



Exploring Attitude and Practices with Family Adoption Programme: A Mixed Method Study among Undergraduate Students of Bangalore Medical College and Research Institute

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Received: 20 December 2025; Accepted: 24 August 2026

Visual Abstract

ABSTRACT

Background: The Family Adoption Programme (FAP), mandated by the National Medical Commission (NMC), is a longitudinal community-based initiative integrated into the undergraduate medical curriculum to enhance community engagement among medical students. As the program requires sustained interaction with families over 3 years, understanding students' attitudes, practices, and the barriers they face is essential for ensuring continuity, effective learning, and meaningful community rapport.

Objectives: To assess the attitude and practice of undergraduate medical students toward FAP, identify associated sociodemographic determinants, and explore the challenges encountered during family adoption visits.

Materials and methods: A mixed-method cross-sectional study was conducted among Phase II undergraduate medical students of the 2022–2023 batch. Quantitative data were collected using a pretested, validated, semistructured, self-administered Google Form questionnaire. Qualitative data were gathered through multiple focus group discussions (FGDs) conducted until thematic saturation. Quantitative analysis was performed using SPSS version 25.0, while qualitative thematic analysis was conducted using NVivo 14 software.

Results: A total of 221 students participated, of whom 177 (80.09%) demonstrated good attitude and practice scores, while 44 (19.91%) showed poor scores. Qualitative findings highlighted multiple student-centric and family-centric challenges. Key barriers included lack of transportation, safety concerns—particularly for female students—uncooperative or hesitant families, communication difficulties due to language barriers, and visit timings that conflicted with students' academic schedules or family availability. These challenges affected the ease of data collection, communication, and the overall quality of student–family interactions.

Conclusion: Despite overwhelmingly positive attitudes and practices, students encountered substantial logistical and interpersonal challenges during FAP visits. Strengthening institutional support by providing transport, ensuring safety measures, offering prefield orientation on communication and local health schemes, and optimizing visit scheduling can significantly enhance student participation and the overall effectiveness of the FAP.

Keywords: Community, Family adoption programme, Mixed study, Undergraduates.

Journal of The Association of Physicians of India (2026); 10.59556/japi.74.1744

INTRODUCTION

The Family Adoption Programme (FAP) has been integrated into the undergraduate medical curriculum in India to enhance community engagement among medical students. This initiative, mandated by the National Medical Commission (NMC), aims to sensitize students to the social determinants of health, foster a deeper understanding of patient care within their communities, and understand the dynamics of the allotted region.^{1,2} By adopting families for a period of 3 years, students are expected to monitor health conditions, provide guidance, develop essential communication skills, learn to analyze the data collected from their families, and ultimately prepare for their future roles as socially accountable primary care physicians.^{3,4}

Globally, community-based education has been emphasized by the World Health Organization as an essential strategy for aligning medical education with community needs. FAP represents a Level 2 community-based approach, wherein students gain structured, sustained exposure to families and communities.⁵ This not only develops personal and professional skills but also strengthens community action by building trust and continuity of care.

The need for this program arises from the effort to strengthen and build upon the existing community engagement within medical education. By complementing hospital-based learning with deeper exposure to the social and cultural determinants of health, the program aims to enrich students' understanding of community

health dynamics and ensure their training remains closely aligned with the real needs of society.⁶

This mixed-method study explores how students engage with adopted families, the challenges they face at individual, family, and institutional levels, and the overall impact on their education and professional development through qualitative and quantitative analyses. The findings will contribute to refining the program, guiding policymakers, and enhancing its effectiveness in fostering healthcare providers who are not only clinically competent but also socially responsive and compassionate.

OBJECTIVES

1. To assess the attitude and practice of undergraduate students toward the FAP.
2. To determine the factors associated with the attitude and practice of undergraduate students toward the FAP.
3. To determine the challenges encountered by students during family adoption visits.

