
Philadelphia Youth Photovoice: Opportunities for Nonprofit Hospitals to Integrate Photovoice as Part of the Iterative Process for Community Health Needs Assessments and Implementation Strategies

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Background

Community Health Needs Assessments (CHNAs) as a Requirement Under the Patient Protection and Affordable Care Act (PPACA)

According to section 501(r)3 of the Patient Protection and Affordable Care Act (PPACA), in order for a 501(c)3 hospital to receive tax exemption, nonprofit hospitals in the United States must conduct a triennial community health needs assessment (CHNA) and adopt a community health implementation strategy (CHIP) to meet the community health needs identified through the assessment. According to this 2010 legislation, later revised in 2013, the needs assessment must account for input provided from representatives of the communities served by the hospital.^{1,2} This legislation rose out of concern that nonprofit hospitals were not meeting the minimum

standards of community benefit to gain tax exempt status.³

According to the IRS, for CHNAs to meet the requirements of PPACA section 501(r)3, they must take into account input received from persons who represent the broad interests of the communities served by the hospital, address needs of all patients in the hospital's catchment area regardless of their abilities to pay for healthcare, provide a prioritized list of significant health needs identified by the community, and describe resources available.⁴ The United States Congressional Budget Office reports that non-profit hospitals serve communities with an average poverty rate of 11.4%, an uninsured rate of 14.6%, and an

average income of \$32,423.⁵ This clearly indicates that nonprofit hospitals need to engage with under-resourced communities to meet the expectations of a CHNA.

In addition, the PPACA requirement for nonprofit hospitals was designed as a single iterative process where a CHNA is performed to inform a CHIP, the CHIP translates to measurable community benefit, which is then reported in the next CHNA and guides the next iteration.¹ However, a 2019 review of 500 randomly selected CHNAs from non-profit hospitals found that only 60.0% of these hospital had published both a CHNA and a CHIP. Of the CHNAs, 25.0% did not include

resources available to communities, and 42.2% did not address the impact of their last CHNA.⁶ This demonstrates that the PPACA's intention to generate an iterative process for assessing, planning, implementing, evaluating, and reassessing community benefit is not being reported by many hospital systems. Integration of methodologies across CHNAs, CHIPs, community benefit, and impact evaluations may improve interoperability between these components and ensure that the PPACA's CHNA requirement reaches the objectives for which it was intended.

Photovoice Research in CHNA

Photovoice is a community-based participatory action research method first described in 1997 by Wang and Burris, that emphasizes moving research methodology and subsequent results towards empowering social change within communities.⁷ The roots of photovoice methodology are four-fold: 1) an intervention to empower individual self-efficacy as a community change agent, 2) an assessment of community strengths and weaknesses as identified and interpreted by community members, 3) a process for building community capacity to implement changes that positively impacts community health, and 4) a mode for influencing policy, systems, and environmental reform that improve sustainability of positive changes implemented.⁸ Photovoice also has great utility in engaging and empowering individuals and under-resourced communities who have been historically marginalized by society and government, and excluded from previous research and advocacy efforts.⁹

There is a growing field of research on how hospital CHNAs and CHIPs are meeting the requirements and expectations outlined by the Internal Revenue Service (IRS) pertaining to the PPACA's section 501(r)3, but there is limited research detailing whether photovoice research is an effective CHNA component to meet these IRS requirements.⁶ In this article, we describe a photovoice project involving Latino youth in

Philadelphia and analyze whether it satisfied certain requirements of CHNAs required by the PPACA as described by the IRS. According to the 2019 US Census Bureau, there are currently 18.6 million Latinos under the age of 18 in the United States, which represents over 30% of the entire US Latino population.¹⁰ In addition to higher rates of poverty, lack of health insurance, and lower educational attainment, Latino youth are disproportionately affected by obesity, asthma, and mental health conditions.¹¹ In Philadelphia, 15.2% of the population identifies as Hispanic or Latino, and when compared to the city, they have disproportionately higher rates of poverty (45.5% vs 24.6%), uninsured people (24.2% vs 12.9%), asthma (28.6% vs 21.5%), diabetes (22.9% vs 13.8%), and mental health conditions (38.1% vs 25.4%).¹²

