



International Collaboration for Participatory Health Research

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Participatory Action Research in Healthcare Systems

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Discussion Paper 1: Participatory Action Research in Healthcare Systems. International Collaboration for Participatory Health Research.

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Participatory Action Research in Healthcare Systems

“We must start with the premise that research in organizations must be collaborative, that the role of the participants is that of researchers in practice and that research, from and for organizations, becomes a key tool for quality improvement” (Abad-Corpa et al., 2010).

1. Introduction

In this article, we present a participatory methodological synthesis of eight participatory action research (PAR) studies developed in the Spanish National Healthcare System (S-NHS) between 1998 and 2021. While most studies adopted Kemmis and McTaggart’s PAR model structured around the phases of planning, acting and observing, and reflecting, we propose that this model does not fully account for the complexity of PAR in healthcare settings. Our analysis was guided by the need to further explore the constitutive elements of each of these phases to explain how PAR can promote meaningful and sustainable change in healthcare.

Based on empirical evidence from these studies, we argue that transformation in these contexts occurs through conscientization, understood in Freirean terms as the process by which individuals and groups critically understand their reality and act upon it to transform it (Freire, 1980). Hence, we propose that conscientization is the “engine of change” for PAR. In an in-depth analysis of what took place in each of these PAR studies, we identified three dimensions (participation & power, dynamization, and feedforward) that occur in each phase of PAR, leading a group to individual and collective conscientization. These three dimensions operate across all phases of the PAR process, shaping and being shaped by the cycles of planning, acting and observing, and reflecting. These dimensions, derived from our cross-case analysis, offer a conceptual and practical contribution to existing PAR models, particularly in contexts marked by strong institutional hierarchies and resistance to change.

PAR is one of several methodologies situated under the umbrella of participatory health research (ICPHR, 2013). This form of collaborative and context-sensitive inquiry is rooted in democratic, inclusive, and emancipatory traditions. The term coined by the International Collaboration for Participatory Health Research (ICPHR) encompasses the paradigmatic, axiological, and methodological range of approaches to knowledge co-production that engage researchers, communities, advocates for patient groups, healthcare users, providers and managers, policymakers, and other decision-makers to improve health (ICPHR, 2013). Within this framework, in this paper, we analyze specifically PAR studies developed over two decades.

This discussion paper is intended for readers who already have an understanding of participatory health research and have participated in co-design or participatory studies, and who may use this synthesis to design future studies. However, for those who need an introduction to the methodology, ICPHR provides valuable resources at

<http://www.icphr.org/position-papers--discussion-papers>.

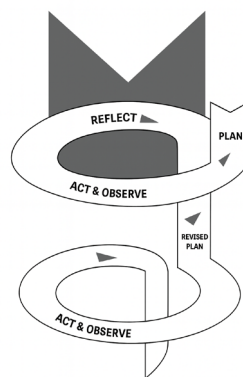
1.1. Characteristics of Participatory Action Research

PAR has origins in Latin America and Anglo-American countries, particularly in the field of education (ICPHR, 2013). In Latin America, PAR is a methodological approach that combines research, social action, and community participation to generate meaningful knowledge to promote social transformation (Fals-Borda, 1985; Freire, 1975; Kemmis & McTaggart, 2000). PAR emerged from a critical, political, and transformative understanding of knowledge production. It is rooted in the pedagogical theory of the Brazilian educator Paulo Freire (1975, 1980) and in the applications of his ideas to participatory research (Brandão, 1999), as well as in the methodological tenets of research for structural change of the Colombian sociologist Orlando Fals-Borda (1985).

PAR is based on the principle that the best way to learn about a phenomenon is for those involved in its everyday processes to try to change it (Gooden & Gastaldo, 2009). In community settings, PAR is presented as a search for concrete change through collective empowerment (ICPHR, 2021; Rappaport et al., 2024). From this perspective, reflection and action are integrated into a single cyclical process, allowing participants (whom hereafter we call co-researchers) not only to investigate their shared reality but also to act to transform it, thereby questioning traditional power structures (Rappaport et al., 2024). PAR requires sustained community participation throughout the process. Participation is not merely a means, but an end in itself, linked to the possibility of empowerment (Cooke & Kothari, 2001; Kemmis & McTaggart, 2000).

Internationally, the most widely utilized PAR model was created by Kemmis and McTaggart and published in 1988 in the “Handbook of Qualitative Research”, possibly the best-known book of qualitative research in Anglo-American academic settings (Denzin & Lincoln, 2000). The authors conceptualize fieldwork in PAR studies, particularly in the field of education, as a spiral process (Figure 1). As previously mentioned, this cycle unfolds through three interconnected phases: a) planning, b) action and observation, and c) reflection (Kemmis & McTaggart, 2000). Once these three phases are completed, a new cycle begins. This iterative process continues, allowing for ongoing development and refinement until meaningful knowledge is produced and transformation is achieved.

Figure 1. The Kemmis and McTaggart Participatory Action Research Model (1988)



Note. Adapted from Kemmis, S., & McTaggart, R. (2000). Participatory Action Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 567-606). Sage Publications.