MATERIALS AND METHODS

The FAP was conducted by the Department of Community Medicine in the urban slum areas of Bengaluru.

As part of the NMC curriculum, each undergraduate medical student was

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How to cite this article: Mathew RT, Nathankodan F, L H, et al. Exploring Attitude and Practices with Family Adoption Programme: A Mixed Method Study among Undergraduate Students of Bangalore Medical College and Research Institute. *J Assoc Physicians India* 2026;74(10):e1–e7.

allotted a minimum of five families to track and support longitudinally. The students conducted periodic field visits to their assigned households to assess health trajectories, provide environmental and nutritional counseling, and facilitate health-seeking behaviors.

Broadly, the adopted population in these urban slums comprises low- to middle-socioeconomic households characterized by vulnerable living conditions, varying degrees of overcrowding, and limited environmental sanitation. This specific community environment served as the experiential learning background for the students, directly exposing them to the social determinants of health and shaping their overall attitudes and communication strategies during the program.

Study Design and Setting

A mixed-method study was conducted among Phase II undergraduate medical students of Bangalore Medical College and Research Institute from March 2025 to August 2025. All Phase II undergraduate medical students who provided digital informed consent and were aged above 18 years were included, while those who did not respond to the Google Form, students who had attendance of <75%, and those who had adopted fewer than three families were excluded.

Sample Size and Sampling Technique

A total of 221 out of 253 students participated. Purposive sampling was employed to

ensure inclusion of students who had direct exposure to and experience with the program.

Method of Data Collection

Quantitative data were collected using a pretested, validated, semistructured questionnaire to obtain information on sociodemographic details and questions related to attitude and practice toward the FAP. A total of seven questions assessed attitude, and three questions assessed practice. Responses were scored, with students obtaining a score of four or above (out of seven) in the attitude section classified as having a good attitude, and those scoring below four categorized as having a poor attitude. For the practice section, students scoring two or above (out of three) were considered to have good practice, while those scoring below two were categorized as having poor practice.

Qualitative data were collected through focus group discussions (FGDs), guided by a predeveloped discussion guide. Prior to participation, the study objectives and the FGD guide were explained to participants, and digital informed consent was obtained, with assurances of anonymity and confidentiality. Participants were encouraged to share their experiences and opinions openly regarding the program. Probing questions were used to explore issues not spontaneously raised and to validate points expressed by participants.

Seven FGDs were conducted with eight students in each group until thematic saturation was achieved. The FGDs were moderated by the principal investigator using a semistructured FGD guide. The core themes explored were practical challenges faced by students, safety and communication issues, ideal timing in the Bachelor of Medicine, Bachelor of Surgery (MBBS) curriculum, and student suggestions for improving the program. With participants' consent, all discussions were audio-recorded to ensure accuracy, and detailed verbatim transcripts were subsequently prepared. A force field analysis of the FAP was conducted, integrating quantitative data (scoring of factors) and qualitative input (derived from FGDs) to identify and weigh the factors supporting driving and restraining forces. Confidentiality was maintained throughout the study, and all data, including recordings and transcripts, were stored securely.

Statistical Methods

The collected quantitative data were entered into MS Excel and analyzed using SPSS version 25.0. Descriptive statistics were presented as frequencies and percentages. The association between categorical variables and students' attitudes and practices was assessed using the Chi-squared test or Fisher's exact test, wherever applicable. The qualitative data were analyzed using NVivo 14 software, through which themes and subthemes were identified.

