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Perceptions and Implementation Challenges of the Family Adoption Programme among MBBS Students in Telangana: A Mixed-Methods Study

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Abstract: **Background**-The Family Adoption Programme (FAP), introduced by the National Medical Commission within the Competency-Based Undergraduate Medical Education curriculum, aims to provide MBBS students with longitudinal, community-based learning. Through repeated contact with families, students are expected to develop an understanding of family health, social determinants of health, healthcare-seeking behaviour, communication and continuity of care. This study assessed MBBS students' perceptions of FAP and explored challenges related to its implementation. **Methods**-A mixed-methods cross-sectional study was conducted over six months in the Department of Community Medicine at SVS Medical College, Mahabubnagar, Telangana. From a sampling frame of 450 MBBS students, 200 students from Phase I, Phase II and Phase III were selected by random sampling. Data were collected using a pretested semi-structured questionnaire administered through Google Forms. The questionnaire included demographic characteristics, five-point Likert-scale statements assessing perceptions of FAP and open-ended questions regarding implementation challenges. Quantitative data were analysed using SPSS version 24.0. Open-ended responses were analysed thematically. **Results**-Of the 200 participants, 104 (52.0%) were male and 96 (48.0%) were female. A total of 116 (58.0%) students reported an urban residence and 84 (42.0%) reported a rural residence. Most participants, 126 (63.0%), had attended private schools before entering medical college. Students in senior academic phases reported more favourable perceptions of FAP across all assessed domains. The highest mean score among Phase III students was for the perceived usefulness of FAP for future medical practice (4.33 ± 0.67), followed by its contribution to understanding social determinants of health (4.32 ± 0.67). The proportion of students classified as having a positive perception increased from 40.0% in Phase I to 61.7% in Phase II and 92.0% in Phase III. The association between academic phase and perception category was statistically significant (reported $\chi^2 = 18.71$, $p = 0.0047$). Thematic analysis identified six implementation challenges: logistical difficulties, competing academic responsibilities, family-related issues, language barriers, documentation problems and limited faculty involvement. **Conclusions**-Students in senior MBBS phases reported more favourable perceptions of FAP than students in junior phases. The findings support the need for structured faculty mentoring, protected time for field visits, standardised documentation, transport and scheduling support, local-language orientation and regular feedback. Because the study was cross-sectional and based on self-reported perceptions, longitudinal studies using validated educational and family-level outcomes are required.

Keywords: Family Adoption Programme; competency-based medical education; community-based learning; undergraduate medical education; student perception; social determinants of health.

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INTRODUCTION

Medical education has increasingly shifted from an exclusive emphasis on hospital-based and disease-centred learning towards educational approaches that prepare graduates to understand the health needs of individuals, families and communities. Community-oriented learning is important because health is determined not only by biological factors and clinical care, but also by socioeconomic conditions, education, housing, sanitation, nutrition, family support, culture, gender, occupation and access to health services [1,2].

The World Health Organisation has advocated transformation of health-professional education to

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produce a workforce responsive to population needs and capable of addressing inequities in health [1]. Medical schools have a social responsibility to train graduates who can provide competent, compassionate and contextually appropriate care, especially for underserved and vulnerable populations [2]. Longitudinal community placements are particularly valuable because they enable students to establish meaningful relationships with patients and families, understand continuity of care and connect theoretical learning with real-world health problems [3]. In India, the National Medical Commission introduced the Family Adoption Programme (FAP) under the Competency-Based Medical Education (CBME) curriculum [4,5]. FAP has been implemented for MBBS students from the 2021–22 batch onwards. Under this programme, students adopt families in rural or urban communities and make periodic visits during their undergraduate training. Students are expected to establish rapport with families, understand household health problems, identify social determinants of health, provide health education, facilitate appropriate referrals and follow the families over time [4]. India continues to have a substantial rural population, with a large proportion of people living in settings where healthcare services, transport, health information and specialist access may be limited compared with urban areas [6]. Exposure to families and communities during medical training can therefore help students understand the realities that shape health-seeking behaviour, treatment adherence, disease prevention and utilisation of public-health services. FAP offers an opportunity to improve communication skills, empathy, community orientation and professional attitudes. It can help students appreciate that effective healthcare requires more than diagnosis and treatment; it also requires understanding a family's circumstances, priorities, beliefs and barriers to accessing care [7]. Previous studies have indicated that students generally consider FAP useful for improving community engagement, communication and professional development. However, they have also identified several operational challenges, including transportation difficulties, academic workload, family cooperation, language barriers, documentation burden and inadequate faculty support [8-11].

