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Social franchising in healthcare: a systematic review and narrative synthesis of implementation and outcomes

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ABSTRACT

Introduction The growing prominence of social franchising in healthcare underscores the need to analyse its implementation and impacts; however, substantial research gaps remain. Therefore, we aimed to conduct a systematic review and narrative synthesis of evidence to analyse the social franchise models, implementation and outcomes.

Methods We conducted a systematic literature search in February 2024 on Medline, Embase, PubMed, Web of Science, CINAHL and Scopus using terms related to 'social franchising' in healthcare. We conducted a qualitative narrative synthesis of study findings into five thematic areas: client impact and utilisation, healthcare outcomes, financial sustainability, innovative technologies and awareness activities.

Results From 4184 search results, 47 studies were included in the analysis. We identified 29 social franchises across 25 countries. Social franchises were mostly present in Africa, Asia and Central America. Most franchises focused on sexual, reproductive and maternal health (n=18) and family planning (FP) (n=25), and most included training (n=21), service provision (n=17) and financial support (n=12). Franchising improved client volumes, satisfaction and contraceptive continuation rates and increased access to healthcare. Vouchers and subsidised services reduced the financial burden among clients. Telemedicine and call centres enhanced healthcare delivery, and community outreach and marketing increased awareness and modern contraceptive use. However, franchises struggled to reach poorer populations due to high fees and competition from public services. It often did not improve FP, reproductive healthcare and child nutrition and had limited branding and promotional activities. Additionally, heavy reliance on donor funding threatened long-term sustainability.

Conclusion Social franchising presents a potential strategy for expanding healthcare access and improving service delivery, though outcomes regarding the effectiveness of social franchising vary across regions. More research is needed to evaluate digital technology use and the long-term impact, equity and sustainability of social franchising.

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WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Healthcare disparities and the rise of private alternatives have driven the need for social franchising to improve service quality, satisfaction and accessibility.

⇒ Existing evidence on social franchising's impact and benefits is limited and outdated, highlighting the necessity for further research.

WHAT THIS STUDY ADDS

⇒ Social franchising improves client volumes, satisfaction, contraceptive continuation rates and access to healthcare services.

⇒ Challenges remain in reaching poorer populations, ensuring sustainability without donor funding, maintaining consistent improvements in healthcare delivery and overcoming poor promotional activities.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study provides crucial evidence on social franchising's implementation outcomes, guiding future research, informing healthcare practices and shaping policies to enhance healthcare delivery in low-resource settings.

INTRODUCTION

In numerous countries, disparities in access to healthcare services, coupled with issues of quality, a shortage of health professionals and escalating healthcare costs, are pervasive challenges.[1 2] Low- and middle-income countries (LMICs) often grapple with inadequately prepared and funded public health sectors, which has contributed to a surge in private healthcare alternatives driven by rising incomes and public service limitations.[3 4] Despite the expanding private healthcare sector, concerns persist regarding the quality and distribution of healthcare services.[3] In many countries, the private health sector suffers from fragmentation

and lacks economies of scale, financial robustness and robust quality control mechanisms. Social franchising has emerged as a strategic avenue to engage the private health sector to enhance the quality of health service delivery, customer satisfaction, client flow and service accessibility.[5]

The term 'social franchise' denotes a network of contractual relationships, typically spearheaded by non-governmental organisations, using the structure of a commercial franchise to achieve social objectives.[6] Social franchises often provide subsidised services to achieve a lower out-of-pocket cost for clients, alongside a distinctive brand name or logo that unifies all service delivery sites.[7] In this network, the franchiser plays a pivotal role in conceptualising a social framework, ensuring network coherence and promoting uniformity among franchisees.[8 9] While franchisees benefit from using the proven model and brand name to achieve social goals, they must adhere to quality standards, share sales and service data and, in some cases, pay franchise fees.[6]