Table 1: Association of categorical variables with type of attitude

Variable	Good attitude (n = 177)	Poor attitude (n = 44)	Chi-square value/Fisher's exact value	p-value/Fisher's exact
Gender			Fisher's exact [#]	0.003*
Male	102 (46.15%)	36 (16.29%)		
Female	75 (33.94%)	8 (3.62%)		
Place of residence			0.473	0.789
Hostel	119 (53.85%)	28 (12.67%)		
Home	56 (25.34%)	15 (6.79%)		
PG	2 (0.90%)	1 (0.45%)		
Type of family			4.284	0.117
Nuclear	156 (70.59%)	38 (17.19%)		
Three generation	12 (5.43%)	6 (2.71%)		
Joint	9 (4.07%)	0 (0.00%)		
Socioeconomic class			6.235	0.101
Upper	16 (7.24%)	6 (2.71%)		
Upper middle	94 (42.53)	30 (13.57%)		
Lower middle	45 (20.36%)	5 (2.26%)		
Middle	22 (9.95%)	3 (1.36%)		
Do you have previous research experience?			Fisher's exact [#]	1.000
Yes	39 (17.65%)	9 (4.07%)		
No	138 (62.44%)	35 (15.84%)		

* $p < 0.05$ is considered significant; [#]Fisher's exact done for cells which has count <5 in >20% cells

RESULTS

Sociodemographic Details of the Participants

A total of 221 participants were included in the study, comprising 138 males (62.44%) and 83 females (37.56%). The majority of participants were from urban areas, $n = 166$ (75.11%), while 55 (24.89%) were from rural areas. Regarding current place of residence, 147 (66.52%) participants resided at home, 71 (32.13%) in hostels, and 3 (1.35%) in other accommodations.

Most participants belonged to a nuclear family, $n = 194$ (87.78%), followed by three-generation families, $n = 18$ (8.15%), and joint families, $n = 9$ (4.07%). In terms of socioeconomic status, classified according to BG Prasad's classification,⁷ the majority were from the upper-middle class, $n = 124$ (56.11%), followed by the lower-middle class, $n = 50$ (22.62%), middle class, $n = 25$ (11.31%), and upper class, $n = 22$ (9.96%).

With respect to mother tongue, the majority spoke Kannada, $n = 153$ (69.23%), followed by Telugu, $n = 19$ (8.60%), Hindi, $n = 13$ (5.89%), Tamil, $n = 9$ (4.07%), Urdu, $n = 9$ (4.07%), and others, including Bengali, English, Marathi, Tulu, and Lambani, $n = 18$ (8.14%).

Type of Practice and Attitude among the Participants

The majority of students were found to have good practice, $n = 177$ (80.09%), and a similar proportion had a good attitude, $n = 177$ (80.09%).

Improvement in Communication Skills

The majority of participants, $n = 194$ (87.78%), reported that they had not experienced any improvement in their communication skills following their participation in FAP.

Association of Type of Practice and Attitude of Students with Categorical Variables

The association between type of attitude and practice is given in Tables 1 and 2, respectively.

Medical Students' Experiences with the Family Adoption Programme

The experiences of medical students with the FAP are detailed in Table 3.

Themes Identified during Focus Group Discussions of Participants

Two main themes were identified during the qualitative analysis: (1) student-centric challenges

and (2) family-centric challenges. The main themes and subthemes are depicted in Figure 1.

Theme 1: Student-centric Challenges

Under student-centric challenges, five subthemes were identified.

1.1 Logistical Constraints

- "It was difficult to reach the area because transportation was not provided." (FGD 1)
- "Autos were not able to get through apps. Sometimes they used to refuse, so we had to wait for a very long time." (FGD 3)
- "We had FAP this week and exams the next week. So, it was hectic for us." (FGD 2)

1.2 Safety Concerns

- "We were hesitant to go individually ... we were afraid of dogs." (FGD 1)
- "It was scary when we were interacting and when we had to enter the house ... we don't know what sort of people they are." (FGD 3)