1.2. Qualitative Research and Participatory Action Research in the Spanish National Healthcare System

In Spain, the evolution of qualitative research (QR) was influenced by the Franco dictatorship (Bover-Bover et al., 2013). Between the 1960s and the early 1970s, QR was used as an alternative approach to give voice to marginalized groups, especially in social sciences research. In nursing, since the 1990s, QR and PAR have represented an academic and political opportunity to position nurses as knowledge producers and agents of change in clinical practice.

Throughout the last decades, PAR emerged as a form of QR in nursing because, starting in 1997, a master's student (Pilar Delgado-Hito) and doctoral student (Concha Zaforteza-Lallemand) were supervised by Denise Gastaldo to conduct PAR projects in hospitals in Spain, while she was working at the Université de Montréal and University of Toronto, in Canada. Dr. Gastaldo was trained in PAR by completing her master's degree in education at the Universidade Federal do Rio Grande do Sul (southern Brazil) in the late 1980s (Gastaldo, 2019), working under the supervision of Dr. Juan Antonio Tijiboy, who was from El Salvador, but also studied and worked in the US. Pilar Delgado-Hito and Concha Zaforteza-Lallemand defended their doctoral theses in the 2000s and subsequently supervised most of the co-authors of this article. Specifically, Pilar Delgado-Hito supervised the doctoral theses of Eva Abad-Corpa, Antonio R. Moreno-Poyato, and Laura de la Cueva-Ariza. Concha Zaforteza-Lallemand supervised Rosa Miro-Bonet, while Diana Tolosa-Merlos was jointly supervised by Antonio R. Moreno-Poyato and Pilar Delgado-Hito. Eva Abad-Corpa supervised Tania Ros-Sanchez, whose research focused on primary healthcare users and was the only study conducted in a community setting.

More recently, PAR has gained relevance in education in Spain, but it remains an emerging methodological approach in health sciences. We believe that, so far, PAR recognition has been fostered by funding from public organizations, such as regional nursing organizations and national research agencies (e.g., FIS-Fondo de Investigación Sanitaria). Yet, it has also been inhibited by the growing focus of academic evaluation on short-term productivity measurements and the dominance of positivist evaluation criteria in the health sciences (Brito, 2019; Webster et al., 2019).

Even though PAR has been shown to address complex problems, improve healthcare practices, and generate relevant knowledge for quality improvement, its utilization remains limited in Spain, as in other countries (Millar et al., 2024). Based on our experience, we believe that many healthcare institutions will not engage with PAR because it problematizes everyday power relations, potentially revealing the shortcomings of the healthcare system and its inadequate management structure. In addition, healthcare professionals are often not perceived as creative agents of change with the knowledge to propose alternatives for improving the healthcare system (De Blok, 2024).

2. Participatory Methodological Synthesis

The first three authors (R.M.B., D.G. and C.F.V.) led this participatory methodological synthesis in collaboration with the other co-authors. In the first phase, they contacted researchers known to have conducted PAR within the S-NHS. Through these researchers, additional individuals were invited to join the study. In parallel, a bibliographic search (2000-2022) was conducted to identify other PAR studies developed within the S-NHS. However, we did not identify any other PAR publications in the health sciences. In total, eight studies were selected. All the researchers identified through these processes accepted to participate and be co-authors of this discussion paper.

We worked from March 2022 to July 2025 to create this participatory methodological synthesis. Once the group was established, the work took place over eight phases in which the following activities were undertaken: (1) Structured summary of the studies, description of the methodology, and list of publications and conference presentations; (2) First collective analytical meeting to compare the data generated and identify gaps, followed by revisions of study descriptions (Spring 2022); (3) Team leaders conducted preliminary data analysis and identified issues to be discussed with each researcher; (4) Team leaders interviewed all researchers to clarify doubts and further improve data, and conducted the second round of analytical meetings (Summer-Autumn 2022). The preliminary results of the analysis were presented in a conference by the lead team (“Solving problems and improving healthcare quality through PAR in Spain” at the 1st International Participatory Health Research Conference); (5) The first complete draft of the synthesis was shared and the second collective analytical meeting to discuss the draft paper took place (Winter 2023); (6) The lead team incorporated proposed changes and all researchers revised the second version of the paper. This version of the document was presented (R.M.B) as a keynote entitled “Transforming healthcare services through PAR” and a workshop entitled “PAR in Healthcare Services” was offered (C.Z.L and A.M.P.) at the 10th Ibero-American Qualitative Health Research Conference (Autumn 2023); (7) The third version of the paper was written by the lead team (Spring 2024) and written feedback was provided by the co-authors (Summer-Fall 2024); and (8) the lead team revised and wrote the final document and co-authors reviewed and suggested minor changes (Spring-Summer 2025) before submission, in August 2025.

3. Results

The PAR studies analyzed were conducted as part of the researchers' graduate studies or postdoctoral fellowship. Appendix A presents the PAR studies in chronological order. Appendix B presents summaries of the study characteristics and publications. From this point on, we will refer to the studies by the principal investigator's surname.