Since FAP is a relatively recent and evolving component of the MBBS curriculum, early evaluation is essential. Understanding student perceptions and implementation challenges can guide institutional modifications, improve student engagement and ensure alignment with the intended CBME competencies. Therefore, the present study was conducted to assess the perception of FAP among Phase I, Phase II and Phase III MBBS students at SVS Medical College, Mahabubnagar, Telangana, and to explore the challenges faced during implementation.

Objectives

1. To compare students' perceptions of the educational value of FAP across Phase I, Phase II and Phase III of the MBBS programme.
2. To assess perceived benefits of FAP in relation to communication, understanding of social determinants of health, community orientation, empathy and future medical practice.
3. To explore challenges experienced by students during the implementation of FAP.

MATERIALS AND METHODS

Study design and setting: This was a mixed-method cross-sectional study conducted in the Department of Community Medicine, SVS Medical College, Mahabubnagar, Telangana.

Study duration: The study was conducted over a period of six months from January to June 2026.

Study participants: The study population consisted of Phase I, Phase II and Phase III MBBS students participating in FAP as part of the Community Medicine curriculum. Students who had been allotted families under FAP, had completed at least one year of FAP activities and provided written informed consent were included. Students who were on long-term leave, unavailable during data collection, declined consent or submitted incomplete responses were excluded. Interns and postgraduate students were not included.

Sample size and sampling: The required sample size was calculated using the formula for prevalence studies, assuming 50% positive perception of FAP, a 95% confidence level and 7% allowable error. The estimated sample size was approximately 200 students. The sampling frame consisted of 450 MBBS students. A total of 200 students were selected through random sampling. The final sample included 40 Phase I students, 60 Phase II students and 100 Phase III students.

Ethical approval: The study was approved by the Institutional Ethics Committee, SVS Medical College, Mahabubnagar [IEC/DHR-02(02-08)/2026]. Written informed consent was obtained from all students before participation. The questionnaire did not collect personally identifying information, and confidentiality of responses was ensured.

Study tool and data collection: Data were collected using a pretested semi-structured questionnaire administered through Google Forms. The questionnaire was developed by the investigators after review of the relevant literature and the NMC FAP competency guidelines [4,5]. Three experts from the Department of Community Medicine reviewed the questionnaire for content validity.

The questionnaire contained four sections:

- **Section A:** Participant demographics, including gender, residence and schooling background

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- **Section B:** Perceptions regarding relevance, educational value and skill-development opportunities of FAP
- **Section C:** Perceptions regarding faculty support and implementation of FAP
- **Section D:** Open-ended questions regarding experiences, challenges, family cooperation, logistics, communication barriers, faculty support and suggestions for improvement

Perception statements were measured using a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). For overall categorical analysis, scores of 4–5 were classified as agree, score 3 as neutral and scores of 1–2 as disagree.

Data Analysis: Data were entered, cleaned and analysed using SPSS version 24.0. Demographic characteristics were summarised using frequency and percentage. Mean and standard deviation were calculated for each Likert-scale statement. Overall perception categories were compared across academic phases using the chi-square test. A p-value less than 0.05 was considered statistically significant. Responses to open-ended questions were read repeatedly, coded and grouped into recurring themes by thematic content analysis. Representative summaries were prepared for each theme.

RESULTS

Participant profile: A total of 200 MBBS students participated in the study from a sampling frame of 450 students. The study included 40 Phase I, 60 Phase II and 100 Phase III MBBS students. Of the participants, 104 (52%) were male and 96 (48%) were female. A majority, 116 (58%), belonged to urban areas, while 84 (42%) belonged to rural areas. Regarding schooling background, 126 (63%) had completed pre-MBBS education in private schools, whereas 74 (37%) had studied in government schools.

