



REVISITING THE FAMILY ADOPTION PROGRAMME UNDER INDIA'S CBME FRAMEWORK: FROM EXPERIENTIAL TO AUTHENTIC LEARNING

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ABSTRACT

Background: India's Competency-Based Medical Education (CBME) framework has progressively elevated the Family Adoption Programme (FAP) from a community orientation exercise to one explicitly framed as a vehicle for authentic learning. The gap between this aspiration and implementation reality across more than 700 medical colleges, however, remains substantial. **Objective:** This review examines the conceptual and regulatory evolution of FAP between the NMC CBME 2022 and CBME 2024 guidelines, appraises implementation evidence, critically evaluates whether FAP as currently delivered constitutes authentic learning in any rigorous educational sense, and proposes a feasible assessment framework embeddable within existing Internal Assessment structures without requiring fresh regulatory sanction. **Methods:** This narrative review synthesises the published Indian literature on FAP implementation, NMC regulatory documents (2019–2024), and relevant educational theory. Theoretical frameworks cited include Kolb, Herrington and Oliver, Boelen and Woollard, and van der Vleuten. Where empirical evidence on FAP implementation was lacking, the recommendations presented represent the author's scholarly interpretation, informed by educational theory and published implementation evidence, rather than direct empirical findings. **Conclusions:** FAP has the structural architecture of authentic learning, but many institutions are still delivering it as supervised fieldwork. An assessment framework aligned with van der Vleuten's utility criteria — embedding FAP outcome indicators within Community Medicine Internal Assessment and mandating portfolio-based evaluation — would bring policy intent and educational reality into alignment.

KEYWORDS : Family Adoption Programme; Authentic Learning; Competency-Based Medical Education; Portfolio Assessment; Social Accountability

INTRODUCTION

When the National Medical Commission (NMC) formally introduced the Family Adoption Programme (FAP) through the Competency-Based Medical Education (CBME) framework — mandated for implementation from the 2021–22 MBBS batch — it placed something new into the undergraduate curriculum: a structured, longitudinal relationship between a medical student and real families in an underserved community, sustained across all three years of training. The original design, proposed by Vanikar and Kumar [1], called for each student to adopt three to five families from a village outside the college's rural health training centre, engaging across Phases I, II, and III for 78 hours in total.

The regulatory language has shifted significantly since that introduction. The 2022 implementation guidelines described FAP in terms of student sensitisation — 'experiential learning' and 'firsthand exposure' were the operative phrases. The CBME 2024 document [2] uses different words: FAP is now a 'critical platform to facilitate authentic learning,' aimed at preparing students for 'the real-life challenges of working for Universal Health Coverage' — the national policy goal set out in the National Health Policy 2017 [3]. That shift is not rhetorical tidying. Experiential programmes can be satisfied by supervised field visits and reflective write-ups. Authentic learning, in the sense Herrington and Oliver [4] defined it, requires students to engage in tasks of genuine real-world consequence — complex, ill-defined, sustained over time, producing outcomes with value beyond the examination hall. Whether FAP as actually conducted across India's medical colleges meets those criteria is a question the published literature has not directly confronted.

Three objectives organise this review. The first is a systematic comparison of what the NMC 2022 and CBME 2024 guidelines actually require of FAP, and why those differences constitute a shift in pedagogical intent (Section 2). The second, taken up in Section 4, is a frank appraisal of whether current implementation reaches the standard of authentic learning — testing FAP against the specific criteria Herrington and Oliver identified, rather than accepting the 2024 guideline's language at face value. The third objective — and the most practically consequential — is a proposal for an assessment framework that can be inserted into existing CBME Internal Assessment provisions without needing fresh NMC regulatory sanction (Sections 5 and 6). An honest account of implementation evidence (Section 3) precedes the critical appraisal, following the sequence a reader naturally expects: theory, then evidence, then interpretation.

Search Strategy and Scope

This review synthesises the published Indian literature on FAP, NMC

regulatory and guidance documents obtained directly from the NMC website, and relevant educational theory. Literature was identified through familiarity with the relevant national journals, conference proceedings, and departmental engagement with FAP delivery and assessment [22], rather than a single structured database search against a fixed protocol. Educational theory literature was selected for its direct bearing on the review's argument — Herrington and Oliver's authentic learning framework, Kolb's experiential learning cycle, Boelen and Woollard's social accountability model, and van der Vleuten's assessment utility criteria — rather than through systematic screening. Nine India-based empirical studies on FAP implementation, cited throughout Section 3, form the empirical core of the review. This is consistent with a narrative rather than a systematic review: the aim is a theory-informed synthesis, not an exhaustive or independently reproducible literature census.