Despite the extensive use of social franchising, the evidence of its market impact, sustainability and socioeconomic benefits remains weak and outdated.[10] Other reviews revealed gaps in understanding client perceptions and the value of franchising in different healthcare contexts.[5 11] Beyeler and colleagues found that while social franchising can improve client satisfaction and service access, there is a lack of robust data on cost-effectiveness and equity.[12] Additionally, there is insufficient evidence on how private sector interventions affect the poor, with many studies failing to address the broader aspects of these interventions.[10] Another review reported uncertainty about whether social franchising models genuinely extend universal access to reproductive health.[13] There is also a general lack of rigorous research evaluating the actual health outcomes of social franchising programmes.[14] To address the significant knowledge gaps identified, this review seeks to answer the following questions: why were social franchises initiated, where were they located globally, how were these franchises implemented and what were the outcomes of franchises? We, therefore, conducted a systematic review and narrative synthesis of evidence to analyse the social franchise models, implementation and outcomes.

METHODS

Study design and search strategy

We conducted an electronic systematic literature search on PubMed, Web of Science, Medline, Embase, CINAHL and Scopus. Search terms included franchise OR franchises OR franchising OR franchised OR franchisee OR franchisees OR franchiser OR franchisers OR enfranchis* OR social franchis* OR health franchis* OR clinical franchis*. A detailed search strategy is available in online supplemental material 1. All records identified with the search terms were considered for screening without date restriction. Database searches were executed in February 2024. We also conducted a forward citation search of relevant systematic reviews and included articles to identify additional studies for our analysis. Duplicate articles were eliminated using EndNote. We adhered to the Preferred Reporting Items for Systematic Review guidelines in constructing this review, as outlined in online supplemental material 2.[15] Articles were distributed equally among five reviewers for abstract screening. Selected articles for full-text review underwent an additional search to find the full text. The same team of five reviewers independently conducted a full-text screening of all selected articles. Any discrepancies in the selection of articles to include in the final analysis were resolved through a discussion. Microsoft Excel was used for the systematic management of the abstract and full-text screening and data extraction.

Criteria for study selection

We included empirical studies employing quantitative, qualitative and mixed-method designs. All levels of healthcare and all types of patients/consumers and healthcare professionals/providers were included in the study. We excluded review articles and studies limited to delivering messages or commodities alone, commonly referred to as social marketing. Services not delivered by formal health providers were excluded, as they may lack the standardisation and reliability needed for consistent health intervention assessments. Franchises unrelated to healthcare, grey literature and literature not in English were also excluded from our analysis. Community healthcare workers were considered as healthcare providers in this study.

Data extraction and narrative synthesis

We used a qualitative narrative synthesis approach to organise and summarise the extracted data. We used a structured data extraction form to collect relevant information from each included study. The extracted data included author, year, franchise names, country, study design, interventions, main findings and funding of the research (online supplemental material 3). If information about any variable was unavailable, we marked the corresponding cell as unclear. Another form was used to list the social franchises and extract data, including franchise name, initiation year, country, health areas, intervention, intervention categories, outcome, government collaboration, the scope of operations (local, regional or national), demand creation, online platform and funding of the social franchise implementation (SM 4). Social franchises were classified into 'International Chain', 'Founded in the Global South' or 'Local' categories based on their funding sources and the extent of their network. If information about any variable was unavailable, we marked the corresponding cell as unclear.

Social franchises were categorised into four health areas including sexual, reproductive and maternal health, family planning (FP), communicable diseases (tuberculosis (TB), malaria, diarrhoea, sexually transmitted

infections and pneumonia) and newborn, infant and child health. The intervention mechanism of the social franchises was categorised into training and capacity building, service provision and access, promotion and demand creation, financial support and subsidies, and quality assurance and monitoring. We identified patterns and themes across studies to understand commonalities and differences in implementation experiences and outcomes, which were synthesised into five thematic areas.

