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Health Beyond Hospitals: Understanding Socio-Cultural Practices and Student Learning Through the Family Adoption Program in Rural Shimla, Himachal Pradesh

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Abstract **Background:** The Family Adoption Program (FAP) enables MBBS students to interact directly with households and understand how socio-cultural beliefs shape health behaviour. During these visits, students encountered practices linked to menstruation, newborn care, hygiene, gender norms and healthcare-seeking patterns. This study analyzes the socio-cultural issues observed, student perceptions and the advice they provided. **Methods:** A qualitative exploratory design was used. 1st year MBBS Students of Indira Gandhi Medical Collge, Shimla, Himachal Pradesh conducted home visits, informal interviews and observations, documenting responses as field notes. Data were analyzed thematically to identify recurring beliefs, attitudes and counselling approaches. Ethical principles of verbal consent, confidentiality and cultural respect were maintained. **Results:** Eight themes emerged: stigma and restrictions around menstruation; honey/ghutti feeding as a cultural blessing; gender and decision-making hierarchy; preference for traditional remedies over preventive care; hygiene practices based on familiarity rather than science; secrecy around reproductive issues; households showing positive adaptation; and marriage norms and contraceptive silence linked with socioeconomic factors. Students' perceptions shifted from viewing these practices as misinformation to understanding their cultural and emotional significance. Their advice focused on menstrual hygiene, exclusive breastfeeding, boiling water, timely medical care and open communication-offered in a respectful, non-confrontational manner. **Conclusion:** Socio-cultural practices were maintained due to tradition, identity and generational influence rather than lack of knowledge alone. The program enabled students to learn empathy, cultural competence and real-world communication skills. Improving community health therefore requires partnership, trust-building and gradual behaviour change rather than direct rejection of tradition.

Key Words Family Adoption Program, Socio-Cultural Health Practices, Menstruation, Newborn Rituals, Qualitative Study, Community Health, Medical Student Learning, IGMC Shimla

INTRODUCTION

Community-based education is recognized as a vital component of medical training, enabling future physicians to understand the social, cultural and environmental determinants of health that influence individuals and families. Traditional classroom teaching often limits exposure to real-world community contexts, while experiential learning can bridge this gap and foster competencies such as communication, empathy, culturally sensitive care and holistic patient understanding [1-4]. The Family Adoption Programme (FAP) was introduced into the MBBS curriculum in India as part of the National Medical Commission's competency-based medical education reforms to address this need. Under this initiative, medical students are assigned to adopt families from rural or underserved communities and engage with them longitudinally over the course of their training. Through repeated visits, data collection, health counselling and observation of household practices, students gain insight into the health behaviours and socio-cultural norms that affect family health and wellbeing, while also contributing to primary preventive care and health education in the community [5-11].

The FAP is designed not only to equip students with clinical and preventive medicine skills but also to sensitize them to the socio-cultural influences on health behaviour,

such as menstrual taboos, childbirth customs, gender roles, hygiene practices and traditional healing beliefs. By documenting illness patterns, community perceptions and family practices, students learn to integrate biomedical knowledge with cultural understanding-a core competency for patient-centred care. The programme has been shown to enhance communication skills, strengthen community engagement and improve awareness of health needs in rural populations [8,9,12,13].

Despite its potential benefits, limited research has been published on the lived experiences of students and families participating in FAP, particularly concerning socio-cultural issues and the nature of advice exchanged during field interactions. To address this gap, the present qualitative study was conducted as part of the Family Adoption Programme where first-year MBBS students visited allotted families, documented socio-cultural problems, reflected on their learnings and provided health counselling. This paper explores the socio-cultural problems identified within families, the perceptions and learning outcomes of students arising from these observations and the types of health advice given to address socially rooted health behaviours. By analysing students' field responses, the study aims to contribute to understanding how field-based community engagements shape medical students' perspectives and inform community health education strategies.

METHODS

Study Design

A qualitative exploratory study design was employed to explore socio-cultural health issues, student perceptions and counselling interventions provided during the Family Adoption Programme (FAP). The study utilized participant observation and open-ended response analysis to generate thematic understanding of community practices influencing health.