Though this photovoice project was a component of a CHNA, this CHNA was not meant to fulfill a requirement for the PPACA and instead aimed to specifically partner with Latino youth to identify and interpret the highest priority health needs of a historically marginalized and under-resourced community in Philadelphia while evaluating the utility of the method in meeting PPACA CHNA requirements.¹²

Methods

Research Team

This study was conducted by a team consisting of a public health research fellow (C.D.), four medical students (V.P., M.A., M.H., and J.M.), and a population health and research

expert with > 30 years of experience (R.B.) who trained the team and supervised data collection and analysis.

Participant Recruitment

Five zip codes were identified as having the highest Latino population density in North Philadelphia using Geographic Information Systems. A community advisory board composed of stakeholders from within these five zip codes was formed, and three organizations from this board volunteered to

recruit up to 20 Latino youth participants, aged 14-18, from their existing programs: 1) a youth advocacy program at a primarily Latino community resource center, 2) an after school program for students with learning disabilities, and 3) a charter school managed by a Latino nonprofit organization.

Study Design

The research design was adapted from the Wang and Burris article first describing photovoice methodology.⁷ Researchers met with participants in an introductory group session #1, followed by interviews and subsequent group sessions #2, #3, and #4.

Group sessions #1-#3 and interviews were conducted separately at each of the three community partner sites in January-March 2019. Groups session #4 involved participants across all three sites at the end of March 2019.

Group Session #1

Participants brought consent forms signed by their parents or guardians. The researchers read the assent and the participants signed. A professional photographer was hired to provide a photography lesson to the participants and participants were offered a camera to use if desired. Researchers reviewed ethical and safety guidelines for taking photographs, and

instructed participants to take photos in response to the research question “What helps and what prevents you from being healthy in your community?” Participants had at minimum one week before their individual interviews to take and select up to 10 photos that would best illustrate their responses to this question.

Interviews

Researchers interviewed individual participants about their 10 photos using the SHOWeD questioning strategy, a set of questions used to elicit a description of the photos, an explanation for their relevance to the research question, and a discussion on how to address issues identified.¹³ Researchers chose to interview participants instead of discussing

photos in small groups in this photovoice design due to the broad nature of the research question, which demanded additional time to address all photos taken. Due to the sensitive nature of some themes, interviews were also used to engage participants in selecting which photos to present in group sessions to highlight their points while protecting the individual

participant's privacy and safety. Participants were permitted to opt-out of the interview. The interviews were audio recorded and transcribed verbatim. After the interview, each participant was asked to write phototexts for three photos

they thought were the most important to the research question. Researchers provided assistance in writing phototexts when requested by participants.

Group Session #2

Researchers de-identified and compiled participant photos and phototexts. Photos and phototexts were projected one at a time for participants to view. Participants were asked to

discuss how each photo may or may not relate to their own experiences. These sessions were audio recorded and transcribed verbatim.

Group Session #3

Researchers individually printed the photos and phototexts reviewed in group session #2 and instructed participants to sort the photos into common themes. Participants were

instructed to name these themes and select which photos within each theme would be included in the final photo exhibit.

Group Session #4

This single session involved all participants from the three partner sites. Researchers printed the photos and phototexts selected during group session #3 and displayed them beneath the themes that the participants developed. Participants from each site presented the themes developed at their site to the entire group. Participants were provided time to review the photos independently. Then, researchers instructed participants to integrate photos and

phototexts from similar themes across sites, create new themes as needed, and name the final themes. Researchers recorded the descriptions of each of the final themes as defined by the participants. Participants provided feedback on how they thought the exhibit and their individual photos and phototexts should be displayed.

Prioritization

During group session #4, researchers asked participants to identify specific health needs presented in the final photo exhibit across multiple themes. Each participant was permitted to vote three times on which of these health

needs were the highest priority. The top five health needs by vote were considered the final ranked priorities.

