

Developing a Family Medicine residency program in Colombia: systematization of an experience

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Abstract

Introduction: Family Medicine is an essential discipline within comprehensive healthcare, focusing on a clinical approach, prevention, and community work, and gaining increasing relevance as a key strategy to strengthen Primary Health Care (PHC). In Colombia, it was consolidated as a specialty in 1984, and the program at a Colombian university began in 2006. **Aim:** To systematize the experiences linked to the creation, training and consolidation of the specialization program in Family Medicine at this university between 2006 and 2024. **Methodology:** An ordered review was constructed to analyze the development of the Family Medicine specialization program at a Colombian university (2006–2024), based on the retrospective collection, classification, and analysis of information from documentary archives and 22 semi-structured interviews. The review of the experience allows for the reconstruction of the program's different periods of development, organizing the evolution of the lessons learned and the changes identified throughout the

creation, evolution, and consolidation of the Family Medicine program. **Results:** The program emerged in response to the needs of the Colombian health system and the principles of PHC. During the evolution phase, the program was strengthened through strategic agreements, curricular redesign, new clinical rotations and the progressive use of educational technologies. However, it faces challenges such as limited institutional recognition. In the consolidation phase, the program has achieved national and international recognition, forming a network of graduates with high-quality standards leading to social impact, although challenges related to labor market insertion and expansion to rural areas persist. **Conclusion:** The program has maintained a trajectory consistent with the principles of PHC, responding to training challenges and positioning itself as a relevant and sustainable model in specialized medical education in Colombia.

Keywords: Family Practice; Focus Groups; Colombia; Social Change; Universities; Comprehensive Health Care; Education, Medical; Primary Health Care

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Introduction

Globally, health systems face the constant challenge of responding efficiently, equitably and sustainably to the changing healthcare needs of the population. In this context, Family Medicine has gained relevance as a fundamental strategy to strengthen Primary Health Care (PHC), an internationally recognized pillar since the Alma-Ata declaration in 1978. Countries such as the United Kingdom, Canada and Spain have successfully incorporated this specialty into the basis of their health systems, promoting comprehensive, continuous and people-

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centered care. In Latin America, its development has been progressive, in response to the fragmentation of care and the growing demand for humanized and responsive services.¹⁻⁵

First and foremost, Family Medicine is a clinical specialty that provides continuous, comprehensive and person-centered medical care, addressing the multiple dimensions of health across all stages of the life cycle. Unlike other specialties, its focus extends beyond the affected organ or system,

integrating biological, psychological, social and cultural factors that affect the health–disease process. It is based on principles such as continuity of care, community orientation, prevention and health education, promotes patient autonomy; and strengthens the doctor–patient relationship.

The family doctor serves as the first point of contact within the health system, coordinating care and managing resources, and is key to improving access, efficiency and quality of services. Training in Family Medicine requires clinical, communication and leadership skills that enable family doctors to intervene effectively across different levels of care and to lead transformation processes in complex community and healthcare environments.^{1,6,7}

Specifically in Colombia, Family Medicine has undergone a process of consolidation in response to the structural challenges of the national health system. Since the creation of the first specialization program in 1984 at the Universidad del Valle, academic initiatives have been implemented at several universities in the country, and to date, the country has 16 approved specialization programs in Family Medicine. With the enactment of Law 1438 of 2011 and the formulation of the Single Family Medicine Programme in 2015, the aim was to strengthen primary care as a public policy strategy, placing the family doctor as the central figure in health care. However, this specialty still faces barriers to institutional recognition, resource allocation and articulation within the system.^{1,8-12}

Therefore, this study aims to systematize the experience of creating, developing, and consolidating a Family Medicine specialization program at a Colombian university.

Methodology

A qualitative experience-based systematization was carried out to explore and analyze phenomena from the perspectives and lived experiences of the participants, enabling the collection, organization, interpretation, and reinterpretation of diverse narratives.^{11,12} This research focused on the Family Medicine specialization program at a Colombian university, covering the period from 2006 to 2024.