The fieldwork for the studies ranged from two to three years. Two studies lasted one year, but in both cases, an assessment was conducted before the first phase of PAR, which was not considered in the study duration. The only exception was the project carried out by de la Cueva-Ariza, which lasted five years due to difficulties in recruiting participants and in staff and management team turnover in the intensive care unit (ICU).

These PAR studies were not linear investigations that reached predictable results. The research process was complex due to the context in which they were situated and the

interpersonal and institutional relations established. Due to PAR emergent design, changes in the methodology required skills not typical of principal investigators in qualitative research, such as negotiating with multiple institutional actors to create administrative opportunities to implement proposed changes.

Kemmis and McTaggart's (2000) PAR methodological model guided the studies with one exception: Abad-Corpa utilized an adaptation of Checkland's soft systems methodology (Checkland, 2000). Regarding PAR cycles, Ros-Sanchez's project is the only one developed over three cycles. In Zaforteza-Lallemand, Abad-Corpa (according to Checkland), and Miro-Bonet's studies, only one cycle took place, whereas the others were developed over two. In our experience, Kemmis and McTaggart's (2000) model offers insufficient guidance on what should happen in each PAR phase for studies in healthcare institutions, which could lead to simplistic interpretations of the work to be developed, especially among those with a superficial knowledge of the methodology.

Through our synthesis, we have identified that, across all studies, conscientization was the driver of change. Our analysis reveals that the process of changing how one perceives reality and one's ability to transform it is not fully explained by the three phases of a PAR cycle. For this reason, we propose a refined reading of Kemmis and McTaggart's model, grounded in empirical insights from the eight PAR projects analyzed. We argue that researchers should work with three interrelated dimensions in each PAR phase (participation & power, dynamization, and feedforward) anchored in conscientization. These dimensions form the methodological engine that sustains meaningful and lasting change in healthcare institutions.

3.1. Conscientization as the Core of Participatory Action Research: Setting Power in Motion

Conscientization is the basis for change creation and sustainability because once one understands how to promote change, this "lesson" can be applied repeatedly and cannot be "unlearned"; it becomes part of professional practice to plan, act, observe, and evaluate to achieve better results, and as long as these professionals remain in that organization, they can promote and sustain changes.

In the studies analyzed, the process of conscientization occurred following two movements: from individual to collective conscientization and from collective to individual conscientization. More often, individual conscientization, that is, the empowerment of participants based on individual and shared reflections and practices, generated collective conscientization. Through sharing individual learning, groups acquired new insights that changed how they perceived their reality and were empowered. However, a counter-movement also occurred when, in two studies, the process of conscientization first emerged as the group became a safe space to question routine practices, leading to a collective search for change. This process generated a new collective identity that enabled co-researchers to empower themselves individually. The creation of this safe space was supported by the principal investigator (whom in PAR is also known as "organic researcher"), who encouraged trust, horizontal relations, dialogue, and critical reflection. From our perspective, it was conscientization that allowed co-researchers to see all involved as part of the problem and potentially part of the solution, leading them to collectively seek the most inclusive

institutional changes to benefit those receiving healthcare (i.e., healthcare users and their relatives).

Next, we provide three examples of how conscientization was enacted and how it promoted long-lasting transformation. In Delgado-Hito's study, conscientization occurred when ICU nurses confronted, through self-observation and reflective diaries, the discrepancy between what they believed they did and what they actually did. Realizing that their interactions were more impersonal and sometimes dehumanizing than they had assumed prompted a deep individual and collective awareness that reshaped their understanding of patient-professional relationships. This recognition became a catalyst for consistent changes in language, interactions, and care coordination.

In Zaforteza-Lallemand's study, conscientization emerged when ICU professionals met to discuss their discomfort with limiting family members' presence in the unit. Reviewing the scientific evidence and discussing their ethical perspectives, they acquired new knowledge and a shared ethical position that enabled them to question the ICU's conservative cultural norms. This realization prompted the group to advocate for more inclusive and humanizing practices, such as increased visiting hours, which became the unit's new schedule.

In Miro-Bonet's study (study 8 in Appendix A) in a hospital emergency department, conscientization began when nurses recognized that their daily difficulties stemmed not from personal but rather structural factors. This shared realization enabled them to question decision-making circuits, leadership models, and forms of work organization that had previously been taken for granted. Co-researchers also expanded their understanding of professional power relations, opening possibilities for alternative organizational practices. These changes went beyond the project's original goals.

