

RESEARCH

Open Access



Is social prescribing feasible in Türkiye? Young family doctors' perspectives: a focus group study

Seyma Handan Akyon^{1*} , Duygu Ayhan Baser² , Ebrar Yazıcı³ , Hanin Hicazi Rıdvan⁴ , Irfan Sencan⁵ and Cristiano Figueiredo^{6,7}

Abstract

Background Social prescribing (SP) addresses patients' non-medical needs by connecting them to community-based services through structured referral pathways. While established in many European countries, SP remains unfamiliar in Türkiye. This qualitative focus group study examines family medicine resident doctors' perspectives on the applicability of SP in Turkish primary care.

Methods This single-centre qualitative study employed online focus group discussions (FGDs). Fourteen family medicine resident doctors were recruited and grouped into three focus sessions. Before the interviews, participants attended a one-hour briefing on the concept of SP. Data were collected through FGDs guided by a semi-structured interview guide, which were audio-recorded with consent and transcribed verbatim. Transcripts were anonymised and analysed in MAXQDA using inductive thematic analysis (Braun & Clarke). Coding was conducted independently by two researchers and finalised through consensus meetings. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Results Analysis yielded 292 codes organized into five themes: conceptual ambiguity, perceived benefits, the central role of family doctors, feasibility barriers and enablers, and training needs. Resident physicians viewed SP as aligned with holistic family medicine but identified multi-level barriers at the clinician level (time/workload), patient level (motivation/costs), and system level (coordination/capacity). They proposed corresponding enablers: physician training, public awareness campaigns, individualized planning, multi-stakeholder coordination, and institutional support.

Conclusion Resident doctors are cautiously optimistic about SP but emphasise practical constraints. They recommended priority actions including concise training, clear referral and feedback pathways with a defined social prescribing link worker, asset mapping, and multi-stakeholder collaboration supported by basic monitoring and evaluation. Pilot implementations in Family Health Centres could test feasibility and inform scale-up and curriculum integration.

Keywords Community health services, Social prescribing, Primary health care, Qualitative research, Implementation

*Correspondence:
Seyma Handan Akyon
drseymahandan@gmail.com

Full list of author information is available at the end of the article



© The Author(s) 2026. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/>.

Introduction

Social and economic conditions (47%) and behaviours (34%) drive health outcomes far more than medical care (16%), meaning that over 80% of health outcomes are influenced by factors beyond traditional medicine [1]. This necessitates coordinated action beyond clinical settings [2, 3]. Social prescribing (SP) is a person-centered approach enabling clinicians to address health-related social needs by connecting patients to community-based supports through structured referral pathways in primary care. In the standard model, a clinician refers to a link worker (community connector/navigator, often with a social work background) who co-produces goals, facilitates access to local assets (welfare advice, activity groups, arts/nature), and provides follow-up feedback to referrers [4, 5]. In this sense, social prescribing is increasingly framed as a practical instrument for integrating health and social care in the community [6]. Research shows potential benefits but mixed findings due to methodological limitations and varying contexts [5, 7]. SP is also discussed alongside lifestyle medicine as a supportive approach for chronic health problems [8]. Across reviews, recurrent facilitators include clear pathways, cross-sector collaboration, adequate link-worker capacity, and data feedback; barriers include time/funding constraints, variable community capacity, limited training, and weak information systems [9, 10]. Across Europe, general practitioners' awareness and use of SP vary, suggesting uneven implementation despite growing interest [11].

In Türkiye, primary care operates through Family Health Centres (FHCs), which provide first-contact,

longitudinal care [12], while fewer Healthy Life Centres (HLCs) offer multidisciplinary services with allied health professionals. Although HLCs provide preventive and lifestyle services (e.g., lifestyle counselling, screenings, psychosocial support), these are not framed in official documents as a standardised SP pathway with link-worker roles and closed-loop referral/feedback [13]. Understanding SP integration into Turkish primary care requires insights from family doctors most likely to initiate referrals. This qualitative study examines family medicine resident doctors' perspectives on the applicability of SP in Turkish primary care.

Methodology

Study design and timeline

This qualitative study was conducted through three focus group discussions (FGDs). A preparatory training session on SP was delivered to establish a common baseline, as SP is a relatively new concept in Türkiye (Fig. 1).

Research team and reflexivity

The research team comprised family medicine resident doctors and specialists, as well as three educators from different family medicine departments. The team held regular debriefings to reflect on their own roles and assumptions and to minimise bias. FGDs were moderated by two resident doctors-researchers (one from the study site and one from another centre). Moderators kept brief reflexive notes and debriefed after each FGD to identify potential biases.

Participant recruitment and data collection flow



Fig. 1 Participant recruitment and data collection process, including pre-session training, focus group attendance, and data analysis

Pre-session training: Social prescribing theory

A 60-minute lecture on SP provided resident doctors with a common conceptual framework. The briefing was developed based on the framework and recommendations set out in the World Health Organisation (WHO)'s toolkit on implementing social prescribing [4]. The session covered:

- Conceptual framework of SP.
- SP types and target populations.
- Referral pathways and requirements.

Participant recruitment and sampling

Participants were recruited using convenient, feasibility-oriented sampling to accommodate rotation schedules. Inclusion criteria were: (i) being an actively practising family medicine resident, (ii) willingness to participate, and (iii) provision of informed consent. The recruitment process is summarised in Fig. 1. Due to illness-related absences, fourteen resident doctors ultimately participated. Data sufficiency was achieved within these three FGDs. We monitored data sufficiency iteratively across FGDs by tracking the emergence of new codes and theme candidates after each session. After the third FGD, no substantively new themes emerged.

