

Community work experiences, innovations to respond to health emergencies

Experiencias de trabajo en la comunidad: innovaciones para responder a emergencias sanitarias

Experiências de trabalho na comunidade: inovações para responder a emergências sanitárias

Gisela Galindo Ortego¹ , Lusy Paulyna Orellana^{2,3,4} , Dora Patricia Bernal^{5,6} 

¹Sociedad Española de Medicina de Familia y Comunitaria – Barcelona, Spain.

²Sociedad Ecuatoriana de Medicina Familiar – Quito, Ecuador.

³Pontificia Universidad Católica del Ecuador – Quito, Ecuador.

⁴Universidad de las Américas – Quito, Ecuador.

⁵Sociedad Colombiana de Medicina Familiar – Cali, Colombia.

⁶Universidad Norbert Wiener – Lima, Perú.

Abstract

Introduction: Recent public health emergencies have highlighted significant gaps in health systems regarding preparedness, coordinated response, and community resilience. The need to strengthen the community response by integrating technological innovations and evidence-based strategies has become a global priority for ensuring more equitable and resilient health systems. **Objective:** To identify lessons learned from recent public health emergencies that are transferable to other regional contexts and to define the role of Family Practice in planning and leading strategies for future public health emergencies. **Methods:** The Delphi method was used with 30 experts from 16 Ibero-American countries, organized into representative groups based on geographic diversity and professional experience. Two rounds of consensus building were conducted using structured electronic questionnaires with a 1- to 5-point Likert scale. The consensus threshold was set at 80% agreement (score ≥ 4). **Results:** Consensus was reached on 42 strategies distributed across three levels of action: macro (16 political-legislative strategies), meso (16 municipal/community strategies), and micro (10 strategies in health centers). The prioritized technological innovations include telemedicine, epidemiological surveillance systems, electronic prescribing, early warning systems, drones and robots, digitization of clinical data, artificial intelligence, and geospatial information systems. **Conclusions:** An effective response to public health emergencies requires aligning public policies with local needs, prioritizing community inclusion, ongoing training, and appropriate technologies. Family Practice plays a fundamental role in community leadership and intersectoral coordination.

Keywords: Disaster emergencies; Family practice; Primary health care; Community participation; Organizational innovation.

Workgroup:

Arias Castillo Liliana (Colombia), Baca Cabanillas Nelida Paola (Peru), Berdeja Galeana Adahi (Mexico), Carrasco González Mónica (Chile), Cezar Dal Chivon Augusto (Brazil), Choquehuanca Calle Verónica Isabel (Bolivia), Cimatti Francisca (Argentina), Del Moral Bernal Alberto (Mexico), Deza Castro Luis Alberto (Chile), Echavarría Cadena Angie Marcela (Argentina), Falco Gerardo (Uruguay), Garré Laura (Uruguay), Gontijo Luísa (Brazil), Gutiérrez Sánchez Loyda María (Panamá), Inga Mayta Nailin Reimundo Mónica (Peru), Izquierdo Skjaer Are (Uruguay), Lamique Gabriela (Uruguay), Lezcano Portillo Federico (Paraguay), Niveló Clavijo Mónica (Chile), Perozo Juan Carlos (Venezuela), Pimentel Danelia, República, (Dominicana), Pomares Pérez Yagen María (Cuba), Portillo García Zitlalli (Mexico), Reyes Lizama Fabiola Angélica (Chile), Solís Fuentes Henry (Bolivia), Teixeira Francisco (Brazil), Vera González María Luisa (Bolivia).