Perceptions of FAP: Students demonstrated increasingly favourable perceptions of FAP with progression in the MBBS course. Mean scores increased steadily from Phase I to Phase III for every perception statement, and all differences were statistically significant (p=0.001). The mean score for the statement, "FAP is relevant to undergraduate medical education," increased from 3.60 ± 0.93 among Phase I students to 3.89 ± 0.88 among Phase II students and 4.30 ± 0.68 among Phase III students. A similar trend was found for understanding social determinants of health. The mean score increased from 3.59 ± 0.94 in Phase I to 3.92 ± 0.86 in Phase II and 4.32 ± 0.67 in Phase III. This indicated that senior students had a stronger perception that FAP enabled them to understand the social and contextual factors affecting the health of families. The perceived benefit of FAP in improving communication skills with families increased from 3.48 ± 0.96 in Phase I to 3.86 ± 0.90 in Phase II and 4.28 ± 0.74 in Phase III. Likewise, scores for understanding community health problems increased from 3.45 ± 0.97 among Phase I students to 3.84 ± 0.89 among Phase II students and 4.25 ± 0.71 among Phase III students. Students increasingly agreed that FAP helped integrate classroom learning with real-life situations. The mean score was 3.52 ± 0.95 in Phase I, 3.88 ± 0.87 in Phase II and 4.29 ± 0.70 in Phase III. The score for perceived improvement in empathy towards underserved families increased from 3.50 ± 0.94 in Phase I to 3.90 ± 0.88 in Phase II and 4.30 ± 0.69 in Phase III. The highest mean score among Phase III students was for the statement, "FAP is useful for my future medical practice," at 4.33 ± 0.67. The corresponding scores in Phase I and Phase II were 3.55 ± 0.93 and 3.93 ± 0.86, respectively. Overall, the findings indicate that students with longer exposure to FAP perceived greater educational and professional value from the programme.

Overall perception categories: The proportion of students categorised as agreeing with the overall positive value of FAP increased substantially across academic phases. Among Phase I students, 16 (40.0%) agreed, 16 (40.0%) were neutral and 8 (20.0%) disagreed. Among Phase II students, 37 (61.7%) agreed, 17 (28.3%) were neutral and 6 (10.0%) disagreed. Among Phase III students, 92 (92.0%) agreed, 6 (6.0%) were neutral and 2 (2.0%) disagreed. The association between academic phase and overall perception category was statistically significant (χ^2=18.71, p=0.0047). This showed that Phase III students were significantly more likely than Phase I or Phase II students to report a positive perception of FAP.

Challenges identified by students: Thematic analysis of open-ended responses identified six recurrent challenges.

Logistical challenges: Students reported transportation problems, distance to allotted families and difficulty coordinating visits on predetermined days. These issues affected the convenience and regularity of family visits.

Time and academic workload: Students stated that balancing FAP visits with routine classes, examinations, internal assessments and other academic responsibilities was difficult. Examination periods were particularly challenging.

Family-related issues: Students described difficulty when family members were unavailable, hesitant to interact or took time to develop trust. Maintaining regular follow-up was challenging in families with migration, changing work schedules or limited availability.

Language barriers: Students who did not speak the local language fluently reported difficulty communicating with families. This affected history-taking, rapport-building and delivery of health education.

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Documentation issues: Students expressed concern regarding non-uniform forms, repeated data collection and the time required for documentation. They suggested a standardized and simple format for family records and follow-up.

Faculty involvement: Students desired more regular faculty supervision, mentoring and feedback during FAP visits. They felt that greater faculty involvement would improve their confidence, clarify learning objectives and support problem-solving in the field.

Table 1. Phase-Wise Mean Likert scores for perception towards Family Adoption Programme (FAP)

Perception statement	Phase I MBBS (Mean ± SD)	Phase II MBBS (Mean ± SD)	Phase III MBBS (Mean ± SD)	p-value
FAP is relevant to undergraduate medical education	3.60 ± 0.93	3.89 ± 0.88	4.30 ± 0.68	0.001
FAP helps me understand social determinants of health	3.59 ± 0.94	3.92 ± 0.86	4.32 ± 0.67	0.001
FAP improves my communication skills with families	3.48 ± 0.96	3.86 ± 0.90	4.28 ± 0.74	0.001
FAP enhances my understanding of community health problems	3.45 ± 0.97	3.84 ± 0.89	4.25 ± 0.71	0.001
FAP helps integrate classroom learning with real-life situations	3.52 ± 0.95	3.88 ± 0.87	4.29 ± 0.70	0.001
FAP increases my empathy towards underserved families	3.50 ± 0.94	3.90 ± 0.88	4.30 ± 0.69	0.001
FAP is useful for my future medical practice	3.55 ± 0.93	3.93 ± 0.86	4.33 ± 0.67	0.001