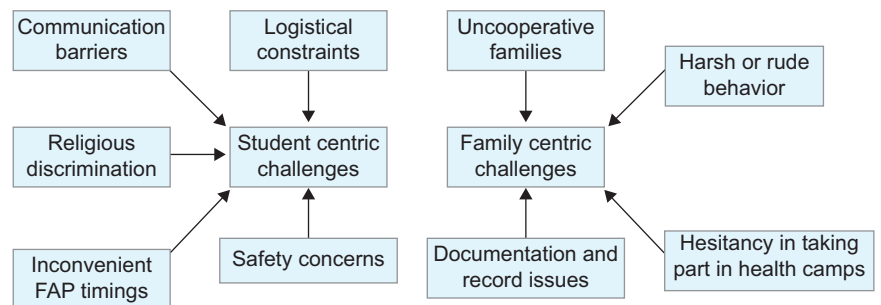


Fig. 1: Themes and subthemes identified through focus group discussions

Table 2: Association of categorical variables with type of practice

Variable	Good practice (n = 177)	Poor practice (n = 44)	Chi-square value/Fisher's exact value	p-value/Fisher's exact
Gender			Fischer's exact [#]	0.003*
Male	102 (46.15%)	36 (16.29%)		
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Table 3: Verbatim quotes of students regarding suggestions for FAP

Theme	Key recommendations	Verbatim quotes
Timing and scheduling	Plan visits at times when families are available (e.g., afternoons) Avoid scheduling close to exams Preferably start at beginning or after completion of academic year	"They should have either kept at the start of the year or after our exams. We had FAP this week and exams the next week. So, it was hectic for us." (FGD 2) "We think the right time to go for case will be 3 pm or 4 pm." (FGD 4)
Year of study	Mixed views: some prefer 1st year for building communication skills, others suggest 2nd/3rd year for better knowledge and time	"It is better to start in the first year since it will enhance communication skills by the time they reach in clinical posting." (FGD 1) "FAP will be better if kept in 2nd or 3rd year but not from 1st year." (FGD 3)
Transportation	Provide college-arranged transport to avoid stress, delays, and extra costs	"So, if college provides transportation, it will be very helpful." (FGD 3)
Safety and grouping	Students should be sent in pairs or small groups Safety support is needed, especially for female students (dogs, strangers, isolated areas)	"It was difficult to communicate if one person goes alone. It should have been better if we were sent as group of two people." (FGD 1)
Preparation and training	Give students orientation/training on how to respond to family queries Provide information about health schemes in local languages (templates/leaflets) Inform families beforehand about visits	"They asked us about schemes. But we were not aware of it." (FGD 2) "It will be better if those families can be informed prior that we will be coming." (FGD 4)
Camp and services	Camps should provide at least basic supplements or free medicines Align camp timing so children and working members can attend	"It would have been better if we were giving some medications like vitamin supplements." (FGD 1) "Many people asked where to get the prescribed medicines. So, it would have been better if free medicines were available." (FGD 3)
Other suggestions	Reduce the number of visits	"Number of visits should have been less." (FGD 1) "It will be better if we can go to rural areas for FAP. We think they will be more cooperative. It will be useful for juniors." (FGD 3)

- "One of the houses, when we opened the gate, a German Shepherd dog came." (FGD 4)
- "One girl was taking history; the guy next door told her to come inside multiple times. When she didn't, he got angry." (FGD 2)

1.3 Communication Barriers

- "It was difficult to communicate if one person goes alone. It should have been better if we were sent as a group of two." (FGD 1)
- "Some of us don't know Kannada ... Some of the adopted families were Muslim and they knew only Urdu." (FGD 4)

1.4 Religious Discrimination

- "They said she is a scammer; they were judging her hijab." (FGD 2)

1.5 Inconvenient FAP Timings

- "Some of the family members were not present at the time of visits. The timing of the visits could have been planned better." (FGD 1)
- "We went in the morning, so the children and husband were not there to take the measurements."

Theme 2: Family-centric Challenges

Under family-centric challenges, four subthemes were identified.