Grouping of participants

Three FGDs were planned to maximise interaction and breadth of perspectives. For sampling and group composition, we stratified participants based on prior exposure to social prescribing before the study briefing: (i) had attended a formal pre-study training session, or (ii) had not attended training but had accessed shared course materials beforehand (Fig. 1).

Data collection procedures

All online FGDs were held in Turkish via Google Meet, audio-recorded with informed consent, and transcribed verbatim. Participants were assigned unique identification numbers to ensure confidentiality, and no personal identifiers were included in the data. A semi-structured interview guide ensured consistency while allowing flexibility. Each session lasted about 50–60 min, and after the meetings, recordings were reviewed, transcribed, and anonymized before analysis. We translated the quotes into English, and a second bilingual researcher cross-checked them for meaning.

Development of the interview guide

The interview guide, finalised with reference to the pre-session training, addressed resident doctors' understanding of social prescribing, perceived facilitators/barriers, and practical integration in routine care (Table 1). All questions were developed and reviewed collaboratively by the entire research team, then internally piloted with two resident physicians not included in the study, and minor wording/order revisions were made for clarity and flow. Open-ended questions encouraged detailed reflections on lived experiences, values, and perceived challenges. Follow-up probes were used where necessary to deepen the discussion. The administration order was standardised as: (1) Demographic questionnaire, then (2) Semi-structured FGD guide.

Before each FGD, participants provided written informed consent and completed a brief demographic form capturing gender (Female/Male/Prefer not to say), age (years), residency year (Year 1/Year 2/Year 3/Year 4+), prior training or experience with social prescribing (Yes/No), and total years in the profession.

Table 1 Semi-structured focus group discussion guide

Section	No	Question
A. Opening	1	Could you briefly introduce yourself? (residency year, current rotation, etc.)
B. Concept Knowledge	2	Before the briefing, had you heard of social prescribing? What did it mean to you?
	3	Based on the briefing, how would you define social prescribing now?
	4	Do you think addressing patients' social needs beyond medical problems is part of the family physician's role?
C. Importance & Necessity	5	From your perspective as a (future) family doctor, what are the main benefits of social prescribing for patients and the health system?
	6	In your clinical practice, when patients raise social needs during a consultation, can you make time to explore them in more depth?
	7	In your opinion, what potential benefits might referring patients to volunteer or community activities have for their recovery and well-being?
D. Feasibility (in Türkiye)	8	Within the current family medicine system, how feasible is social prescribing, and to what extent?
	9	In busy outpatient settings, how could we implement such referrals?
	10	What challenges might arise in implementing social prescribing?
E. Barriers	11	What is needed for successful social prescribing?
F. Enablers & Solutions	12	How should social prescribing be incorporated into family medicine residency training? Which methods do you suggest?
G. Residency Training	13	Is there anything else you would like to add that we did not cover today?
H. Closing		

Data analysis

We conducted inductive thematic analysis of FGD transcripts following Braun and Clarke's approach. Two researchers independently coded the data, followed by consensus meetings and iteratively refined theme definitions to resolve discrepancies. Line-by-line open coding generated initial codes, which were iteratively compared, merged, and refined through constant comparison. Related codes were clustered into candidate themes, which were then supported by illustrative quotations. Researcher triangulation was employed throughout to enhance the credibility of the findings.

Use of qualitative software

We managed, coded, and visualized the data in MAX-QDA 2024 (VERBI GmbH, Berlin, Germany). This software facilitated efficient comparison across transcripts and enabled the development of thematic matrices.

Data management and confidentiality

Audio files and transcripts were stored in encrypted, access-restricted repositories. Transcripts were anonymised before analysis. In accordance with institutional policy, raw audio will be retained for up to 12 months (as approved by the ethics committee) for verification purposes, after which it will be securely destroyed.

Ethical approval

The study was approved by the Sincan Training and Research Hospital Scientific Research Ethics Committee, approval no. SEAH-BAEK-2025-36 (24 June 2025). All participants provided informed consent before data collection. All procedures involving human participants were conducted in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments.

Results

A total of 14 family medicine residents participated in three FGDs (4, 5, and 5 resident doctors in Groups 1, 2, and 3, respectively). The mean age of the participants was 28.9 years (median, 27; range, 25–43). Eleven participants were female, and three were male. By residency year, 12 were in Year 1, and 2 were in Year 2. Prior theoretical education on social prescribing was evenly distributed (Yes = 7; No = 7).

We generated 292 codes and organised them into five overarching themes (Fig. 2).

A summary of all themes, sub-themes, and representative illustrative quotes is provided in Table 2.