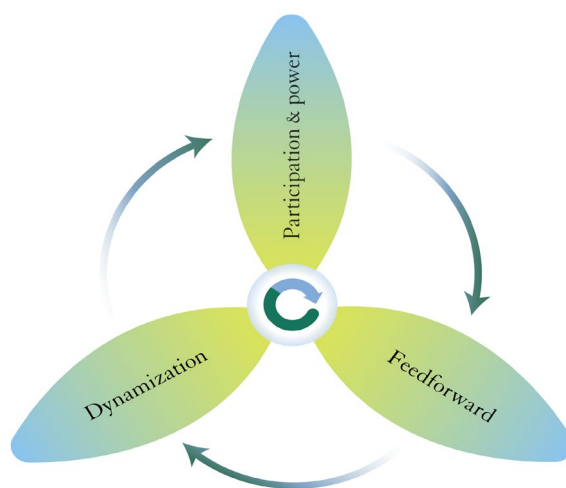
In these examples, conscientization occurred because motivated individuals were given the opportunity to critically analyze and transform their own practices and their organizational norms within a safe environment that promoted individual and collective reflexive activities. The research project offered time and space to engage in "slow" dialogue and critical thinking in a "fast" and prescriptive healthcare system. Conscientization was revealed through a renewed professional identity, which included professionals' new understandings and abilities to produce knowledge and challenge power imbalances in the workplace, mainly to improve the quality of care for patients and their relatives. Another evidence of conscientization was the sustainability of the transformations in all three examples, suggesting that the learning that occurred during the projects became embedded in the units' professional culture (Freire, 1980).

3.2. Dimensions Embedded in Each Participatory Action Research Phase: Participation & Power, Dynamization, and Feedforward

The synthesis of eight PAR studies has allowed us to place a "magnifying glass" to explore what happens in each of the study phases (i.e., planning, acting and observing, and reflecting). For each phase, we identified that there are three dimensions embedded in the work done by researchers: a) participation & power; b) dynamization, and c) feedforward. The separation of these three dimensions is artificial, since they are closely related, but it allows us to better describe the research process and to offer a graphical representation of what happens in each PAR phase.

To convey the idea of dimensions connectedly generating movement, we have chosen the image of a wind turbine's propeller, which allows us to represent the energy, mobilization, and sustainability of the institutional transformation created by PAR. The wind, or the energy of the group, moves the three blades, and at their centre we find conscientization (Figure 2). We place conscientization at the core of the three dimensions that make up the helix, representing the engine of personal and collective processes that lead to institutional transformation. Conscientization arises from critical reflection about one's own practices, interpersonal relationships, and institutional structures. It may begin at the individual level and extend to the collective, or vice versa. It is the engine that sustains change over time, transforming how co-researchers perceive their current reality and the possibilities for improvement it entails.

Figure 2. Dimensions of the process of conscientization.



Note. Created by the authors.

In the three phases of PAR, these dimensions must be enacted so that the study can produce personal, group, and institutional transformation based on new power relations, new skills for mobilizing groups for change, and knowledge production that enables learning to be shared within the institution and among other institutions. The definitions and meaning of each dimension are presented next.

3.2.1. Definition of Dimensions

Figure 3 presents the three interrelated dimensions (participation & power, dynamization, and feedforward) and their definitions.

Figure 3. Definitions of the dimensions that support the development of each PAR phase.

Participation & Power	Dynamization	Feedforward
refer to the intentional use of strategies that foster equitable engagement of all co-investigators throughout the research process, from design to evaluation. It also entails a critical awareness of the power relations embedded in the study and the organization in which it unfolds, ensuring that participation is transformative.	relates to the process of setting purposeful, energizing activities that drive each phase of the study forward. The co-investigators undertake activities that promote engagement, enthusiasm, trust, and group cohesion, cultivating the vitality needed for prolonged engagement and transformative action.	aims at producing knowledge that is both actionable and transferable. It ensures that the study contributes to both understanding and transforming social realities in the study organization and offering empirically grounded insights that other groups or institutions can adapt in their own processes of change.

Note. Created by the authors.

3.2.2. Participation & Power

The “participation & power” dimension aims to ensure the intentional use of strategies for genuine participation of all co-researchers in the study, from design to evaluation, and to foster a critical understanding of the power relations shaping the study and the institution where it takes place. To foster participation, it is essential to define the levels of commitment and roles of co-researchers at the beginning of the study. This dimension requires a clear understanding of the principal investigator's and other researchers' roles.

Regarding power, it is fundamental to systematically map power relations within the institution where the study occurs. The principal investigator should take time to familiarize herself with the field of study, the relationships among professionals, formal and informal leaders, and institutional norms. It is also essential to identify the interest groups, their decision-making power, and how they shape both the phenomenon under study and the possibilities for transformation. Based on this understanding, the research team members should be able to establish a relationship of trust among themselves, acting as “critical friends” (Martínez-Galaz et al., 2024), asking each other challenging questions to engage co-researchers in self- and collective critique and to envision alternative, more equitable ways of thinking and doing in that context.

The study by Zaforteza-Lallemand offers an example of how the participation & power dimension can be operationalized through the definition of three levels of participation: organic researcher (1), co-researchers who were representatives of other professionals (11), and a broader group of professionals (49). This structure allowed different levels of involvement based on the participants' availability, while ensuring a consistent flow of information among 61 people. This reflects a deep understanding of the differentiated roles co-researchers could play in a large project with a democratic approach to participation, as those less involved had co-researcher representatives. Through reflexive dialogue, the research team identified and confronted traditional, hierarchical dynamics, such as unequal access to information between nurses and physicians, creating spaces for collective engagement in practices beneficial to patients and their relatives. The organic researcher

acted as a “critical friend”, facilitating discussions about institutional power and supporting the team in designing change strategies.

