UCL
THE BARTLETT

Integration of Social Prescribing into Primary Health Centres in Rural India:

A Built Environment Framework for Equity and Resilient Care

Theme: Creating Sustainable Healthcare Systems to promote Health, Equity and Resilience in Times of Global Crises

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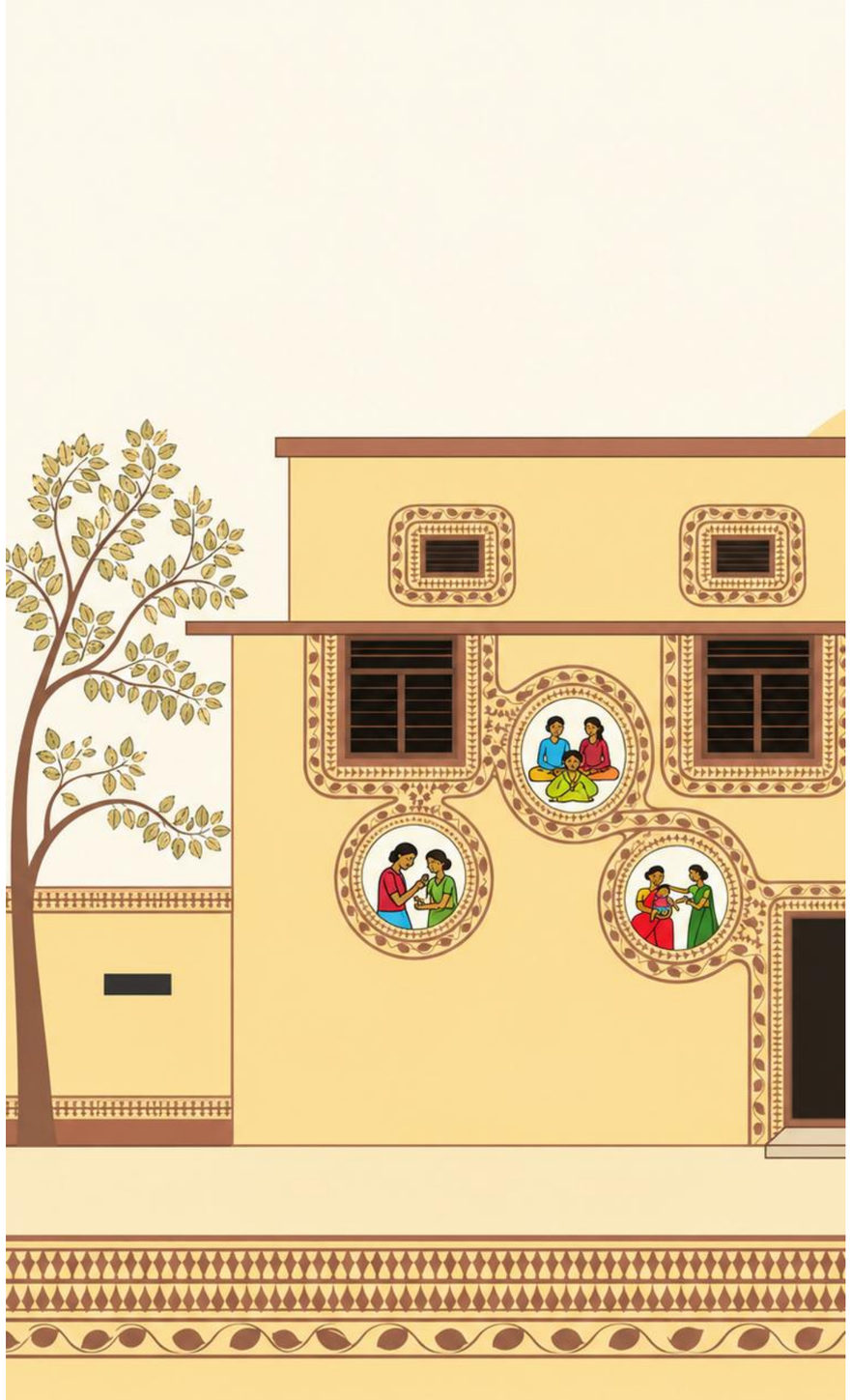
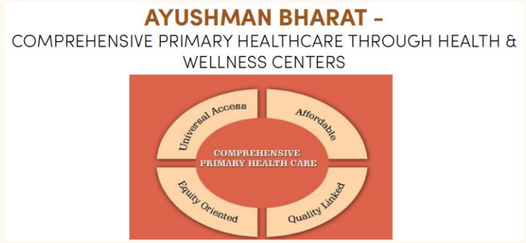


Why this matters?