Data-Analysis

Software

Interview transcripts, group session transcripts, and phototexts were uploaded into

NVivo 12.0, a software program used to analyze qualitative data.¹⁴

Coding and Code-Book Development

The final 10 themes and respective names and definitions developed by participants during group session #4 were used as primary codes. Then, using line-by-line reading of the data, researchers met as a team to develop subcodes and their explicit definitions. Two members from the research team independently coded all

interview transcripts, group session transcripts, and phototexts into codes. This process was repeated to code data from all codes into subcodes. Coding discrepancies were resolved by consensus during review sessions.

Reliability

Intercoder reliability and percentage of agreement was calculated in NVivo 12 using the mean κ coefficient, which can be interpreted as moderate agreement ($\kappa = 0.41$ to 0.60),

substantial agreement ($\kappa = 0.61$ to 0.80), or near-perfect agreement ($\kappa = 0.81$ to 0.99).¹⁵

Conceptual Model

Researchers utilized the World Health Organization's Framework on the Social Determinants of Health to categorize subcodes as 1) a structural determinant of health, defined as factors that contribute to inequitable social stratification, 2) an intermediary determinant of health, defined as factors that directly protect or put individuals at risk of health-compromising conditions, or 3) a proposed solution.¹⁶

This study received Institutional Review Board approval, involving written parent or guardian consent and youth assent to participate. Participants received \$60 and a framed photo of their choosing for completing the project.

Results

A total of 34 participants completed the photovoice across the three community partner sites as displayed in table 1, producing a final photo exhibit consisting of 76 photos and phototexts across 10 codes. Combined findings from interview transcripts, group session transcripts, and photos/phototexts are

summarized below for each of the ten codes, presented in alphabetical order by the names assigned by participants to each code, followed by prioritization and a conceptual model. Analysis revealed near perfect agreement in this study (mean $\kappa = 0.94$), and 96.5% agreement.

Table 1.

Participant Demographics. This table summarizes the demographics of participants in this photovoice including age, gender identity (M= Male, F= Female), and their distribution across the three community partner sites. All participants identified as Latino and gender binary.

Age	Frequency (Male, Female)
14 Years	5 (3M, 2F)
15 Years	7 (5M, 2F)
16 Years	7 (3M, 4F)
17 Years	8 (4M, 4F)
18 Years	7 (6M, 1F)
Location	Frequency (Male, Female)
Site 1	5 (4M, 1F)
Site 2	14 (10M, 4F)
Site 3	15 (8M, 7F)
Total	34 (21M, 13F)

Beauty of the Natural Beast

Participants found beauty in the “beastly” green spaces in their neighborhoods, represented by photos of unkept lots, parks, and gardens. Participants reported that the government invests in green space upkeep in other neighborhoods more than their own. They reported associating green spaces with feeling safe, saying, “since there are more trees in the area...you will feel safer,” and that engaging in

activities in these outdoor spaces improves mental health. Participants said that trees provided clean air which they linked to decreased instances of asthma and respiratory disease. They suggested that planting more trees and having frequent neighborhood cleanups would improve their health.

Hope

Participants highlighted a wide variety of factors that improved their health and gave them hope. Participants remarked that participation and self-expression through sports, the arts, and volunteering improved their mental health. Participants reported that the support they received from their friends, family, mentors, and teachers through these activities

helped them be “spiritually healthy” and “keep them out of gangs, fights, cutting school, and smoking weed,” but not many youth in their community have a trusted adult in their lives. They suggested that increasing access and visibility of these efforts would benefit their communities.

Mindfulness is Power

Participants frequently emphasized the power they found in taking control of their mental health, but they shared that there are several factors that negatively impact their collective mental health. They reported that their community experiences higher rates of

stress, especially in lower income areas. Some participants explained that their peers rely on alcohol and marijuana to self-medicate; however, the majority of participants reported using self-care techniques as a means to overcome stress.

One Life = Game Over

Participants remarked on their understanding of life's fragility through their exposure to a myriad of dangerous situations and poor health behavior practices. They reported an "increase in mental illnesses" that they associate with increasing exposure to gun violence, traumatic death, and the resulting memorials found frequently throughout their neighborhoods. Some participants said this

creates barriers to leaving their homes. They reported attributing these violence to easy access to guns, tobacco, marijuana, and alcohol through local business or illegal markets in their community. They remarked that "We gotta stop taking each other's lives," and, "People should be more strict about who they are giving guns to."