The theoretical foundation of the experience systematization methodology lies in the intent to comprehend the significance of the actions undertaken within an educational program. This understanding emerges from an in-depth exploration of the available information regarding its historical development and trajectory. Through this process, it becomes possible to derive verifiable descriptive findings within a defined contextual framework, which enables the interpretation of how the Family Medicine postgraduate program has evolved and achieved consolidation. Furthermore, these descriptive findings offer plausible explanations of the sequence of events that occurred from the Family Medicine program's inception to its consolidation, articulated through a temporal analysis that addresses what changes occurred, how they unfolded, and why they took place within the development of the program itself.^{10,13}

The study was carried out in 2024 and was developed through a qualitative systematization of experiences conducted in three interconnected phases. Phase 1 involved a focus group that reconstructed the program's timeline and identified key milestones across its creation, evolution, and consolidation (Table 1). Phase 2 consisted of semi-structured interviews with founding members, faculty, and administrative staff; whereas Phase 3 included a documentary review of institutional records and reports. The information gathered was chronologically organized and thematically analyzed in seven predefined categories, integrating documentary analysis and grounded theory principles to capture the program's historical development and lessons learned.

The first phase involved a semi-structured interview conducted within a focus group. In the second phase, additional semi-structured interviews were carried out, using a convenience sampling until theoretical saturation was achieved. Participants included directors, founders, teachers, graduates and first graduates of the Family Medicine Programme at a Colombian university, as well as directors of programs at other universities in the country and medical associations. Invitations were sent via institutional email, and participation was voluntary. All invitees agreed, but interviews with two candidates could not be scheduled despite

Table 1: Guiding Questions (GQ) for each of the phases

Phase 1	Phase 2	Phase 3	Phase 4
Focus group	Semi-structured interviews	Documentary review	Information processing and analysis
Three of the actors involved in the creation of the program and who are still part of it participated.	Sampling was carried out by convenience until theoretical saturation was reached.	It included the analysis of four institutional documents.	Descriptive analysis of the information, through the interpretation of answers obtained in interviews and documents.
GQ	GQ creation stage		
1. When and how did you start the process for the formation of the specialization at the Universidad de La Sabana? 2. Could you describe the program process in stages and what would they be? 3. Which people have been key in the process of creation and construction of the program? 4. Do you know where I can find information about the history of the program?	1. When and how did the process for the formation of the specialization at the Universidad de La Sabana begin? 2. What differences were you looking for concerning other existing programs? 3. Who participated in the start-up process?	1. When and how did you start the process for the formation of the specialization at the Universidad de La Sabana? 2. What need or problem were you seeking to solve at the time?	<i>Motivation:</i> this refers to the reasons that led the founders to set up the program. <i>Description of the process of starting the program:</i> These are the events that occurred from the motivation to the practical and educational start of the program.
	GQ Evolution stage		
	4. What obstacles did you encounter during the development of the program and how did you overcome them? 5. What have been the main milestones or stages in the development of the program? 6. How do you think the program has evolved? 7. What lessons have you learned from this process?	3. What have been the significant changes in the objectives and structure of the program in Family Medicine at the Universidad de La Sabana? 4. How has the duration and content of the residency evolved over the years?	<i>Achievements and difficulties:</i> these are the obstacles and outstanding results that have occurred during the program. <i>Turning points:</i> these are the decisive moments of change and rethinking in the course of the program. <i>Lessons learned:</i> the lessons associated with the previously identified difficulties, achievements and turning points.
	GQ Consolidation stage		
	8. Do you consider that consolidation has taken place? 9. What do you consider to be the gaps or failures in the program? 10. What strengths has the program had during its development? Which ones do you currently highlight? 11. Do you know where we can look for information about the history of the program?	5. How was compliance with quality standards ensured over the years? 6. What is the new curricular reform of the program at the Universidad de La Sabana? 7. With the new curricular reform, what challenges has the program in Family Medicine of the Universidad de La Sabana faced?	<i>Current gaps or shortcomings of the program:</i> these are the opportunities for improvement that the program currently has. <i>Strengths:</i> these are the strengths that currently characterize the program.
Own elaboration. This table presents the guiding questions applied in each phase (focus group, interviews, and documentary review) to explore the creation, evolution, and consolidation of the Family Medicine program.			

multiple attempts. However, data saturation had already been reached, so no further follow-up was necessary. All participants provided informed consent and were assigned anonymized codes for subsequent analysis. The third phase consisted of a documentary review of institutional materials guided by specific questions that complemented the analysis of the program's three stages.¹⁴

Data analysis was based on grounded theory. The interviews were transcribed and coded via a combination of speech recognition software,

manual analysis, and machine learning to facilitate data organization; no formal machine learning analyses were applied. The researchers, who were teachers and students in the program, adopted reflective strategies such as triangulation of the data to reduce bias and ensure the credibility of the analysis, enabling a comprehensive analysis, which was organized into seven thematic categories.