1. Conceptual Foundations: Experiential Learning, Authentic Learning, and Why the Distinction Matters

The terms 'experiential' and 'authentic' learning travel together so often in Indian medical education writing that they have begun to look synonymous. They are not. The distinction has direct implications for how FAP is designed, taught, and assessed.

Kolb's [5] model describes experiential learning as a four-stage cycle: concrete experience generates reflective observation, which produces abstract conceptualisation, feeding into active experimentation that initiates a new cycle. The defining characteristic is that the learner's subjective experience — real or simulated — is the primary material from which knowledge is constructed. Taywade [6] has noted the particular relevance of this cycle to CBME in Indian medical education, where community medicine postings have long relied on precisely this structure.

Authentic learning, by contrast, shifts the emphasis from the learner's internal cognitive process to the external characteristics of the task itself. Herrington and Oliver [4] defined authentic learning environments as those in which students engage in activities matching 'as nearly as possible, the real-world tasks of professionals in practice.' The framework these authors subsequently elaborated with Reeves [7] identifies ten characteristics of authentic activities — among them, that tasks are ill-defined, complex and sustained over time, dependent on collaboration with genuine stakeholders, and open to multiple solutions. The criterion that most sharply distinguishes authentic from merely experiential tasks: the work must have value beyond the academic context, mattering to someone other than the examiner.

The relevance of authentic learning to FAP is not merely technical. Boelen and Woollard [8,9] defined social accountability in medical

education as the obligation of schools to direct their education, research, and service activities toward the priority health concerns of the communities they serve; their Conceptualisation-Production-Usability model holds that a socially accountable school must not only plan and train well but demonstrate a measurable difference to population health (usability). Authentic learning is the pedagogical mechanism through which this 'production' phase is realised — students doing genuinely consequential community work are being trained for exactly the usability Boelen and Woollard describe, a pattern also documented in comparable experiential learning initiatives built around the same goal [10]. This theoretical bridge is what gives FAP its distinctive significance within the NMC's reform agenda.

Two further criteria bear directly on FAP: students must periodically step back and process observations with a mentor rather than merely journal, and assessment must capture real-world performance, not

knowledge recall alone. A systematic review of authentic learning in healthcare education [11] confirmed that such environments produced significant gains in higher-order thinking and knowledge integration — but only where structured mentorship and performance-based assessment were both present.

A practical test helps clarify the distinction for FAP purposes. Does the student's activity make any difference to anyone outside the academy? In a family study where students collect baseline data and submit a write-up, the answer is no. Where students identify a child with severe acute malnutrition, link the family to the nearest Nutrition Rehabilitation Centre, track the child's weight recovery across Phase I visits, and reflect with their mentor on what facilitated or obstructed that process — there, the answer is yes. The CBME 2024 guidelines are designed around the second scenario. How closely current implementation approaches it is examined in Section 4.

Table 1: Distinguishing Experiential Learning from Authentic Learning — Implications for FAP

Dimension	Experiential Learning	Authentic Learning
Definition	Learning through direct experience, followed by reflection; may be simulated or real field exposure	Learning through engagement in real-world tasks of genuine consequence, with outcomes that carry value beyond the academic evaluation context
Theoretical basis	Kolb's Experiential Learning Theory [5]: Concrete experience → Reflective observation → Abstract conceptualisation → Active experimentation	Constructivist learning theory; situated learning (Lave & Wenger [12]); Herrington & Oliver's authentic learning framework [4]
Learning environment	Semi-structured; classroom, skills lab, or community field posting	The actual environment where knowledge is applied — homes, villages, primary health settings, community health worker networks
Learner's role	Active participant in a guided or staged activity	Problem-solver, health advocate, and reflective practitioner with genuine accountability to the community
Nature of tasks	Controlled, designed to teach specific competencies (surveys, role-plays, OSCEs)	Complex, ill-defined problems with no predetermined outcomes, closely mirroring real public health responsibilities
Faculty role	Facilitator who designs the experience and debriefs students	Mentor and co-learner supporting students as they navigate real-world challenges
Assessment	Skill-based, checklist-oriented, structured reflective write-up	Portfolio, longitudinal outcome tracking, faculty rating rubrics, community or health worker feedback
Distinguishing criterion	Value to the student's learning	Value beyond the classroom — the student's work should tangibly benefit the community