- **Client impact and utilisation:** evaluate the needs, utilisation, knowledge and satisfaction of healthcare services among the clients.
- **Healthcare outcomes:** evaluate the social franchise's impact on health improvement among the clients.
- **Financial viability and sustainability:** assess the economic stability and long-term sustainability of healthcare services, focusing on cost-effectiveness and financial benefits for providers and clients.
- **Innovative strategies and technologies:** explore novel methods and technologies that enhance healthcare delivery, accessibility and monitoring.
- **Awareness and demand generation:** involve activities aimed at increasing public knowledge and demand for healthcare services.

Patient and public involvement

This systematic review did not involve directly the patient or the public. As a systematic review, it relied on secondary data from previously conducted studies.

RESULTS

From a total of 4184 search results, 142 studies were selected for full-text review, of which 47 studies were included in the analysis and review (figure 1). There were 18 cross-sectional, 11 quasi-experimental, five mixed method, four qualitative, three descriptive, two cohort, two cost-effectiveness analysis, one non-inferiority trial and one cluster-randomised evaluation studies. The included papers were published between 2004 and 2021, with the greatest number of papers published in 2018 (n=7) (online supplemental material 3).

Global distribution of social franchises

We identified a total of 29 social franchises implemented in 25 countries. Social franchises were concentrated in Africa, Asia and Central America (figure 2).

Health area and interventions of social franchises

Most of the social franchises addressed sexual, reproductive and maternal health (n=18) and FP (n=15), followed by communicable disease (n=6). The majority of social franchise interventions focused on training and capacity building (n=21), service provision and access to healthcare (n=17) and financial support and subsidies (n=12) (figure 3).

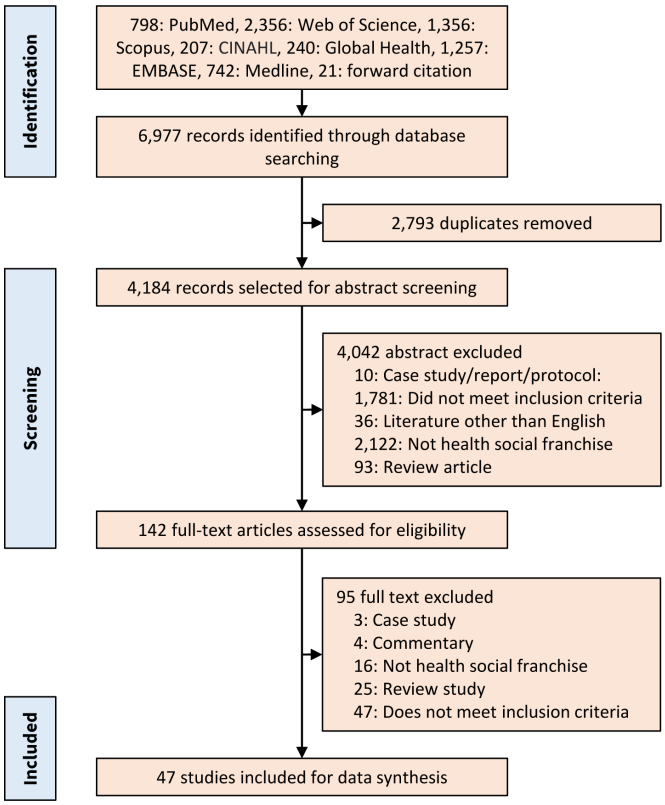

Figure 1 Flow diagram of the study selection process.

Why social franchises were initiated?

The social franchises were initiated to address various issues in reproductive health, FP and general healthcare services, particularly in underserved regions. In Pakistan and Nepal, efforts included addressing high levels of unmet FP needs among urban poor,[16] inadequate resources for reproductive health and FP[17 18] and disruptions caused by COVID-19 impacting contraceptive prevalence.[19] They also aimed to tackle low contraceptive prevalence rates,[20 21] low utilisation of long-acting reversible contraceptives (LARCs) due to misperceptions and lack of trained providers,[22 23] high unmet needs for FP in rural areas[24] and low usage and high discontinuation rates of intrauterine contraceptive devices (IUCDs).[25] Efforts focused on improving maternal health services in private facilities,[26] ensuring the quality and standardised services in FP across private health facilities[27] and addressing the lack of access to accurate information for self-managing medical abortions.[28]