The initial thematic index was based on literature and frameworks in community health, while new subcategories emerged inductively to enrich and

contextualize the analysis.^{10,15} The categories are: (1) motivation; (2) description of the program's development process; (3) achievements and challenges; (4) key milestones; (5) lessons learned; (6) current gaps or weaknesses; and (7) strengths.

Results

Phase 1: Focus group

A semi-structured interview was conducted with two of the founding professors and a graduate from the first cohort of residents, who currently serve as members of the program's teaching staff. Together, they co-constructed a timeline highlighting key historical milestones of the program (see Graph 1 and Table 2). This section also identified the candidates to be interviewed in the next phase, as well as the documents to be included in the documentary review.

Phase 2: Semi-structured interviews

During this phase, a convenience sample of 41 potential interviewees was used as a starting point. Semi-structured interviews, both virtual and face-to-face, were conducted until theoretical saturation was reached, which was achieved with a total of 22 participants. The interviewees included people linked to the Universidad de La Sabana, as well as external participants. The information was collected through recordings and field notes (Table 2). The results obtained at each stage are presented below:

Stage of creation of the Family Medicine program at a Colombian university:

In the 1990s, an elective course in Family Medicine appeared in the undergraduate program, followed by the presentation of the master document in 2000. The postgraduate program was approved in 2006. The competency-based curriculum was designed to respond to the reforms of the Colombian health system, with a focus on PHC. The training model prioritized health promotion in community contexts, with an integral focus on the person, the family and the community.

One interviewee mentioned: *“The process was tortuous. The document was sent to the Ministry in 2000, but it took them five years to respond because the process was lost in the ICFES and then changed the competencies. It was only in 2005 that we*

received a visit from peers, and we were able to start in 2006” (E4).

The creation of the program was possible due to the articulation of multiple strategic actors, including undergraduate medical professors who promoted the early inclusion of the discipline through electives; academic directors who promoted the creation of the program as a response to the needs of the country's health system; and family doctors who had graduated from other universities and had experience in academic training.

One interviewee mentioned: *“It was a collective effort, where everyone contributed from their own experience. We were clear that we wanted to train doctors with a different, more human vision, closer to the community. That is why we relied on professionals from different areas to build something solid from the start”* (E4).

Stage of the evolution of the Family Medicine program at a Colombian university:

During the first stage, there were obstacles, among which the following stand out: the regulatory limitations for the approval of the program; limited recognition of the specialty within the health system; the resistance of other medical disciplines to collaborative training with residents; and initially low applicant demand. To overcome these obstacles, academic dissemination campaigns were implemented, alliances with hospitals and municipalities were strengthened, and the program actively participated in national and international congresses to enhance visibility and legitimacy.

One participant noted: *“At the beginning, many doctors from other specialties did not understand what we were doing. There were ignorance and resistance. However, over time, the residents were our best ambassadors, demonstrating with their work the relevance of family doctors”* (E11).

With respect to the main milestones of the process, in February 2006, the Family and Community Medicine Specialisation Programme officially began. In 2009, the first curricular reform was carried out, which allowed for the refinement of the competency-based model and the incorporation of innovative pedagogical strategies. In 2013, the