Corresponding author:

Gisela Galindo Ortego
E-mail: ggalindoo@semfyc.es

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Resumen

Introducción: Las emergencias sanitarias recientes han evidenciado brechas en los sistemas de salud relacionadas con la preparación, la respuesta coordinada y la resiliencia comunitaria. Fortalecer la respuesta comunitaria mediante la integración de innovaciones tecnológicas y estrategias basadas en la evidencia se ha convertido en una prioridad global para garantizar sistemas de salud más equitativos y resilientes. **Objetivo:** Identificar las lecciones aprendidas de emergencias sanitarias recientes que sean transferibles a otros contextos regionales y definir el papel de la Medicina Familiar y Comunitaria en la planificación y el liderazgo de estrategias para futuras emergencias sanitarias. **Métodos:** Se utilizó el método Delphi con 30 expertos procedentes de 16 países iberoamericanos, organizados en grupos representativos según criterios de diversidad geográfica y experiencia profesional. Se realizaron dos rondas de consenso mediante cuestionarios electrónicos estructurados con una escala *Likert* de 1 a 5 puntos. El umbral de consenso se estableció en un 80% de acuerdo (puntuación ≥ 4). **Resultados:** Se alcanzó consenso sobre 42 estrategias distribuidas en tres niveles de actuación: macro (16 estrategias político-legislativas), meso (16 estrategias municipales/comunitarias) y micro (10 estrategias en centros de salud). Las innovaciones tecnológicas priorizadas incluyen la telemedicina, los sistemas de vigilancia epidemiológica, la prescripción electrónica, los sistemas de alerta temprana, los drones y robots, la digitalización de datos clínicos, la inteligencia artificial y los sistemas de información geoespacial. **Conclusiones:** La respuesta efectiva a las emergencias sanitarias requiere articulación de las políticas públicas con las demandas locales, priorizando la inclusión comunitaria, la capacitación continua y el uso de tecnologías apropiadas. La Medicina Familiar y Comunitaria desempeña un papel fundamental en el liderazgo comunitario y la coordinación intersectorial.

Palabras clave: Emergencias en Desastres; Medicina Familiar y Comunitaria; Atención Primaria de Salud; Participación de la Comunidad; Innovación Organizacional.

Resumo

Introdução: As emergências sanitárias recentes evidenciaram lacunas nos sistemas de saúde relacionadas à preparação, à resposta coordenada e à resiliência comunitária. O fortalecimento da resposta comunitária por meio da integração de inovações tecnológicas e estratégias baseadas em evidências tornou-se uma prioridade global para garantir sistemas de saúde mais equitativos e resilientes. **Objetivo:** Identificar lições aprendidas com emergências sanitárias recentes que possam ser transferidas para outros contextos regionais e definir o papel da Medicina de Família e Comunidade no planejamento e na liderança de estratégias para futuras emergências sanitárias. **Métodos:** Utilizou-se o método Delphi com 30 especialistas provenientes de 16 países ibero-americanos, organizados em grupos representativos segundo critérios de diversidade geográfica e experiência profissional. Realizaram-se duas rodadas de consenso por meio de questionários eletrônicos estruturados, utilizando uma escala *Likert* de 1 a 5 pontos. O limiar de consenso foi estabelecido em 80% de concordância (pontuação ≥ 4). **Resultados:** Alcançou-se consenso sobre 42 estratégias distribuídas em três níveis de atuação: macro (16 estratégias político-legislativas), meso (16 estratégias municipais/comunitárias) e micro (10 estratégias em centros de saúde). As inovações tecnológicas priorizadas incluem telemedicina, sistemas de vigilância epidemiológica, prescrição eletrônica, sistemas de alerta precoce, drones e robôs, digitalização de dados clínicos, inteligência artificial e sistemas de informação geoespacial. **Conclusões:** A resposta efetiva às emergências sanitárias requer a articulação das políticas públicas com as demandas locais, priorizando a inclusão comunitária, a capacitação contínua e o uso de tecnologias apropriadas. A Medicina de Família e Comunidade desempenha papel fundamental na liderança comunitária e na coordenação intersetorial.

Palavras-chave: Emergências em Desastres; Medicina de Família e Comunidade; Atenção Primária à Saúde; Participação da Comunidade; Inovação Organizacional.

