ORIGINAL ARTICLE

Implementation of family adoption programme at Maheshwara Medical College and Hospital - A Pilot Study of 2024-25 batch

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ABSTRACT

Background: The National Medical Commission (NMC) had recently included of the Family Adoption Programme (FAP) in the competency based medical education (CBME) curriculum, an innovative approach. It aims to offer Indian Medical Graduates a valuable learning experience in community-based healthcare. **Objectives:** To improve the access to quality health services to rural people by adopting 5 families each by every student in the selected village and identify the challenges in implementation of the programme. **Materials and Methods:** As a part of CBME curriculum, 150 students of 1st Professional year students admitted in 2024-25 have adopted 5 families each, at Nandigama village with a population of 3729. The study subjects are the adopted families. Data was collected from November 2024 to July 2025, entered in Microsoft-Excel sheets. Descriptive and analytic statistics were performed using Statistical Package for Social Sciences (SPSS, Inc., Chicago, IL, version 23); $p < 0.05$ was considered as significant and the results are presented in tables as absolute and relative frequencies. **Results:** 96% of the families were adopted, with 970 family members. Regular interaction with families, students enhanced their communication skills, which are vital for conveying complex medical information in a comprehensible manner. It also enhanced their cultural sensitivity by exposing them to diverse patient backgrounds, making them better equipped to provide culturally competent care. It strengthened their bond between patients, families and healthcare providers, leading to improved health outcomes. Language, lack of interest and lack of clinical knowledge among the students were the major hurdles encountered in the implementation of the programme. **Conclusion:** The key findings show that an effective communication strategy should be drawn to ensure that students who do not know local language should learn it in stipulated time, so that knowledge can be translated into local language especially in rural areas. Recognizing the detrimental impact of Chronic Diseases/NCDs on individuals, families and the healthcare system, it becomes imperative for stakeholders to prioritize concerted action to mitigate the burden of chronic diseases, fostering a healthier future for its population. A Health care system should listen, learn and lead the families for well-being of villagers. Healthy families lead to Healthy village, as a basic unit.

KEYWORDS
Family Adoption Programme, National Medical Commission, Competency-Based Medical Education

INTRODUCTION

The National Medical Commission (NMC) envisages the Family Adoption Programme (FAP) as an opportunity for the Medical colleges to discharge their social responsibility and as a critical platform to facilitate *Authentic learning* of the under-graduate students to sensitize them with the real-life challenges of working for the Universal health coverage (UHC).[1,2] In India,65.5% of population live in rural areas, who are in need of essential health care services. [3] Hence, there is a need, to make healthcare more accessible to these needy population, impart community-training to future healthcare professionals. NMC has included the FAP as a part of the MBBS training curriculum in 2022.[3] It is an opportunity for the students to experience the health inequities and understand the social factors contributing to it.[4] It is expected to complement the other Competency-Based Medical Education (CBME) reforms for producing socially-responsive competent Indian Medical Graduate (IMG,) who would contribute for the cause of reducing inequities in health in the future.[3] Effective communication is crucial for medical students, the future doctors in the community, as it impacts patient trust, compliance and overall health outcomes. It is vital for establishing a strong patient-physician relationship based on trust and empathy. Clear and empathetic communication enhances patient understanding and adherence to treatment. Good communication can lead to better patient satisfaction, reduce stress and improve health outcomes. Strong communication skills are a fundamental aspect of professionalism in medicine. The importance of teaching and learning communication skills as a core competency in medical education, along with clinical knowledge and skills is a well-known fact. These are essential for building rapport, understanding patient perspectives and delivering effective care. Hence a pilot study is undertaken to see how students could acquire the required skills through implementing the FAP. A case report was captured by one of the students, is presented in this paper. Both identities, name of student and case are concealed for confidentiality.