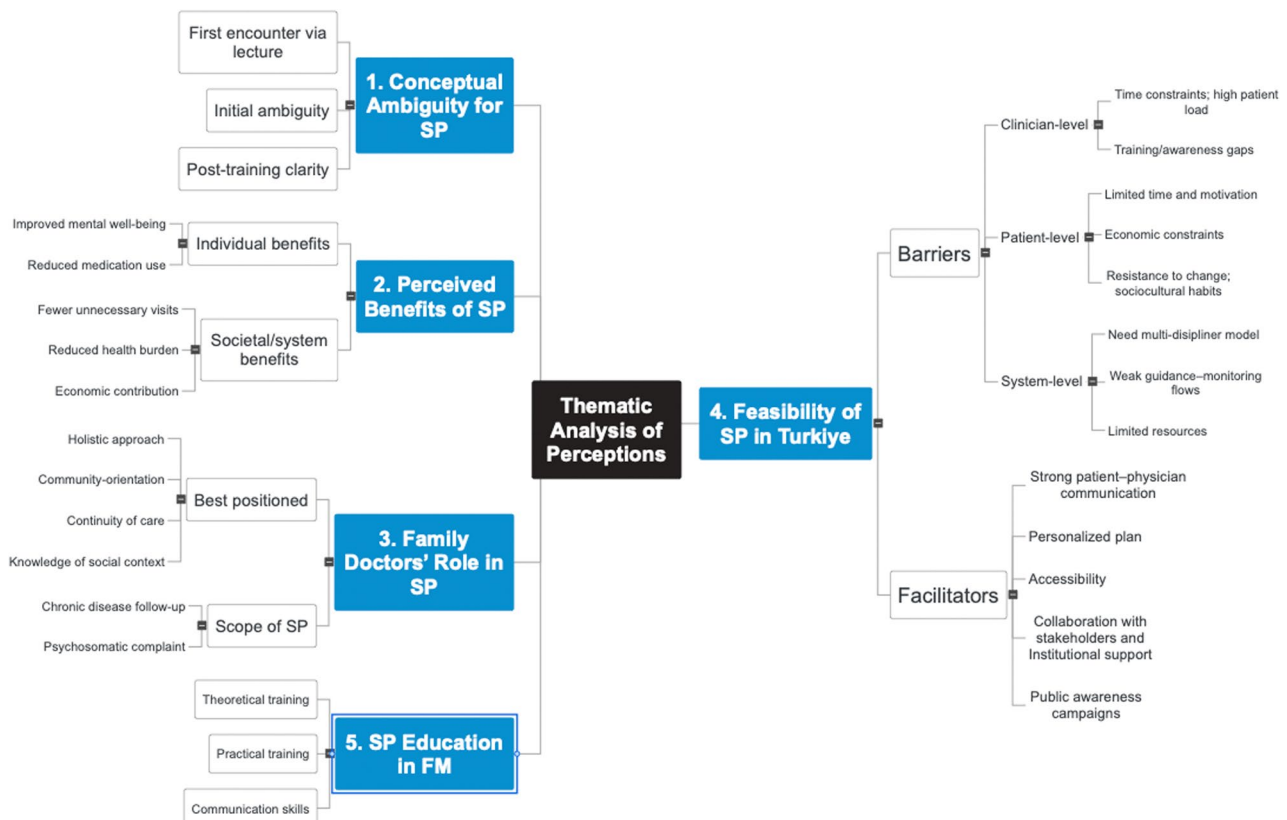


Fig. 2 Thematic analysis map of participants' perceptions of social prescribing

Table 2 Summary of themes, categories, and sub-categories

Themes	Categories	Sub-categories
Conceptual Ambiguity	Initial misassociation Post-briefing clarity Extended scope of SP	
Perceived Benefits	Individual-level Societal/system-level	
Family Physicians' Role	Holistic, community-oriented Need for a dedicated support unit	
Feasibility	Scope of SP Barriers	Clinician-level Patient-level System-level
	Enablers	Individualised planning Collaboration with stakeholders Accessibility Public awareness campaigns
Training Recommendations	Theoretical training Practical training Communication skills	

Theme 1. Conceptual ambiguity about social prescribing

None of the participants had encountered the term before the training sessions and initially associated it with unrelated ideas.

- ❖ Several reported first contact via the lecture, after which the concept became clearer.
- ❖ Early misassociations included neighbour-to-neighbour “medicine advice” or “alternative/herbal treatments.”

➤ “When I first heard ‘social prescribing’ I thought of neighbours recommending medicines to each other.” (FG1, line 36, female).

➤ “I first thought of herbal remedies, not this kind of thing.” (FG2, line 15, male).

- ❖ Following the training, participants emphasised that SP could formalise psychosocial recommendations alongside medical prescriptions:

➤ “Things we want patients to do but don’t put on the official prescription can actually be delivered via social prescribing.” (FG3, line 7, female).

- ❖ They also argued SP should extend beyond exercise and hobbies to include volunteering, animal welfare, environmental activities, and social aid:

➤ “Not just person-focused, helping animals, reforestation, social aid. Participation gives moral satisfaction and benefits the environment.” (FG1, line 88, female).

Theme 2. Perceived benefits of SP

Participants highlighted benefits at both individual and societal/system levels.

Category 1. Individual-level benefits

SP was seen as supporting mental well-being, coping with depression, and reducing medication use, with volunteering linked to greater self-esteem.

- ❖ “Exercise, theatre; these increase happiness and health, and reduce medicine use.” (FG2, line 54, female).

- ❖ “Some patients are tired of medications and are really asking for something different; SP can complete their care” (FG1, line 84, male).

Category 2. Societal/system benefits

Participants expected fewer unnecessary visits, a lighter service and drug burden, and economic gains:

- ❖ “The state’s drug burden and service load would decrease. The economic contribution would be large.” (FG3, line 39, female).

Theme 3. Family physician’s role perception in SP

Participants considered SP especially suitable for family physicians due to its emphasis on continuity of care and understanding of the patient’s social context.

- ❖ The role aligns with family medicine’s holistic, community-oriented competencies:

➤ *"It's our duty. Family medicine is built on a holistic, societal view; we're the most accessible at the first level." (FG2, line 38, female).*

❖ Still, participants stressed the need for multidisciplinary support and possibly a separate unit for planning and implementation:

➤ *"Family physicians can inform, but another unit should plan and run the activities." (FG2, line 42, female).*

Theme 4. Feasibility of SP in family medicine

Category 1. Scope of SP

❖ *SP was seen as particularly relevant in chronic disease follow-up and for psychosomatic presentations:*

"In chronic disease follow-ups, it may be in the form of whether there is such a need as far as I have observed." (FG1, line 71, male).