INTRODUCTION

Health emergencies — defined as situations that exceed the ordinary response capacity of health systems and pose an immediate or potential threat to public health — have increased in frequency and impact in the Ibero-American region over the past few decades. The COVID-19 pandemic was the most recent and far-reaching example, but health systems have also had to respond to epidemic outbreaks (dengue, Zika, influenza A H1N1), natural disasters (earthquakes, floods, fires), and complex humanitarian crises that disproportionately affect the most vulnerable populations.

These crises have highlighted structural gaps in preparedness, coordination, and community resilience. In the face of these challenges, Primary Health Care (PHC) — and, in particular, Family Practice — has proven to be a strategic pillar of the response, serving as the first point of contact with the population, ensuring continuity of care, and acting as a liaison with the community and other sectors. However, the available evidence on best practices and innovative strategies at this level of care remains scattered and fragmented.

The Ibero-American Confederation of Family Medicine (*Confederación Iberoamericana de Medicina Familiar* – CIMF) — an organization that brings together the national societies of Family Practice from 21 countries in Ibero-America — convened thematic working groups at its 2025 Uruguay Summit with the aim of producing consensus documents on the discipline's priority challenges in the region. This paper is the outcome of Working Group 3, which focused on community-based experiences and innovations for responding to public health emergencies.

To synthesize the available knowledge and lessons learned in the region, the group adopted the Delphi method, considered optimal for addressing complex problems through structured expert judgment when scientific evidence is insufficient or heterogeneous to support definitive recommendations.¹ The method allows for reaching consensus-based answers based on a review of existing research and collective experience.

METHODS

Design

A consensus study was conducted using the Delphi technique in two rounds, supplemented by a non-systematic literature review. The statements submitted to the consensus process were formulated based on the responses to five guiding questions answered by the participants in the initial phase, supported by the literature each participant provided.

Participants

The panel consisted of 30 experts in Family Practice and related disciplines from 15 Ibero-American countries: Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Ecuador, Spain, Mexico, Panama, Paraguay, Peru, the Dominican Republic, Uruguay, and Venezuela. The participants were selected and assigned by the coordinators of the CIMF Uruguay 2025 Summit to four working groups, based on criteria of geographic representation and diversity of professional experience (family physicians, public health managers, researchers, community representatives, and representatives of international organizations). Of the 30 initial participants, 28 responded to the first round (response rate: 93%) and 27 to the second round (90%). The table listing the institutional affiliations of all authors and contributors appears in the authorship section of the manuscript.

Delphi Procedure

The process unfolded in the following phases:

Phase 0 – Literature Review and Formulation of Questions: Prior to the start of the rounds, the participants — organized into subgroups based on criteria of country representation — answered the five guiding questions for the process:

- What lessons learned from recent public health emergencies are transferable to other regions or scenarios?
- What technological innovations have demonstrated the greatest impact on community response during emergencies?
- How can community partnerships be strengthened to prevent health crises?

- What strategies should be prioritized to ensure equity in the emergency response for vulnerable populations?
- How can Family Practice lead community plans for future emergencies?

The responses were based on the literature review provided by each participant. From this phase, the coordinators of each subgroup extracted the statements deemed most relevant by subgroup consensus, which constituted the items for the first Delphi questionnaire.

First Delphi round: The selected statements were distributed via an electronic questionnaire to all panelists. Each participant rated their level of agreement using a Likert scale from 1 (strongly disagree) to 5 (strongly agree), with the option to add supporting comments.

Second Delphi round: Following the analysis of the first round, a second questionnaire was developed that included the statements on which consensus had not been reached, incorporating the modifications suggested in the comments. In this second phase, a sixth question was also added, aimed at gathering information on successful community experiences during health crises: "What have been some successful community experiences during health crises in your country or region?"

Consensus Criteria

The degree of agreement was defined as the percentage of panelists who assigned a score of 4 or 5 to each item. The consensus threshold was set at 80% agreement. The statements that reached this threshold in both the first and second rounds are included in the results.

Once the items were selected after the two rounds, and to conduct a more in-depth analysis of the results for each question, six thematic subgroups were organized, each coordinated by one or two designated leaders.