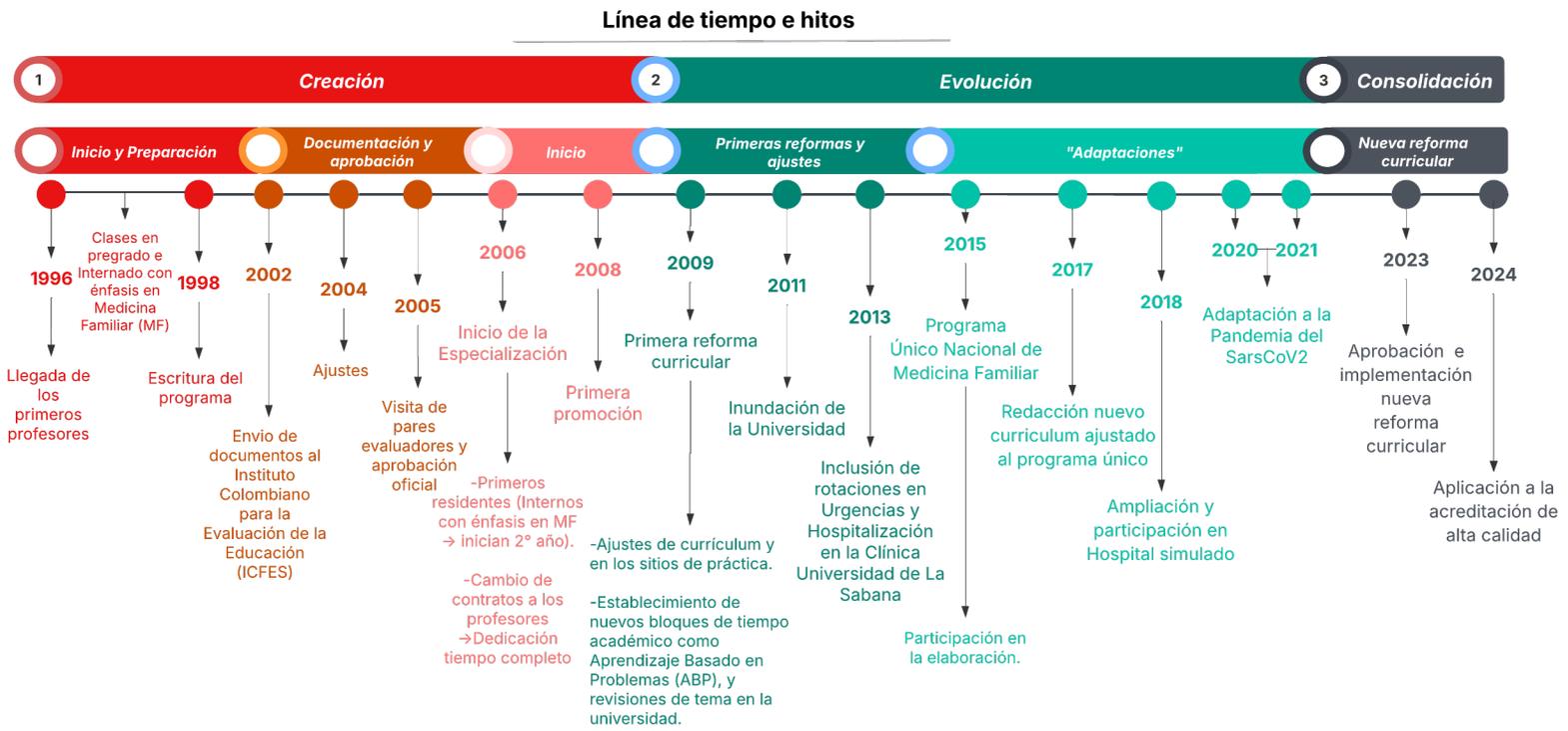
Table 2: Milestones of the Family Medicine Program at a Colombian university