The study by Abad-Corpa is another example of how genuine participation can be built by creating a diverse team of co-researchers, which included nurses, managers, and experts from outside the hospital. The process began with a mapping exercise of existing power relations, using group discussions to analyze institutional data, videos, and statistics to identify the gap between evidence and everyday clinical practice. In this approach to participation & power, the role of the organic researcher was defined as that of a facilitator. By understanding the institutional dynamics, interest groups, and decision-making hierarchy, the team was able to identify both barriers and enablers to implementing evidence to improve the quality of patient care. Using Checkland’s soft systems approach, the research team succeeded in mapping and transforming the institutional system from within, by promoting active participation and developing critical context analysis skills.

The study by Miro-Bonet (study 5 in Appendix A) provides another example of how the participation & power dimension can be operationalized in a hospital setting. Participation was structured through differentiated yet interconnected roles, including the organic researcher, formal and informal leaders, and a broader group of professionals, allowing varied levels of involvement while ensuring shared decision-making. Through regular group discussions, co-researchers and professionals identified that practices were shaped by hierarchical norms and unequal access to information. The creation of these dialogical spaces led to the redistribution of power by legitimizing diverse professional voices. Again, the organic researcher acted as a “critical friend”, facilitating co-researchers’ reflection on institutional power relations and supporting their negotiations with management. This process strengthened their political competence and capacity to act collectively to transform interprofessional dynamics.

3.2.3. Dynamization

We have called this dimension “dynamization” because the term allows us to discuss purposefully designed activities that must be carried out in each phase to advance change, revealing the ongoing dynamism required for the development of PAR studies. In each phase of a cycle, the organic researcher and co-researchers should engage in intentionally designed, dynamic, energizing activities such as data generation, analysis, or result evaluation. Strategies that maintain group cohesion and generate vitality to withstand the long hours the project entails are essential for sustained engagement and transformative action in the study.

The study by Delgado-Hito shows how the dynamization dimension is fostered through deliberate efforts to energize and sustain the group across the research cycle. From the beginning, the organic researcher worked across organizational, interpersonal, and methodological issues, negotiating meeting schedules with the head nurse, ensuring that the study did not burden co-researchers, and providing specific tools to support their observation and reflection activities. The organic researcher also promoted group vitality and cohesion, providing personalized follow-up via phone calls, informal support, and flexible scheduling for group meetings, ensuring all participants remained engaged despite their demanding ICU

shift work. The group remained active not only through many meetings but also through their individual, reflexive practices, transforming the research process into a dynamic and sustained personal and collective effort.

The study conducted by Ros-Sanchez provides another example of how dynamization is achieved when working with users of the healthcare system, in this case, older women with limited self-care and agency. The research process involved 22 group sessions organized around four themes, with creative, interactive dynamics that kept participants engaged throughout. The group was energized through bonding practices, trust-building activities, and session contents tailored to the women's interests and needs. The organic researcher acted as a facilitator and motivator, adjusting the sessions to avoid civic holidays and vacation periods and always prioritizing the group's vitality and cohesion. These strategies maintained participants' enthusiasm and brought life to the co-creation of knowledge throughout the project.

3.2.4. Feedforward

In the feedforward dimension, we adopt the concept as articulated by Martín (2023), who brings together the terms *feedback* and *forward* to emphasize the value of inviting someone to do something new, drawing from the original idea proposed by Marshall Goldsmith (2012). Rather than focusing on feeding back into the past and on limitations, as feedback tends to do, *feedforward* centers on future possibilities for transformation, innovation, and action. It aims to encourage individuals and groups to engage in actionable and forward-looking practices, in a solution-focused way, which aligns with the transformative aims of PAR, where the goal is not merely to evaluate but to empower collective action and generate transferable knowledge that enables alternative futures.

The elements that enable personal, group, and institutional learning, the co-production of knowledge, and the sustainability of change are closely linked to this dimension. Feedforward, in this sense, reinforces the idea that PAR must generate new and transferable knowledge, allowing other groups to adapt the findings to their own contexts and move directly into processes of change and transformation. PAR studies contribute not only to understanding power dynamics but also to producing empirical evidence both *about* and *for* healthcare institutions.

The study by de la Cueva-Ariza is an example of how the feedforward dimension was designed to sustain change within the institution and generate transferable knowledge. This was achieved by reflecting on past practices and on creating new, evidence-based strategies that could be adapted and applied in similar healthcare settings. The emphasis on understanding the evolution of nurses' knowledge patterns during the change process contributed to the development of knowledge that supports ongoing improvement in nursing care practices.