Ethical Considerations

Participation was voluntary and informed. Participants are identified as authors or contributors in accordance with the criteria of the International Committee of Medical Journal Editors (ICMJE). The study did not collect patient data and did not require review by an ethics committee.

RESULTS

At the end of the process, consensus was reached on 42 statements. In the first round, consensus was reached on 35 statements (83.3% of the total); consensus on the remaining 7 was reached in the second round after incorporating the comments and proposed modifications. The results are presented below, organized by question.

1. Lessons learned from public health emergencies that are transferable to other settings

The lessons learned identified by the panel are organized into three levels of action: macro (political-legislative, national, and international), meso (municipal/community), and micro (health centers and hospitals). At the end of the two rounds, 16 strategies were agreed upon at the macro and meso levels, and 10 strategies at the micro level (Table 1).

Table 1. Key lessons learned from public health emergencies that are transferable to other scenarios.

MACRO (International/National Political-Legislative)	MESO (Municipal/Community)	MICRO (Health Centers/Hospitals)
1. International health regulations/standards 2. National and international emergency operations committees (resource integration, priorities, and coordination) 3. Training, education, and continuing certification 4. Inter-country collaboration agreements, cross-border cooperation, and coordination among government agencies 5. National and international early warning systems 6. National prevention strategies 7. Independent and realistic information management to prevent panic and misinformation 8. Digitization of national and international organizations (official websites providing guidance, information, and resources) 9. Political will: health in all policies, with investment and resources 10. Policies with a One Health approach in all countries 11. Legislation to protect indigenous peoples, ethnic minorities, cultural diversity, local languages, and vulnerable populations 12. Protection of the environment and biodiversity 13. Investment in and improvement of infrastructure to reach remote areas and reduce travel-related accidents 14. Investment in mental health support and prevention programs 15. Legislation promoting healthy habits 16. Architectural and construction regulations regarding materials and locations	1. Regulations and monitoring systems for river flood prevention 2. Environmental and water sanitation 3. Provision of basic services 4. Vector control 5. Training and capacity building for professionals, technicians, and key community members 6. Community education and training 7. Information management 8. Digitization 9. Coordination among levels/entities 10. Creation of community networks 11. Involvement of the community in decision-making (respect for traditions and customs) 12. Leadership of community organizations: empowerment of indigenous communities and ethnic minorities 13. Training, education, and promotion of healthy lifestyles 14. Prevention strategies for the future 15. Multidisciplinary mental health support groups 16. Strategies for mitigating mental health incidents	1. Self-management capacity of health centers and hospitals 2. Effective intra- and inter-level coordination 3. Digitization of medical records 4. Use of telemedicine 5. Development of regulations and prevention strategies for the future 6. Capacity to provide education and training 7. Availability of technology that enables point-of-care diagnosis 8. Lifestyle interventions 9. Treatment and support for mental health issues 10. Comprehensive clinical care for individuals and families

MACRO: international and national political-legislative level; MESO: municipal and community level; MICRO: health center and hospital level. The 42 strategies achieved a level of agreement of $\geq 80\%$ in both Delphi rounds (1–5 Likert scale; consensus defined as $\geq 80\%$ of panelists scoring ≥ 4).

The macro level encompasses structural governance strategies and legislation: international health standards,² implementation of agreements and consolidation of emergency operations committees,^{2–7} ongoing training,⁶ transparent information management,^{4,5,7} mental health prevention

programs,^{5,6} policy development with a One Health approach,³ and protection of indigenous peoples and other ethnic minorities.⁸

At the community level, health education,⁹ environmental sanitation,⁷ community empowerment and active participation, and the creation of community networks^{8,9} are considered fundamental pillars.

In health centers, the key elements for an effective response to future emergencies are comprehensive, person- and family-centered care,^{5,6} decentralized management,^{6,10} effective coordination, and the adoption of technologies such as digitization and telemedicine.¹⁰ Political will, investment in resources, and the training of professionals and the general population are identified as essential enabling factors at all levels.