In Myanmar, there was a focus on improving access to quality TB treatment,[29] essential medicines,[30] malaria treatment,[31] diarrhoeal death[32] and tackling low uptake of modern contraceptive methods.[33] Social franchises in Kenya faced aimed to tackle low contraceptive prevalence and access to FP services,[34–36] disparities in access across wealth quintiles[37] and improving service quality in the private sector.[27 38] In Vietnam, the franchise aimed to improve infant and young child feeding (IYCF) practices,[39–41] reduce poor perceptions of service quality[42] and address suboptimal infant feeding practices.[43] The

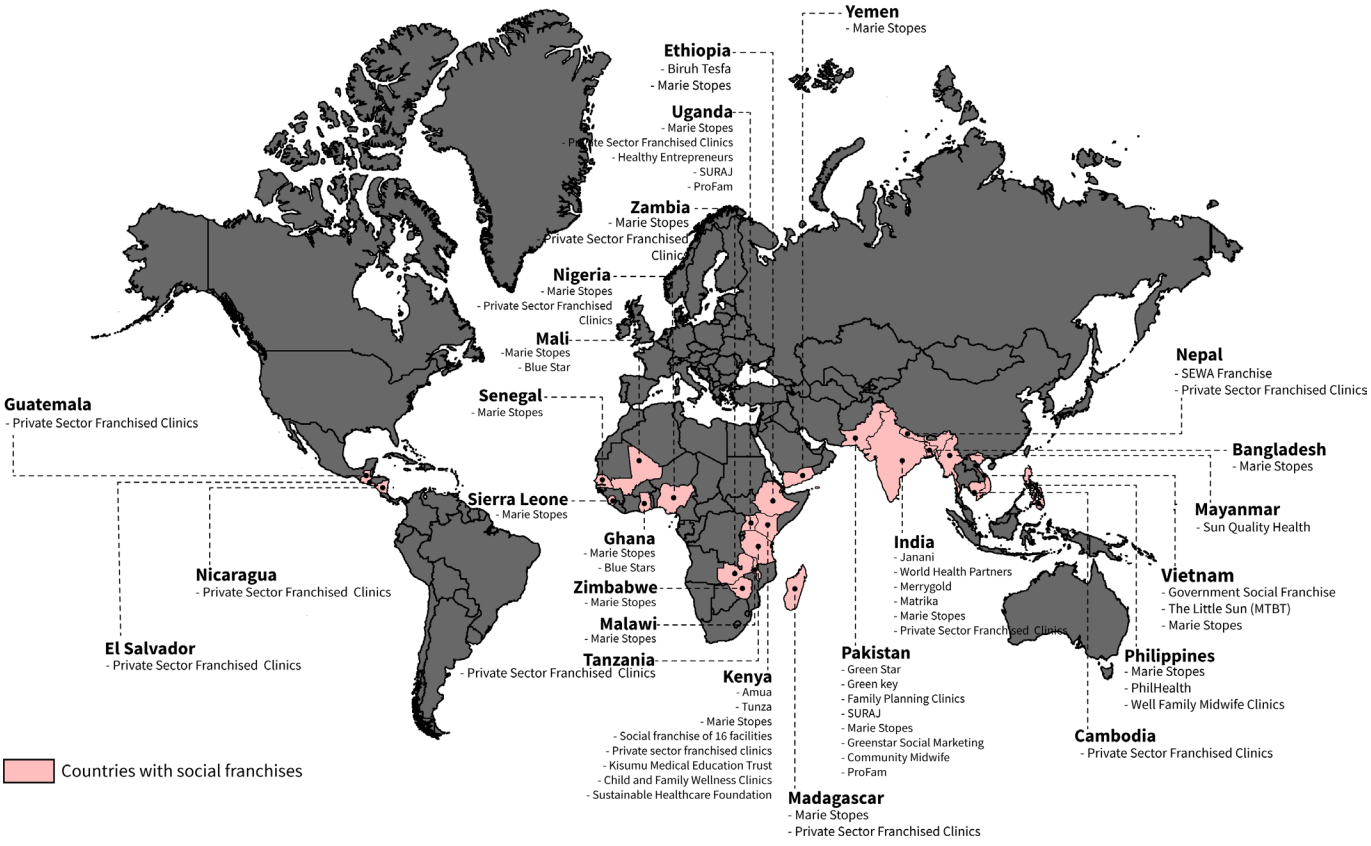

Figure 2 Global distribution of social franchises.

Philippines aimed to reduce high maternal mortality by enhancing access to prenatal and delivery care.[44] In India, initiatives targeted poor rural healthcare quality for child diarrhoea and pneumonia[45] and aimed to enhance maternal healthcare quality and accessibility.[46 47] Additional efforts included improving contraceptive method availability,[48] addressing inadequate maternal health services for the poor[49] and tackling challenges in sexual and reproductive health services[50] across various regions.

Who funded the social franchise implementation and research?