Study Setting

The study was conducted in the field practice area associated with the Department of Community Medicine, Indira Gandhi Medical College (IGMC), Shimla, Himachal Pradesh, India. Families residing in semi-urban and rural pockets within the designated outreach region were included.

Study Population and Sampling

First-year MBBS students assigned families under the FAP served as primary data collectors and respondents. Each student was allotted one family for interaction and follow-up. A purposive sampling technique was applied to include families visited during the academic year. Responses from students documenting socio-cultural issues, observations and advice provided formed the study sample. Families with incomplete responses or missing interaction data were excluded.

Data Collection Procedure

Students visited the allotted families in person as per FAP guidelines. During each visit, they:

- Conducted rapport-building and informal interviews
- Observed socio-cultural practices within the household
- Identified menstrual, birth-related, traditional or custom-based practices affecting health
- Documented perceptions and learnings
- Provided medically appropriate advice or counselling

Information was recorded in structured field proformas containing three open-ended questions:

- Socio-cultural problems identified in the allotted family
- Perceptions and learnings gained regarding these practices
- Advice or health guidance provided to address the issues

Data Management and Analysis

The collected responses were compiled, anonymized and reviewed for accuracy. A thematic content analysis approach was used. Responses were coded manually into emergent categories, followed by grouping into major and minor themes. Recurring patterns were identified to construct thematic domains such as menstrual taboos, birth-related customs, gender norms, hygiene practices and openness to change. No statistical software was used, as the study remained qualitative in nature.

Ethical Considerations

Participation was voluntary and no personal identifiers were disclosed. Students informed families about the academic purpose of the visit and provided respectful counselling without enforcing behavioural change. Cultural sensitivity and non-judgmental interaction were maintained throughout.

RESULTS

A total of field responses from MBBS students participating in the Family Adoption Programme at IGMC Shimla were analyzed. The data underwent inductive thematic analysis. Eight major themes with corresponding sub-themes emerged from repeated patterns in the dataset. Verbatim participant quotes are presented to support analysis, with identifiers anonymized (Gender-Age).

Theme 1: Menstruation as a Socially Regulated and Stigmatized Experience

Across several households, menstruation emerged as a biologically normal event that is culturally treated as a social boundary. Rather than being understood through a medical lens, it is governed by norms of purity, separation and modesty. The responses illustrate that stigma is not rooted in ignorance alone but in inherited cultural identity, where restrictions are followed to preserve tradition rather than prevent harm. Even where awareness existed, behavioural change lagged behind, indicating that menstrual stigma is a social habit, not just a knowledge gap:

- "Periods mein aurat alag rehti hai… kitchen mein nahi aati. Ye gaon ki parampara hai." (Female, 32 years)
- "Educated log bhi baat karne se katrate hain… sharam ka maamla samajh kar." (Male, 21 years)

- "Aisa lagta hai jaise kuch galat ho raha ho, jaise body ki kami ho." (Female, 19 years)

Subtheme 1.1: Menstrual Isolation and Spatial Control
Women were restricted from kitchens, prayer spaces and sometimes sleeping areas. Isolation was not presented as punishment but as *routine compliance* with what is culturally expected. These restrictions subtly reinforce that a menstruating woman is temporarily "less present" in family life:

- "Us dino alag rehna padta hai… ghar ka niyam hai, beizzati nahi." (Female, 46 years)

Subtheme 1.2: Purity Ideology and Perception of Impurity
Menstruation was described as a state of impurity rather than physiology. Restrictions were framed as protection of ritual cleanliness rather than care for the woman. This reflects a cultural hierarchy where purity is privileged over comfort, choice or health:

- "Paak nahi hoti… isliye rasoi aur puja se door rehti hai." (Male, 54 years)

Subtheme 1.3: Silence, Privacy and Restricted Dialogue
Communication around menstruation was muted. Girls were expected to "manage quietly" and many felt they lacked permission to seek guidance. Silence was interpreted as respect, not suppression, making the stigma harder to challenge:

- "Khul kar baat nahi hoti… jo seekhna hai, khud samajh ke chalna padta hai." (Female, 28 years)

Subtheme 1.4: Emotional Discomfort and Internalized Shame
Participants described feelings of embarrassment, hesitation and guilt. This emotional burden indicates that stigma has moved beyond rule-following into self-policing, where women monitor their own behaviour to avoid discomfort for others:

- "Bolne mein sharam lagti hai… chup rehna aasaan lagta hai." (Female, 19 years)

Overall, this theme illustrates that menstruation is governed more by cultural regulation than medical understanding. Stigma persists not due to lack of knowledge alone but because it is tied to identity, purity norms and generational habit. Silence, isolation and emotional discomfort reinforce internalized stigma, making menstruation a socially controlled experience rather than a private biological one. Therefore, meaningful change requires culturally sensitive dialogue and behaviour-focused intervention, not just information or correction.

Theme 2: Birth Rituals and Neonatal Customs Negotiating Between Culture and Medicine
This theme illustrates that newborn care practices were driven primarily by cultural belief systems rather than biomedical understanding. A common ritual observed was the feeding of honey or ghutti to newborns immediately after birth, often before breastfeeding. These practices were anchored in emotional reassurance, ancestral validation and symbolic protection, rather than clinical evidence. Students attempted to address misconceptions, yet acceptance relied on interpersonal trust and generational authority, indicating that behaviour change is a negotiated cultural process rather than a direct informational correction:

- "Bachche ko pehle shahad chataate hain… parampara hai, tabhi bachcha tandurust hota hai." (Female, 55 years)
- "We didn't know honey can be harmful; hum toh hamesha se karte aaye." (Male, 29 years)

Subtheme 2.1: Honey/Ghutti Feeding as a Cultural Blessing
This practice was seen as a symbolic "first protection" rather than a nutritional decision. Families believed it initiated good health, strength and luck, giving the ritual a spiritual significance that outweighed medical caution:

- "Shahad se zindagi shubh hoti hai, issi se shuruaat karte hain." (Female, 50 years)

Subtheme 2.2: Ritual Feeding Before Breastfeeding
In many cases, breastfeeding was postponed because cultural correctness was prioritized over physiological need. The ritual feed was considered mandatory before colostrum or breastfeeding, underscoring culture as the first authority over neonatal care:

- "Pehle rasam hoti hai, phir doodh pilate hain… pehle reet nibhaani zaruri hai." (Male, 33 years)

Subtheme 2.3: Belief-Based Reasoning Over Medical Logic
Families trusted continuity- "it has always been done"-more than scientific explanation. The rationale came from tradition, not biology, reflecting that inherited practice holds higher legitimacy than external advice:

- "Hamare buzurgon ne kiya, sab theek raha; isliye hum bhi karte hain." (Female, 44 years)

This theme shows that neonatal rituals persist not from lack of awareness but because they provide emotional security, cultural identity and continuity with elders' wisdom. Changing these practices requires trust-building and respectful dialogue, where medical guidance is presented as an extension of care-not a rejection of tradition.

Theme 3: Gender Role Fixity and Silent Hierarchies in Family Structure

This theme reflects how gender roles, although not always openly stated or forcefully imposed, are embedded within the everyday functioning of households. Women's participation in decision-making, mobility and healthcare access appeared limited not through explicit denial but through quiet acceptance of long-standing expectations. Education did not consistently translate into autonomy; instead, domestic responsibility remained the default identity for many women. These patterns suggest that patriarchy is enacted less as confrontation and more as cultural normalcy, shaping choices, opportunities and access without being directly questioned:

- "Ladkiyon ka kaam ghar sambhalna hi hota hai, padhai se zyada fayda ghar mein hi hota hai." (Male, 47 years)
- "She is educated but doesn't work; family doesn't allow outside job." (Field note, Female observer) "We kept trying until we had a boy." (Female, 38 years)

Subtheme 3.1: Male-Centric Decision Making

Men were commonly positioned as the final authority in financial, educational and healthcare decisions. The expectation that male members "decide for the family" was seen as responsibility rather than control, reinforcing the idea that leadership is inherently masculine:

- "Faisla ghar ka mard leta hai… sabki bhalai isi mein hoti hai." (Male, 52 years)

Subtheme 3.2: Domestic Confinement Despite Education

Female education did not guarantee occupational choice. Women, including those with higher schooling, remained confined to household duties with their qualifications seen as secondary to caretaking. This demonstrates a disconnect between educational attainment and social permission:

- "Padhai hui hai par zarurat nahi bahar jaane ki… ghar hi sabse pehle." (Female, 30 years)

Subtheme 3.3: Patriarchal Control of Healthcare Access

In several families, women required permission or accompaniment to seek medical care. This control was presented as protection rather than restriction, yet it limited autonomy in reproductive and personal health decisions:

- "Doctor ke paas akele nahi jaa sakti… koi saath hona chahiye." (Female, 35 years)

Subtheme 3.4: Preference for Male Children

While not universal, some families expressed continued preference for a male child, associating sons with legacy, security and social status. Repeated pregnancies until the birth of a male child reflected how deeply gender expectation shapes reproductive choices:

- "Beta chahiye tha… koshish karte rahe." (Female, 38 years)

Gender norms operated as a quiet structural force rather than overt enforcement. Autonomy was shaped by cultural expectation, not ability; education expanded knowledge but not necessarily freedom. Patriarchal values persisted through normalization rather than domination, making change dependent on gradual shifts in approval, agency and shared decision-making within the household.

Theme 4: Traditional Health Beliefs as Primary, Medicine as Secondary

This theme reveals that traditional, experience-based health practices were often prioritized above biomedical care. Families commonly relied on familiar home remedies, generational advice and cultural logic rather than clinical guidance. Medical consultation was perceived as a measure reserved for emergencies, not for routine or preventive care. Healthcare engagement was therefore reactive rather than preventive, driven by the belief that long-standing practices were sufficient as long as "nothing serious" occurred. These observations underline that the challenge is not misinformation alone but a cultural perception that ancestral methods are inherently trustworthy and adequate:

- "Paani uballa nahi jaata… sadion se yahi peete aaye, kuch nahi hota." (Male, 61 years)
- "Doctor tab jaate jab haalat bigad jaaye; choti baat mein kya hospital jana?" (Female, 42 years)

Subtheme 4.1: Home Remedies Preferred Over Clinical Visits

Households consistently favored home-based solutions such as herbal mixtures, rest or prayer rituals. These remedies were seen as efficient, accessible and emotionally comforting, creating a reliance on familiar methods:

- "Ghar ke nuskhe pehle try karte hain, hospital baad mein." (Female, 50 years)

Subtheme 4.2: Preventive Care Seen as Unnecessary

Preventive check-ups, purified water use or early healthcare intervention were viewed as unnecessary unless symptoms became severe. Illness was approached as a moment of crisis rather than a process that could be prevented:

- "Bina wajah doctor kyu jaayein? Bimari badhe tab hi jaana sahi." (Male, 45 years)

Subtheme 4.3: Ritual Belief>Medical Reasoning

Ritual reasoning often outweighed biomedical logic. If a practice had "worked for generations," it was assumed valid. This demonstrates that trust is historical, not scientific and advice from elders held stronger authority than medical recommendations:

- "Purane tareeke se sab theek hua, aage bhi hoga." (Female, 60 years)

Traditional belief systems shaped healthcare choices more strongly than clinical advice. Medicine was seen as a backup, not a baseline. This indicates that successful intervention must begin by respecting cultural familiarity, then gradually integrating preventive care-not by replacing tradition but by reframing medical guidance as an extension of protection and wellness.