2.1 Uncooperative Families

- "Some of the families were not cooperative at all." (FGD 1)
- "They were suspicious why we needed these details ... when we asked for Aadhaar card." (FGD 2)

2.2 Harsh or Rude Behavior

- "Few houses, they shooed me also." (FGD 3)
- "One of my friends, when he knocked the door, he was scolded. They asked him, who are you to knock the door." (FGD 4)

2.3 Hesitancy in Participating in Health Camps

- "Most of the families didn't want to bring their children for health checkup." (FGD 3)
- "For the health camp, only two out of five families came." (FGD 4)

2.4 Documentation and Record Issues

- "Many didn't know their blood group ... Some were hesitant to give Aadhaar cards." (FGD 3)
- "Health records also could not be reviewed due to the absence of the respective individual." (FGD 1)
- The frequency of student- and family-centric challenges reported in FGDs is depicted in Figure 2.

Force Field Analysis

- The force field analysis identified the major driving and restraining forces influencing the implementation of the programme (Table 4).

DISCUSSION

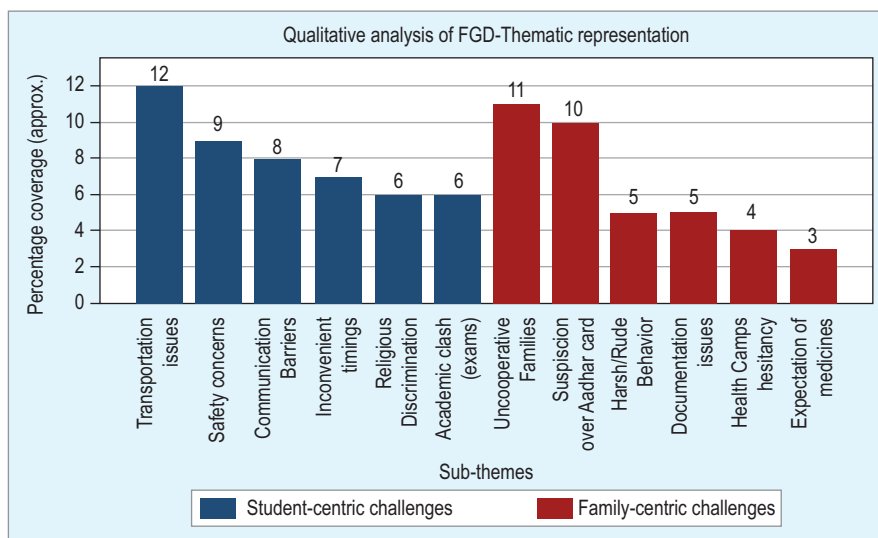
The FAP is a commendable initiative mandated by the NMC to align medical education with community health needs and foster social accountability among future physicians. Our mixed-method study, conducted among Phase II undergraduate medical students, provides a critical assessment of its on-the-ground implementation, revealing both encouraging attitudes and significant logistical and interpersonal barriers.

The quantitative findings indicate a high level of receptivity, with 80.09% of students reporting a good attitude and a similar proportion exhibiting good practice toward the FAP. This positive outlook is consistent with the study by Shikha et al. on FAP implementation in new medical colleges, as well as one in Jharkhand by Sharma et al., which also noted a generally favorable student disposition toward community engagement.^{2,8} However, our study highlights a major disconnect: a

Table 4: Force field analysis with strength scores of FAP

Inputs supporting FAP	Strength	Rationale (evidence)	Inputs against FAP	Strength	Rationale (evidence)
I. Program structure and logistics			I. Academic and logistical burden		
High perceived adequacy of hours	5	The large majority of students (196/221) indicated the allocated hours were adequate	Academic conflict/time burden	5	Students felt time was better spent on core MBBS subjects, leading some to say they “won’t recommend FAP to juniors”
Perceived appropriate timing	4	A majority of students (156/221) found the current timing in the curriculum appropriate	Lack of transportation/ access	5	Students reported it was “difficult to reach the area because transportation was not provided”
II. Family and community factors			II. Family and communication issues		
General family cooperation	4	Most students (165/221) reported that their adopted families were cooperative	Misaligned family expectations	4	Families frequently requested financial help or medication rather than just health education, leading to frustration
Tangible value (use of instruments)	2	Families were “more cooperative” when students carried instruments like BP apparatus, showing a positive response to clinical activity	Communication barriers (language)	4	Difficulties in taking cases arose due to students not knowing Kannada, Urdu, or Tamil (local languages)
			Low family attendance	3	Key family members (working men, schoolgoing children) were often absent during visits, hindering comprehensive data collection
			Physical discomfort and safety worries	2	Complaints included having to wear aprons “under the sun” and concerns such as being afraid of dogs
III. Student development					
Skill enhancement and clinical readiness	3	Skill enhancement and clinical readiness			