The sources of funding for the studies were often unclear (n=6). For those studies with specified funding, the predominant sources included USAID (n=9), the Bill & Melinda Gates Foundation (n=7), the David and Lucile Packard Foundation (n=3) and MSD for Mothers (n=3) (online supplemental materials 3 and 4).

Similarly, funding sources for most social franchise implementations were not mentioned (n=8). Among those social franchises where funding sources were specified, most were primarily supported by Marie Stopes International (MSI) (n=5), the United States Agency for International Development (USAID) (n=3) and Population Services International (n=3). Overall, three were funded by Global South-based institutions, and 16 were funded by international donors based in the Global

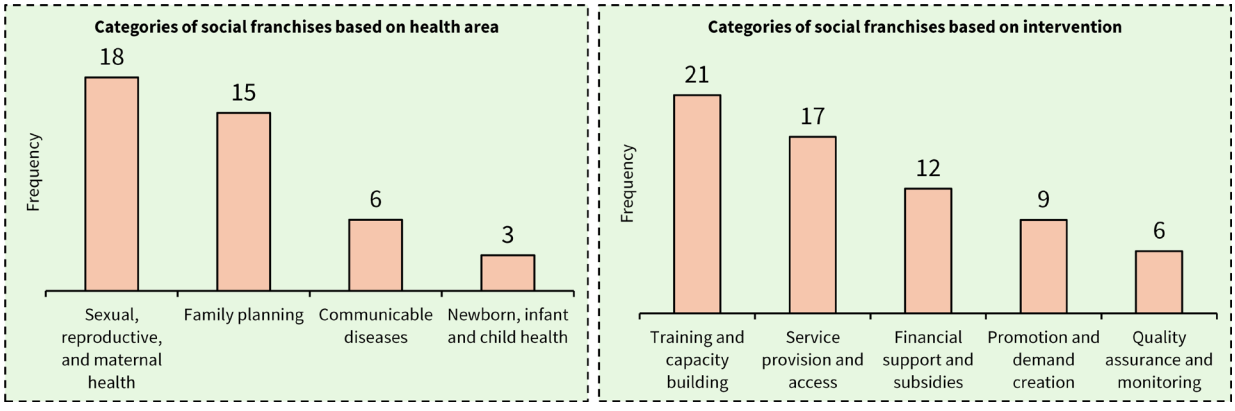

Figure 3 Frequency of the health area and intervention categories of social franchises (multiple responses).

North. Ten of the identified social franchises were part of an international chain (table 1).

Government collaboration

Seven social franchises followed government recommendations or were integrated into the government health system. Seven formed partnerships with public health authorities or complied with national health policies, involving government entities in activities like training health workers and conducting educational campaigns. Two initiatives were entirely government-led. In terms of the scope of operation, 11 initiatives operated locally, and eight programmes extended their operations regionally (table 1 and online supplemental material 4).