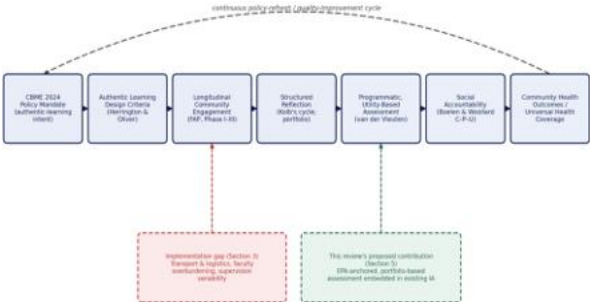


Figure 1. Conceptual Model Linking CBME Policy Intent to Community Health Outcomes Through FAP. The Upper Pathway Traces the Theoretical Chain From Regulatory Mandate Through Authentic-learning Design, Longitudinal Community Engagement, Structured Reflection, Assessment, and Social Accountability to Population-level Outcomes, With a Feedback Loop Returning Evidence to Policy. Callouts Mark Where this Review's Empirical Findings (Section 3) and Proposed Assessment Framework (Section 5) Intersect the Pathway.

2. Regulatory Evolution of FAP: What Changed Between 2022 and 2024?

Tracking the pedagogical shift in FAP requires reading what the two sets of guidelines actually say rather than relying on summaries that circulate at faculty development workshops. Several points of substantive change stand out.

The 2022 implementation guidance framed FAP almost entirely in terms of student sensitisation — 'firsthand exposure' to community life, with the student positioned as an empathetic observer and logbook submission as the principal artefact; assessment was left to institutional discretion. The CBME 2024 document departs from this framing in ways that matter educationally: FAP is now a 'critical platform to facilitate authentic learning,' phase-wise competencies are explicitly specified rather than left to institutional interpretation, and the NMC FAQ [15] states that batches introducing FAP 'shall assess the students as per the assessment module displayed on the website' — the first regulatory acknowledgement that logbook submission alone is insufficient. The reduction from five families to three, paired with explicit phase-wise objectives, reflects a deliberate trade-off of breadth for depth, consistent with what authentic learning theory requires. Table 2 sets out the full comparison.

Table 2: Comparative Analysis of NMC CBME 2022 and CBME 2024 Guidelines on FAP, with Educational Implications

Parameter	NMC CBME 2022	NMC CBME 2024	Educational Implication
Stated learning framing	"Experiential learning opportunity" and "firsthand exposure" — centred on student sensitisation	"Critical platform to facilitate authentic learning" — explicitly invoking real-world service and community impact	Frame assessment tasks around community outcomes, not just student reflections; shift faculty from supervisor to mentor role
Number of families	Minimum 3, preferably 5 per student — emphasis on breadth of exposure	Minimum 3 per student with structured phase-wise objectives — emphasis on depth of engagement	Fewer families with richer objectives allows for the sustained, complex engagement that authentic learning requires
Student role	Observer and documentor of family health conditions and social determinants	Health advocate, first point of contact, collaborator with ASHA/ANM, driver of measurable health improvement	Implies entrustable professional activity framing: student must demonstrate they can be trusted in a quasi-professional community role
Task specification	Family study and periodic follow-up; methodology largely left to individual colleges	Phase-wise competencies explicitly defined: family diagnosis (Phase I), follow-up and intervention (Phase II), action projects and outcome analysis (Phase III)	Ill-defined, phase-wise tasks are more educationally powerful; map each task to CM5.1–CM5.16 competencies in departmental FAP plan

Community system linkage	Not systematically delineated	Explicitly mandated: colleges to partner with public health system, ASHA/ANM, local governance	Linkage with HMIS, family folder, ABHA health ID, and Health and Wellness Centres should be operationalised as part of Phase II tasks
Assessment expectation	Qualitative write-up and logbook submission	Logbook plus NMC assessment module [15]; outcome indicators included; portfolio approach recommended	Assessment should satisfy van der Vleuten's utility criteria [16]: validity (authentic tasks), educational impact (portfolio drives field engagement), feasibility (rubric-based), and acceptability (community feedback)
Hours allocated	27 hours (Phase I) + 30 hours (Phase II) + 21 hours (Phase III) = 78 hours total across all three phases [17]	78 hours retained; CBME 2024 anchors each phase's hours to explicit competency-based tasks and mandates outcome-based assessment	Phase-wise hour allocation should be protected in timetabling and not displaced by other CBME activities
Social accountability framing	Implicit — mentioned as aspiration	Explicit: FAP as institutional obligation to discharge social responsibility and produce socially-responsive Indian Medical Graduates	Aligns with Boelen & Woollard's social accountability framework; FAP operationalises the 'production' phase of the Conceptualisation-Production-Usability model