2. Technological Innovations with the Greatest Impact on the Community Response

Among the technological innovations that achieved consensus for having demonstrated the greatest impact on the community response during public health emergencies (Table 2), the following stand out: telemedicine,^{9–12,16} epidemiological surveillance systems,^{9,10,12} electronic prescribing,^{12,13,15} early warning systems,^{17–23} drones, robots, and social media,²⁴ the digitization of clinical data and the implementation of Artificial Intelligence (AI)^{25–27}, and geospatial information systems.^{28–30}

Table 2. Major technological innovations with the greatest impact on the community response during public health emergencies.

No.	Technological innovation	Main Advantages / Limitations
1	Early warning systems for evacuations and disaster relief	They anticipate and mitigate the impact of natural disasters / They require specific infrastructure and training
2	Epidemiological surveillance systems (early detection, monitoring, and reporting of epidemics/pandemics)	Early detection and control of outbreaks / Limitations in integrating information across systems
3	Digitization of clinical data and AI	Cost reduction (5–10%), automation, and process optimization / Requires data coverage, ethical safeguards, and training
4	Telemedicine (remote care)	Reduces the risk of transmission and expands access / Depends on digital infrastructure and professional acceptance
5	Electronic Prescribing	Facilitates remote medication dispensing / Requires internet access, healthcare professionals, and a dispensing location
6	Geospatial information systems and satellite imagery	Better territorial analysis for decision-making / High costs and the need for technical training
7	Portable devices for clinical diagnosis (point-of-care)	Rapid diagnosis at the point of care / Cost and limited availability in resource-constrained settings
8	Drones and robots (rescue operations, resource distribution, disinfection)	Access to hard-to-reach areas and support for healthcare teams / Require cybersecurity protocols and specific regulations
9	Social media and mobile apps (WhatsApp, SMS, TV, radio)	Communication and emotional support for communities / Risk of misinformation; need for cybersecurity

AI: Artificial Intelligence; SMS: Short Message Service. All innovations achieved a consensus of ≥80% in the Delphi rounds. The advantages and limitations are based on the literature review provided by the participants.^{9–30}

These technologies have significant advantages and limitations. Telemedicine reduces the risk of transmission but depends on infrastructure and public acceptance.^{12,16} Epidemiological surveillance

systems enable early detection but still face limitations in information integration.^{9,10,12} Electronic prescribing facilitates remote medication dispensing and is contingent on internet availability and dispensing locations.^{12,13,15} Early warning systems anticipate and mitigate the impact of natural disasters but require infrastructure and training.¹⁷⁻²³ Digitalization and AI can reduce costs by 5–10% and optimize processes, although their implementation requires safeguarding ethical considerations and ensuring universal coverage.²⁵⁻²⁷ Geospatial information systems enable territorial analysis for decision-making, subject to cost and training constraints.²⁸⁻³⁰

3. Strengthening Community Partnerships to Prevent Health Crises

In the face of current civilizational, health, and socio-environmental crises, it is essential to move toward decentralized management models in which community participation is key to decision-making and the implementation of health strategies.

Community and neighborhood networks play a central role in creating spaces for participation, establishing local partnerships, and promoting shared responsibility for health care. They enable the identification of needs, the conduct of participatory local assessments, and the design of action plans tailored to the local context. Notable examples include Peru's Integrated Health Networks,³¹ the Network of Community Kitchens and Soup Kitchens, the Network of Health Care Users, the Network of Healthy Municipalities and Communities, and the Mental Health Roundtable of Western Montevideo (Uruguay), as well as Chile's *Ollas Comunes*.

Intersectoral collaboration and inter-institutional partnerships are essential for strengthening preventive efforts. Public-private partnerships can optimize the distribution of supplies and strengthen health infrastructure, although they can also create dependence on donations and private interventions.³²

Another central pillar is the collective development of community knowledge through the exchange of knowledge from intercultural, gender, and human rights perspectives. In Ceará (Brazil), an action-oriented training program for Community Health Workers was implemented during the pandemic, reducing inequalities and strengthening local resilience.^{33,34} Community participation in eliminating mosquito breeding sites during the Zika outbreak in Latin America is another relevant example.