Demand creation

Ten social enterprise entities used local efforts such as interpersonal communication, community meetings and partnerships with local health workers to generate demand. Seven conducted mass media campaigns, educational sessions and health product distribution. Six franchises employed national campaigns with extensive media outreach, community mobilisation and professional marketing strategies. A total of 17 social franchises maintained online platforms as part of their operations, and two franchises used online platforms for telemedicine consultation (table 1). Online supplemental material 4 provides detailed findings on social franchises, covering intervention, outcomes, demand creation, government collaboration, operation scope, funding sources and types, franchises and online platform presence.

Findings of social franchise implementation

Client impact and utilisation

Social franchising considerably improved client volumes, satisfaction and contraceptive continuation rates by enhancing the delivery of FP and reproductive health services for underserved populations. For instance, capacity-building initiatives for healthcare providers, focusing on FP provision, contraceptive delivery, counselling, developing referral networks and offering accessible, quality sexual and reproductive health services for underserved populations reported increased client volumes and satisfaction.[19 23 27 38 42 51 52] Training providers and delivering FP services were also reported to have also enhanced contraceptive continuation rates[53] and effective contraceptive method adoption.[33] Training, support and resources provided to healthcare providers to improve reproductive health services, including antenatal care (ANC), STI management and counselling, contributed to improved perceived quality, access to services and knowledge about the effectiveness of FP methods. This led to increased client loyalty, volume and satisfaction in reproductive and FP services.[17 54 55]

However, FP interventions reported inconsistent impacts on client volumes, with franchise programmes struggling to reach poorer populations and compete with public services. For example, the impact of FP interventions on client volumes was inconsistent across different settings and regions.[19 22 51] Many users of FP services were not the intended target population, resulting in the low use of newborn and child health services among the intended groups.[16 45] Franchises also had limited reach to poorer populations compared with public facilities for FP and child health services.[37] Franchise clients were predominantly from higher socioeconomic backgrounds, particularly those seeking out ANC,[49] and faced competition from public services in FP, child health and ANC.[37 49] Primary-level providers struggled to promote ANC attendance effectively,[46] and franchised maternal health services did not result in increased facility births.[47] Provider participation in addressing child diarrhoea and pneumonia was reported as low.[45]

Many papers reported that the use of long-acting and modern contraceptive methods increased by franchising of private health facilities[21 22 33 34 38 50]; however, short-term contraceptive methods did not see a similar rise.[33] There was a notably high discontinuation rate of IUCDs and other modern contraceptives among women.[25 53] Passive follow-up also led to reduced continuation of LARC.[23] Additionally, franchise membership often failed to increase the use of FP and reproductive health services[35 42] and IYCF services.[39] Details are in table 1, figure 4, and online supplemental material 4.

Healthcare outcomes and effectiveness of social franchising

Franchising had a considerable effect on improving the availability of FP brands, access to care and quality of health services. For example, franchising in healthcare increased the availability of FP brands and decreased stock-out.[27 36 51] The ability of franchises to enhance access to care is well-documented, with evidence showing that franchising improved access and quality of FP, TB services and malaria information, particularly among low-income populations.[17 29 37 52 56–58] It also enabled access to low-cost oral rehydration treatments and nutrition counselling services.[32 40] Additionally, franchising was reported to enhance the quality of care, with evidence indicating improvements in maternal and reproductive healthcare.[38 49] Franchising also enhanced IYCF counselling quality and improved breastfeeding practices.[39 43]

Papers also reported that franchises were effective in decreasing maternal and child mortality, at least in part by averting unintended pregnancies and maternal deaths[38] as well as mortality due to malaria. They have also reported reduced diarrhoeal deaths in children under five[32] and decreased malaria morbidity and mortality in rural Myanmar.[31]

Despite efforts to enhance healthcare through franchising, several challenges remain, especially in maternal health and FP. The Matrika social franchise model, for example, failed to improve the quality and coverage of maternal health services at the population level.[47] Midwife clinics were unable to change prenatal care standards, and some users of IUCDs experienced health issues that led them to seek removal.[25 44] To achieve effective FP, one