Theme 5: Hygiene and Environmental Practices Influenced by Belief, Not Knowledge

This theme demonstrates that hygiene and environmental practices were shaped largely by personal beliefs and perceived purity rather than evidence-based understanding. Families often relied on nature-associated assumptions-such as river water being "pure because it is natural"-or self-defined cleanliness standards that differed from biomedical recommendations. These practices were not necessarily rooted in neglect but in a belief that traditional or intuitive methods were sufficient. The findings highlight that health behaviour depends not only on resource availability but also on how cleanliness, purity and safety are culturally interpreted:

- "Nadi ka paani saaf hota hai, kudrat se aata hai toh paak hota hai." (Male, 35 years)
- "Saaf-safai hum apne hisaab se kar lete; hospital jaane ki zarurat nahi." (Female, 27 years)

Subtheme 5.1: Unboiled Water Consumption as "Naturally Safe"

Families often consumed unboiled or untreated water based on the belief that natural sources were inherently pure. The assumption of natural water being "paak" (pure) replaced microbiological safety considerations, indicating that purity was a cultural judgement, not a hygienic assessment:

- "Kudrat ka paani ganda kaise ho sakta hai?" (Male, 36 years)

Subtheme 5.2: Plastic Burning and Local Disposal as Acceptable Practice

Waste management was guided by convenience and informal norms rather than environmental awareness. Plastic burning and open disposal were seen as practical solutions, reflecting limited awareness of long-term ecological and health consequences:

- "Jala dena aasaan hota hai, isse jagah bhi nahi gandi hoti." (Female, 40 years)

Subtheme 5.3: Self-Defined Hygiene Standards

Hygiene was understood as visible cleanliness, rather than preventive sanitation. Families believed that if surroundings "looked clean," there was no need for purification processes or medical consultation. This perception made illness seem accidental rather than preventable:

- "Jab dikhta sab saaf hai, toh bimari kaise hogi?" (Male, 29 years)

Hygiene behaviours were shaped more by perceived purity than microbiological safety, with nature, visibility and familiarity defining what was considered "clean." This indicates that environmental and sanitation counselling must begin by acknowledging local logic and cultural definitions of cleanliness, gradually integrating preventive hygiene practices through respectful, behaviour-focused dialogue.

Theme 6: Psychosocial Privacy and Resistance to Disclosure

This theme highlights how personal and reproductive health matters were protected through a norm of privacy, creating reluctance to share concerns with outsiders. Rather than rejecting medical guidance, families appeared guarded because discussing intimate health topics was seen as socially inappropriate. Privacy functioned as a cultural shield, preserving dignity and family reputation. As a result, openness depended less on awareness and more on emotional safety, familiarity and trust with the visitor. This indicates that effective intervention must begin with rapport-building, not immediate correction:

- "Mahilaon ki baatein ghar ki hoti hain, bahar bataane ki nahi." (Female, 40 years)
- "Birth control pe baat karna theek nahi lagta." (Male, 33 years)

Subtheme 6.1: Health Problems Seen as Private Matters

Participants internalized the belief that illness or reproductive concerns should remain within the household. Disclosure was perceived as a risk to respectability, not a step toward treatment:

- "Ghar ki baat ghar mein hi theek hoti hai." (Female, 35 years)

Subtheme 6.2: Hesitation Around Reproductive and Sexual Health

Conversations related to contraception, menstrual hygiene or intimate health were seen as socially delicate. Silence was used as a protective mechanism, maintaining cultural modesty and emotional boundaries:

- "Aisi baatein sabke saamne karna theek nahi lagta." (Male, 30 years)

Subtheme 6.3: Trust-Building as a Prerequisite for Openness

Families were more receptive when students approached with empathy rather than authority. Acceptance of medical advice grew only after rapport, signalling that trust-not instruction-opens the door to change:

- "Aap samajh kar poochte ho toh bolna aasaan lagta hai." (Female, 28 years)

Psychosocial silence emerged as a culturally protective behaviour rather than denial. Families guarded intimate concerns to maintain dignity and social respect. Therefore, change requires relational confidence, empathetic listening and stepwise engagement; without trust, information alone cannot shift behaviour.