Community training in identifying warning signs, the use of technologies to disseminate information, and the conduct of drills are key to effective preparedness. Notable examples include the "*Renca Centinela va a tu barrio*"³⁵ project (preventive PCR testing) and the early warning system for floods in Bangladesh.³⁶

4. Strategies to Ensure Equity in Vulnerable Populations

Vulnerable populations — people living in poverty, ethnic minorities, immigrants, people with disabilities, women, and children — face significant barriers during emergencies. To ensure an equitable response, it is essential to adopt strategies that promote inclusion, reduce inequalities, and ensure access to essential resources. The panel identified seven strategic areas:

1. risk management;
2. community participation that takes interculturality into account;
3. the promotion of equitable access and public policies;
4. strengthening of the health system and primary care;
5. use of information technologies and monitoring systems;

6. research and community resilience; and
7. knowledge management in public health emergencies.^{37–41–56}

Identified strengths: community participation with an intercultural approach; strengthening of PHC in highly vulnerable contexts; implementation of public policies tailored to the local context; strategic use of information technologies; and promotion of local collective learning networks.^{43,45–47,57}

Identified limitations: lack of continuity among health teams; insufficient structural focus on social determinants; poor integration across levels of government; persistent digital divides; and limited installed capacity.^{58–62}

No evidence was found of methodological models for managing health emergencies in vulnerable populations that are fundamentally centered on equity. The group's proposal establishes connections between equity, interculturality, community strengthening, and Family Practice, which constitutes a significant contribution to professional practice and future research.

The role of Family Practice in this area involves community education, recognition and empowerment of local capacities, preventive work, development of action plans with local leaders, and coordination with civil protection systems.⁶³ Professionals must be trained in culturally competent approaches, skills for working under pressure, and effective communication in contexts of uncertainty.^{64,65} Practice must also be oriented toward intersectoral work and transdisciplinary approaches, acting as a bridge between formal systems and community networks.^{66–68}

5. Leadership of Family Practice in Future Emergencies

Family Practice is the foundation of PHC and provides a comprehensive approach to the care of individuals, families, and communities.^{69–71,72} Its close ties to the population make it a key player in the planning and implementation of strategies to address emergencies, ensuring efficient responses tailored to local realities.⁷³

Actions by Family Practice:

- Community preparedness and resilience: Family physicians can identify vulnerabilities, map risks, and work with the community to develop prevention and mitigation strategies.⁷⁴ The implementation of programs in native languages on the prevention of respiratory diseases in indigenous communities in Latin America has reduced the incidence of tuberculosis and pneumonia.⁷⁵
- Coordination of health resources and services: Family Practice professionals are essential for ensuring the adequate distribution of supplies and the continuity of basic services.⁷⁶ Home care and the monitoring of chronic diseases to prevent exacerbations have proven essential for reducing the burden on hospitals.⁷⁷
- Epidemiological surveillance: Because they know their communities well, family physicians can identify unusual signs and alert health authorities. They can establish community surveillance networks that include doctors, nurses, and volunteers, enabling a rapid and efficient response.⁷⁸
- Psychosocial support and community mental well-being: Emergencies also affect the mental health of the population. Family Practice, with its holistic approach, plays a crucial role in mitigating the psychological impact of a crisis.⁷⁹ Solidarity and community collaboration are key to resilience.
- Intersectoral coordination and networking: Family Practice must integrate with and draw on other sectors — government, nongovernmental organizations (NGOs), and international organizations.

Coordination across levels of care is necessary to ensure the smooth referral of patients based on the severity of their condition.^{80,81}

6. Successful Community Experiences in Health Crises

The crises identified in different countries focus primarily on two types of health problems: the COVID-19 pandemic and noncommunicable diseases (NCDs). The criteria applied to classify a problem as a health crisis were: impact on mortality and morbidity; reduction in life expectancy and increase in disability; public health implications; collapse or overload of the health system; and economic and social consequences.

