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COMMENTARY ARTICLE

Is Family Adoption Programme as What It Seeks: A Resident's Perspective?

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Abstract

The National Medical Commission recently launched the Family Adoption Programme for the medical undergraduates across the country in the process of making Indian Medical Graduates a full-fledged primary care physician. The program has been running across in few institutes across the country and such large level replication of the same with objectives of giving public health exposure to medical undergraduates is a welcome step. But the program brings with it their own set of challenges for the implementation of the same. Hence, the article attempts to identify the lacunae in the policy and suggests a way forward for better conduct of the program and achieve what it actually desires.

Keywords: Indian Medical Graduate, Family adopt programme, Village adoption programme, National Medical Commission

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Background

In India, a huge majority of the population (around 65.5%) resides in rural areas, where access to healthcare is a major concern [1]. The fact that only 27.5% of rural districts have medical colleges adds to this concern. So as to make healthcare accessible for the neediest population, a community-based approach among healthcare professionals, especially upcoming ones, becomes necessary [1].

MGIMS Sewagram has set a model for a village adoption program where the first professional students of the medical college are allotted families in a village and given an opportunity to get acquainted with the community's needs [1]. While the village adoption program focuses on an integrated development of a village that requires cooperation from every sector, family adoption came into the picture, aiming for enhanced healthcare services in rural areas with the help of medical colleges.

Taking inspiration from the already-running model of Sewagram, the National Medical Commission (NMC) devised the Family Adoption Programme (FAP) for the undergraduate medical curriculum in 2022 under which fresh undergraduate students were to adopt five families and take care of them for the next three years. With the objective of sensitizing the students towards the community needs and their practices along with the development of better communication skills from the start of their MBBS curriculum and the creation of leaders at the level of primary health care, the layout of the program was set.

The steps to be implemented were precise as follows [2]:

1. Allotment of families in villages or urban slums (bastis, jhuggis, etc.) other than those already covered under the rural health training centers of the college.
2. Regular visits divided over a span of three years followed by telemedicine practice for the next two years after the first year and three-monthly data collection subsequently along with annual data collection.
3. Conduction of annual vaccination drives will also serve the dual purpose of expanding immunization coverage.

Apart from this, several advantages of the overall development of the postgraduate students and the senior residents will also be a simultaneous goal achieved through this program.

Challenges

The great story doesn't end here while implementation of the same remains a mammoth task at the ground level. To begin with, the identification of villages not covered under the field practice areas already has devised in the NMC policy is one of the primary challenges which involves the allocation of various resources in terms of transportation, manpower, etc. Especially for metropolitan cities like Delhi and Mumbai which are so widespread, traveling within the city has so many barriers due to the rising traffic, taking the students to long distances within a stipulated time, conducting the session, and coming back to the college is typically impossible. To solve this, some colleges have approached nearby slum areas in place of outreach villages to conduct the program as the slum areas will also serve in the development of the competencies asked [3]. Apart from distance, the number of vehicles required to carry out the program must also be looked up as some colleges with batches

of 150-250 students would require 5-10 such buses which practically no college in India has currently.

Coming to the next challenge is the scarcity of the manpower required to carry out such visits in terms of students' security and timely allotment of families. Since the urban slums mostly comprise of the illiterate population living in inadequate conditions and mostly not well-lit, it becomes a concern for the authorities to send the fresher batch to these families. Since the house demarcation is also not concrete, it is difficult for the supervisor to look after all students visiting five- seven families with a full focus on their security. Again, in colleges with batches of 150-250, approximately 20-25 residents are required. This means that whole of the Department needs to be deployed in a single activity at such times. While the policy plans to be conducted under the supervision of young faculty, the designation of single or even two faculty will make them overloaded with various concerns and make the targets unachievable. Another issue at ground-level implementation is that the junior residents have to be actively involved and while most of the colleges have five or even below five postgraduate seats in every college, they are overburdened as even in a batch of 100 MBBS students, each resident will be responsible for fifty families considering their exemption from all other work of the department and their training. This whole exercise of traveling to their practice area, allotting the families, and then returning sounds vague for almost all of the colleges.

Moreover, the process of monitoring the exercise at the end of three years through a log book is also vague. If any student does not attend any of the visits, this might not affect his overall minimal attendance criteria since there is no guideline on attending a minimum number of visits and if they come with their complete logbooks, it is hard to keep a check on their attendance and the authenticity of the data they present. Hence, there is an evident loophole in the monitoring and evaluation of the program at the end of three years.