3. Implementation Evidence: What the Literature Tells Us

A substantial body of Indian literature on FAP implementation has accumulated since 2022. Several patterns recur with enough consistency to be treated as generalisable findings rather than local idiosyncrasies.

Faculty, students, and community members across diverse settings welcome the programme. SWOC and stakeholder studies from Jharkhand [13], Assam [18,19], and Uttar Pradesh [20] all reported broadly positive attitudes toward FAP's goals — students in the Uttar Pradesh study identified it as their most impactful community engagement experience in MBBS — and a separate effectiveness study found similarly favourable outcomes [21].

The implementation gaps are equally consistent. Transport and logistics top every list of challenges, with particular severity in government colleges lacking a dedicated vehicle. Faculty overburdening comes second — small group discussions, early clinical exposure, and AETCOM modules have each added to departmental workloads under CBME, and FAP mentoring absorbs whatever time remains. Village selection, maintaining student-family continuity across years, and students' difficulty building rapport during initial visits are also repeatedly flagged; a study from Jorhat Medical College [18] found faculty were already stretched before FAP's supervision demands were added. These are structural constraints requiring institutional solutions, not motivational ones.

Assessment remains the most ambiguous area in the literature. Multiple institutional reports describe logbook submission as the sole evaluation mechanism — no structured faculty rubric, no outcome measure, no basis for distinguishing students who engaged thoughtfully from those who produced neat paperwork. The NMC FAQ [15] specifies that an assessment module is available on the NMC website, but its uptake appears limited across reporting institutions.

The interprofessional potential of FAP is a consistent gap. The CBME 2024 guidelines gesture toward ASHA/ANM collaboration, but few institutions have formalised linkages with nursing colleges, social work departments, or nutrition programmes — a gap Section 6.2 returns to, along with the two exceptions so far reported in the literature [14,22].

A dimension largely absent from FAP implementation literature is the programme's potential interface with India's public health data infrastructure. The family folder — maintained at the sub-centre level under HMIS — contains baseline data that directly complements what students collect during Phase I visits, and the Ayushman Bharat Health Account (ABHA) digital ID and linked Health and Wellness Centre framework provide a ready channel for students to register cases, initiate referrals, and track outcomes electronically. Linking FAP logbook data to the family folder and ABHA ID would require only a departmental protocol and coordination with the Block Medical Officer, converting FAP from a parallel academic exercise into a genuine contribution to the government's primary health care strengthening agenda.

4. Is FAP Really Authentic Learning? A Critical Appraisal

The CBME 2024 language calls FAP a platform for authentic learning. That claim warrants scrutiny. Testing the programme against the Herrington-Oliver criteria, using the implementation evidence reviewed in Section 3, produces a mixed picture.

4.1 Real-world Relevance

FAP scores well on this criterion in design. Students visit actual families, in real villages, and encounter genuine health problems — a first-year student discovering that a 60-year-old head of household has uncontrolled hypertension and has never attended a health facility faces a professional challenge with no scripted answer. In execution, the criterion is met variably: proximity of the village, whether a faculty member accompanies students, and how thoroughly students have been prepared all affect the depth of engagement.

4.2 Ill-defined, Complex Tasks

Early FAP (2022) was a structured survey — questions predetermined, logbook guided every step. CBME 2024 changes this by requiring students to formulate objectives for each family and design action projects, introducing genuine ill-definedness. Evidence from Jorhat Medical College [18] found that most faculty still described activities as structured logbook visits, with limited scope for student-initiated problem identification — the gap between guideline intent and institutional practice on this criterion remains wide.

4.3 Sustained Engagement and Collaboration with Real Stakeholders

FAP's three-year longitudinal structure — spread across 78 hours — is its most authentically distinctive feature, separating it structurally from every other community medicine activity in the MBBS curriculum. Whether this mandate translates into a genuinely continuous relationship depends on transport reliability, faculty consistency, and administrative continuity across years — all of which the implementation literature identifies as variable [18,23].