Phase	Year	Milestone	
<i>Creation</i>	1996	Arrival of the first professors of Family Medicine at the Universidad de La Sabana.	Corresponds to the arrival of the first professors. This moment marked the beginning of the biopsychosocial and integral approach in Family Medicine training.
	1997	Beginning of undergraduate classes.	It began with an extensive rural rotation. This experience was perceived as a diploma course in Family Medicine due to its depth and duration.
	1998	Writing of the program's master document.	The master document was drawn up with the participation of several professors. It was the structural basis of the program.
	2002	Sending the master document to Colombian Institute for Educational Evaluation (ICFES).	Interviewees report bureaucratic difficulties and delays in approval, which delayed implementation.
	2004	Adjustments to the document.	Adaptations were made to respond to the recommendations of the academic peers.
	2005	Peer review visit and official approval.	The peer review visit culminates in the official approval of the program, consolidating the institutional effort to establish the specialty.
	2006	Start of the specialization program in Family Medicine.	The formal start of the program with residents who had already completed the Family Medicine course and internship, as they already had first-year competencies. As a result, the first 3 residents started directly in the second year.
	2008	First graduating class of Family Doctors.	First graduating class. This represents an institutional milestone that reflects the initial success of the program.
<i>Evolution</i>	2009	First curricular reform.	First curricular reform: time blocks and practice sites are reorganized. Continuity with families is sought.
	2011	University flooding.	The flood forced the adaptation of training strategies, demonstrating the program's responsiveness.
	2013	Inclusion of emergency and inpatient rotations.	Opening of rotations in emergency and hospitalization, extending the clinical training of residents.
	2015	Single Family Medicine Program.	Active participation in the formulation of the single national curriculum, working with the Ministry of Education, the Ministry of Health, and a group of people from other medicine and Family Medicine programs.
	2017	Drafting of the new curriculum adjusted to the Single Program.	The curriculum was adapted to the guidelines of the approved single national curriculum.
	2018	Expansion and participation in Simulated Hospital.	Clinical simulation in the simulated hospital becomes a key tool for complex skills training.
	2020-2021	Adaptation to SarsCoV2 pandemic.	Pandemic adaptation: virtual classes and consultations are implemented, with changes in practice sites and methodologies.
<i>Consolidation</i>	2023	Approval and implementation of new curriculum reform.	Implementation of the new curriculum reform based on the national curriculum, with integration of global and digital competencies.
	2024	Application for high-quality accreditation.	Stage of consolidation of the program to achieve high-quality accreditation.

Own elaboration.

This table summarizes major milestones of the program from 1996 to 2024, classified by phase: creation, evolution, and consolidation. Each entry includes contextual relevance and impact on program development.

Graph 1: Timeline and milestones



Grafica #1

Elaboración propia en Lucid.app

program underwent a process of renewed registration, which strengthened its recognition. Subsequently, practices in simulated hospitals and digital technologies were implemented and integrated into the Single-Family Medicine Programme, which prompted another reform in 2023. In 2024, it will apply for high-quality accreditation.

One participant said: *“Well, look, I think that, as always, starting is very challenging. I think this programme started off very well. In addition, I think that a big milestone was to start [...] The other milestones, let us say, have also been very much linked to the exercises of the programme as such. Therefore, for example, the link with international networks [...] Now we have just passed an important situation for the programme that I hope will be the important milestone of this decade, and that is that we have just passed the visit of peers from the National Accreditation Council”* (E10).

Interviewees described the program’s evolution as dynamic and adaptive. Among the most relevant aspects noted were the program’s capacity to adapt its curriculum; the integration of educational technologies; the expansion of agreements and stakeholders; and the strengthening of teaching quality. Similarly, self-evaluation and continuous updating processes have been implemented, reflecting an institutional framework committed to permanent improvement and academic excellence.

As one participant recounted: *“Situations like the pandemic come along that make us all have to mobilise to respond to these educational needs and health needs. So, we have to change our teaching strategies quickly, [...] not to change completely, but to be flexible [...], to include them in the curriculum that perhaps initially was not there, I do not think anyone had considered COVID and its entire approach”* (E17).

With respect to the lessons learned, maintaining a flexible and receptive posture in the face of challenges has enabled the curriculum to be adapted, maintaining a balanced integration between clinical and community training, improving teaching strategies and strengthening coordination with the national health system. Additionally, the recognition of collaborative work between teachers, managers, graduates and external institutions is fundamental for overcoming obstacles, legitimizing the Family Medicine specialty and projecting its impact on public health.

One interviewee mentioned: *“This visibility that our management had at that time helped to improve understanding of the concept of Family Medicine, of primary care, of this much more comprehensive approach and from the perspective of the principles of Family Medicine [...] this allowed us to consolidate the programme and give it a much greater projection in the health system”* (E4).