OBJECTIVES:

- To improve the access to quality health services to rural people by adopting 5 families each by every student in the selected village
- To identify existing links between the community of Nandigama village and Maheshwara Medical College and Hospital
- To assess student's perception on communication skills
- Identify the challenges faced in implementation of Family Adoption Programme

MATERIAL & METHODS

As a part of CBME curriculum, 150 students of 1st Professional year students admitted in 2024-25 at Maheshwara Medical College and Hospital were divided into 3 groups of 50 students each. Each student had adopted 5 families. The sample size is 250 families (50 students x 5 families). Only one group was selected for the study as a pilot as this is a Noval approach. Sampling was done by simple random sampling by lottery system. The study tool (FAP LOGBOOK) was prepared as per NMC guidelines and validated before administration in the field. Local language was used by the students to communicate with the families. A team of 2 students with one who can communicate in local language was tied up with a non-local student to facilitate them to communicate with the families. These students were supervised and also observed how they were communicating with the families by a faculty/mentor from the department of Community Medicine and assisted by a Social Worker from the institute, in addition to ASHA and MPHW (F) of the Village/Sub-centre. NMC guidelines were meticulously followed for every visit to the selected village, Nandigama, which was allotted by the District Medical Health Officer, Sangareddy District, Telangana state, India, on the request of Maheshwara Medical College

and Hospital (MMCH) in the year 2024, as shown in fig-1. It is 8 k.m from the institute, towards east of district head-quarters, Sangareddy, with a population of 3729. The students visited 8 times at the rate of 3 hrs per visit, 24 hrs in total, as per the guidelines. The students were oriented a day before the field visit on the activities to be done by them. Role plays were also conducted to ensure that they approach the families without hurdles. An action plan was prepared for 1st & 2nd visit, where-in they collected demographic and environmental data of the adopted families in the prescribed FAP logbook. Medical camps were conducted with specialists on board to help the community of the selected village. The students learnt to refer the patients and also accompanied the needy patients to the camp site. This shows the empathy among them. This is a longitudinal study, as the same families will be followed up by the medical students for continuously 3 years. The study started in November 2024, where 9 visits at the rate of 3 hrs per visit (total 27 hrs) were completed in the 1st Professional year. The adopted families are the units of study. Inclusion criteria: "A family residing permanently in the study area and willing to participate in the study. Exclusion criteria**:** Migrated families who have come for a livelihood, relatives and friends who visited the families on temporary basis were excluded. Incomplete data was also excluded. The locked houses were revisited by the respective students. Only one group of 50 student's data was randomly selected for this paper, which is taken up as a pilot. All details of demographic, family members and environmental data were collected and entered in a standardized Master excel sheet, prepared by the department of Community Medicine. The data was shared with the concerned faculty/mentor through their emails in Windows Operating System in Micro-soft software. Descriptive and analytic statistics were performed using Statistical Package for Social Sciences (SPSS, Inc., Chicago, IL, version 23); $p < 0.05$ was considered as significant and the results are presented in tables as absolute and relative frequencies.

RESULTS

The Demographic, socio-economic characteristics of the study population are shown in Table 1. The total families adopted were 240 (96%) against 250 families, with 970 family members. The mean size of the family was 4 with a standard deviation of 1.3. The family members ranged from 1 to 10. Their age ranged from 1 to 80 years. The maximum number of participants [728 (75%)] were aged between 16 to 60 years. Males and females were equal in number, both 50% each. Many of them preferred nuclear families, 185 (77%); even in this digital era, illiteracy dominates, with 239 (25%) of them illiterate, 251 (26%) of the women were house-wives, with equal number of skilled workers, 254 (26%) which included 44 (5%) of the farmers. Professionals and semi-professionals were 65 (7%); unemployed were 42 (4%); Many of the participants [114 (12%)] revealed a per capita income between Rs.4549 and Rs.9097, belonged to class II of B.G.Prasad's SES classification. Most of them lived in Pacca house 223 (91%); overcrowding was present among 45 families (18%); also in the same families, cross-ventilation was absent. There was no separate kitchen in 35 (14%) families; 20 (8%) of them had insufficient lighting in their houses. There was stagnant water in and around 95 (39%) houses with breeding of mosquitoes. Artificial water collection was found in 99 (40%). Animals with kept in the same premises where they lived in 110 (45%) of the families; 221 (90%) families used household bins to dispose refuse but segregation of the waste was seen among 159 (65%) of them, 195 (80%) had underground drainage system; 237 (99%) had a sanitary latrine. Drinking water supply was mostly Municipality, 154 (64%), followed by bore well water [49 (20%)] and 37 (16%) consumed mineral water. Pregnant women were 11 in number, out of which 7 of them were from Joint families. There was only a single Post-natal case. Coming to health seeking behavior, 226 (94%) of the families, preferred Allopathic medicines, while remaining preferred Ayurveda, Homeopathy etc., As shown in Table-2, there was an association between the type of family and number of children in the

family. Similarly, association was seen between age, type of family and chronic diseases, which was statistically significant ($p < 0.05$). However, there was no association between gender, SES and chronic diseases. 23 students (50%) perceived that family visits enhanced their communication skills. The local language was a barrier in the remaining students as they were from other states like Maharashtra, Odisha, etc.,