4.4 Reflection and Articulation

Structured reflection — the mechanism by which field experience is converted into professional learning — is mentioned in FAP documents but mandated with little specificity in either set of guidelines. Students who complete their Phase I hours without a single structured debrief remain at the experiential level; the cognitive processing that would constitute authentic learning has not occurred. This is the most fixable gap: fortnightly debrief sessions cost nothing and change the learning quality substantially.

4.5 Value Beyond the Academic Context

This is the criterion on which most current FAP implementation falls short. A student who completes all Phase I visits, fills every logbook section, and submits on time has satisfied the programme requirement — regardless of whether any family member's health trajectory changed. CBME 2024 creates the structural conditions for genuine impact through action projects and Phase III outcome analysis, but these are not yet tied to any assessment that creates accountability. The evidence that FAP improves students' understanding of social determinants is real [20,23]; the evidence that it currently changes family health outcomes in measurable ways is not established, largely because no one has yet been required to measure it. Students who track a family's health trajectory across three years, documenting the ASHA worker's role, referral decisions, and barriers to compliance, more closely approximate authentic learning than those who complete the logbook and move on — a distinction of degree rather than kind, but the degree the 2024 guidelines are trying, imperfectly, to mandate.

5. Assessment of FAP: An Under-Addressed Determinant of Programme Quality

Among the implementation barriers identified in the literature, the absence of structured assessment stands out as one of the more modifiable. The mechanism is well understood: when logbook submission is disconnected from examination eligibility or Internal

Assessment marks, the programme is treated as administrative overhead — not a failure of motivation, but the rational response to a misaligned incentive structure. Assessment drives learning, as van der Vleuten [16] established; programmes that are not assessed are programmes that are not taken seriously.

The common departmental assumption — that FAP cannot be assessed

Table 3: Proposed Phase-Wise FAP Assessment Framework — Implementable within Current CBME Internal Assessment Provisions

Phase / Year	What to assess	Who assesses and how	Where it fits in CBME structure	Minimum threshold
Phase I (1st Prof Year)	Logbook completeness, rapport-building, family health data accuracy, reflective diary entry quality	Faculty mentor using structured rubric (5-point scale across 4 domains)	Satisfactory completion mandatory before Phase I Internal Assessment submission	Minimum 3 completed family profiles with baseline data; at least 2 reflective diary entries; faculty sign-off on logbook
Phase II (2nd Prof Year)	Quality of follow-up records, identification of health risks, accuracy of referral decisions, AETCOM-linked communication skills in field	Faculty rubric + structured community/ASHA feedback form (3-item Likert scale)	Formative marks within Community Medicine Internal Assessment (IA) — allocable within existing 20% IA component	At least 4 documented follow-up visits; evidence of at least one referral or health action; completed ASHA/ANM feedback form
Phase III (3rd Prof Year)	Action project design, implementation rigour, evidence of outcome (before-after immunisation data, dietary change), final portfolio presentation	Faculty rubric + structured oral/viva (Community Medicine viva to include FAP portfolio review)	Short structured oral or mini-presentation on FAP outcomes within existing Community Medicine practical/viva — no regulatory change required	Completed action project report with outcome data; final portfolio submitted; faculty certification of satisfactory participation

5.0 Evaluating the Proposed Framework Against Assessment Utility Criteria

Any proposed assessment framework should be evaluated against established standards of assessment quality. Van der Vleuten's (1996) utility formula — $\text{Utility} = \text{Validity} \times \text{Reliability} \times \text{Educational Impact} \times \text{Acceptability} \times \text{Feasibility}$ — provides a practical lens. On validity, the proposed FAP framework performs well: tasks closely mirror the real-world work of a community physician, satisfying content and construct validity for authentic assessment. Educational impact is its strongest argument: requiring outcome data and a reflective portfolio directly shapes field engagement, shifting behaviour from logbook completion to genuine family engagement. Feasibility is moderate — the faculty rubric requires roughly two hours of standardised training and periodic calibration. Acceptability requires deliberate attention: families participating in feedback, ASHA workers completing response forms, and students accepting that their portfolio may determine examination eligibility all require prior orientation and trust-building. The framework's most significant limitation is reliability: without formal inter-rater calibration, rubric scores may vary in ways that compromise fairness — departments piloting the framework should build in at least one annual calibration session where two faculty members independently rate the same portfolio and reconcile differences. The framework is therefore best described as conceptually valid and practically feasible, pending prospective reliability validation.