The analysis uses a strength score of 1 (weak) to 5 (strong) to indicate the magnitude of influence

**Fig. 2:** Frequency of student- and family-centric challenges

staggering 87.78% of participants reported no improvement in their communication skills—a core objective of the program. This finding contrasts with self-reported high rates of communication skill improvement in studies

by Arora et al.⁹ and Rathod et al.¹⁰ This suggests that while students are willing, the current unstructured or unsupported implementation is failing to translate engagement into tangible skill development.

A key quantitative result is the statistically significant association between gender and both good attitude and good practice ($p = 0.003$), with female students demonstrating superior engagement. While the reason for this is multifactorial, it is possible that female students, in a culturally conservative setting, are perceived as less threatening during home visits, leading to better rapport and, consequently, better self-reported practice and attitude scores. Conversely, the study by Yalamanchili et al. focused on perspectives of FAP, while not specifically analyzing gender differences, raised concerns about the practical viability of the program amid busy clinical postings.¹¹ Our study, which focused on undergraduate students, shows that the burden of academic scheduling is a universal logistical constraint, regardless of the students' level of training. As one student mentioned in FGD 2: “FAP this week and exams the next week.”¹²

The qualitative data from the FGDs are instrumental in explaining these quantitative findings, pointing to systemic challenges

categorized as student-centric (logistical constraints, safety concerns, communication barriers, inconvenient timings, and religious discrimination) and family-centric (uncooperative families, harsh/rude behavior, hesitancy in health camps, and documentation issues). The lack of college-provided transportation emerged as a critical logistical hurdle, compounding issues of safety in urban slum settings, where students reported fear of dogs and strangers. Logistical and student-related hurdles like transport and language barriers have been consistently reported as major challenges in FAP implementation surveys across India.^{12,13} The verbal accounts of students being “shooed away” or judged due to religious bias underscore the cultural and personal risks students face, which can negatively impact their enthusiasm despite a generally positive attitude.

The low reported improvement in communication skills is primarily due to linguistic barriers, where Kannada-speaking students struggle with other regional languages like Tamil and Urdu, compounded by the heterogeneity of Bengaluru’s culture. Furthermore, the rule of adopting families outside the designated field practice area introduces additional, unexpected language barriers. This finding is echoed in broader literature on community-based education in diverse populations, which emphasizes the necessity of orientation on cross-cultural training. The reported uncooperative families and hesitancy in health camps also point to a critical gap in community entry and trust-building. Students noted that without tangible benefits like “basic supplements or free medicines,” families are reluctant to cooperate or participate, viewing the students’ data collection with suspicion (e.g., reluctance to give Aadhaar details). Similar findings, where families expect curative treatment that students cannot provide, leading to resistance and lack of cooperation, are widely reported in the FAP literature.^{13,14} This highlights that FAP must be perceived by the community not just as a student learning exercise, but as a reciprocal health service delivery mechanism. It benefits adopted families directly by providing vital health education and screening while simultaneously facilitating access to formal medical care and connecting them with relevant health schemes.