The Code of Urban Art

Most participants identified a dichotomy in how art in their community can be either productive or destructive. The majority of participants stated that graffiti for gang or drug-related activity, was common but unwelcomed in their community. They embraced how the presence of colorful and culturally inspired mural arts improved individual and collective mental health, promoted tourism, and increased

community pride, but that these murals were less common in their neighborhood community. Like in Photo 1, they recommended that more funds be invested in creating culturally grounded murals in lower income communities, which may also improve the sustainability and upkeep of such displays.



Photo 1. Graffiti for Art. "We want the community to change to something better. We need to change the graffiti to cultural art. The art needs to mean something important for the community so that they like it, respect it, and take care of it."

The Unseen World

Participants frequently noted that the subpopulation of individuals experiencing homelessness and opioid addiction residing in their neighborhoods were neglected, or left unseen, by everyone else. Participants recounted frequently witnessing people injecting drugs and finding needles in public spaces, which they report negatively impacts mental health and safety for the rest of the community. However,

many participants discussed that “people don’t see them as a person, which is another big problem... but they don’t have the resources to get help.” They suggested increasing access to food, shelter, and opportunities to recover for these individuals, and increasing availability of sharps disposals to help improve the safety of the community.

Trash Effects. Trash Affects.

A large majority of participants discussed how the effects of high rates of litter and illegal disposal of trash have negatively affected the health of their community, posing a critical safety hazard, particularly for young children. Participants reported feeling neglected by their neighbors who litter, by the city sanitation workers who are supposed to pick it up, and by short dumpers who come from outside the community and dump trash in empty lots. One participant stated, “It’s depressing because

there’s trash everywhere, and when people come to Philly to see that, that’s what they think represents us.” Some stated that the negative perceptions of their community had a negative impact on their self-worth. Participants expressed frustration regarding the lack of sustainability of the community cleanups and want better accountability for litterers and short dumpers.

Verses of Adversity

Participants recounted experiencing various forms of adversity, which sometimes were motivators to improve their circumstances, but at other times led to negative coping mechanisms. Participants identified factors that improved their ability to overcome stressors such as strong family relationships, religious practice, and community social support. Some participants cited The Broken Window Effect,¹⁷ stating “The Broken Window Effect to me is if

you don’t really give a f*** about it and if other people don’t give a f***, then you’re just going to feel... worthless.” Many participants reported feeling they had exhausted their efforts to improve their community, claiming that the government keeps the wealthier areas clean and safe, while under-resourcing their communities, which added to feelings of neglect and hopelessness.

Wasted Spaces

Participants identified innumerable empty buildings and lots they described as a waste of space. Participants explained that abandoned sites festered drug use, illegal dumping, and other criminal activities causing safety concerns and health risks throughout their neighborhoods. Participants reported feeling neglected by the city and property owners for

letting abandoned buildings and lots deteriorate, as displayed in Photo 2. They agreed that these abandoned spaces should be repurposed as parks, community gardens, health centers, or daycares to meet the community’s needs, saying, “They could make it into something positive for the community...like a shelter for the homeless.”



Photo 2. Abandonment. "In this picture there are abandoned buildings. This building has been there like this since I was a little boy. I am now 18 years old. These buildings used to be owned by manufacturing companies. These companies left while still owning the building. The city does not want people to fix these buildings for their own reasons. This is not okay."

Prioritization

The participants determined the highest priority health needs of their community based on health needs represented across multiple themes. In order, the priorities are 1) mental

health, 2) trauma, safety, and violence, 3) built environment, 4) health behavior and health education, and 5) physical health.

Conceptual Model

Researchers found that within each code identified and defined by participants, subcodes spanned across structural determinants, intermediary determinants, health and wellbeing, and proposed solutions for eight out

of the ten themes. The remaining two codes spanned three of these four constructs. Figure 1 summarizes these findings.