5.1 The FAP Portfolio as the Central Assessment Artefact

The portfolio differs from the logbook in one essential respect: it records not only what happened during a visit but what the student made of it. An e-portfolio study in Community Medicine at an Indian medical college, using a similar structure for immunisation competency assessment, found significant improvements in knowledge, skill, and reflective writing alongside high satisfaction among students and faculty [24]. A workable FAP portfolio requires five sections: family profiles with baseline health data; visit logs recording observations, actions, and outcomes; structured reflective diary entries (at least two per year) responding to a specific prompt; documented evidence of at least one health action or referral per family per year; and, for Phase III, the action project report with before-and-after data. By Phase III, the portfolio should be sufficient to make an entrustment judgement — in the Entrustable Professional Activity (EPA) sense [25]: can this student be trusted to function as an unsupervised first health contact for a community family? That question, answered through portfolio review at the end of the programme, represents FAP's most powerful assessment moment.

5.2 Faculty Rubric for Direct Assessment

Faculty mentors who accompany students on field visits hold the most direct evidence of performance — and that evidence currently disappears because there is no instrument to record it. A five-domain behaviourally anchored rubric — preparation for visits, communication and rapport-building with the family, accuracy of health assessment, quality of interventions or referrals initiated, and reflective capacity in post-visit debriefs — would translate faculty

because it carries no formal marks — misreads the CBME architecture. Community Medicine Internal Assessment in Phase III carries a formative component, and the CBME framework explicitly permits portfolios, direct observation, logbooks, and viva as assessment methods. No regulatory barrier prevents a department from embedding FAP performance indicators within its existing Internal Assessment rubric. Table 3 proposes a framework for doing so.

observations into formal assessment evidence. The structure is analogous to the mini-CEX used in clinical postings. It requires roughly two hours of departmental faculty training to standardise and, critically, annual calibration sessions to maintain inter-rater reliability.

5.3 Community and Health Worker Feedback

A three-item questionnaire — administered to the adopted family or the linked ASHA worker at the end of each academic year, covering regularity of student visits, clarity of health communication, and follow-through on previously discussed health issues — provides evidence genuinely external to the institution. This is authentic assessment in the truest sense. The feasibility of collecting such feedback has been demonstrated in the Jharkhand FAP experience reported by Shikha et al. [13], where families proved willing to participate when approached respectfully and briefly.

5.4 The Pass/Fail Gate: Ensuring Minimum Accountability

Making satisfactory FAP completion a prerequisite for appearing in Phase III Community Medicine Internal Assessment or the university examination — subject to applicable university statutes — creates a meaningful accountability floor without touching the marks distribution. Minimum thresholds should include: visits completed, portfolio submitted, faculty sign-off obtained, and community feedback form returned. Several colleges have introduced informal versions of this gate; formalising it at departmental level and reporting compliance to the Principal's office converts FAP from a voluntary activity into a gatekept competency.

5.5 Connecting FAP to CBME Competency Mapping

Community Medicine competencies CM5.1 through CM5.16 cover family health, social determinants, nutritional assessment, and community health programmes — precisely what FAP addresses in the field. Explicitly mapping FAP activities to these competencies, and recording in the student's competency achievement log which CM and AETCOM competencies were demonstrated through FAP rather than classroom instruction, reinforces that FAP is not supplementary to the curriculum but a primary delivery vehicle for assessed competency achievement. AETCOM competencies 1.1 (respect and dignity) and 1.3 (empathy in practice) are particularly amenable to evidencing through portfolio reflections and faculty rubric scores.

6. Deepening Authenticity: Complementary Approaches

Two strategies can extend FAP's authentic quality without adding curriculum hours.

6.1 Action Projects as the Authentic Core of Phase III

The CBME 2024 requirement for Phase III action projects is the most educationally powerful element of the revised framework. A time-bound, student-led effort to address a specific identified health need — improving immunisation coverage among children under two, a dietary modification initiative for households with an anaemic woman of reproductive age, or a screening and linkage project for elderly members with undetected diabetes or hypertension — satisfies every Herrington-Oliver criterion simultaneously: the problem is real, not

scripted; the solution requires negotiation with the family, the ASHA worker, and sometimes the primary health centre; and the outcome can be measured before and after. Submitting that report as the Phase III portfolio capstone gives the programme its most defensible claim to authentic learning.

