1378).

Both – images and transcripts of the interviews were analyzed simultaneously, since the researchers noticed their close connection (Smith et al., 2022: 1382). Two main themes were identified: the isolation due to stigma and mistrust and the individual experience of support system in recovery (*Ibid.)*. Despite limitations such as small sample size and COVID-19 pandemic, its findings can be considered valuable guidelines for the services working with people recovering from problem substance use (Smith et al., 2022: 1390).

7. Conclusions – advantages and limitation of photovoice in health-related research

The right to health is universally recognized as one of fundamental human rights. The fact that health contains a subjective component as well, also implies that policy and decision makers in the sphere of health care and protection ought to take into consideration the perspective of those whose health is concerned – i.e. citizens as actual or potential patients or caregivers. Such approach is in accordance with the right to social participation of the entire community in various activities and processes, as one of key components of the right to health.

This particularly refers to patients' needs assessment and evaluation of the implementation of certain measures in the area of health protection, including health care quality improvement. The aforementioned suggests that in the sphere of health, evidence-based or evidence-informed policy should also consider how the patients perceive some issues or concerns that affect them. One of the ways in which this can be accomplished is the implementation of participatory action research methods, including photovoice.

There is a growing body of literature about the application of photovoice method in the areas such as health care quality improvement, health policy making, needs assessment in the field of health protection and raising community awareness about particular health issues. Photovoice method is flexible, easily adaptable to various research participants, especially those who belong to vulnerable and marginalised groups, which makes it suitable for application in diverse contexts, allowing the researchers to treat the findings of "common people" as the main source of expertise (Wang, Burris, 1997: 372; Batrićević, 2021: 35-36). By giving a voice to those whose words otherwise might remain

unheard, photovoice enables the participants to provide an insight into their problems and needs from their perspective, which often differs from the perspective of academic researchers or other members of the community. The potential that photovoice has when it comes to creating valuable, authentic and useful data suggests that it should be applied in the area of health policymaking, needs assessment and quality improvement, as an addition to traditional research methods.

Several examples, some of which are cited in this paper, suggest that photovoice brings together scientific research and activism, which should be seen as its unique advantage, especially when it comes to health. In that sense, the insights that it provides are not relevant solely to decision-makers but to the broader community as well. Sharing with the community participants' reality from their perspective may contribute to raising public awareness about the challenges that persons with particular health issues are facing. Strong impact of visual images can play a significant role in the prevention of discrimination, marginalisation and stigmatisation of persons who are already in the vulnerable position due to their health issues. Powerful visual images can increase solidarity and empathy of both – community members and decision-makers for those facing health challenges and, hence, initiate positive changes.

At the same time, photovoice method empowers the participants by enabling to express their feelings in a creative way, exchange their experiences, promote critical thinking and take part in constructive discussions about the topics of their concern, which is in accordance with their right to participation, as an inherent component of the right to health.

There are also some challenges and limitations regarding the implementation of photovoice method in general, which are, of course, present in the cases when it is used for the purpose of research in the area of health as well. One of the challenges related to photovoice research method is related to its connection with activism, in the sense that participants may be exposed to various risks and placed in a vulnerable position because of their efforts to instigate positive changes in their community (Wang, Burris, 1997: 374; Batrićević, 2021: 36). Another limitation of this method is derived from its subjective approach, which implies that the researcher should always consider who is taking the photos, what is the criterion for their selection etc. (*Ibid.*). Finally, as already mentioned previously, it is rather difficult to measure the impact that the implementation of photovoice research can have on decision and policy-makers. The very fact that it brings in front of decision-makers and the public an entirely new and different set of data (in the form of visual images and authentic narratives) certainly has the potential to make a difference, particularly in the sphere of protection and promotion of the right to health and bridge the gap between policy-makers, health care providers and beneficiaries.

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