Likert scale: 1 = Strongly disagree to 5 = Strongly agree

Table 2. Overall perception category across academic years (Agree/Neutral/Disagree)

Phase	Agree (4–5) n (%)	Neutral (3) n (%)	Disagree (1–2) n (%)	χ^2 value-18.71
Phase I MBBS Students	16 (40.0)	16 (40.0)	8 (20.0)	**p-value-0.0047**
Phase II MBBS Students	37 (61.7)	17 (28.3)	6 (10.0)	
Phase III MBBS Students	92 (92.0)	6 (6.0)	2 (2.0)	

Categorical comparison (Agree = 4–5, Neutral = 3, Disagree = 1–2)

Table 3. Thematic analysis of open-ended responses: Challenges faced during FAP

Theme	Key codes identified	Representative summary
Logistical challenges	Transportation issues, distance, fixed visit days	Students reported difficulty in reaching allotted families and coordinating visit timings.
Time/workload	Time constraints, exam overlap, academic workload	Students felt it was challenging to balance FAP with regular classes and examinations.

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Family-related issues	Family availability, cooperation, trust building	Some families were hesitant, unavailable, or took time to build trust with students.
Language barriers	Local language differences	Students faced communication difficulties when they did not speak the local language well.
Documentation issues	Non-uniform forms, repeated data collection	Students mentioned that lack of standardized tools made documentation time-consuming.
Faculty involvement	Limited faculty presence and supervision	Students desired more regular faculty guidance and feedback during FAP visits.

DISCUSSION

The present mixed-method study assessed perceptions of the Family Adoption Programme among MBBS students at different stages of their undergraduate training. A key finding was the progressive increase in positive perception from Phase I to Phase III students. Senior students reported higher mean scores for all domains of FAP, including its relevance to medical education, understanding of social determinants of health, communication skills, community health problems, integration of theory with practice, empathy and future professional usefulness.

These findings are consistent with the educational purpose of FAP. The programme is intended to provide sustained and meaningful community exposure, allowing students to observe family health needs over time rather than through isolated or short-duration field visits [4]. The NMC framework envisages that students progressively develop communication skills, understand community and family dynamics, identify health needs and appreciate the broader socio-economic influences on health [4,5]. The progressive improvement in student perception in the present study suggests that repeated exposure may help realise these intended outcomes.

The mean score for relevance of FAP to undergraduate medical education increased from 3.60 among Phase I students to 4.30 among Phase III students. This may indicate that initial exposure alone may not be sufficient for students to fully appreciate the value of the programme. Junior students often have limited clinical exposure and may find it difficult to interpret household observations in the context of health systems, diseases and preventive strategies. By Phase III, students have greater clinical and public-health experience and may be better able to relate household-level observations to the content learned in community medicine and clinical subjects.

Understanding social determinants of health was one of the highest-rated benefits among Phase III students. The score increased from 3.59 in Phase I to 4.32 in Phase III. Family visits provide direct exposure to factors such as housing, sanitation, food security, education, employment, healthcare costs, social support and health literacy. Such exposure makes social determinants tangible and enables students to recognise why clinical advice may not always be feasible for patients and families. The WHO has emphasised that health-professional education must be responsive to population needs and must prepare graduates to address social inequities in health [1].

The perception that FAP improves communication skills also increased substantially with academic progression. Communication with families in their homes requires sensitivity, respect, active listening, cultural awareness and the ability to explain health issues in understandable language. This differs from a brief outpatient consultation and may strengthen students' confidence in communicating with patients and caregivers. Longitudinal community placements have been reported to support professional development, continuity-of-care learning and understanding of patient experiences [3,9-11].

The present study also observed improvement in students' perceived empathy towards underserved families. The empathy score increased from 3.50 among Phase I students to 4.30 among Phase III students. FAP enables students to move beyond an abstract understanding of poverty, illness and inequity by seeing their direct effects on daily family life. Repeated contact with families may increase awareness of the emotional, financial and practical burdens of illness, thereby supporting the development of empathy and social accountability.

The highest Phase III mean score was observed for the statement that FAP is useful for future medical practice. This finding has important implications because it suggests that students recognise FAP as more than a curricular requirement. It may prepare them for professional responsibilities such as counselling patients, understanding family circumstances, identifying barriers to adherence, communicating with caregivers and providing context-sensitive care.