Primary care is where health inequity becomes visible

- Over 65% of India’s population lives in rural areas.
- Rural PHCs are often the first formal point of care.
- Many health needs are shaped by social conditions, not only disease.
- Current PHC models remain largely biomedical, episodic, and visit-driven.



Policy-backed comprehensive care, but social and mental-health support still lack a clear place and pathway

What Social Prescribing Adds?

Prevention and Health Promotion

Social Participation and Well-being

Mental health and Loneliness support

Navigation to welfare and community resources

Shifts PHCs from reactive treatment to proactive, community-linked health management while reducing avoidable clinical load

SP helps reposition PHCs as Health-promoting services – not only treatment points

Research Aim & Objectives

Aim:

To develop an evidence-informed framework for integrating Social Prescribing into rural Indian PHCs through built environment and service-delivery adaptations.

Objectives:

- Assess rural PHC readiness for Social Prescribing, including spatial and service-delivery gaps.
- Examine global community-based models to identify transferable lessons.
- Evaluate Indian health policy support for non-clinical and built environment interventions.
- Propose a PHC-level implementation framework adapted to rural India, with Built-environment provision as a Core Enabler.

Analytical Framework

WHO Social Prescribing enablers + Built Environment

1. **Link Worker Role**
   Defined responsibilities, training, and ongoing support
2. **Referral Pathways**
   Structured, trackable systems (paper or digital)
3. **Community Asset Mapping**
   Updated service directories for tailored signposting
4. **Multisector Collaboration**
   Formal coordination across health, housing, education, and welfare
5. **Primary Care Integration**
   Embedded into care pathways with team-based delivery
6. **Policy and Governance**
   Institutional recognition, funding, and regulation

Added lens 7 **Built Environment Readiness**

To assess how spatial configurations support or constrain SP delivery, with attention to consultation rooms, wellness areas, and shared community spaces.

Source: WHO 2022. A toolkit on how to implement social prescribing, Manila, World Health Organization Regional Office for the Western Pacific. Built Environment lens added by author.

Method and Case Selection

01

India

Baseline Readiness
Case across the workforce, referral, digital, governance and spatial

02

Brazil

Family Health Strategy / UBS: embedded CHWs and purpose-ready primary care spaces

03

England – Link Worker

PCN integrated model: formal connector role, referral systems, supervision and follow-up