"Directly when the patient enters, if the complaint is a psychosomatic complaint, this can be considered directly." (FG1, line 72, female).

Category 2. Barriers

Subcategory 1. Clinician-level While most participants stated that SP is a valuable practice, they also emphasised that it is challenging to implement within the current healthcare system due to time constraints. The limited time available to physicians and the daily patient workload limit the application.

➤ *"In the outpatient clinic, this is difficult, both timewise and because patients may be reluctant to open up." (FG2, line 83, male).*

➤ *"Likewise, the number of patients is extremely high, the number of patients per doctor is already very high; generally, it may not seem very right to go into the patient's private matters sometimes, but I cannot spare much time." (FG2, line 70, male).*

❖ Follow-up is challenging and often depends on repeat visits.

➤ *"...Maybe it may be difficult to follow up. The patient needs to come again in this respect." (FG3, line 97, female).*

❖ Training and awareness gaps: physicians need structured knowledge of "where to refer and what to do."

➤ *"I think first of all, for it to be successful, education is needed. I mean, doctors need to know what it will be like. They need to know more systematically where they can refer to and what they can do..." (FG2, line 134, female).*

➤ *"First of all, I think we should be presented to the public as very well equipped in terms of information." (FG1, line 145, male).*

➤ *"We also need to gain a little more experience." (FG3, line 103, female).*

❖ Not all physicians will be willing to implement SP even after training.

➤ *"Yes, that is, at first, perhaps all family physicians need to receive training for this, need to have some knowledge about what social prescribing is. After knowing, not all of them may be willing to implement this..." (FG2, line 124, female).*

Subcategory 2. Patient-level

❖ Limited time and low motivation due to workload.

➤ *"It is beneficial, but I do not believe that our people will participate a lot. Everyone is up to their necks in work." (FG1, line 92, female).*

❖ Economic constraints limiting participation, even a daily 30-minute walk, may be neglected.

➤ *"But in their case, again, for example, due to time and economic reasons... for example, the patient does not give himself/herself the right to take a half-hour walk a day." (FG3, line 91, female).*

❖ Resistance to change is tied to sociocultural habits.

➤ *"And also, socioculturally, not all patients may want to participate in this, may not want to implement this likewise..." (FG2, line 130, female).*

❖ Need for personalised SP and attention to age-related challenges.

➤ *"Well, I also frankly think that there will be difficulties depending on age." (FG1, line 136, male).*

❖ Engagement often hinges on whether the patient signals readiness early in the encounter.

➤ *"The patient actually made it clear from his/her first step, from his/her first sentences, that he/she came for social prescribing. I think it depends on whether the patient reveals himself/herself and opens up or not."* (FG3, line 53, female).

Subcategory 3. System-level The fact that the multi-actor structure has not yet been institutionalised and that there are no "guidance-monitoring" flows has been frequently mentioned.

❖ Resource limitations and the need for state backing and planning were repeatedly emphasised.

➤ *"I definitely agree with what everyone says financially; I think that a larger plan needs to be made behind this, both as institutions that will provide their training and ensure its supervision; I think there may be such limitations."* (FG2, line 130, female).

Category 3. Enablers

❖ Training and awareness for physicians and the public; clinicians modelling healthy behaviours strengthens messaging.

➤ *"First of all, physician training is required. This awareness needs to be increased among physicians."* (FG1, line 145, female).

❖ Strong patient–physician communication and motivational framing.

➤ *"I think reaching the patient is very important. If you tell the patient to take a walk as they leave the room, they won't do it. I mean, you need to explain it a bit. In a slightly effective way, through the right communication path."* (FG3, line 111, female).

❖ Individualised planning based on interests, resources, and context.

➤ *"I think a special unit should be established to make a special plan for those whose financial situation is worse, and for those whose situation is better, to make a plan specific to them, to be in constant communication with them and to be able to spare time for this, to make it a little easier."* (FG2, line 136, male).

➤ *"I think that knowing the patient and what he/she is interested in ... and directing accordingly would be easier. Not everyone may want to walk or participate in a physical activity ... directing by getting to know them would be easier."* (FG2, line 144, male).

❖ Accessibility, including in-clinic group activities at FHCs.

➤ *"Other than that, other facilitators, in terms of accessibility, it needs to be easy. I think having activities that can be within the Family Health Centre would make it much easier."* (FG2, line 134, male).

❖ Collaboration with stakeholders, partnership and coordination among local governments (municipal/provincial authorities), FHCs, and NGOs; possibly a coordination unit for information and monitoring.

➤ *"Because the physician cannot handle it alone, definitely the most important thing here is cooperation, cooperation, cooperation. Because there are many items here, many types of social prescribing we use; I think cooperation is necessary for these."* (FG1, line 146, female).

❖ Institutional support and incentives will be provided once SP is integrated into the health system.

➤ *"The physician should be the manager, but adequate support should be provided ... adequate opportunities so that society and individuals can benefit ... it should not remain only with the effort of the physician."* (FG1, line 147, female).

❖ Public awareness campaigns/Public service announcements to normalise participation.

➤ *"Social awareness needs to be created."* (FG1, line 145, male).

Theme 5. Recommendations for SP education in family medicine

Participants described a three-layered training approach:

Category 1. Theoretical training

❖ Short, structured sessions covering SP principles and age/condition-specific menus of activities in the family medicine curriculum.