Stage of consolidation of the Family Medicine programme at a Colombian university:

The consolidation of the program reflects a strategic vision underpinned by PHC, evidenced in its institutional and academic recognition, and in its capacity to respond to the needs of the Colombian health system. Key factors contributing to this process included the continuous updating of the curriculum; the implementation of active learning methodologies; and the articulation with institutional and academic networks. The program has also promoted a culture of permanent evaluation and continuous improvement, aligned with national quality standards and accreditation frameworks. A notable marker of consolidation has been the leadership roles assumed by graduates in various academic, clinical, and policy-making settings. As one participant highlighted:

“The number of graduates, their links at a national level, their knowledge, their graduates have, how to say, high positions, yes, I think they have had a great trajectory, there is a consolidation of the programme” (E8).

Graduates from the program have contributed to improving service quality and patient care outcomes. Community-based projects and chronic

disease initiatives highlight the program’s role in enhancing health service responsiveness and community health.

One interviewee mentioned: *“Paola Rodríguez joined Javesalud to manage the COPD patient programme. Paola has set a record, focusing her career on COPD, but is she a champion of the cause? Yes. In addition, is she recognised nationally for her work in managing COPD in healthcare? Yes”* (E22).

Despite the progress achieved, the program continues to face important challenges, such as the difficulty of placing graduates into the health system, reflecting the outgoing low institutional recognition of family doctors. In addition, there is still a need to strengthen research skills through the development of competencies, the creation of research groups and the focus on territorial problems. The expansion of practical training in more complex clinical scenarios is also identified as an opportunity.

One interviewee mentioned: *“Although it has improved a lot, [...] I think that, in terms of research, yes, we still have a long way to go. How to establish these lines of research. I think that is the point we need the most, as in our programme”* (E19).

In contrast, the program’s current strengths were consistently highlighted by participants. These include its innovative pedagogical model, which is based on competencies and centered on PHC, which integrates clinical, community and humanistic training. The use of technological tools such as clinical simulation, teleconsultation and active learning methodologies are also positive aspects of the program. Other strengths include the program articulation with academic and professional networks; the leadership roles assumed by its graduates in public health and teaching; and its ongoing commitment to self-evaluation, curricular reforms and training with a solid academic identity and coherence with institutional principles.

One interviewee acknowledges: *“I think that you have evolved in this sense by strengthening the clinical aspects, that is what I understand from what*

I have spoken to graduates, and it is in a way that allows one, let us say, to have complete confidence in the doctors who have graduated from the savannah. [...] you see how they handle patients, and they are very good at it. [...] they are people who try to be decisive” (E14)

Additional documentary sources of information:

Four institutional documents were collected and reviewed from Phase 3.

Phase 3: Documentary Review

Simultaneously, with Phase 2, a review of four institutional documents of 93, 126, 25 and 327 pages each was carried out. In the creation stage, the need to train doctors with a holistic approach, with a focus on primary care, health promotion and understanding of the health-disease process, was identified. During the evolution stage, two relevant curricular reforms were identified: that of 2009, which introduced methodological adjustments aligned with the requirements of the Ministry of Education and self-evaluation processes; and that of 2023, which reorganizes the contents by thematic nuclei, strengthened competencies in PHC and integrated new technological tools for education. In 2023 the name was changed to the Family Medicine Specialisation Programme, following the recommendation of the Single Family Medicine Programme. In the consolidation stage, advances in quality assurance, such as the renewal of the qualified registration in 2013 and preparations for high-quality accreditation in 2024, were documented.

The reports reflect a flexible, competency-based curriculum structure adapted to the needs of the health system. Challenges arising from the implementation of the new reform, such as the reorganization of practice settings and the adaptation of the teaching staff, were also reported (16-19).

Data Processing and Analysis

The Family Medicine Programme at a Colombian university emerged in response to a national imperative to strengthen PHC. Designed with a comprehensive pedagogical model and humanistic approach, the program has evolved through

strategic alliances, curricular innovation, technological integration, and a strong community focus. Despite ongoing challenges such as the limited recognition of family doctors, gaps in research, and barriers to employment integration, the program has managed to consolidate itself through strategic alliances, curricular updates, technological incorporation and community expansion. Its impact is reflected in graduates with leadership roles in public health. The program continues to face structural and academic challenges but has demonstrated adaptability, commitment to quality and person- and community-centered training (17-19).