Table 1 List and summary of social franchises

Franchise name (Initiation year, if reported)	Intervention	Outcome
Green Key[51]	Birth spacing counselling training, hormonal contraceptives and a referral network for extensive counselling and service support.	Increased overall and family planning (FP) client volume.
Janani[51] (1996)	Provide low-cost, high-volume STI tests, abortion and FP services in rural areas.	Increased FP and reproductive health clients.
FP clinics[16]	Give poor urban married women information on FP, female sterilisation and intrauterine device.	New clinics had little impact on contraceptive prevalence and mainly served poor, low-parity women.
Kisumu Medical Education Trust (KMET)[34]	Provide youth franchise members with FP or abortion training, clinical equipment, contraceptive supplies and low-interest loans for facility improvement.	Increased attention among providers to FP through training, improved access and utilisation of FP services.
Sustainable Healthcare Foundation[56] (1999)	Improve rural communities' healthcare access by distributing essential drugs and basic healthcare services through nurse-run clinics.	Improved access to essential drugs and basic healthcare services for underserved populations.
PhilHealth[44] (1995)	Provide insurance to government retirees, employees and dependents, with a sponsored programme for the poor and informal workers.	Increased uptake of prenatal services and improved minimal prenatal care standards.
Private sector franchised and affiliated clinics[22] (2009–2010)	Offer LARC methods, especially IUDs, through routine services at franchised clinics, with staff support for high-volume public reproductive health clinics	Integration of LARC services, particularly IUDs, into healthcare delivery systems and increased IUD insertions.
Government Social Franchise (GSF)[42] (2007)	Established a network of public clinics, trained staff in CRM, service quality, clinical delivery, branded RHFP services, set standardised fees and used external marketing.	Increase in reproductive health and family planning (RHFP) service utilisation at smaller public health clinics and client volume.
Child and Family Wellness Clinics (CFWShops)[30] (2000)	Local nurses run clinics offering diagnostics, malaria and respiratory infection treatment, vaccinations, rapid HIV testing, ANC, health counselling and hygiene products.	Improved acute illness treatment and vaccinations for low-income countries.
Sun Primary Health (SPH)[31] (2008)	Training and deploying volunteer health workers with Rapid Diagnostic Tests (RDTs) to diagnose and treat malaria and educate on prevention.	Communities with SPH providers had higher malaria knowledge and treatment-seeking.
Community Midwife (CMW)[20]	Partnership with community midwives to provide quality contraceptive, promote modern methods and educate women about contraception.	Increased contraceptive awareness and IUD use. The increase in contraceptive use was smaller than in control areas.
World Health Partners (WHP) Sky programme[45] (2011)	Established a network of telemedicine facilities and trained health providers to improve child diarrhoea and pneumonia treatment.	Improved treatment and decreased childhood diarrhoea and pneumonia cases.
Greenstar[51 54 57] (1997)	Providers receive FP, commodity support and demand generation training. Develop private doctors and midwives' FP skills and offer affordable contraceptives to poor urban people.	Improved client satisfaction and care quality, increased contraceptive brand availability and client volume and enhanced FP coverage, access, quality and sustainability.
Merrygold[49] (2014)	Offer FP, delivery and postnatal care, train community health workers and conduct quality assurance and outreach.	Consumption increased among wealthier quintiles and decreased among poorer ones.
Matrika[46 47 49] (2013)	Created a private provider network to improve maternal health services in the public system, offering free ANC, affordable FP, postnatal care, telemedicine and social health training, with incentives for referrals and emergency care.	Not effective in improving the quality and coverage of maternal health.