The study by Tolosa-Merlos and Moreno-Poyato is another example of feedforward in their standardization and dissemination of two strategies to improve nurse-patient therapeutic relationships: "post-incident analysis" and the creation of "private therapeutic spaces". These strategies were not only implemented in the 18 participating mental health units, but the knowledge generated was systematized for transferability to other settings. This example reflects the feedforward dimension, as the new knowledge produced was so robust that it

was applied locally and nationally. Structured practice protocols were developed with institutional sustainability and transferability in mind. Additionally, pre- and post-intervention evaluations were used to assess the impact of practice changes, providing insights into evidence-based practice, empathy, and therapeutic alliance. The action process generated knowledge about how to embed reflexive and relational practices in mental healthcare, knowledge that other institutions can adopt to improve healthcare.

The study by Miro-Bonet (study 8 in Appendix A) provides a final example of how the feedforward dimension was enacted through the continuous systematization and documentation of the research process, using meeting minutes, analytical summaries, and group meetings to project learning into the future. These research outputs enabled co-researchers to recognize the impact of their actions and to visualize the pace and progression of change. The knowledge generated was not limited to evaluating past actions but served to guide co-researchers' new practices, open new institutional spaces for participation, such as working committees, and prepare them to address resistance. In this way, the process generated transferable learning and contributed to the sustainability of transformations beyond the duration of the project.

4. Conclusions

This participatory methodological synthesis has identified three interrelated dimensions (participation & power, dynamization, and feedforward) that are mutually reinforcing across all phases of PAR. While analytically distinct, these dimensions operate in a dynamic interplay that sustains equitable, dialogical, and energizing spaces for collective inquiry and organizational transformation. When intentionally cultivated throughout the PAR cycle (planning, acting and observing, and reflecting) these dimensions not only foster meaningful participation and shared agency but also propel forward new knowledge, practices, and relationships capable of improving working conditions and the quality of care.

Despite taking place in constrained institutional contexts, the studies analyzed illustrate that PAR can be a powerful lever for change. The interplay of the three dimensions creates the conditions for individuals to recognize their embeddedness in systems, engage in dialogue, and reimagine their roles in collaborative, interdisciplinary ways. These findings suggest that the presence and progressive consolidation of these dimensions can serve as methodological indicators that a PAR process is advancing meaningfully and ethically.

Our findings also illustrate that the deliberate utilization of these dimensions supports conscientization, understood in Freirean terms. This process unfolds through a reciprocal movement between individual and collective conscientization. While some reach conscientization individually, being supported to critically examine informal norms, organizational structures, and professional roles, others need to belong to a group that collectively thinks and practices change strategies to reach the critical awareness required to see their organizations, co-workers, and themselves differently. In doing so, participants become agents of change within their teams and institutions, offering and receiving critique, experimenting with alternatives, and engaging with the complex task of transforming both themselves and the systems they inhabit. Such skills sustain the changes made and prepare professionals to face future challenges.

The studies conducted in the S-NHS were made possible by the support of regional and national funding bodies. Given the purpose, duration, scale, and complexity of the studies analyzed, it would be naive to assume they could be conducted without an investment of resources from those involved and their institutions, as well as funding agencies. What differentiates Spain from other countries is that many funding bodies in the health sciences did not discriminate against emerging methodologies, like PAR, allowing for a series of studies to positively impact the healthcare system and create expertise on how to conduct PAR in the country.

The value of PAR lies not only in its capacity to generate situated, transferable knowledge (feedforward) but also in its methodological commitment to democratizing knowledge production (participation & power) and sustaining collective energy and momentum for change (dynamization). These features are particularly relevant at a time when professional burnout and the sustainability of healthcare systems are being discussed across multiple countries. Ultimately, these three dimensions, anchored in conscientization, form a methodological engine that drives sustainable, meaningful transformation in healthcare institutions. Their deliberate application across all PAR phases offers both a conceptual framework and a practical guide for researchers committed to advancing dialogue, equity, and action to improve healthcare systems.

This discussion paper offers a methodological synthesis of eight participatory action research projects conducted in the S-NHS. Rather than proposing a prescriptive model, we identified three interrelated dimensions (participation & power, dynamization, and feedforward) that we conceptualized to support critical reflection on how PAR unfolds in complex healthcare institutions. We invite researchers, practitioners, managers, and healthcare users to critically engage with these research dimensions, examine their relevance in other institutional and socio-political contexts, and explore how they may be adapted, challenged, or expanded. Future dialogue and empirical work may further refine them, particularly by examining how processes of conscientization unfold in settings with different institutional constraints. Hence, this discussion article's contribution is to open a space for collective methodological debate and invite future knowledge production.

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Appendices

Appendix A. Participatory Action Research Studies Analyzed in the Participatory Methodological Synthesis.