➤ “A half-hour slide session where the instructor shares experience could be enough to start.” (FG2, line 148, female).

Category 2. Practical training

➤ “Supervisors could collect monthly social prescribing forms and feedback... obtain consents... and document baseline and 2–3-week returns.” (FG1, line 153, male).

Category 3. Communication skills

❖ Emphasis on motivational interviewing, persuasion, and tailoring; reinforced by live demonstrations/videos/role-play and instruction on monitoring/feedback tools.

➤ “First, everyone needs to hear the concept of social prescribing and know what it is. Since we have a communication deficiency, we need to see how communication is done as a live example, maybe a video or role-play; as residents, seeing it live would be helpful.” (FG2, line 152, female).

Discussion

Five themes emerged: conceptual ambiguity, perceived benefits, the central role of family doctors, feasibility constraints, and training needs. Resident physicians identified key enablers, including physician training, patient education, individualized planning, accessible activities, and multi-stakeholder coordination. Participants described feasibility barriers at three levels: clinician (time constraints, workload, limited referral knowledge); patient (motivation, activity costs, lifestyle habits); and system (poor coordination, insufficient resources, lack of monitoring). These align with international literature's barrier–facilitator clusters, particularly time and funding constraints [14, 15].

The findings can be interpreted through an implementation lens: resident doctors recognised the relative advantage of social prescribing for holistic care, but also described low practical feasibility within routine primary care because of limited time, unclear referral pathways, and weak system readiness.

Concept of social prescribing

Participants' initial confusion (e.g., conflating SP with general lifestyle advice or “alternative” remedies) indicates that SP remains a relatively unfamiliar concept for resident doctors, reinforcing the need for training and implementation standards. The important point is that SP should be distinguished from general lifestyle counseling or health promotion: while HLCs in Türkiye provide

lifestyle advice and screenings, SP involves a formalized, closed-loop referral pathway through a designated link worker who provides feedback to the clinician who co-determines and guides goals; this is a structured process not yet found in current HLC operations [13].

An international Delphi study helped clarify SP by agreeing on conceptual and operational definitions and highlighting it as a structured, closed-loop pathway from non-medical needs to community connection and feedback [16]. Consistent with our briefing and subsequent discussions, resident doctors' movement from uncertainty to a pathway-oriented understanding reflects core models in practice guides and realist syntheses that frame SP [4, 10]. Resident doctors occasionally used paternalistic language (e.g. ‘things we want patients to do’), yet also articulated a holistic view of SP that extended beyond exercise or leisure to volunteering, animal welfare, environmental initiatives, and social aid.

Benefits of social prescribing

Participants' anticipated psychosocial gains (e.g., improved mood, purpose) and system-level dividends (e.g., less unnecessary utilisation). Qualitative studies report reduced loneliness, greater self-efficacy, healthier routines, and behavioral change, particularly when link workers have time to build trust [17–19]. Clinical updates also describe the potential to ease GP workload and reduce downstream demand, while noting the need for robust outcome frameworks [5]. Evidence on outcomes remains mixed, largely due to variation in SP models and evaluation methods, which limits strong causal conclusions [20]. More recent evidence suggests small but meaningful impacts on quality of life and population outcomes when SP is implemented at scale [21–23].

Central role of family doctors

Across high-income countries, SP is predominantly embedded in primary care, with general practitioners as the main referrers. A 13-country mapping review shows that evaluations typically focus on mental health, lifestyle, patient experience, service use, and economic impact; domains that align with family medicine's first-contact remit [24, 25]. These models position family doctors as key gateways linking patients' social needs to community connections, sustained by referral pathways, dedicated link workers, and feedback mechanisms [24–26]. Consistent with this international experience, our participants view family doctors as ideal SP initiators because of their continuity of care and understanding of patients' social contexts. Reviews indicate primary care's crucial role relies on physician commitment, clear referral pathways, skilled support staff (e.g., link workers, social workers) with sufficient time, and effective feedback systems [9, 10].

Barriers to social prescribing

In Turkey, family physicians manage registered patient lists (referred to as patient lists or panels in some systems) of ~ 3,600–3,700 patients, seeing 40–80 patients daily in 5–10 min consultations, highlighting structural time pressures for SP integration [27, 28]. These constraints make in-depth assessments and personalized referrals complex, consistent with international evidence showing workload pressures limit SP integration [29]. Similar concerns have been reported among GPs in Europe, where clinicians often see potential value in linking medical and non-medical supports but highlight workload, infrastructure, and coordination challenges [30]. Furthermore, physicians' lack of knowledge and awareness about 'where and how to refer' and inadequate follow-up/feedback loops may reduce the appropriateness and motivation for referrals [15, 31]. While resident physicians felt responsible for tracking patient attendance, established SP models allocate this follow-up to link workers who monitor engagement and report back [4]. This underscores the need for clearly defined follow-up responsibilities within SP pathways.

Participants identified low motivation, economic/time constraints, and sociocultural resistance as barriers to participation. The literature shows that engagement improves when referrals align with patient needs and when a supported transition to the first community contact is provided, rather than patients navigating services alone [10]. The informal multi-stakeholder structure, inadequate guidance and monitoring flows, and resource/funding issues highlighted in the focus groups align with the weak governance, rushed go-live, short-term funding, and capacity constraints in the third sector indicated by the systematic review [15]. In Portugal, a qualitative study identifies three primary barriers: inadequate cross-sector communication, limited user awareness, and insufficient robust monitoring data [29]. Implementation guides emphasize the importance of multi-stakeholder early preparation, community asset mapping, structured monitoring and evaluation, and leadership as essential to overcoming these barriers [4].