Theme 7: Positive Deviance-Families Displaying Modern Adaptation

This theme captures households that diverged from restrictive socio-cultural norms and demonstrated adaptive, health-supportive behaviour. These families did not abandon cultural identity; rather, they reinterpreted tradition in ways that coexist with medical guidance. Their practices reflected openness, balanced decision-making and selective acceptance of modern healthcare. Such households represent transitional spaces-where science and culture are not in competition but functioning side by side:

- "We don't follow isolation. Periods are normal, aurat beemar nahi hoti." (Female, 26 years)
- "Ham doctor ki salah maante hain; parampara se pehle sehat zaruri." (Male, 51 years)

Subtheme 7.1: Absence of Menstrual Restrictions

Menstruation was treated as a normal physiological event with no movement or participation restrictions. Women continued daily responsibilities without stigma or isolation, reflecting a shift toward body-normalisation rather than shame:

- "Periods mein alag rehne ki zarurat nahi… yeh swabhavik hai." (Female, 30 years)

Subtheme 7.2: Preventive Hygiene and Healthcare Acceptance

These families used boiled or purified water, attended medical check-ups before complications arose and viewed healthcare as a preventive measure rather than a crisis response:

- "Behtar hai pehle dekhwa lo, baad mein badhne se mushkil hota hai." (Male, 44 years)

Subtheme 7.3: Shared Roles and Decision Participation

Women were involved in household choices and were not confined solely to domestic duties. Responsibilities were shared, suggesting a shift toward partnership rather than hierarchy:

- "Ghar chalana dono ka kaam hai, sirf aurat ka nahi." (Male, 36 years)

Subtheme 7.4: Respectful Engagement With Medical Advice

Medical consultation was considered complementary rather than confrontational to tradition. Advice was accepted when delivered respectfully, indicating that health behaviour improves when communication aligns with cultural dignity:

- "Samjha kar bataya jaye toh baat manni asaan hoti hai." (Female, 29 years)

These families modelled positive deviance: Adaptive practices that depart from restrictive norms while preserving cultural identity. Their behaviour suggests that sustainable change is possible when health communication is respectful, shared decision-making is encouraged and tradition is reframed rather than rejected.

Theme 8: Structural Constraints, Marriage Norms and Reproductive Decision Control

This theme represents socio-cultural factors not rooted in ritual practices alone but in structural limitations, social expectations and reproductive autonomy. These include unemployment, low education, non-modernized livelihood practices, restrictions on intercaste marriage, age-gap marriages and hesitation around contraception. These patterns reflect how family systems maintain continuity and social identity through control of marriage boundaries and reproductive decisions. The issue is less resistance and more normalization-restrictions are seen as tradition, not oppression.

Subtheme 8.1: Educated but Unemployed-Dependence Sustaining Tradition

Participants mentioned youth holding degrees yet remaining jobless, continuing dependence on parents, delaying autonomy and limiting decision-making power-especially for women:

- "Padhai ki hai par kaam nahi milta… abhi bhi maa-baap par nirbhar hain." (Male, 28 years)

Subtheme 8.2: Low Education and Limited Skill for Health Decision-Making

With incomplete schooling or poor health literacy, families relied on hearsay or tradition rather than verified information, unintentionally reinforcing outdated practices:

- "Kam padhai ke chakkar mein samajh bhi kam hai… jo suna wahi sahi lagta hai." (Female, 45 years)

Subtheme 8.3: Intercaste Marriage Restrictions as Identity Protection

Families discouraged intercaste marriage to preserve caste identity and community acceptance. This control was framed as "tradition" rather than discrimination, making regulation invisible but strong:

- "Jaat ke bahar shaadi nahi karte… parampara aur izzat ka sawaal hai." (Male, 41 years)

Subtheme 8.4: Marriage as Obligation Over Personal Choice

Partner selection was perceived as a family responsibility. Autonomy was less about choice and more about maintaining reputation, ensuring marriage aligned with familial expectations:

- "Shaadi parivaar tay karta hai… ladki ko faisla nahi karna hota." (Female, 29 years)

Subtheme 8.5: Age-Gap Marriages Normalized as Practical

Larger age differences between spouses, mainly older men and younger women, were justified by economic stability rather than compatibility:

- "Umar ka farak zaroori nahi, zimmedari nibhaani hoti hai." (Male, 50 years)

