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Original Research Article

Experience of Family Adoption Programme Implementation in Phase I MBBS Curriculum in a Medical College of Western India

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ABSTRACT

Background: Family Adoption Programme (FAP) aims to provide an experiential learning opportunity to Indian medical graduates towards community-based health care and thereby equity in health. This paper describes the output of FAP implementation in Phase I MBBS curriculum in a medical college of western India.

Methods: A brief orientation was conducted on the needs and competencies of FAP as recommended by the National Medical Commission of India which was followed by sensitization of the students to the FAP proforma prepared by the department along with hands on practice. Department planned and conducted periodic FAP visits for students along with their assigned mentors at the selected nearby two villages. During these visits, students interacted with the families and details regarding health profile of the family were documented. Students wrote reflection on FAP Visits in log book and were reviewed by faculties. Feedback assessment was done using Google link.

Results: A total 100 students were enrolled in FAP and out of those 92 submitted the feedback through Google link. M:F ratio was 1:1. Out of 92 responses 80% students responded that FAP was a very good experience and would like to be part of such activity throughout the professional years.

Conclusion: Implementation of FAP requires meticulous planning, intersectoral co-ordination, good sensitisation, and training activities in advance.

Keywords: Family Adoption Programme, Feasibility, Indian Medical Graduates, Implementation

INTRODUCTION

National Medical Commission (NMC) in their recent notification[1] included the Family Adoption Program (FAP) in the undergraduate medical curriculum to provide a learning opportunity towards community-based health care to Indian Medical Graduates. Notification documented that "around 65.5 % of population resides in rural settings (as per 2020 statistics) whereas availability of health care facilities and services are skewed towards urban set ups. Though adequate healthcare supplies exist in the community, it is the access to healthcare to a rural citizen that is a major concern. Issues like health illiteracy, ignorance about communicable and non-communicable diseases, means to reach health care facility, services, take time off from their daily wages work and workforce shortages are some of the

barriers that limits timely and quality health related awareness and care leading to a scenario of 'Scarcity in abundance.' Hence there is a need to take measures to make healthcare more accessible to the rural and needy population and impart community based and community-oriented training to budding healthcare professionals." [1]

Vanikar AV et al had depicted the road map of FAP, where one or more villages outside the field practice area (Rural and urban Health Training Centre) of community medicine department will be allotted to every new batch of a medical college assigning 5-7 households to each student. With the emphasis on FAP, the orientation to the rural health problems with rural health infrastructure will start from the very beginning of the foundation course in the first professional year. Assistant Professors and Senior Residents of department of Community Medicine will act as the mentors and coordinate with local Panchayat Raj Institution (PRI) members, villagers, local Accredited Social Health Activist (ASHA) worker and medical social workers. The students will collect data from the households by visiting them physically along with availing telemedicine facilities, besides they will also take part in the outreach health and awareness camps. As a step towards environmental consciousness, the students will be encouraged for tree/ medicinal tree plantation.[2]

Several studies[2-5]across different parts of world anticipated the advantages of learning in 'the community as a classroom in achieving communication skills; understanding role of the customs and cultural factors affecting health, learning to be a human and develop empathy; inculcate leadership skill; working as primary consultants for the households; and learning basic skills of diagnosing and managing health problems, ultimately having training in family medicine.

In the given context, our department had implemented FAP for the MBBS Batch 2021-2022 medical students as per the given NMC guidelines in notification[1] and tried to analyse output of implementation efforts for family adoption programme in our institute.

METHODOLOGY

A] Preparatory phase:

As per the guidelines shared in NMC notification, two villages viz. 'Chinchawali' and 'Ukhrul', outside the field practice area (Rural and Urban Health Training Centre) were selected by Community Medicine Department considering their population and accessibility from parent medical college. Frequent visits were carried out by the faculty members to the village head/ *sarpanch* to sensitize and gain their acceptance and confidence regarding the implementation of FAP.

Total six FAP visits covering twenty-seven hours for 1st MBBS FAP as per NMC norms were planned for MBBS (2021-22) batch of 100 medical students.

The students were divided into five batches with one mentor assigned for each batch to assist and guide them during the visits: Batch A (Roll no. 1 – 20), Batch B (Roll no. 21 – 40), Batch C (Roll no. 41 – 60), Batch D (Roll no. 61 – 80) and Batch E (Roll no. 81-100). Village Chinchawali was allocated to Batch A and Batch B while village Ukhrul was allocated to Batch C, D and E.