Enablers of social prescribing

Our findings regarding the need for 'physician training and awareness' are consistent with evidence showing that phased implementation, pre-meetings/workshops, standardised briefing and training, simple referral forms, and stakeholder participation facilitate SP [15]. Furthermore, the WHO recommends "Steps 5 and 6: Involving Everyone in the Process and Link Worker Training" to clarify roles across the team and establish communication and oversight mechanisms [4].

Resident doctors often referenced an undefined 'coordination unit' rather than concrete link-worker roles, reflecting limited SP insight despite prior education. Their suggestions for accessible activities and coordination within FHCs align with the literature, which emphasizes clear referral pathways, linking worker competence, and closed feedback loops [9]. These suggestions also highlight the need to adequately fund third-sector organizations, ensuring financial and geographic accessibility for low-income patients. A system-level model that integrates robust evidence-informed policy with dedicated funding for the voluntary and community sector, providing activities, is equally critical [32]. UK experience shows that making link workers visible through regular supervision, two-way feedback, and multidisciplinary integration increases uptake [4, 9]. In the Turkish context, HLCs, thanks to their existing multidisciplinary staff and preventive service responsibilities, are well-positioned to coordinate referrals from nearby FHCs, maintain local community resource records, and complete the feedback loop. However, without formal role definition, coordination, and funding, implementation will remain limited. Currently, hospital-based social workers address patients' needs on a case-by-case basis rather than systematically. These staff could be trained and positioned within HLCs to fulfill link-worker coordination roles.

Our findings emphasizing 'planning according to interest/conditions' and 'rapid early intervention' align with literature showing patient-centered approaches, accessible options, supported first appointments, and competent facilitators increase participation [4, 10]. This supports cross-sectoral communication training for family doctors, link workers, and community facilitators [4]. Participants' calls for cooperation among municipalities, FHCs, and NGOs align with evidence that SP should be designed as a multi-stakeholder program based on local assets, with continuous monitoring and evaluation [4, 15]. Building on our findings, implementation in Türkiye may be feasible through a stepwise approach (Fig. 3).

Resident doctors primarily viewed SP as a top-down, state-led intervention requiring national planning and funding, rather than a bottom-up movement. The Portuguese experience shows that communication strategy and early stakeholder engagement facilitate implementation, while a lack of intersectoral preparation hinders it [29]. Addressing participation will likely require reducing direct costs (e.g., activity fees, transport) and indirect costs (time off work), while pairing primary-care-centred workflows with municipal/third-sector funding and clear governance/feedback loops, conditions repeatedly associated with better engagement in international examples [24–26].

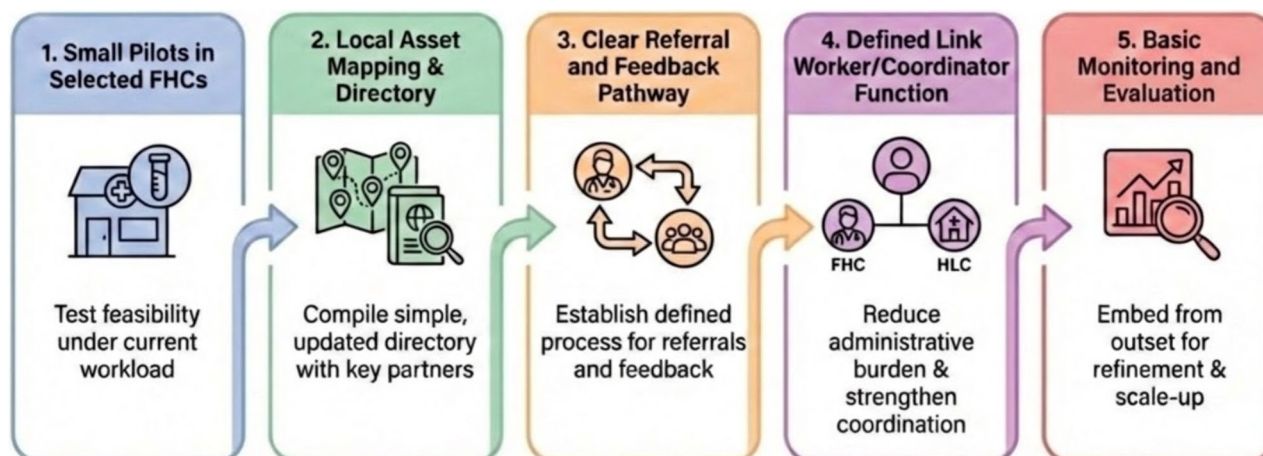


Fig. 3 Stepwise approach for implementing social prescribing in Türkiye

Strengths and limitations

This appears to be the first qualitative exploration of SP in Turkish family medicine training, adding locally grounded insights to an international evidence base often lacking country-specific perspectives. Limitations include single-center sampling, small sample sizes, and pre-session educational materials that may have primed participants toward particular SP models. To mitigate framing bias, the briefing session was structured around the WHO toolkit [4] and delivered by one researcher who did not moderate the FGDs; moderators were instructed to probe critically and explore both positive and negative views. Nevertheless, although the introductory lecture covered foundational concepts, it may have shaped views on SP's benefits and family doctors' central role. However, participants' perspectives on barriers, facilitators, and training needs reflect their own judgments. Most participants, being early in residency, were predominantly Year 1 residents from a single centre, which limits transferability to experienced or rural physicians. Their early-career stage may have shaped their implementation views, as these were formed before prolonged exposure to the time pressures and structural constraints of everyday primary care.