Subtheme 8.6: Contraceptive Hesitancy and Reproductive Silence

Contraception discussions were avoided due to embarrassment, fear of judgement or perception that fertility decisions "belong to elders" or husbands. This delayed access to family planning and reproductive autonomy:

- "Birth control pe baat karna theek nahi lagta… sharam si aati hai." (Male, 33 years)
- "Goli ya copper-T ke baare mein poochna bhi ajeeb lagta hai." (Female, 31 years)

Subtheme 8.7: Traditional Farming and Economic Stagnation

Traditional agricultural practices without modernization sustained low income, reinforcing dependence on existing norms instead of adaptation or mobility:

- "Purani kheti karta hoon… naye tareeke mushkil lagte hain." (Male, 42 years)

Subtheme 8.8: Fragmented/Separated Family Structures

Some families described living separately due to disputes, financial strain or generational conflict, altering caregiving roles and dependence networks:

- "Alag rehna pada… majboori thi, parivaar toot gaya." (Male, 39 years)

Theme 8 demonstrates that socio-cultural patterns are reinforced by structural limitations-unemployment, low literacy, caste-bound marriage norms, reproductive silence and economic stagnation. These do not operate through force but through normalization; families follow them because "this is how it has always been." Meaningful change must therefore target livelihood, education and communication empowerment-not only medical advice.

DISCUSSION

This study under the Family Adoption Program (FAP) helped medical students understand how cultural beliefs, family traditions and community identity shape health behaviours in everyday life. By visiting homes, talking with family members and observing practices directly, the students learned that many behaviours which appear medically incorrect are often socially meaningful and emotionally protective for the community. Families did not necessarily consider practices like menstrual isolation, honey feeding to newborns, avoidance of contraception discussions, unboiled water consumption or delayed hospital visits as health problems. Instead, they saw them as part of tradition, respect for elders and continuation of cultural identity.

Menstrual beliefs showed this clearly. In several households, women were isolated during periods, avoided the kitchen or prayer room and spoke about menstruation in hushed tones. One student noted, "Even educated families hesitate to talk about periods; it's still treated as something shameful." Another said, "Women are educated but still stay quiet due to fear of disrespecting elders." These perceptions helped students realise that stigma was rooted in emotional and social pressure, not just lack of knowledge. In response, students gave advice gently rather than confrontationally. They explained that menstruation is a normal biological process, encouraged hygiene and reassured women that entering the kitchen or staying with family does not cause harm. One student shared, "We told them that isolation is not required; periods need care, not punishment." Through such dialogue, advice became a partnership rather than an instruction.

Birth-related and newborn care practices further demonstrated the influence of tradition. Feeding honey or ghutti to newborns was a common ritual based on the belief that it improves health and is auspicious. Families shared statements like, "Hum toh hamesha se karte aaye; isse bachcha tandurust hota hai." (We have always done this; it makes the child healthy). Students understood this was done with protective intention, not negligence. However, by connecting risks to real-life outcomes, they explained gently that honey can cause infection like infant botulism and that breastfeeding should be the first feed. Advice such as, "Please avoid honey; mother's milk is the safest first food," was used to balance cultural respect with medical safety.

Gender roles, household hierarchy and reproductive silence also affected health decisions. Some women hesitated to seek care without permission and contraception discussions were avoided. Students perceived that this silence came from embarrassment, not refusal. One student wrote, "Birth control pe baat karna unko theek nahi lagta," (Speaking about birth control didn't feel right to them), which showed that communication itself was restricted socially. Advice in these homes focused on opening safe conversations rather than forcing choices. Students encouraged couples to ask questions, supported shared decision-making and reminded families that reproductive health discussion is private but not shameful.

Hygiene and healthcare-seeking patterns reflected confidence in routine rather than awareness gaps. Families drinking unboiled water or delaying treatment believed that nothing harmful would happen because "nothing happened before." Instead of criticising, students offered relatable, practical explanations. For example: "Waterborne diseases can be prevented just by boiling water for 10-20 minutes," and "Early check-ups save money and prevent emergencies." This kind of advice respected financial limitations while promoting preventive health.