04

England - Bromley by Bow

Co-located exemplar: welcome spaces, gardens and visible community support

Qualitative Desk-based Comparative Case Study Synthesis

India

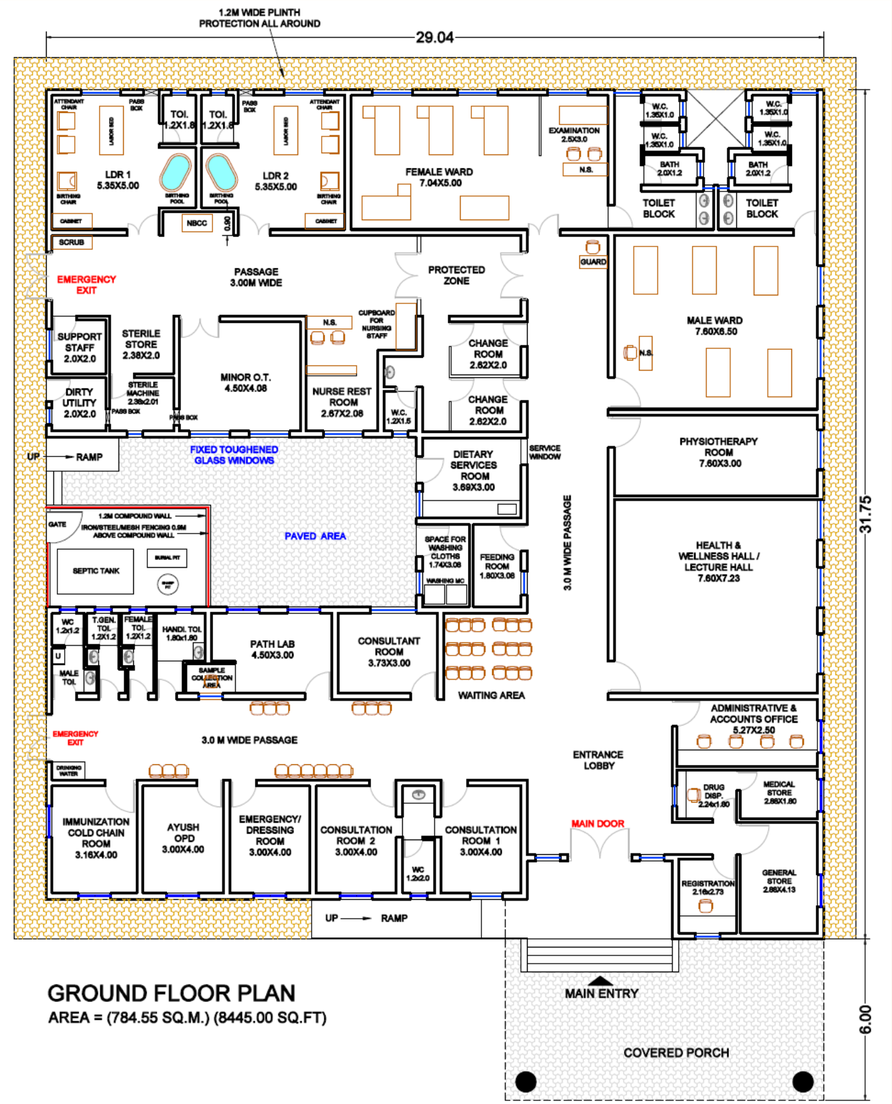
WHO Enabler	Current Foundation	Critical Gap
Link-Worker Role	Community Health Workers (ASHA), and PHC Staff (ANM, MPW, CHO) already connect communities with PHCs.	No formal SP connector function, protected time, training or supervision.
Referral Pathway	ASHAs informally guide people to schemes, Anganwadi Centres, NGOs and health programmes. Tele-MANAS National Mental Health support.	No standardized non-clinical referral form, feedback loop or follow-up record.
Community Assets	Village Health Committees and Groups (VHSNCs, JAS, SHGs), NGOs, AYUSH and local welfare actors exist.	Assets are not routinely mapped, displayed, updated or embedded into PHC workflows.
Multi-Sector Collaboration	National Health Policy and initiatives, JAS, VHSNCs support convergence with non-health sectors and community platforms.	Collaboration remains fragmented across NGOs, AYUSH, welfare and local governance.
Primary Care Integration	AB Health and Wellness Centres and IPHS shift PHCs towards comprehensive, preventive and promotive care.	SP is not yet part of routine OPD, outreach, documentation or team coordination.

Accredited Social Health Activist (ASHA)

1,003,790 ASHAs in position

- **CHWs** with **strong household-level reach**, with an expanding role supporting wider HWC services.
- **Incentivised Female Volunteers** receiving pre-deployment training and covering 1000 people, working up to 20 Hrs./Week across nearly 30 Programmes.
  Informal Navigation to Community Assets.
- Limited **Welfare**: **ASHA Room**/Ghar in some locations.

Source: NHSRC 2023. ASHA UPDATE 2022-23 Local Leaders, Global Impact: ASHAs Changing Lives.



HWC PHC Ground Floor Plan

India's readiness through the Built Environment lens

Medicalised Spatial Focus

- Indian Public Health Standard PHC layouts prioritise consultation rooms, examination areas and ward-based functions.

Generic Health & Wellness Room

- Included in IPHS, but with limited programming for group wellness, counselling, health education, AYUSH or community-led support.

CHW Spatial Gap

- ASHAs, MPWs, ANMs and CHOs are recognised in service delivery, but lack workflow-ready space.

Welfare space ≠ workflow space

- **15,667 ASHA Resting rooms** are reported nationally to support rest/welfare rather than PHC-level coordination.

Underused Wellness Infrastructure

- Evidence from a sample of **16 HWC sites** found that only **18.75%** implemented wellness activities, and fewer than half conducted IEC activities.

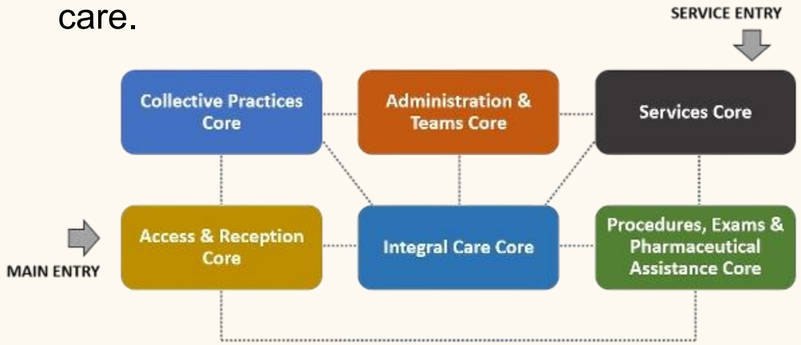
Source: MOHFW 2022b. Indian Public Health Standards Health and Wellness Centre-Primary Health Centre. In: WELFARE, M. O. H. F. (ed.).