Initially, a brief orientation session of an hour explaining the needs and competencies to be learned through Family Adoption Programme (FAP) as recommended by the National Medical Commission of India was conducted by Professor and Head of Community Medicine Department on 29th May2022. In this session, all 100 students were sensitized about necessity of reaching out to the rural community and providing health care services to those who are in need. The students were informed about adoption of three to five families per student and the importance of being a part of the families adopted by them.

Other faculties from department shared their experience about the importance of communication skills, the role of physician in primary health care and gave valuable comments to inspire the newly joined students.

Faculty explained all students about the collection of information from their allotted families in the field utilizing structured FAP proforma followed by an

introductory session on the FAP log book. The data elements given in the log book were discussed thoroughly. All the basics required for filling the family details, clinical history, clinical examination, etc. were explained as students were novice about medical terminologies.

On the next day, a hand on practice session for FAP proforma was conducted from 10.00am-12.00pm. Also, role plays were organized for students to ensure their active participation. It was an interactive session where the students acted as health care workers and family members. The queries, difficulties, and barriers to fill FAP proforma were answered by faculties. The students were very receptive and participated enthusiastically in the sessions conducted at the Department.

B] Implementation phase:

During the first visit, four families were allocated to each student as per the feasibility. Students along with their assigned mentors visited the respective families, explained the purpose of the visit to head of the family and sought verbal consent to collect information regarding various health parameters. The family members co-operated well with the students. The detailed history of each family including socio-demographic profile and clinical examination was recorded on FAP proforma. The students interacted in a professional manner with the family members under the guidance of mentors and all the families gave a positive response to our visit.

During remaining subsequent five visits, students followed up their allocated families and maintained the detailed records of the health profile of the family members. These records were periodically reviewed by respective mentors.

At the end of all visits, a pre-structured feedback questionnaire form was shared with all the students through a Google form link and responses were recorded for further analysis. Reflections on these FAP visits were recorded in the log book by all students and were reviewed by mentors.

RESULTS

A total 100 students were enrolled in FAP and out of those 92 submitted the feedback through Google link. M:F ratio was 1:1. Out of 92 responses 73(80%) students responded that FAP was a very good activity and would like to be a part of such activity throughout the professional years. Overall experience was graded on fair, good and excellent and 58% responded it was excellent. (Figure 1)

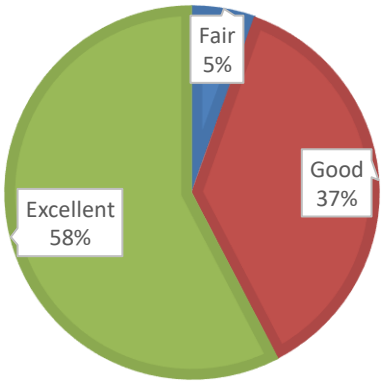

Figure 1: Experience of FAP Activity

Reflection summary:

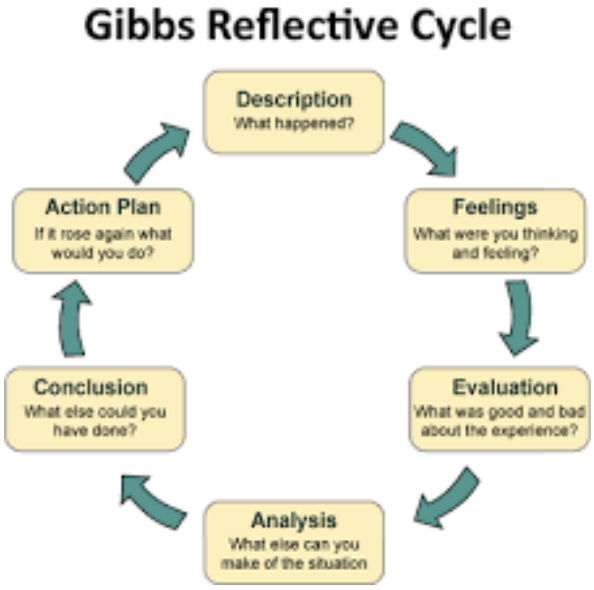

Figure 2: Gibbs Reflective Cycle

Description: "We all1st phase MBBS students visited villages (Ukhrul and Chinchwali) for FAP activity by bus transport from institute on the day of visits". First outdoor learning in community setting outside the college campus gave an extraordinary experience. It was homely environment; family members were co-operative and friendly. Family offered food and space to sit and interact comfortably during visits. Though families were suffering from health issues they were more concerned about geographical, health care facility, social, economic, and cultural problems which they were telling more frequently than health problems. We learned to communicate with the family members; they were also attached with us.