Fig-1 Study Area – Nandigama Village

Table-1 Demographic Socio-economic characteristics of the study Population

Parameters		No.	%
Age - yrs	Under - 5	062	06
	6 - 15	119	12
	16 - 60	728	75
	> 60	061	07
Gender	Males	486	50
	Females	484	50
Type of Family	Nuclear	185	77
	Joint	044	18
	Three Generation	011	05
Education	Illiterate	239	25
	Primary school	089	09
	Upto High school	112	12
	Seconday school	129	13
	Intermediate	163	17
	Degree	170	17
	Post-Graduate	017	02
	Others	068	05
Occupation	Professional and Semi-Professional	065	07
	Skilled and Semi-Skilled Workers	263	27
	Unskilled Workers	094	10
	Unemployed	042	04
	Others	506	52
Socio-economic status	I	043	18
	II	114	48
	III	056	23
	IV and V	027	11
Housing	Kuccha	022	09
	Paccca	218	91
Drinking Water Supply	Muncipality	154	64
	Bore well	49	20
	Mineral water	37	16

Table-2 Association between Demographic, Socio-economic Characteristics and Morbidity among the Study Population

Type of family	**≤ 2 children**	**> 2 children**	**χ2 value**	**p-value**
Joint	18	31	48.73	0.00001*
Nuclear	169	22		
Chronic Diseases				
Age (Yrs)	**Yes**	**No**	10.6391	0.001*
<16	5	175		

>16	84	706		
Gender				
Males	50	436	17.514	0.55
Females	42	442		
Type of family				
Joint	28	345	2.762	0.05*
Nuclear	64	533		
SES				
I	11	153	5.993	0.2
II	51	423		
III	18	217		
IV	9	68		
V	5	15		

p-value of 0.05 was considered as significant

DISCUSSION

Overall, 96% of families were adopted which improved the accessibility to tertiary care through effective referral system, which is the highest level of care, offers specialized facilities and services for the treatment of patients. It also ensures that there is a close relationship among all levels of health care, and individuals can receive the best possible care, which is fitting with the National Health Policy.[5] The mean family size of 4, is on par with National Family Health Survey -5(NFHS-5).[6] Females are 50% which were lower in number when compared with NFHS-5[6]. 91% of the families lived in Pacca houses, which is more than the national survey.[6] The physical surroundings with stagnant water in and around the houses with mosquito breeding in 39% of houses are prone for mosquitoes borne diseases. Age and gender play pivotal roles in the prevalence and distribution of Non-communicable diseases (NCDs)/chronic diseases risk factors, as evidenced by various studies. Association between age and chronic diseases which is statistically significant s similar to study conducted Nepalese adults.[7] In gender disparities studies, males often exhibit higher rates of specific NCD risk factors[7] unlike in this study which showed no association between gender and chronic diseases. Similar there was no association between SES and chronic diseases, unlike in numerous studies conducted across countries.[8,9,10] Around 70% of students perceived that FAP helped in enhancing their communication skills, which is on lower side when compared to a study conducted by Rajalakshmi et al.[11] This was mainly due to diversity among the students, as MBBS course is a national selection through NEET. They have flown from various states and almost 30% did not know the local language (Telugu). Hence language barrier, lack of interest and lack of clinical knowledge among 1st Professional year students were the major hurdles/challenges encountered in the implementation of the programme. Similar concerns were reported by Yalamanchali *et al*.[12]and Langde *et al*.[13] However, they got an insight of the community, understood the customs and cultural beliefs of the rural population, developed empathy; inculcated leadership skills; learned to refer and follow-up family members of their adopted families.

CONCLUSION

We could conclude that the accessibility to primary health care at the doorstep of the community has improved by adopting the families in the rural areas. A special medical camp was conducted and referred the cases to the tertiary hospital. Local language was a barrier for students who have come from other states.

RECOMMENDATION

An effective communication strategy should be drawn to ensure that all of students learn local language in stipulated time, so that knowledge can be translated into local language especially in rural areas. A Health care system should listen, learn and lead the families for well-being of villagers. Healthy families lead to Healthy village, as a basic unit.