New PAC UBS Standardized Floor Plan

Brazil

Family Health Strategy & Requalifa UBS

- Brazil's SUS provides universal healthcare through decentralized, equity-oriented primary care.
- The Family Health Strategy embeds community health agents within local primary care teams.
- Community Health Agents are salaried, supervised, and linked to household outreach and UBS-based care.



UBS Spatial thematic nuclei for psychosocial care and community engagement

UK model of Social Prescribing

England

National Link Worker Model in Primary Care Networks (PCNs)

- Social Prescribing Link Workers are embedded in Primary Care Networks.
- Supervision, induction and competency frameworks support role clarity.
- SPLWs hold personalized conversations, co-produce social care plans and connect people to community services.
- Lack of dedicated spaces for SPLWs in GP Estates, SP delivery relies on VCFSE and community venues.

UK Bromley by Bow Campus

England

Bromley by Bow:

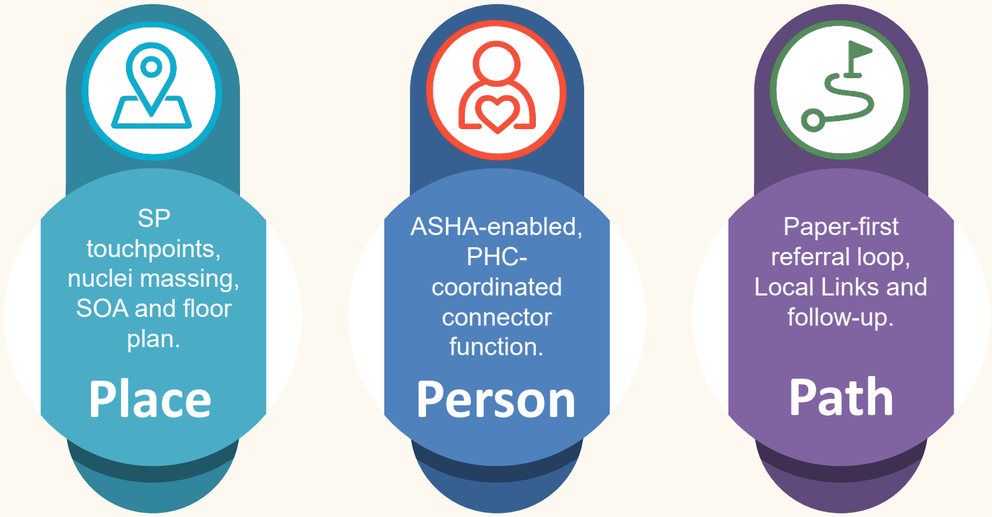
Co-located Health and Wellbeing Campus

- Charity-led community services are co-located with primary care.
- The Welcome Hub acts as a shared front door for clinical, social, welfare and community support.
- Permeable routes between health centre, advice, activity spaces and gardens.
- Therapeutic gardens and informal seating create dwell time, conversation and trust.
- Short routes and visible offers reduce the gap between identifying need and accessing support.

Comparative Synthesis

	Case/ Context	Mechanism Identified	India fit Translation
01	**Brazil**	Embedded CHAs + UBS nuclei for group, psychosocial and community care.	Use nuclei logic to cluster PHC functions around clinical, connector, wellness and community interfaces.
02	**England SPLW**	Formal Link Worker role, referral documentation and governance.	Create an ASHA-enabled, PHC-coordinated connector function and capture a minimal referral dataset.
03	**England Bromley by Bow**	Co-location, Welcome Hub, gardens, Local Links and warm handovers.	Make local support visible through Welcome/Help Point, Partner Desk and Local Links Wall.
04	**India Baseline**	ASHAs, HWCs, VHSNCs, JAS, AYUSH and policy intent already exist.	Organize and coordinate existing assets rather than creating a new vertical programme.