NCDs currently constitute health crises, as they account for more than 70% of deaths worldwide, with a growing burden associated with an aging population, lifestyle changes, and risk factors such as obesity and physical inactivity. Additionally, the COVID-19 pandemic demonstrated that people with NCDs were at greater risk of hospitalization and death.

Regarding experiences related to other health issues, those involving communicable diseases (dengue, Zika, influenza A H1N1) and intersectoral coordination for disaster mitigation (fires, floods) stand out. The experiences summarized by the panel are presented in Table 3.

DISCUSSION

The results of this expert consensus process are consistent with global health frameworks, based on a comprehensive approach that combines strategies for health promotion, prevention, and community participation with concrete actions in environmental sanitation, mental health, and risk management. The consensus statements highlight the need to align public policies with local demands, prioritizing the active inclusion of communities, the ongoing training of health teams, and the use of technologies to improve care.

The organization of the results into three levels — macro, meso, and micro — reflects a systemic approach widely recognized in the literature on emergency preparedness, which distinguishes between the realm of governance and legislation (macro), the municipal and community levels (meso), and PHC services (micro). This framework allows for a more precise identification of the responsible actors and the necessary resources at each level.

Telemedicine, epidemiological surveillance systems, and geospatial information tools emerged strongly as high-impact innovations, consistent with the experience gained during the COVID-19 pandemic and the available literature.^{10,12,28–30} Their implementation, however, faces significant barriers in the region, particularly digital and infrastructure gaps that disproportionately affect rural and indigenous communities.

Family Practice repeatedly emerges in the results as the backbone of the primary-level emergency response. Its ability to establish long-term relationships with the population, understand the local context, and coordinate with other sectors positions it as an irreplaceable actor in the five identified roles: community preparedness and resilience, resource coordination, epidemiological surveillance, psychosocial support, and intersectoral coordination. These findings are consistent with the evidence on the value of PHC in crisis contexts.^{71,72}

It is important to note that most of the recommendations generated require sustained political commitment and investment in human, technological, and infrastructure resources, which represents the main limitation to their implementation in contexts of high economic and institutional vulnerability.

Table 3. Successful community-based initiatives during health crises in Ibero-American countries.

Initiative	Health issue addressed	Type of emergency*	Type of innovation	Responsible entity	Country	Reference
Model for monitoring patients with COVID-19	COVID-19 / Burnout among healthcare workers	CS	Hospitalization and Virtual Appointments	Dr. Marcelino Vélez Hospital	Dominican Republic	—
Active COVID-19 Case Detection	COVID-19	CS	Telephone follow-up and home care	ASSE – Metropolitan RAP	Uruguay	83
Community kitchens and community health workers	COVID-19	CS	Dissemination of preventive measures	Local communities / FIOCRUZ	Brazil	84
Health education to prevent infection	COVID-19	CS	Health Education Programs	Ministry of Public Health	Panama	85
Hygiene, vaccination, and early detection	COVID-19	CS	Community training	NGOs	Bolivia	86
Integration of private-sector hospital beds into the public system	COVID-19	CS	Coordination of care	Ministry of Health	Chile	87
Digitization of the healthcare system	COVID-19	CS	Telemedicine and remote care	Ministry of Public Health	Ecuador	—
Telemedicine and Biosafety Training	COVID-19	CS	Use of technology	Güemes Clinic	Argentina	—
Neighborhood Support Networks During the Pandemic	COVID-19	CS	Community Support	Barcelona City Council	Spain	—
Long-Term Care Unit at CESFAM	COVID-19	CS	Testing, isolation, follow-up, and telemedicine	CESFAM	Chile	—
Mental health support	COVID-19	CS	International Group Crisis Therapy	SEMF	Ecuador	—
Health-Promoting Schools	Cardiovascular Health / Health Promotion	PE	Planning of initiatives in educational institutions	Ministry of Health – CHSC Commission	Uruguay	88
Bot Dengue for Patient Monitoring	Dengue	ES	Classification and Remote Monitoring	Güemes Clinic	Argentina	—
Geospatial Monitoring for Zika Control	Zika	ES	GIS	Ministry of Health	Ecuador	—
AI and Release of Genetically Modified Mosquitoes	Dengue	ES	Technology and citizen participation	Singapore Ministry of Health	Singapore	—
Health Situation Rooms – H1N1 Influenza	H1N1 Influenza	ES	Strategic Information Management	Government of Argentina	Argentina	89
Intersectoral Coordination in Floods	Floods	ES	Coordinated Home Care	Local government	Chile	—
Community kitchens (food resource management)	COVID-19	ES	Community Resource Management	Social organizations	Chile	—