Feelings: Visits were very exciting, where students learned about the purpose of programme and ground reality of village life. *"I feel that this programme will guide me to reform myself and make me a good doctor."* Visits helped me to realize the importance of family in health and diseases. Lot of hesitation, fear and anxiety was in mind during first time visit to allocated family. Felt empathetic towards lifestyle and issues being faced by them. There were mix responses when we were visiting frequently and asking same questions in follow up visits. *"Families shared mobile number and now communicating on phone for their problem so feeling as a family physician in my 1st year of MBBS."* "*We* formed good bonding and rapport with family members." "*Waiting for 2nd years visit schedule so that we can go back to village and interact with family*."

Evaluation: FAP activity was newly implemented in our batch so lot of confusion and rumors were thrown initially among us. Subsequently guidelines and support from faculty in community medicine department made it interesting experiential learning. FAP is good concept of experiential learning but need meticulous planning, support, and co-ordination. Each visit made a different experience and learned about different pattern of lifestyle among families of same village. Linguistic barrier was observed while interacting with families. Students got less time to interact with family as sometimes families were busy in their commitments. Some of the family members were very co-operative but some were reluctant to give information on their health issues. Increased health expenses after Covid-19 pandemic made families overburden and stressed. Needy community is still not getting their felt need. Universal health coverage is lacking at gross root level. ASHA and *Angan Wadi* Worker (AWW) were present and helping during visits.

Analysis: Majority families belonged to Hindu religion**;** lower middle and upper middle socio-economic class. Maximum families were of nuclear type residing in a *pukka* house. Adopted villages are in close vicinity of metro city Mumbai so they were following urban lifestyle with poor healthy diet practices. Most of them were consuming mixed diet and junk food in breakfast or snacks. Long distance travelling for job and busy schedule was primary obstacle to adopt healthy lifestyle practices. Very few families had elderly at their home. Majority families had only adults in their family. People were following small family norm and adopting family planning methods to limit their family size. Most of the family head were literate but not above secondary or higher secondary school education. Non communicable diseases were more prevalent over communicable diseases. Surrounding environment was pleasant, no open-air defecation was noticed. Good sanitary facility was present in each family. Water supply was adequate and families were aware about criterion of safe and clean drinking water. Awareness about public health care delivery system was fair but they were not using services from public health care facility either due to lack of time or long distance to travel. Health facility at subcentre was adequate; ASHA and AWW were co-operative.

Conclusion: Families need proper guidance and support to tackle their health problems. There is need to inculcate healthy and balance diet practices in routine schedule. There is requirement of awareness about healthy lifestyle, importance of exercise, diet, and stress-free life. Awareness about health services and health scheme must be reached at the door step. Poverty is still prevalent and main cause for many health problems.

DISCUSSION

The concept of Village Adoption entails development practice that is reflexive, and socially useful. It involves moving from ideation to action. It must

result in improvement in the local situations, refinement of a local practice, and betterment in the conditions of living of the people in the rural community. Therefore, Village Adoption aims at: (i) Instituting socially useful action; and (ii) sharpening the professional competence and development of facilitating students to guide them for conducting health education to the families/ households. This will require 4-10 mentors depending upon the size of the batch. [2]

The aim of imparting medical education to the students is to make them team leaders for health care, primary consultants and learn the basic skills. The practical field training from the beginning will make them better doctors. Importance may be laid about training in Preventive Medicine and giving knowledge of implementation of various health care related schemes. Students would also be able to understand the disease profile in a rural setting that may be different from the secondary / tertiary care setting of Medical Colleges. In addition, they would understand local beliefs and faith in various methods of disease management other than allopathy. It is expected that FAP will widen their vision of holistic health care and management of common ailments encountered in these settings by a Family Physician.[2] our study findings also agree with what literature[2-4] says.

Under FAP each student will be maintaining a log book with separate sections for each house-hold data record during every visit which will help them to analyse health and disease profile of those families at the end of 3rd year. This programme will ensure production of doctors with good psychomotor skills.

The FAP will provide an opportunity to academicians, policy makers and growing primary health care physicians to get sensitised and understand the problems and social dynamics that exist at the grass root level and assimilate the facilitating factors responsible for building sustainable and cohesive communities. The successful implementation of the family adoption programme will empower the students and faculty for better training, community-oriented research, and community oriented medical education.

CONCLUSION

The implementation of the programme involves a great team work, time management, intersectoral co-ordination (management level, institutional priorities, human resources, transport, villages) sensitization and training efforts.

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