The next phase of family allotment is to make sure that the students are allotted families focusing on the cases they need to emphasize like under-five children, adolescent age group, older age people, etc which is again difficult to identify in places where the migratory population is so large consisting mainly of young males mostly living together in the areas focused here. Such houses have to be excluded from the program due to the lack of availability at the desired time and the lack of potential cases for the students to learn and polish their academic and clinical skills. Coming to the post-allotment phase, students have been directed to take the history of the family members, build rapport with them and advise accordingly. All the clinical exposure and competencies required to carry this out are initiated in the second-year curriculum after the beginning of their clinical postings. But while executing this program, the onus again lies on the Department of community medicine to academically build up the students to interact appropriately during the family visits. So, in toto, not only the execution of FAP is an added responsibility, but even academically the burden has increased on the faculty and there is repetition since they will be taught this again in depth once they enter the third phase of MBBS.

Another issue arises when the guidelines suggest that these MBBS students also need to facilitate hospital

visits for their families whenever needed. But in certain colleges, most of the students are day scholars, and hence the challenge arises of who will facilitate this once they are away from the campus. Also, the MBBS curriculum is so tightly packed that it rarely gives the time to these MBBS students during college hours to arrange for the same while it gives a bad impression to these families if we are not able to support them in their moments of need; loss and exploitation on both sides. Most importantly, there is no provision of attending to these patients in hospitals on a priority basis. Hence, these patients also have to go through the same procedure as general patients for their specialist consultation and other services.

Moreover, as per the experiences so far, though most of the families have been receptive, some families are not that conducive and create a challenge for the students further. They are not comfortable with a doctor visiting their house, entering their personal space, and various other issues. And if they cooperate, they have their other demands which they want to be fulfilled since preventive health is a concept yet to reach the poor. They demand the facilitation of clinical visits to the nearby hospitals, prescription, and delivery of medicines at their homes which is not feasible as there is no such hospital policy to date.

Suggested Solutions

The program has been inculcated into the MBBS curriculum with realistic objectives which are also the need of the hour. But apart from designing the objectives, a stipulated division of the curriculum and the field visits is also required to make the implementation better. Since a lot of manpower is required for the same, it can be better if we start with short-term and realistic commitments. A flexible attitude in allotment of families in small colleges where there is not as much manpower and in large colleges where there are not many families to be allocated for a large number of students, we can start with one family per student. Alongside this, a better design of hour-wise allotment must also be done to create a better understanding of what has to be done on the ground. A minimum duration of visits in terms of the number of hours has been well described in the curriculum policy, for instance, 27 hours and 9 visits in to during the first professional year but it does not take into account the travel time which inadvertently gets included as the other parts of the daily curriculum cannot be hampered [2].

Another issue is how to measure the achievements which can be done by designing a uniform logbook for the students which can be used all over the country. Since monitoring is tough in the current design, measures must be taken to ensure the authenticity of the data collected and recorded by the students. Stringent evaluation measures also need to be deployed for the same. Specific guidelines on how to benefit the families post visits and facilitating the hospital visits in the absence of any such hospital policy for them, facilitating subsidized treatment charges for them as mentioned in the guidelines can also be perceived to be a tough task for the MBBS students since they are not well acquainted with the hospital settings and their curriculum doesn't allow that much free time. This point is also to be noted since if we fail to help the families with in-hospital treatment, it is going to give a bad impression and lead to fallout. A vivid workup on the benefits

perceived by the families and the students involved can also be taken up to understand their outlook on the policy. Involvement of other departments especially the clinical ones must also be made for better outcomes of the initiative and not be done at the intra-department level only. After this, modifications can be done to make up a better plan.

So, we conclude that the program is the beginning of a change and every change brings its own challenges. Any policy whenever introduced must always contain three main components post launch: 1) Proper implementation 2) Reporting from the stakeholders on the policy implementation and 3) feedback from the same which can help in providing a glimpse of the ground reality to the policymakers and hence expand the scope of improvisation. The challenges, though many, are not impossible to combat and hence, we support the initiative with the suggestion for modification of the program and time-to-time evaluation of implementation at various colleges for improving the feasibility, sustainability, and effectiveness of the program.

Conflicts of interest

The authors declares that they do not have conflict of interest.

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