Discussion

Family Medicine has emerged globally as a response to the fragmentation of health systems, offering a model grounded on McWhinney's postulates, i.e., a discipline centered on the person, the family and the community, with a strong emphasis on PHC. At a Colombian university, the creation of a program in this specialization was proposed as a strategic response to the systemic challenges of the Colombian health system, particularly after the reforms introduced by laws 100 of 1993 and 1438 of 2011 (1,5,6,20).

Building upon this context, the classification into three phases—creation, evolution, and consolidation—helped to structure the program's historical trajectory and highlight its main turning points. This three-phase structure aligns conceptually with the *stages of change* model described in the African context, which has been used to analyze the maturation of Family Medicine and Primary Health Care training programs. Such parallel frameworks reinforce the notion that program development is a dynamic process shaped by contextual, institutional, and policy factors.²¹

Within this developmental framework, the curricular design of the program was innovative for its early adoption of a competency-based approach. Unlike other Latin American experiences, where competency-based curricula have been criticized for conceptual overload and lack hierarchy, the program at a Colombian university managed to adapt effectively through a contextual analysis of

the graduate profile and the progressive integration of international models. This enabled the competencies to be relevant and applicable to PHC scenarios in Colombia.²²

One of the initial challenges, common in the region, was the scarce institutional recognition of Family Medicine and the resistance of other clinical specialties. This situation has also been documented in contexts such as the Dominican Republic and Peru, where the integration of Family Medicine in hospitals has faced similar obstacles. In the case of the program at a Colombian university, effective strategies were implemented, such as greater participation in scientific events, interinstitutional agreements and academic dissemination spaces, similar to those carried out at the Albacete Family Medicine Teaching Unit in Spain, where the visibility of the role of the family doctor was key to its consolidation.^{5,12,23,24}

Over the years, the program has achieved significant milestones, such as the renewal of the qualified registration in 2013 and two major curricular reforms in 2009 and 2023. These reforms introduced technological innovations such as clinical simulation and teleconsultation, which were strengthened in their application during the COVID-19 pandemic. These types of educational technologies have been widely recognized as crucial elements for contemporary medical training, enhancing interactivity, flexibility and quality of learning experiences.²⁵

A distinctive feature of the program has been its articulation with both the education and health systems. The model has been developed mainly in urban and peri-urban settings; through agreements with municipalities in the Sabana of Bogotá, as well as in the capital, rotation has been promoted in PHC settings, mainly at the first levels of care. This strategy is consistent with experiences such as those of the Family Medicine programme at the Universidad del Valle, which is committed to prolonged immersion in rural communities.^{26,27}

In terms of curricular integration, the program has successfully balanced clinical and community training, thus confronting one of the most common

weaknesses in medical training in Latin America: fragmentation between the different levels of care. In addition, the consolidation of a coherent model focused on PHC has also facilitated the participation of its graduates in institutional leadership and public policy-making processes.^{5,28}

Moreover, the integration of the program with Colombia's education and health systems has fostered mutual strengthening. Through residents' active participation in diverse healthcare settings, the system benefits from their preparedness and problem-solving skills, which enhance the comprehensiveness and quality of patient care. This bidirectional relationship links academic training with real service delivery, improving learning outcomes and system responsiveness.^{1,6}

The program is aligned with the recommendations of the Pan American Health Organisation (PAHO), which promotes interdisciplinary teams led by family doctors to strengthen PHC and health equity. However, important challenges remain, such as the labor market insertion of graduates and the need to strengthen scientific production. The latter is part of a broader structural problem regarding the weak research culture in postgraduate medical training programs in Colombia, particularly those with less trajectory or visibility.^{29,30}

In addition, the need to expand practice settings to highly complex hospitals was identified. This expansion is key to complementing community training with a more robust clinical approach, strengthening the family doctor's decision-making capacity without compromising his or her professional identity. Latin American experiences agree that integration between levels of care is essential for the comprehensive training of specialists. In this context, the strengthening of research, the expansion of training scenarios and raising the visibility of the role of the family doctor are all necessary actions to advance towards more comprehensive, critical medical training that is committed to social transformation (Table 3 and Table 4).^{27,31,32}