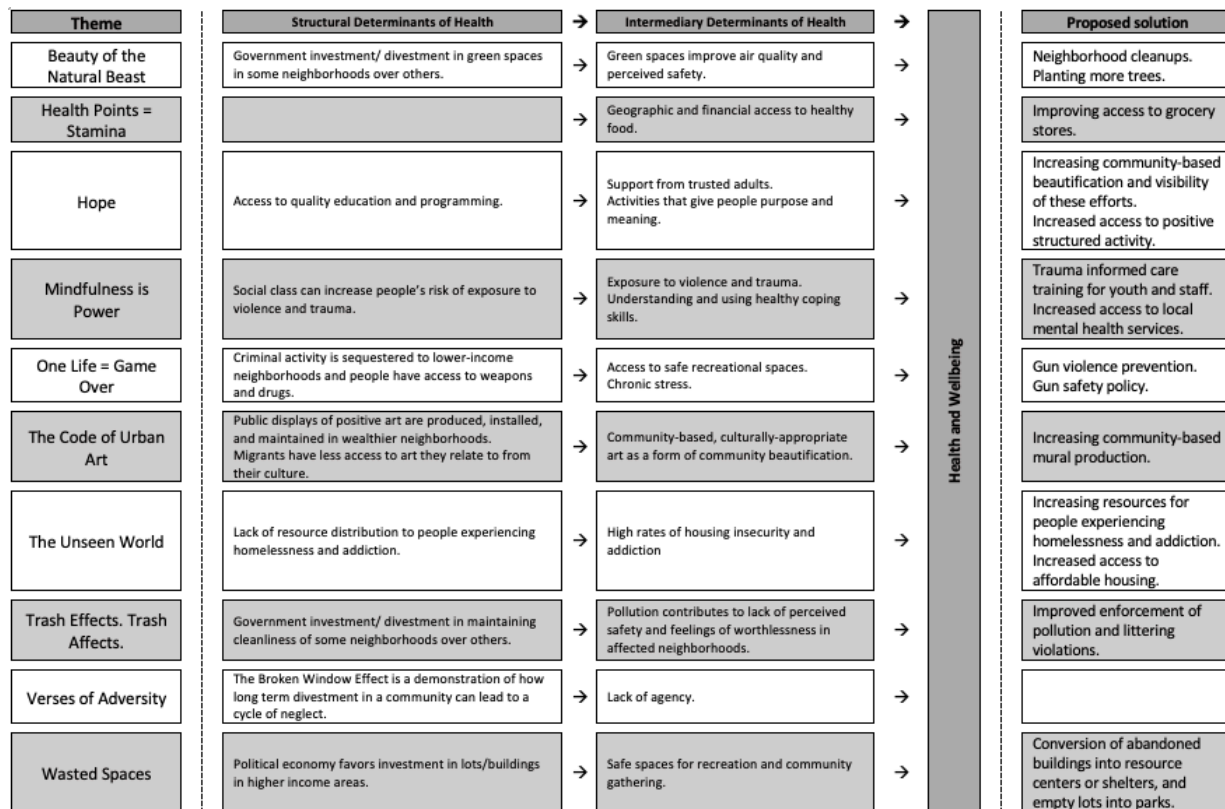


Figure 1. The World Health Organization’s Framework on the Social Determinants of Health. This conceptual model lists the ten codes named and defined by participants in the left column. Researchers mapped concepts from subcodes, defined by researchers, as “Structural Determinants of Health” or “Intermediary Determinants of Health” as defined by this framework and illustrated how participants suggested they affect health and wellbeing. Solutions proposed by participants are listed in the right column. Empty boxes indicate fields that were not addressed by participants in their respective themes.

Discussion

As demonstrated in Figure 1, photovoice methodology proved successful in engaging Latino youth to span a breadth of ten codes and the depth of conversation within each of these codes connecting structural determinants of health to intermediary determinants of health to health and wellbeing, and proposing feasible solutions. Our results also demonstrate the ability of photovoice to produce a prioritized list of community health needs and a description of resources available to the community, as required for a CHNA.