6.2 Interprofessional and ASHA/ANM Integration

Where nursing or allied health colleges are co-located with a medical college, joint FAP visits offer a low-resource pathway to interprofessional learning — MBBS and nursing students visiting together learn to work as a team and appreciate different professional perspectives on the same family's health problems, direct preparation for primary health care practice. At JNMC, AMU, Aligarh, integrating 150 first-year MBBS students with healthcare workers in an interprofessional FAP programme centred on IYCF produced significant improvements in student knowledge, mothers' feeding practices, and child dietary diversity, with communication skills ratings rising from 86.7% to 98% post-intervention [22]. Where co-location is not feasible, a structured visit alongside the ASHA worker or ANM achieves comparable learning, using the validated interprofessional FAP module developed by Ganganahalli et al. [14].

7. Institutional Prerequisites for Authentic FAP

Assessment reform will accomplish little if basic operational conditions are absent. Three prerequisites are non-negotiable.

Transport is the most frequently cited constraint [13,18,23]. Colleges with resources should dedicate a vehicle to FAP field days; others can coordinate with the District Health Officer for immunisation or VHND transport, since most block-level vehicles are underutilised on non-camp days.

The faculty mentor is the programme's fulcrum. A mentor who accompanies students, debriefs them after each visit, and maintains a working relationship with the village's ASHA worker and sub-centre staff transforms FAP from supervised fieldwork into something closer to genuine apprenticeship. A standardised one-day faculty development workshop — covering debriefing technique, the faculty rubric, and portfolio feedback — should be a departmental annual activity, a case well made elsewhere in the literature [26].

The third prerequisite is continuity: students must follow the same families across all three years. The accumulated relationship — trust built visit by visit, health trajectory tracked, face recognised at the doorstep — is what distinguishes authentic engagement from repeated first visits. Consider a student returning in Phase III to check whether the anaemic woman identified in Phase I started iron supplementation, finding she did not, and working with her to understand why — qualitatively different from meeting a new family for the first time in the final year. This is what produces a doctor who carries a community's health story as a professional obligation, not a curricular task.

CONCLUSION

FAP represents a genuine attempt to produce medical graduates accountable to the communities they will serve. The language shift from the 2022 to the 2024 NMC guidelines — from 'experiential learning opportunity' to 'critical platform for authentic learning' — reflects a real escalation of ambition, aligned with Boelen and Woollard's social accountability framework [8,9]. Whether this is currently realised in practice remains uncertain; most institutions appear to be delivering a high-quality experiential programme rather than the authentic one the 2024 framework describes.

The assessment framework proposed here is intended as a bridge between those two states. It does not require regulatory amendment, additional budget, or new curriculum hours. What it requires is departments willing to embed FAP performance indicators in Internal Assessment using van der Vleuten's utility criteria [16] as a guide, to calibrate faculty mentors annually, and to treat the student portfolio as a genuine academic artefact rather than a compliance document. In Miller's Pyramid terms [27], FAP logbook submission documents what students know (knows) and can demonstrate in structured settings (knows how). A portfolio-based, outcome-linked FAP assessment — with community feedback and faculty observation rubrics — begins to capture what students actually do in practice (does). Programmatic assessment [28] across three years of FAP, integrating multiple data points from field, faculty, and community, represents the gold standard toward which the proposed framework points.

It should be said plainly that this framework has not been empirically tested. It is built on published implementation evidence and established assessment theory, not on a pilot of its own; how the faculty rubric performs across raters, whether the portfolio adds meaningful information beyond the logbook it replaces, and how families and ASHA workers respond to being asked for structured feedback over a full academic year are questions this review can reason about but not answer. A prospective evaluation of the framework in Section 5 — ideally across more than one institution — is the logical next step.

For India's Community Medicine faculty, the concrete agenda is: finalise a departmental portfolio format, run a faculty mentor calibration day before the next batch begins, map FAP activities to CM5.1–CM5.16, link Phase II tasks to the family folder and ABHA infrastructure, and formalise the satisfactory completion gate subject to university regulations. Early institutional evidence — including interprofessional FAP initiatives demonstrating simultaneous gains in student competency and community health outcomes [22], though so far single-institution rather than multicentre — suggests this is an achievable agenda rather than a purely aspirational one.

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