Conclusion

This study shows that family medicine resident doctors in Türkiye view SP as valuable and aligned with primary care principles, but challenging to implement under current service pressures and system constraints. They want SP for their patients and are willing to refer, yet prefer a top-down model in which another unit or a designated link worker leads implementation and coordination; time and workload, unclear referral pathways, patient motivation and access, and weak coordination and monitoring

emerge as key barriers. Enablers include standardised training, clear referral pathways with a link worker, asset mapping, multi-stakeholder partnerships, and basic monitoring systems, supporting small-scale pilots in Turkish primary care and educational modules before wider rollout.

Acknowledgements

We thank the family medicine resident doctors in Sincan Education and Research Hospital who participated in the focus group discussions for sharing their time and insights.

Disclosure statement

The authors declare no conflicts of interest.

Authors' contributions

SHA conceived the study and delivered the social prescribing briefing/training session. DAB and IS supported SHA in conceptualizing the study and planning the methodology. EY and HH conducted the online focus group meetings, transcribed the recordings, and translated the transcripts into English. SHA and DAB cross-checked the English translations for accuracy and meaning. SHA and DAB performed inductive thematic analysis using MAXQDA and developed the coding framework; themes were refined through consensus meetings and researcher triangulation. SHA wrote the main manuscript. CF and all authors reviewed the manuscript critically and contributed to revisions. All authors read and approved the final manuscript.

Funding

This research received no external funding.

Data availability

The anonymized transcripts and coding framework supporting the findings of this study are available from the corresponding author upon reasonable request, subject to ethical approval and participant confidentiality.

Declarations

Ethics approval and consent to participate

The study was approved by the Sincan Training and Research Hospital Scientific Research Ethics Committee, approval no. SEAH-BAEK-2025-36 (24 June 2025). All participants provided informed consent before data collection. All procedures involving human participants were conducted in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

¹Department of Family Medicine, Home Healthcare Unit, Sincan Training and Research Hospital, Ankara, Türkiye

²Department of Family Medicine, Hacettepe University School of Medicine, Ankara, Türkiye

³Department of Family Medicine, Ankara Education and Research Hospital, Ankara, Türkiye

⁴Department of Family Medicine, University of Health Sciences, Ankara Bilkent City Hospital, Ankara, Türkiye

⁵Department of Family Medicine, Sincan Training and Research Hospital, Ankara, Türkiye

⁶Primary Health Care Area, Unidade de Saúde Familiar da Baixa, Unidade Local de Saúde São José, Lisbon, Portugal

⁷NOVA National School of Public Health, Public Health Research Centre, Comprehensive Health Research Center, NOVA University Lisbon, Lisbon, Portugal