Part of this photovoice was a CHIP that included a photovoice exhibition in community sites and City Hall, youth policy and advocacy training, and \$600,000 in community catalyst grants, which has previously been described by

Dafilou et. al. 2022.¹⁸ Many of the photovoice participants and associated community organizations were involved in this CHIP through proposed solutions presented in our results and Figure 1. It has been well established that taking an intentionally moral, strategic, and pragmatic approach to stakeholder engagement is essential to health needs assessments and success in developing and implementing collaborative interventions and solutions.¹⁹ When photovoice researchers adapt this approach to incorporate intentional action planning into their engagement with participants, results can lead to community mobilization towards positive, sustainable change.²⁰ This photovoice demonstrates how investing in the engagement of participants, in

particular from under-resourced communities, and including them in action planning through photovoice led to a series of community benefit initiatives co-led by community members and organizations with the hospital as an anchor institution. This embodies the purpose that the PPACA envisioned for CHNAs, CHIPs, and community benefit.

What is notably lacking from many CHNAs and CHIPs is an understanding of the iterative process for which they are intended. Figure 2 demonstrates how CHNAs are meant

to inform CHIPs, which should then be implemented for community benefit purposes. We have demonstrated, using our photovoice project, that photovoice is an effective method at engaging community members longitudinally across these three components. While our claims may be limited by illustrating these points using a single initiative, the benefits described are common findings of photovoice research when utilized for needs assessments.^{21,22}

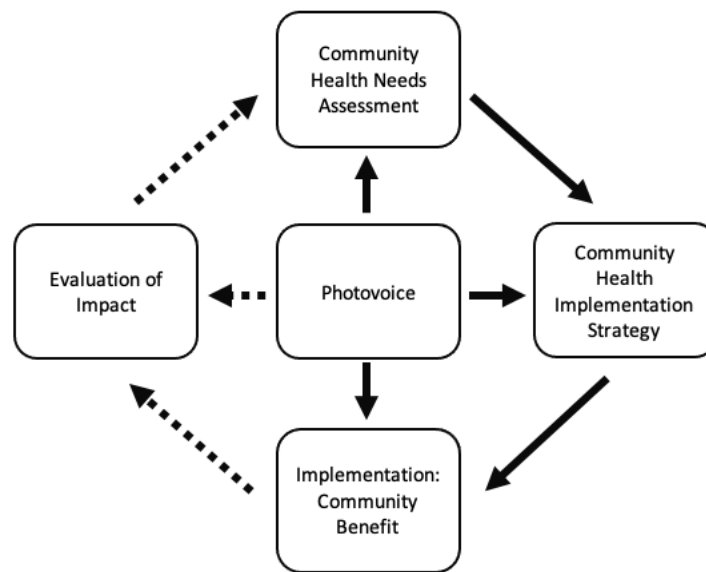


Figure 2. Strengths and Opportunities for Photovoice in taking Community Health Needs Assessment to Community Benefit to Reassessment. Researchers developed this figure to illustrate the iterative process for community health needs assessments to translate to community health implementation strategy, implementation of community benefit, impact evaluation, and reassessment to inform future iterations of this process as intended by the Patient Protection and Affordable Care Act. This figure shows how photovoice can play a role throughout this process. Solid lines indicate strengths that were demonstrated in this research study and dotted lines indicate opportunities for future research.

However, a notable weakness of this photovoice project is the lack of evaluation of the CHIP described in Dafilou et. al. 2022, and the photovoice process itself as a single iterative process that supports community benefit while informing re-assessments.²³ This has been a well-documented shortcoming of both photovoice research and of CHNAs and CHIPs historically, and is thus represented by a dotted line in Figure 2.^{21,24} Future research should

target opportunities for photovoice to extend beyond the intergradation CHNAs, CHIPs, and community benefit, to also include impact evaluations and re-assessment. This may demonstrate further utility for photovoice to play a role in each component displayed in Figure 2 as part of a single process to inform future assessments, implementation strategies, and community benefit initiatives.

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Conflicts of Interest

The authors have no known conflict of interest to disclose.

Statement of Contributions

All listed authors were involved in conducting the photovoice research, analysis of data, and development of the final manuscript. Caleb Dafilou served as the project manager and Rickie Brawer served as the Principal Investigator.