Proposed PHC Level Framework



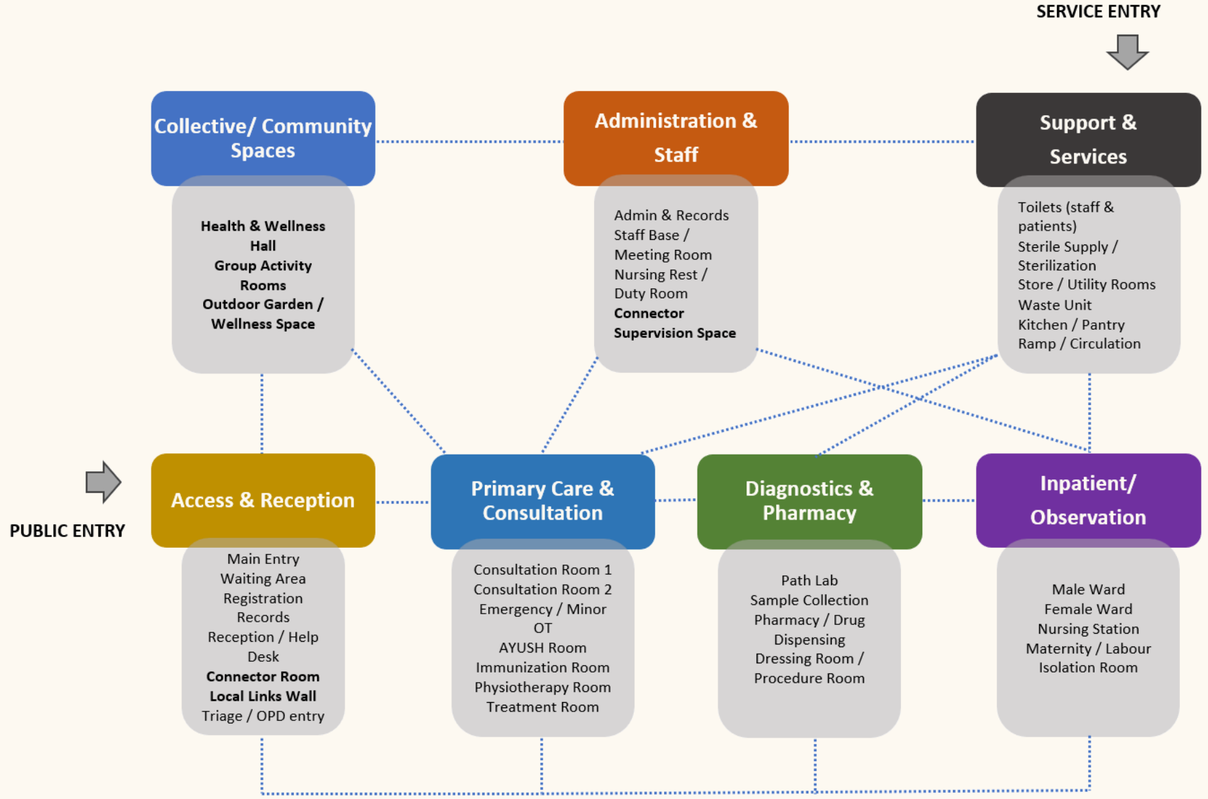
Design outputs

SP touchpoints | Nuclei massing | SOA addenda | PHC workflow pathway

Spatial Principles:

VISIBILITY | **CONFIDENTIALITY** | **SHORT-PATH ADJACENCY** |

FLEXIBILITY | **COMMUNITY INTERFACE** | **LOW-COST ADAPTABILITY**



SP Enabled PHC Massing - Nuclei model

Recommendations: Pathway and Policy

Operational Pathway

Without **Spatial provision**, this pathway remains informal; with defined rooms, touchpoints and adjacencies, it becomes operational.

Practical Recommendations

- **IPHS Guidance:** Define the connector room, wellness room, Local Links, partner desk and outdoor space.
- **Programmed Spaces:** Health & Wellness Room for group support, AYUSH/yoga, peer activity and counselling.
- **Visible Community Interface:** Place Local Links wall and Partner Desk in reception/waiting zone.
- **Paper-first Referral:** Capture need, asset referred to, date, attendance and 6–12-week outcome.

Policy Implications

- **Ayushman Bharat:** Strengthens comprehensive care without creating a new vertical programme.
- **IPHS Addenda:** Use light-touch updates: adjacencies, signage, storage, timetable and privacy.
- **ABDM Alignment:** Later add simple non-clinical referral fields and periodic sync.
- **District Partnerships:** Build micro-partnerships with NGOs, SHGs, AYUSH, welfare actors and local groups.

Thank You!

“Health promotion begins when care moves beyond illness - towards places, people and pathways that enable communities to live well.”