Finally, the program is positioned as a national benchmark in the training of family doctors, with

Table 3: Strengths and opportunities for improvement of the Family Medicine program at a Colombian university

Strengths	Opportunities for improvement
Innovative pedagogical model based on Primary Health Care (PHC).	Greater recognition of the specialty in the health system.
Comprehensive approach in the training of family doctors.	Expansion of practice scenarios in rural areas.
Consolidation of agreements with health institutions.	Increase in research production in Primary Health Care (PHC).
Use of technological tools for teaching.	Strengthening of employability strategies for graduates.
Impact of graduates on public and community health.	Optimization of teaching methodologies with Information and Communication Technologies (ICTs)
	Strengthen integration with national and international academic networks.
<p>Own elaboration. This table identifies internal strengths and current opportunities for improvement within the program, based on triangulated input from interviews and document analysis.</p>	

Table 4: Recommendations and lessons learned

Recommendations	Learnings
Implement strategies to improve the insertion of graduates in the health system, promoting their recognition in hospitals and primary care centers.	Need for more effective communication strategies.
Expand agreements with rural and urban health institutions to diversify learning spaces for residents.	Need to maintain a constant balance between clinical and community approaches.
Encourage scientific production and resident participation in research projects.	Early clarity of the professional profile facilitates the labor insertion of graduates.
Strengthen collaboration with national and international Family Medicine programs for academic and experience exchange.	Strengthening international collaborations enhances the global recognition of the program.
Continue with the integration of digital tools and telemedicine to optimize the training of residents.	Effective academic communication strategies increase visibility.
Maintain constant curriculum updates, aligned with advances in Primary Health Care (PHC) and community health.	
Strengthen the management of public health emergencies and pandemics, incorporating simulations and practical training that allow residents to develop key skills.	
<p>Own elaboration. This table highlights practical recommendations and critical lessons derived from the systematization process, aimed at guiding future improvements and adaptations of similar training programs.</p>	

recognized strengths in its pedagogical approach, its capacity for curricular adaptation and its community impact. These aspects are in line with the criteria defined by CESU Agreement No. 3 of 2016, which establishes social relevance, academic quality and continuous improvement in higher education programs in Colombia. The systematization carried out also shows how critical analysis of accumulated experience can strengthen the internal processes of institutional evaluation and planning, contributing to a culture of academic excellence and commitment to social transformation.³²

Limitations

This study provides useful information, but it is limited to an institutional context. Persistent challenges in terms of recognition and integration of the system, coupled with the absence of government stakeholders, may have reduced the diversity of perspectives.

Conclusions

The systematization of experiences of the Family Medicine program at a Colombian university illustrates a solid formative process, built on a foundation of institutional reflection, social relevance and progressive adaptation. Since its creation in 2006, the program has managed to articulate clinical, community and humanistic dimensions, consolidating a model centered on PHC, in coherence with international recommendations to reorganize health systems around teams led by family doctors.

The findings highlight the program's capacity to respond to the challenges of the healthcare environment through curricular reforms, the integration of educational technologies, the expansion of practice scenarios and the strengthening of the family doctor's identity as an agent of change in territories. However, there are still structural challenges that reflect both internal problems and the Colombian context: the low recognition of the Family Medicine specialty in some settings; the need for greater scientific

production; and the scarce links with highly complex hospitals. These challenges represent strategic opportunities to continue positioning Family Medicine as a pillar of the health system.

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Previous publications

This manuscript has not been previously published and is not under consideration elsewhere.

Conflict of interest

The authors declare that they have no conflicts of interest.

Authors' contributions

LR, MO and EH participated in the planning and conceptualisation of the project. LR, MO and EH designed the methodology. LR, MO and MU carried out the fieldwork and execution of the research. LR and MO carried out the data collection, processing and analysis. EH, MU and AC were involved in supervision and mentoring. LR, MO, EH, MU and AC contributed to the drafting of the manuscript and approved its final version.

Data availability statement

The data that support the findings of this study (interview transcripts and institutional documents) are not publicly available due to confidentiality agreements and ethical considerations but may be available from the corresponding author upon reasonable request and with institutional approval.

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