Limitation of the Study

As it is a pilot study, the results cannot be generalized.

AREAS FOR FURTHER RESEARCH: The concept "A sound mind in a sound body" highlights the interconnectedness of physical and mental health, suggesting that by taking care of one, we can positively influence the other.

Efforts should be made to assess mental health of the adopted families by utilizing Self Reporting Questionnaire developed by W.H.O, to screen for psychiatric disturbances,[14] in 2nd Professional year during their visits, which will help the individuals and families by providing appropriate treatment of them.

Authors Contribution

All authors have contributed equally.

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Nil

Conflict of Interest

There are no conflicts of interest.

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Declaration Of Generative Ai And Ai Assisted Technologies In The Writing Process

The authors haven't used any generative AI/AI assisted technologies in the writing process.

References

1. Fathima FN, Johnson AR, Kiran PR, Ratnakumari S, Joseph B. Impact of a residential rural community-based training program for medical students on cognitive and affective domains of learning in community medicine: A mixed methods study. Indian J Community Med. 2021;46:247–57. doi: 10.4103/ijcm.IJCM_545_20
2. Undergraduate Medical Education Board, National Medical Commission Guidelines. Available from: https://www.nmc.org.in/MCIRest/open/getDocument?path=/Documents/Public/Portal/LatestNews/Implementation.pdf)
3. Vanikar AV, Kumar V. The family adoption programme: Taking Indian medical undergraduate education to villages. Indian J Prev Soc Med. 2021;52:177–83.
4. Arumugam B, Sanjana L, Singh DG, Kuppuraj P, Sayee TSM. A narrative review on the experience of "family adoption programme" in a tertiary care institute. J Community Health Manag. 2022;9:54–9.
5. Ministry of Health and Family Welfare, Government of India. Specific Targets Under National Health Policy 2017. Ministry of Health and Family Welfare, Government of India. 2017
6. National Family Health Survey (NFHS - 5), 2019–21 INDIA REPORT International Institute for Population Sciences Deonar, Mumbai- 400088 Technical assialth Survey (NFHS - 5), 2019–21 (NFHS - 5) INDIA
7. Effects of age on non-communicable disease risk factors among Nepalese adults. Sapkota BP, Baral KP, Rehfuess EA, Parhofer KG, Berger U. PLoS One. 2023;18:0. doi: 10.1371/journal.pone.0281028
8. Socioeconomic status and non-communicable disease behavioural risk factors in low-income and lower-middle-income countries: a systematic review. Allen L, Williams J, Townsend N, Mikkelsen B, Roberts N, Foster C, Wickramasinghe K. Lancet Glob Health. 2017;5:0–89. doi: 10.1016/S2214-109X(17)30058-X.
9. Socioeconomic inequalities in non-communicable diseases and their risk factors: an overview of systematic reviews. Sommer I, Griebler U, Mahlknecht P, Thaler K, Bouskill K, Gartlehner G, Mendis S. BMC Public Health. 2015;15:914. doi: 10.1186/s12889-015-2227-y.
10. Socioeconomic inequalities in the risk factors of non-communicable diseases among women of reproductive age in Sub-Saharan Africa: a multi-country analysis of survey data. Yaya S, Uthman OA, Ekholuenetale M, Bishwajit G. Front Public Health. 2018;6:307. doi: 10.3389/fpubh.2018.00307.
11. Rajyalakshmi chepuru, Kuppili Sai Sushma, Sarada vadlamani, Rongala V Manasa, Bodhi Srividya Vennam. Family adoption program (FAP) as a learning tool—perceptions of students and faculty of community medicine. A Journal of Family Medicine and Primary Care, 2025 Jan 13;14(1):51–55. doi: 10.4103/jfmpc.jfmpc_510_24
12. Yalamanchili V, Uthakalla V, Naidana S, Kalapala A, Venkata P, Yendapu R. Family adoption programme for medical undergraduates in India-The way ahead: A qualitative exploration of stakeholders' perceptions. Indian J Community Med. 2023;48:142-6
13. Landge J, Kasbe S, Singh R, Satardekar A. Experience of family adoption programme implementation in phase I MBBS curriculum in a medical college of western India. J Med Sci. 2023;3:74-79.
14. A user's guide to Self Reporting Questionnaire, , A division of Mental Health, World Health Organization, Geneva, PSF_94.9.pdf