Source: Authors

<p>Study 1: The modification of nursing practice through reflection: PAR in Barcelona</p> <ul style="list-style-type: none"> Principal investigator and master's thesis supervisor: Pilar Delgado-Hito and Denise Gastaldo. Abstract: The aim of the research was to promote reflection about nursing care based on a participatory process among professionals in an ICU in a Barcelona public hospital. The new way of conceiving nursing practice led to better quality and humanization of healthcare, as nurses achieved greater respect for patients, greater understanding and support for families, improved coordination of care, and greater interprofessional collaboration.
<p>Study 2: Promotion of healthcare aimed at the relatives of the critically ill patient through PAR</p> <ul style="list-style-type: none"> Principal investigator and doctoral thesis supervisors: Concha Zaforteza-Lallemand, Denise Gastaldo and Camilo Cela-Conde. Abstract: The aim of the research was to make changes to improve the care of the relatives of critically ill patients in two ICUs in two Balearic Islands public hospitals. Participants extended the visiting hours of family members in ICUs, they changed the way they thought about family members (they realized that they were an asset for patients' wellbeing), acquired knowledge about grieving processes and how to deliver bad news, developed reflexive and critical skills, were empowered to establish consensual changes and improved their resumes by publishing articles and presenting at conferences.
<p>Study 3: The implementation of evidence in nursing practice: A process of change through PAR</p> <ul style="list-style-type: none"> Principal investigator and doctoral thesis supervisors: Eva Abad-Corpa, Pilar Delgado-Hito and Julio Cabrero-García. Abstract: The aim of the research was to make changes to evidence implementation in the clinical practice of an onco-haematology nursing unit in a public hospital in Murcia. These institutional changes were made at the nursing, managerial and patient levels. Nursing practices related to professional performance (control of signs and symptoms) were modified while being maintained over time, leading to changes in clinical practice and improvements in patients' psycho-emotional state (anxiety, burnout, satisfaction) and patient safety (pain, mucositis, nosocomial infections).
<p>Study 4: Improving nursing intervention with the family of critically ill patients: A qualitative, participatory approach and knowledge in action</p> <ul style="list-style-type: none"> Principal investigator and doctoral thesis supervisors: Laura de la Cueva-Ariza, Pilar Delgado-Hito and M^a Teresa Lluch-Canut. Abstract: The aim of this study was to understand the process of change targeted at improving the healthcare offered to the relatives of critically ill patients in the three multipurpose ICUs of a public hospital in Barcelona. The participants observed, reflected, and changed the type of language, activities, and relationships they established with the patient, family, nursing team, and other professionals during the patient's admission process.
<p>Study 5: Changes in teamwork dynamics in an inpatient unit through PAR</p> <ul style="list-style-type: none"> Principal investigator and doctoral thesis supervisors: Rosa Miro-Bonet, Concha Zaforteza-Lallemand and Carlos Calderón-Gómez. Abstract: The aim of this study was to transform interprofessional practices in the healthcare team of a hospitalization unit of a public hospital in the Balearic Islands. Healthcare work in a hospital is subject to a strong inertia, a way of doing and thinking that hinders real collaboration amongst team members. The results showed a shift toward much more democratic dynamics. They were sustained in reflection and dialogue between equals, giving rise to new professional positions among the members as well as within the organization, leading to a new group identity.
<p>Study 6: Improving the therapeutic relationship in nursing care through evidence: A multicentre study in acute psychiatric units in Catalonia</p> <ul style="list-style-type: none"> Principal investigator and doctoral thesis supervisors: Diana Tolosa-Merlos, Antonio R. Moreno-Poyato and Pilar Delgado-Hito. Abstract: The aim of this study was to improve the nurse-patient therapeutic relationship in 18 acute mental healthcare units in Catalonia. It was possible to reach consensus and design two strategies to improve the therapeutic relationship in all units: (a) "post-incident analysis" and (b) "private therapeutic space". The strategies supported both the advancement of evidence-based practice and reduced personal distress among nurses, thus improving the therapeutic relationship.

Study 7: Improving self-care for women aged 60-80 by fostering empowerment

- Principal investigator and doctoral thesis supervisors: Tania Ros-Sanchez; Eva Abad-Corpa and María-Beatriz Lidón-Cerezuela.
- Abstract: The aim of the study was to generate changes in self-care among women aged 60 to 80 years old who were users of primary healthcare in Murcia, employing empowerment as a tool for self-improvement. The results showed that in older women, the separation of their inner and outer world is very deep. Participants developed greater self-esteem, self-determination and self-confidence in their inner self and later projected outwards these achievements, changing how they faced group relationships and fostering better social lives.

Study 8: Transforming nursing teamwork dynamics in a hospital emergency and urgent care unit through PAR

- Authors: Rosa Miro-Bonet, Miguel-Ángel Rodríguez-Calero, M. Inmaculada Gayà-Mayol, I. Aurora García-Buges and M. Elena Barceló-Llodrà.
- Abstract: This study aimed to transform nursing teamwork dynamics in a hospital emergency unit in the Balearic Islands through participatory action research. Emergency services were marked by organizational inertia that limited collaboration. The participatory process fostered critical reflection on practice, structures, and power relations. Results showed a shift towards more participatory and dialogical ways of working among team members. These changes strengthened the nursing team's collective identity and supported the sustainability of changes proposed by the participants.

Legend: Participatory Action Research (PAR); Intensive Care Unit (ICU).

Appendix B. Study Characteristics.

Source: Authors.