References

1. Department of Treasury. *Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule.*; 2013.
2. 111th Congress. The Patient Protection and Affordable Care Act. 2010.
3. Pennel CL, McLeroy KR, Burdine JN, Matarrita-Cascante D. Nonprofit hospitals' approach to community health needs assessment. *Am. J. Public Health* 2015;105(3):e103-13. doi:10.2105/AJPH.2014.302286.
4. Internal Revenue Service. Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3). *Internal Revenue Service* 2021. Available at: <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>. Accessed May 14, 2021.
5. United States Congressional Budget Office. *Nonprofit Hospitals and the Provision of Community Benefits*. United States Congressional Budget Office; 2006.
6. Lopez L, Dhodapkar M, Gross CP. US nonprofit hospitals' community health needs assessments and implementation strategies in the era of the patient protection and affordable care act. *JAMA Netw. Open* 2021;4(8):e2122237. doi:10.1001/jamanetworkopen.2021.22237.
7. Wang C, Burris MA. Photovoice: Concept, Methodology, and Use for Participatory Needs Assessment. *Health Education & Behavior* 1997;24(3):369-387. doi:10.1177/109019819702400309.
8. Strack RW, Orsini MM, Ewald DR. Revisiting the roots and aims of photovoice. *Health Promot Pract* 2022;23(2):221-229. doi:10.1177/15248399211061710.
9. Sutton-Brown CA. Photovoice: A methodological guide. *Photography and Culture* 2014;7(2):169-185. doi:10.2752/175145214X13999922103165.

10. The Office of Minority Health. Profile: Hispanic/Latino Americans. *The United States Department of Health and Human Services* 2022. Available at: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>. Accessed September 18, 2022.
11. Isasi CR, Rastogi D, Molina K. Health issues in hispanic/latino youth. *J. Lat. Psychol.* 2016;4(2):67-82. doi:10.1037/lat0000054.
12. Dafilou C. *The North Philadelphia Latino Community Health Needs Assessment*. (Brawer R, ed.). The Philadelphia Collaborative for Health Equity; 2019.
13. Shaffer R. *Beyond the Dispensary: (On Giving Community Balance to Primary Health Care)*. (English Press, ed.). African Medical and Research Foundation; 1979:90.
14. QSR International. *NVIVO*. QSR International; 2020.
15. Viera AJ, Garrett JM. Understanding interobserver agreement: the kappa statistic. *Fam Med* 2005;37(5):360-363.
16. Solar O, Irwin A. *A Conceptual Framework for Action on the Social Determinants of Health*. Geneva, Switzerland: World Health Organization; 2010.
17. Lanfear CC, Matsueda RL, Beach LR. Broken windows, informal social control, and crime: assessing causality in empirical studies. *Annu. Rev. Criminol.* 2020;3:97-120. doi:10.1146/annurev-criminol-011419-041541.
18. Dafilou C, Arisi MF, Pepe V, et al. Action beyond exhibition: amplifying photovoice through social action after a community health needs assessment in philadelphia. *Health Promot Pract* 2022;23(2):338-344. doi:10.1177/15248399211059810.
19. Kujala J, Sachs S, Leinonen H, Heikkinen A, Laude D. Stakeholder engagement: past, present, and future. *Business & Society* 2022;61(5):1136-1196. doi:10.1177/00076503211066595.
20. Lofton S, Grant AK. Outcomes and intentionality of action planning in photovoice: A literature review. *Health Promot Pract* 2020;22(3):318-337. doi:10.1177/1524839920957427.
21. Seitz CM, Orsini MM. Thirty years of implementing the photovoice method: insights from a review of reviews. *Health Promot Pract* 2022;23(2):281-288. doi:10.1177/15248399211053878.
22. Liebenberg L. Photovoice and being intentional about empowerment. *Health Promot Pract* 2022;23(2):267-273. doi:10.1177/15248399211062902.
23. Dafilou C, Arisi M, Pepe V, et al. Action beyond exhibition: Amplifying photovoice through social action after a Community Health Needs Assessment in Philadelphia. *Health Promot Pract* 2022.
24. Rozier MD. Nonprofit hospital community benefit in the U.S.: A scoping review from 2010 to 2019. *Front Public Health* 2020;8:72. doi:10.3389/fpubh.2020.00072.