Study Strengths and Limitations

The strengths of this study are rooted in its mixed-method design, which allowed for a robust understanding by triangulating quantitative data on what (attitude and practice levels) with qualitative data on why

(challenges and experiences). This provided a holistic and contextual understanding of the FAP implementation. The sampling of all Phase II students who responded to the Google Form provided a large participant pool ($n = 221$), which increases the statistical power of the quantitative analysis. Moreover, Phase II students recorded the maximum number of visits, so their data strengthens the credibility of the study’s conclusions. Furthermore, conducting multiple FGDs until thematic saturation ensures the richness and validity of the student-voiced experiences and recommendations.

However, the study is subject to several limitations. First, the sample is drawn from a single medical college in a metropolitan city, which limits the generalizability of the findings to private institutions or colleges in geographically diverse regions of India where rural–urban dynamics and health infrastructure differ significantly. Second, this study evaluates only a single initial batch of undergraduate students navigating a newly introduced curriculum. Evolving student attitudes, systemic adaptations by the institution, and the long-term sustainability of the program cannot be fully captured without tracking subsequent cohorts.

Furthermore, because the FAP is a mandatory component of the NMC curriculum, the potential for social desirability bias cannot be ruled out; students may have over-reported positive practices or attitudes during quantitative surveys and FGDs. Because this was a cross-sectional design, it prevents us from analyzing how these specific family backgrounds shape long-term student empathy, professional development, or concrete community health outcomes over time.

Recommendations

To ensure the FAP fosters enduring community partnerships, policymakers must implement targeted structural and pedagogical changes that extend beyond mere compliance. Institutional logistical support must be strengthened by providing dedicated transportation and mandating visits in groups, which directly mitigates safety concerns and logistical stress.

Simultaneously, enhanced preparation and training are vital, requiring previsit orientation focused on local language proficiency, cross-cultural communication, and practical knowledge of public health schemes to better address complex family queries.

Crucially, institutions must implement a phased student handoff protocol or “buddy system” to ensure the continuity of

care and build trust over the longitudinal program duration, preventing families from being abandoned upon student transition. This sustained trust is further reinforced by establishing community reciprocity through immediate, tangible benefits such as providing basic supplements or essential medicines during health camps to incentivize cooperation.

Finally, optimized scheduling is necessary to avoid examination periods and align visits with the availability of all family members, thereby maximizing both data quality and student learning opportunities.

By implementing these structural and pedagogical changes, institutions can better harness the positive student attitude and fulfill the FAP’s vision of creating socially accountable and compassionate primary care physicians.

CONCLUSION

The implementation of the FAP at the study institution has been met with a highly positive attitude and good practice among undergraduate medical students, fulfilling the core objective of community engagement. However, the study reveals a significant gap between this positive disposition and the program’s practical execution, as evidenced by the statistically significant association between gender and better engagement and the finding that an overwhelming majority of students (87.78%) reported no improvement in communication skills. The qualitative data provide the necessary context, highlighting systemic barriers across two main themes: student-centric challenges (e.g., lack of transportation, safety concerns, communication barriers) and family-centric challenges (e.g., uncooperative behavior, hesitancy toward health camps). These logistical and interpersonal hurdles directly undermine the program’s ability to foster core skills and achieve social accountability.

To fully realize the NMC’s vision for FAP, institutional efforts must pivot from mere compliance to structural and pedagogical reform. The enthusiastic student body needs to be supported through tangible measures, including providing dedicated transportation and safety in group visits, offering enhanced previsit training on local languages and public health schemes, and restructuring the program to ensure community reciprocity (e.g., providing basic medications at health camps). By addressing the identified challenges—particularly the logistical constraints and the need for a reciprocal relationship with the adopted families—institutions can effectively

translate the students' positive attitudes into meaningful skill development and cultivate a generation of socially responsive, clinically competent, and compassionate primary care physicians.

ACKNOWLEDGMENTS

We express our heartfelt gratitude to the MBBS Phase 2 students of Bangalore Medical College and Research Institute for actively participating in both quantitative and qualitative data collection. We also extend our sincere thanks to the Department of Community Medicine for their indispensable guidance and resources throughout the research process.

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