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Editorial

Beyond Household Allocation: Reimagining the Family Adoption Programme for Rural and Hilly India

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The transition to Competency-Based Medical Education (CBME) in India marked a paradigm shift in undergraduate medical training, emphasizing community orientation, patient-centred learning, and social accountability. Among its most innovative components is the Family Adoption Programme (FAP), introduced by the National Medical Commission (NMC) to provide medical students with sustained engagement with families and communities from the earliest stages of their training. The programme seeks to bridge the longstanding gap between classroom teaching and real-world public health practice by enabling students to understand the social determinants of health, disease patterns, healthcare-seeking behaviour, and barriers to healthcare access within community settings.

The underlying philosophy of FAP is both timely and commendable. In an era where medical education is increasingly influenced by technological advancements, sophisticated diagnostics, and super-specialized care, there remains a pressing need to reconnect future physicians with the communities they ultimately serve. Through repeated interactions with assigned families, students gain insights that cannot be obtained through lectures or hospital postings alone. The programme encourages experiential learning, nurtures empathy, strengthens communication skills, and fosters a deeper appreciation of the complex interplay between social, economic, environmental, and cultural factors that influence health outcomes. In this regard, FAP represents one of the most promising educational reforms in contemporary Indian medical education.

However, as implementation experiences accumulate across the country, several operational challenges have emerged, particularly in medical colleges located in hilly and geographically difficult regions. These challenges do not diminish the value of the programme but highlight the need for contextual adaptation and policy refinement.

One of the less discussed yet increasingly evident concerns is the repeated allocation of the same households and villages to successive MBBS batches. In many institutions, especially those with limited catchment areas or logistical constraints, the same families may interact with multiple cohorts of students over several years. While this approach offers administrative convenience, it risks generating community

fatigue and diminishing enthusiasm among participating households. Families repeatedly subjected to demographic surveys, environmental assessments, and health interviews may gradually perceive the exercise as repetitive and disconnected from tangible health benefits. Consequently, student-community interactions risk becoming procedural rather than meaningful, undermining the programme's intended objective of fostering authentic and sustained engagement.

The challenge is particularly pronounced in hilly regions where village accessibility often dictates the selection of field areas. According to current implementation expectations, adopted villages should preferably be located outside the routine field practice areas of the medical college to broaden student exposure and strengthen community outreach. Although educationally desirable, this requirement may inadvertently create substantial logistical burdens in mountainous terrains. Travel to remote villages frequently involves prolonged road journeys, difficult terrain, seasonal weather disruptions, and limited transportation infrastructure. Faculty members and students may spend several hours commuting for a single field visit, significantly reducing the time available for productive community interaction and follow-up activities.

The issue extends beyond geography and enters the domain of workforce capacity. Effective implementation of FAP requires continuous supervision, coordination, documentation, and monitoring. Yet many Community Medicine departments function with limited faculty strength, a shortage of medical social workers, and competing academic responsibilities. Faculty members are simultaneously expected to manage undergraduate and postgraduate teaching, research activities, field practice areas, national health programme responsibilities, accreditation requirements, and community outreach initiatives. The addition of longitudinal family adoption activities further stretches already constrained resources. Medical social workers, who play a crucial role in facilitating community engagement and maintaining continuity, remain insufficient in number in many institutions. Without corresponding investment in human resources, the burden of implementation may compromise both educational quality and programme sustainability.

Another important concern relates to continuity of follow-up, a cornerstone of the Family Adoption Programme. Longitudinal observation enables students to understand disease progression, treatment adherence, behavioural change, and health outcomes over time. However, maintaining such continuity becomes challenging in geographically dispersed mountain communities. Seasonal migration, adverse weather conditions, road closures, and extensive travel times often disrupt scheduled visits. As a result, students may struggle to establish the sustained relationships envisioned under the programme framework. The educational experience may become fragmented, and opportunities for meaningful public health interventions may be lost.

These implementation realities should not be interpreted as arguments against the

Family Adoption Programme. Rather, they highlight the need to evolve the programme from its current batch-centric approach toward a continuity-centric model. Instead of repeatedly initiating baseline assessments, medical colleges could establish institution-wide longitudinal community health records that remain linked to adopted households irrespective of student batch transitions. Successive cohorts would contribute to a continuously expanding repository of community health information, reducing duplication while strengthening continuity.

The integration of digital health technologies offers a particularly promising pathway forward. Mobile-based data collection platforms, geotagged household mapping, teleconsultation support, and cloud-based community health registries could significantly enhance programme efficiency. In remote and difficult-to-access regions, hybrid models combining periodic physical visits with supervised tele-follow-up may ensure continuity while reducing logistical burdens. Such innovations would align closely with India's expanding digital health ecosystem and broader public health modernization efforts.

Equally important is the need for regulatory flexibility. A uniform implementation framework may not adequately address the realities of geographically diverse regions. Medical colleges located in mountainous areas may require context-specific provisions regarding village selection, visit frequency, and follow-up mechanisms. Tailoring programme expectations to local terrain, accessibility, and available manpower would improve feasibility without compromising educational objectives.

The Family Adoption Programme remains a visionary initiative with the potential to redefine community-based medical education in India. Its strengths are undeniable: it humanizes medical training, strengthens community orientation, and equips future physicians with a deeper understanding of public health realities. Yet the programme's long-term success will depend on acknowledging and addressing implementation challenges related to geography, workforce limitations, continuity of follow-up, and repetitive household allocation. By embracing digital innovation, strengthening institutional support, and adopting context-sensitive implementation strategies, FAP can evolve from a curricular mandate into a sustainable model of community-engaged medical education. The future of the programme lies not merely in adopting families but in building enduring partnerships between medical institutions and the communities they serve.

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