Principal investigator	Title	Duration	Paradigm	Theoretical/ Conceptual Framework	Context	Participants	Financing	Ethics Committee Approval	Doctoral thesis and publications
Delgado-Hito	Modifying nursing practice through reflection: PAR in Barcelona	1998-2000	Constructivist	Schön's theory, individualization of care by Riopelle, and Ledu-Ladonde, Benner and Chinn's change implementation strategy	ICU in a tertiary-level hospital in Barcelona	Nurses	Funded by Fondo de Investigación Sanitaria, PI00/0752, Spanish Ministry of Health	Research Ethics Committee, Hospital de la Santa Creu i Sant Pau	Delgado-Hito (2001) Delgado-Hito (2010) Delgado-Hito et al. (2001) Delgado-Hito & Gastaldo (2010)
Zaforteza-Lallemand	Promotion of care for the relatives of the critically ill patient through PAR	2006-2009	Critical Social	Pedagogy of the oppressed and pedagogy of hope by Paulo Freire	Two ICUs in tertiary-level public hospitals in the Balearic Islands	Nurses, Auxiliary Nursing Staff, Lab Staff, Porters and Social Workers	Funded by Fondo de Investigación Sanitaria, PI06/90156, Spanish Ministry of Health	Balearic Islands Research Ethics Committee and Research Ethics Committee in each hospital	Zaforteza-Lallemand (2010) Zaforteza-Lallemand et al. (2008) Zaforteza-Lallemand et al. (2012) Zaforteza-Lallemand et al. (2015)
Abad-Corpa	The implementation of evidence in nursing practice: A process of change through PAR	2007-2008	Constructivist	Everett Rogers' theory of diffusion of innovations	Onco-haematology unit in a tertiary-level hospital in the region of Murcia	Nurses and physicians	Funded by Fondo de Investigación Sanitaria, PI05/1330, Spanish Ministry of Health	Research Ethics Committee, Morales Meseguer Hospital	Abad-Corpa (2012) Abad-Corpa et al. (2009) Abad-Corpa et al. (2010) Abad-Corpa et al. (2012) Abad-Corpa et al. (2013)
De la Cueva-Ariza	Improving nursing interventions with the family of critically ill patients: A qualitative, participatory approach and knowledge in action	2013-2018	Constructivist	L. de la Revilla's family general systems theory and integrated theory and knowledge development in nursing by Chinn and Kramer	Three multipurpose ICUs in a tertiary hospital in Barcelona	Nurses	Funded by Fondo de Investigación Sanitaria, PI13/00459, Spanish Ministry of Health and by the Official College of Nurses of Barcelona (COIB), PR-1809-13	Research Ethics Committee, Bellvitge University Hospital	de la Cueva-Ariza (2025) de la Cueva-Ariza et al. (2012) de la Cueva-Ariza et al. (2018) Martínez-López et al. (2023)

Miro-Bonet	Changes in teamwork dynamics in an inpatient unit through PAR	2014-2017	Critical-social	Nancy Fraser's theory of social justice and interprofessional teamwork for health and social care by Scott Reeves et al.	Neurology and gastroenterology units in a tertiary-level hospital in the Balearic Islands	Nurses, Nursing Auxiliary Staff and Physicians	Funded by the Official College of Nurses of the Balearic Islands (COIBA)	Balearic Islands Research Ethics Committee and Hospital Research Ethics Committee	Miro-Bonet (2018)
Tolosa-Merlos & Moreno-Poyato	Improving the therapeutic relationship in nursing care through evidence: A multicentre study in acute psychiatric units in Catalonia	2018-2020	Constructivist	Hildegard Peplau's interpersonal relations model	PAR in a hospital mental health unit in Barcelona followed by PAR in 18 acute mental health units across Catalonia	Nurses	Funded by the Official College of Nurses of Barcelona (COIB)	Research Ethics Committee in each participating hospital or centre	Moreno-Poyato et al. (2021) Moreno-Poyato et al. (2022) Tolosa-Merlos (2023) Tolosa-Merlos et al. (2023a) Tolosa-Merlos et al. (2023b)
Ros-Sanchez	Improving self-care for women aged 60-80 by fostering empowerment	2019-2020	Critical-social	Feminist theory and the theory of the self	Primary healthcare in Murcia	Women aged 60 to 80 years old	No external funding	Research Ethics Committee of Area VII of Health in the Region of Murcia	Ros-Sanchez (2023) Ros-Sanchez et al. (2020) Ros-Sanchez et al. (2023a) Ros-Sanchez et al. (2023b)
Miro-Bonet	Transforming the nursing teamwork dynamics in a hospital emergency & urgent care unit through participatory action research	2019-2021	Critical-social	Interprofessional Teamwork for Health and Social Care by Scott Reeves et al.	Hospital emergency and urgent care unit in the Balearic Islands	Nurses, Nursing Auxiliary Staff and Physicians	Funded by the Official College of Nurses of the Balearic Islands (COIBA)	Balearic Islands Research Ethics Committee and Hospital Research Ethics Committee	Miro-Bonet et al. (2026, in press)

Legend: Participatory Action Research (PAR); Intensive Care Unit (ICU).