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Similar findings have been reported from other Indian studies. A recent study of medical students reported favourable perceptions of FAP, including improved community engagement, communication skills and understanding of the purpose of family visits [12]. Another study of newly admitted MBBS students found that students perceived FAP as beneficial for communication, leadership and professional growth, and that adopted families generally viewed the programme positively [13]. Research on experiential learning through FAP has also highlighted its potential to integrate medical knowledge with practical exposure in community settings [7].

The present study identified substantial implementation barriers. Logistical issues such as transportation, distance and fixed visit schedules were major concerns. These are important because FAP requires repeated visits, and students may struggle to reach distant families while also fulfilling academic responsibilities. Similar difficulties related to transport and logistics have been documented in other Indian reports on FAP [9,10]. A feasible family allocation system, cluster-based allotment and planned transport support could reduce these barriers.

Time constraints and academic workload were also prominent. The perceived burden of FAP may increase if visits are organised without integration into the academic calendar. Protected time for family visits, avoidance of examination periods and coordination between departments may make participation more practical. Linking FAP activities to formal formative assessment and clearly defined CBME competencies may also encourage students to view the programme as an integral component of learning rather than an additional task.

Family availability, cooperation and trust-building emerged as another challenge. Students may face situations in which families are absent during visits, reluctant to share information or unclear about the purpose of the programme. These concerns reinforce the importance of initial community sensitisation, informed consent and clear explanation of the student's role. Students should be trained to manage expectations, maintain confidentiality and avoid creating an impression that they are independently providing clinical care or material assistance.

Language barriers affected communication, especially among students who did not speak the local language well. This may influence history-taking, health education and rapport. Students should receive orientation in commonly used local phrases, culturally appropriate communication and use of community health workers as facilitators where appropriate. Bilingual or locally adapted FAP documentation may also improve communication and follow-up.

Documentation issues were frequently mentioned. Repetitive information collection and non-uniform formats can reduce student motivation and compromise continuity. A simplified, standardised, phase-specific FAP record should be developed. It should allow students to document household information, risk factors, identified health needs, health education, referral advice, follow-up actions and reflective learning without unnecessary duplication.

Limited faculty involvement was the final major concern. Faculty mentorship is critical for ensuring that students can interpret field experiences, manage ethical issues, recognise health priorities and translate observations into meaningful learning. The literature also identifies faculty support as an important facilitator of FAP implementation.[8,9] Structured mentoring, periodic review of records, joint initial field visits and scheduled feedback meetings may strengthen student confidence and programme quality.

The present study has several strengths. It included a relatively large sample of 200 students across three phases of MBBS training and used a mixed-method approach. Quantitative findings demonstrated a clear phase-wise gradient in perception, while qualitative data identified operational barriers that can guide programme improvement. The findings are relevant to medical colleges implementing FAP in comparable settings.

Limitations

It was conducted in one medical college, and its findings may not be directly generalisable to all institutions. Because of the cross-sectional design, the phase-wise differences cannot establish that individual students' perceptions improved over time. The questionnaire measured self-reported perceptions and may be susceptible to social-desirability bias. The study did not assess objective outcomes such as demonstrated communication competence, validated empathy scores, health outcomes among adopted families or faculty and family perceptions. Future multicentric, longitudinal studies should include these perspectives and use validated tools to assess educational outcomes.

CONCLUSION

The Family Adoption Programme was perceived positively by MBBS students at SVS Medical College, Mahabubnagar. Perceptions became significantly more favourable with increasing academic seniority and longitudinal exposure to adopted families. Students particularly valued FAP for its contribution to understanding social determinants of health, strengthening communication with families, promoting empathy, linking classroom learning with real-life contexts and preparing them for future medical practice. Effective implementation requires planned institutional support. Regular faculty mentoring, standardised documentation, protected time for visits, transport and

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scheduling support, local-language orientation and ongoing student feedback are necessary to improve the feasibility, quality and educational impact of FAP. Longitudinal, Multicentre studies using validated educational measures and incorporating student, faculty and family perspectives are needed to determine whether FAP improves demonstrated competencies and contributes to meaningful family-level outcomes.

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Declaration

Ethical approval

The study was approved by the Institutional Ethics Committee, SVS Medical College, Mahabubnagar [IEC/DHR-02(02-08)/2026].

Informed consent

Written informed consent was obtained from all study participants.

Conflict of interest

The authors declare no conflict of interest.

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