Importantly, not all families followed restrictive practices. Some households used purified water, avoided menstrual restrictions, allowed women to work or study and preferred medical care for childbirth and illness. These examples acted as positive role models and showed that cultural identity and modern healthcare can coexist. Students saw that social change is already happening gradually and that complete rejection of tradition is not necessary for improvement.

Across all households, the students' learning followed a similar pattern. First, they identified practices as harmful; then they understood the emotional and cultural reasons; finally, they adapted their communication style. Their counselling changed from instructing to guiding, from correcting to understanding and from giving orders to offering options. They realised that change cannot be forced-it must be invited. This helped them grow as future doctors who can speak with empathy, cultural sensitivity and respect for lived realities. In this way, the programme successfully linked medical education with social understanding, which is essential for effective public health practice in diverse communities.

In summary, this study shows that socio-cultural practices are rooted in belonging, emotion and respect rather than ignorance. Students perceived that cultural norms can support identity but may also restrict health decisions. They responded with advice that balanced respect with safety, making change possible through trust instead of confrontation. The Family Adoption Program therefore proves to be an effective learning model that helps medical students understand real communities, communicate better and build the foundation for culturally respectful healthcare. True improvement in community health will come not from replacing culture but from guiding it forward with dignity, partnership and science.

CONCLUSIONS

This study shows that socio-cultural practices in the community are guided not only by lack of awareness but by long-standing beliefs, emotional comfort, family authority and fear of social judgement. Practices related to menstruation, newborn care, hygiene, gender roles and delayed healthcare were found to be socially accepted rather than questioned. Medical students learned that health behaviour is deeply connected to cultural identity and therefore, behaviour change cannot be forced through information alone. Instead, change requires trust, respectful communication and gradual adaptation. The Family Adoption Program successfully exposed students to real-life community situations, helping them understand that medical practice must include empathy, cultural sensitivity and patient-centred communication. Overall, the study concludes that improving community health requires collaboration between cultural practices and medical guidance, rather than replacement of one by the other.

Recommendations

Based on the findings, it is recommended that future interventions focus on culturally respectful health education rather than direct correction of practices. Menstrual hygiene, newborn feeding and preventive healthcare should be discussed in local language and within the emotional comfort of families. Community meetings, women's discussion groups and school-based sessions can help create safe spaces for reproductive and menstrual health conversations. Training health students and workers in communication skills, especially for sensitive topics like contraception and childbirth, should be strengthened. Local panchayat support, engagement of frontline workers (ANMs, ASHAs) and periodic monitoring can help sustain behavioural changes. Long-term improvement will require combining medical advice with cultural understanding so that practices evolve with dignity and acceptance rather than resistance.

Strengths

A major strength of the study was the direct home-based interaction, which provided authentic insights that cannot be obtained in hospital settings. The qualitative design allowed families to express beliefs in their own terms, producing rich, real-life data. The study also strengthened medical student learning by developing empathy, communication skills and an understanding of how social and cultural factors affect health outcomes. The presence of both traditional and progressive households allowed comparison and showed natural variation in community practices. The Family Adoption Program's structure ensured continuity, familiarity and trust-building, which increased the accuracy of responses and depth of understanding.

Limitations

The study has certain limitations. Data were based on a single visit or short interaction in some homes, which may have limited openness, especially on sensitive issues like contraception and reproductive health. Responses depended on the comfort level of families, so some practices may have remained unspoken. The findings are specific to one geographical area and cultural setting and therefore may not represent all communities in India. The qualitative nature of the study does not measure statistical prevalence, so results cannot be generalized numerically. Despite these limitations, the study provides valuable insight into socio-cultural influences on health and highlights the need for future follow-up visits, deeper interviews and longitudinal community engagement.

Acknowledgement

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Conflicts of Interest

The authors declare that there is no conflict of interest regarding the conduct of this study, the interpretation of findings or the preparation of the manuscript.

Ethical Considerations

Informed verbal consent was obtained from all participating families prior to visits and discussions. No identifying personal information was recorded. Respect for cultural beliefs, confidentiality and voluntary participation was maintained throughout the study, in accordance with ethical standards for community-based educational research.

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