Received: 31 January 2026 / Accepted: 8 April 2026

Published online: 16 April 2026

References

- Hood CM, Gennuso KP, Swain GR, Catlin BB. Relationships Between Determinant Factors and Health Outcomes. *Am J Prev Med*. 2016;50(2):129–35. <https://doi.org/10.1016/j.amepre.2015.08.024>.
- Marmot M, Bell R. Social determinants and non-communicable diseases: time for integrated action. *BMJ*. 2019;365:l251. <https://doi.org/10.1136/bmj.l251>.
- Islam MM. Social Determinants of Health and Related Inequalities: Confusion and Implications. *Front Public Health*. 2019;7:11. <https://doi.org/10.3389/fpubh.2019.00011>.
- World Health Organization Regional Office for the Western Pacific. A toolkit on how to implement social prescribing. Website: <https://www.who.int/publications/i/item/9789290619765>. Published May 20. 2022. Accessed 24 Jan 2026.
- Drinkwater C, Wildman J, Moffatt S. Social prescribing. *BMJ*. 2019;364:l1285. <https://doi.org/10.1136/bmj.l1285>.
- Evers S, Kenkre J, Kloppe T, Kurpas D, Mendive JM, Petrazzuoli F, et al. Survey of general practitioners' awareness, practice and perception of social prescribing across Europe. *Eur J Gen Pract*. 2024;30(1):2351806. <https://doi.org/10.1080/13814788.2024.2351806>.
- The Lancet. Social prescribing: bringing community back to health? *Lancet*. 2025;406:103. [https://doi.org/10.1016/S0140-6736\(25\)01435-7](https://doi.org/10.1016/S0140-6736(25)01435-7).
- Baska A, Kurpas D, Kenkre J, Vidal-Alaball J, Petrazzuoli F, Dolan M, et al. Social Prescribing and Lifestyle Medicine-A Remedy to Chronic Health Problems? *Int J Environ Res Public Health*. 2021;18(19):10096. <https://doi.org/10.3390/ijerph181910096>.
- Tierney S, Wong G, Roberts N, et al. Supporting social prescribing in primary care by linking people to local assets: a realist review. *BMC Med*. 2020;18:49.
- Husk K, Blockley K, Lovell R, Boylan AM, Park S, Abrams R, et al. What approaches to social prescribing work, for whom, and in what circumstances? A realist review. *Health Soc Care Community*. 2020;28:309–24. <https://doi.org/10.1186/s12916-020-1510-7>.
- Kurpas D, Mendive JM, Vidal-Alaball J, Petrazzuoli F, Morad M, Kloppe T, et al. European Perspective on How Social Prescribing Can Facilitate Health and Social Integrated Care in the Community. *Int J Integr Care*. 2023;23(2):13. <https://doi.org/10.5334/ijic.7636>.
- Öcek ZA, Çiçeklioğlu M, Yücel U, Özdemir R. Family medicine model in Turkey: a qualitative assessment from the perspectives of primary care workers. *BMC Fam Pract*. 2014;15:38. <https://doi.org/10.1186/1471-2296-15-38>.
- Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü TC. Sağlıklı Hayat Merkezleri. Website: <https://hsgm.saglik.gov.tr/tr/shm>, Accessed 24 Jan 2026.
- Yadav UN, Paudel G, Ghimire S, Khatiwada B, Gurung A, Parsekar SS, et al. A rapid review of opportunities and challenges in the implementation of social prescription interventions for addressing the unmet needs of individuals living with long-term chronic conditions. *BMC Public Health*. 2024;24:306. <https://doi.org/10.1186/s12889-024-17736-2>.
- Peschery JV, Pappas Y, Randhawa G. Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC Health Serv Res*. 2018;18:86. <https://doi.org/10.1186/s12913-018-2893-4>.
- Muhl C, Mulligan K, Bayoumi I, Ashcroft R, Godfrey C. Establishing internationally accepted conceptual and operational definitions of social prescribing (CUSP): a Delphi study. *BMJ Open*. 2023;13:e070184. <https://doi.org/10.1136/bmjopen-2022-070184>.
- Moffatt S, Steer M, Lawson S, Penn L, O'Brien N. Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ Open*. 2017;7(7):e015203. <https://doi.org/10.1136/bmjopen-2016-015203>.
- Wildman JM, Moffatt S, Steer M, Laing K, Penn L, O'Brien N. Service-users' perspectives of link worker social prescribing: qualitative follow-up. *BMC Public Health*. 2019;19:980. <https://doi.org/10.1186/s12889-018-6349-x>.
- Jensen A, Bungay H. Swedish primary-healthcare practitioners' perspectives on Arts on Prescription. *BMC Health Serv Res*. 2021;21:1277. <https://doi.org/10.1186/s12913-021-07258-7>.
- Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ open*. 2017;7(4):e013384. <https://doi.org/10.1136/bmjopen-2016-013384>.
- Hawthorne K, Osborn-Forde C. The growing evidence base for social prescribing. *Lancet*. 2025;406(10507):1007. [https://doi.org/10.1016/S0140-6736\(25\)01686-1](https://doi.org/10.1016/S0140-6736(25)01686-1).
- Munford LA, Wilding A, Bower P, Sutton M. Effects of participating in community assets on quality of life and costs of care: longitudinal cohort study of older people in England. 2020;10:e033186. <https://doi.org/10.1136/bmjopen-2019-033186>.
- Wilding A, Agboraw E, Munford L, Sutton M, Mercer SW, Salisbury C, et al. Impact of the rollout of the national social prescribing link worker programme on population outcomes: evidence from a repeated cross-sectional survey. *Br J Gen Pract*. 2025. <https://doi.org/10.3399/BJGP.2024.0542>. :BJGP.2024.0542.
- Scarpetti G, Shadowen H, Williams GA, Winkelmann J, Kroneman M, Groenewegen PP, et al. A comparison of social prescribing approaches across twelve high-income countries. *Health Policy*. 2024;142:104992. <https://doi.org/10.1016/j.healthpol.2024.104992>.
- Pola-García M, Enríquez Martín N, Turón Lanuza A, Méndez-López F, Gasch-Gallén Á, Lou Alcaíne ML, et al. Assessing the implementation and impact of a social prescribing protocol in primary care. *BMC Prim Care*. 2025;26:169. <https://doi.org/10.1186/s12875-025-02862-6>.
- Martínez G, Davidson Carroll G, Rodríguez AK, Burch S, Colverson AJ, Pesata V, et al. Social prescribing outcomes: a mapping review of the evidence from 13 countries to identify key common outcomes. *Front Med (Lausanne)*. 2023;10:1266429. <https://doi.org/10.3389/fmed.2023.1266429>.
- Yavuz E, Yayla ME, Kırımlı E, Bilge U, Çelik SB, Demirtaş HF, et al. Daily Workload And Service Profile Of Family Physicians In Turkey: A Snapshot Of One-Day Work. *Konuralp Med J*. 2020;12(2):175–82. <https://doi.org/10.18521/ktd.659576>.
- Republic of Turkey Ministry of Health. Health Statistics Yearbook. 2023. Ankara: Ministry of Health; 2024. website: <https://sbsgm.saglik.gov.tr/TR-93567/health-statistics-yearbook.html>. Accessed 24 Jan 2026.
- Hoffmeister LV, Gama A, Gonçalves B, Figueiredo C, Cordeiro JV, Polley M, et al. Implementing a social prescribing program in primary care units in Portugal: A qualitative study exploring enablers, barriers and lessons learned from the perspectives of stakeholders involved in the program implementation. *PLoS ONE*. 2024;19(6):e0306404. <https://doi.org/10.1371/journal.pone.0306404>.
- Herrmann WJ, Napierala H. GPs' perspectives on care models integrating medical and non-medical services in primary care—a representative survey in Germany. *BMC Prim Care*. 2024;25:441. <https://doi.org/10.1186/s12875-024-02693-x>.
- Au Eong JTW. The challenges and rewards of social prescribing in family medicine. *Front Health Serv*. 2024;4:1446397. <https://doi.org/10.3389/frhs.2024.1446397>.
- Morris D, Thomas P, Ridley J, Webber M. Community-Enhanced Social Prescribing: Integrating Community in Policy and Practice. *Int J Community Well-Being*. 2022;5(1):179–95. <https://doi.org/10.1007/s42413-020-00080-9>.

Publisher's note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.