*Type of emergency: CS: Health crisis (a situation that exceeds the health system's ordinary capacity and requires an extraordinary response; e.g., the COVID-19 pandemic); PE: Disease prevention (a proactive strategy to reduce incidence before an emergency occurs); ES: Public health emergency (an event with limited impact in terms of time or territory that requires an urgent, coordinated response; e.g., dengue outbreak, flood).

ASSE: State Health Services Administration (Uruguay); RAP: Primary Care Network; FIOCRUZ: Oswaldo Cruz Foundation (Brazil); NGOs: Non-Governmental Organizations; CESFAM: Family Health Center (Chile); SEMF: Ecuadorian Society of Family Medicine; CHSC: Honorary Commission for Cardiovascular Health (Uruguay); GIS: Geographic Information System; AI: Artificial Intelligence.

Study Limitations

This study has methodological limitations that must be acknowledged. The Delphi process was conducted entirely online during the months leading up to the CIMF Uruguay 2025 Summit, through monthly virtual meetings in which the subgroups worked on the literature review, the formulation of statements, and the consensus rounds. The in-person Summit served as a forum for presenting and sharing each group's conclusions; therefore, the consensus-building process itself was not subject to the group conformity bias typical of in-person dynamics. The literature review was not systematic but rather guided by the participants themselves, so it may not have incorporated the literature in an exhaustive or uniform manner.

Although the panel was broad and multinational (16 countries, 30 experts), it consisted primarily of specialists in Family Practice affiliated with national member societies of the CIMF, which may have limited the diversity of institutional and community perspectives. Nor was it possible to ensure representation from all regions of the participating countries.

The consensus statements should be understood as the result of an expert agreement informed by a literature review, and not as recommendations based on established scientific evidence. Their value lies in the regional synthesis of experiences and the identification of shared priorities, which makes them particularly useful for health planning and for formulating hypotheses for future research.

CONCLUSIONS

An effective response to public health emergencies requires interconnected actions at the macro, meso, and micro levels, with public policies aligned with local needs. The key elements identified are: active community involvement, ongoing training of health teams and communities, and the adoption of technologies appropriate to the context.

Family Practice plays an irreplaceable role in the management of public health emergencies. Its comprehensive approach, leadership capacity, and commitment to the population make it a key discipline for the planning and implementation of prevention and response strategies, through community preparedness and resilience, resource coordination, epidemiological surveillance, psychosocial support, and intersectoral coordination.⁸²

Inequities amplify crises. Mutual aid networks, the training of community health promoters, and social support strengthen health responses and contribute to social cohesion. Most recommendations require sustained political commitment and investment in human resources, technology, and infrastructure to ensure resilient and equitable health systems.

CONFLICT OF INTEREST

Nothing to declare.

AUTHORS' CONTRIBUTIONS

GGO: Conceptualization, Formal Analysis, Project administration, Writing – original draft, Writing – review & editing. POL: Conceptualization, Formal Analysis, Project administration, Writing – original draft, Writing – review & editing. PBD: Conceptualization, Project administration, Writing – review & editing.

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