Continued

Table 1 Continued

Franchise name (Initiation year, if reported)	Intervention	Outcome
Healthy Entrepreneurs[50] (2015)	Trained Village Health Team workers as community health entrepreneurs, providing entrepreneurial training, startup credit, solar tablets and micro-pharmacies for essential medicines.	Increased access to essential medicines and reproductive health services, boosting contraceptive adoption and knowledge in rural communities.
Population Services International (PSI)[33]	Distributed contraceptives through private clinics, community health workers and micro-franchising networks using social franchising.	Improved women's adoption of LARCs like implants and IUDs and addressed cost, access and misinformation.
SURAJ (The Sun)[18–20 24 25 53 58] (2008)	Provided training, increased FP access and choices, accredited clinics for contraceptives, issued vouchers for poor women, subsidised services, branded clinics, boosted demand and awareness and ensured high-quality care.	IUCD access and use increased, enhancing FP acceptability, continuation and quality, especially in underserved areas. Unmet need and discontinuation rates decreased, but COVID-19 limited the access.
MTBT (The Little Sun)[39–41 43] (2013)	Promote optimal IYCF by training health workers, inviting mothers and standardising counselling, integrated into government facilities to improve CF and child growth.	Enhanced nutrition and IYCF counselling improved breastfeeding practices and client satisfaction. Social franchising boosted CF practices among mothers.
Marie Stopes[23 28 38 48 54 61] (1990)	Expanded voluntary FP services with LARCs and permanent methods. Trained private facilities in counselling, provided vouchers and commodity support and demand generation training.	Increased access to FP services, modern contraceptive use and LARCs, with higher user satisfaction, service quality and LARC continuation rates.
Tunza[35 37 60] (2009)	Provide FP, child health services, cervical cancer screening, safe motherhood and STI/HIV testing.	Enhanced reproductive health services increased LAPM use but reached fewer clients than public and faith-based facilities.
Blue Star[52 60] (2008)	Provided FP counselling, pills, condoms, injectables, IUDs and implants; supported franchisees with training, supervision, quality audits and subsidised supplies.	Wider access to voluntary FP services, including long-acting contraceptives, in rural areas.
Amua[60] (2004)	FP services, cervical cancer screening, safe motherhood and STI/HIV testing.	Access to FP services improved reproductive health and reduced health burdens.
ProFam[26 49 53] (2007)	Offer FP, HIV/AIDS treatment, malaria treatment, cervical cancer screening and ANC, delivery and postnatal care.	Improved FP counselling, retention and respect; higher use by wealthier clients. Focused on success stories for funding.
Biruh Tesfa (Ray of Hope)[51 57] (2000)	Train healthcare providers in contraception, STD prevention, HIV/AIDS counselling, post-abortion care, referrals, financial management, procurement and supervision.	Fewer reproductive services but more contraceptive brands than non-franchise sites, improving FP, STD prevention, HIV/AIDS counselling and post-abortion care.
Social franchise of 16 health facilities[27 36]	Organised private healthcare into quality networks offering standardised FP services through certified facilities, with incentives for franchise membership.	Better client satisfaction and training enhance FP services, with minimal difference between franchised and non-franchised facilities.
SEWA franchise[17 55] (2001)	Trained franchise members and providers in reproductive health, ANC, IUD insertion, market skills, STI symptom identification, syndromic management and STI/AIDS counselling.	Increased perceived quality, client satisfaction, client loyalty, return visit and access to reproductive health services.
Well Family Midwife Clinics[44]	Improve prenatal care by increasing the overall number of prenatal visits for pregnant women.	Increased overall prenatal visits for pregnant women but did not significantly change prenatal care standards.
Sun Quality Health[21 29 32 59 67] (2001)	Training and treatment for TB, malaria, FP, HIV/AIDS, reproductive health, pneumonia, diarrhoea, VCT, contraceptives, ORS-Z, subsidised medical products and quality monitoring.	Increased TB notifications, treatment success, equitable access, FP use, client volume, reproductive care access, ORS-Z coverage and lowered TB costs.

ANC, antenatal care; FP, family planning; IUCD, intrauterine contraceptive device; LARCs, long-acting reversible contraceptives ; ORS-Z, oral rehydration solution + zinc; TB, tuberculosis.

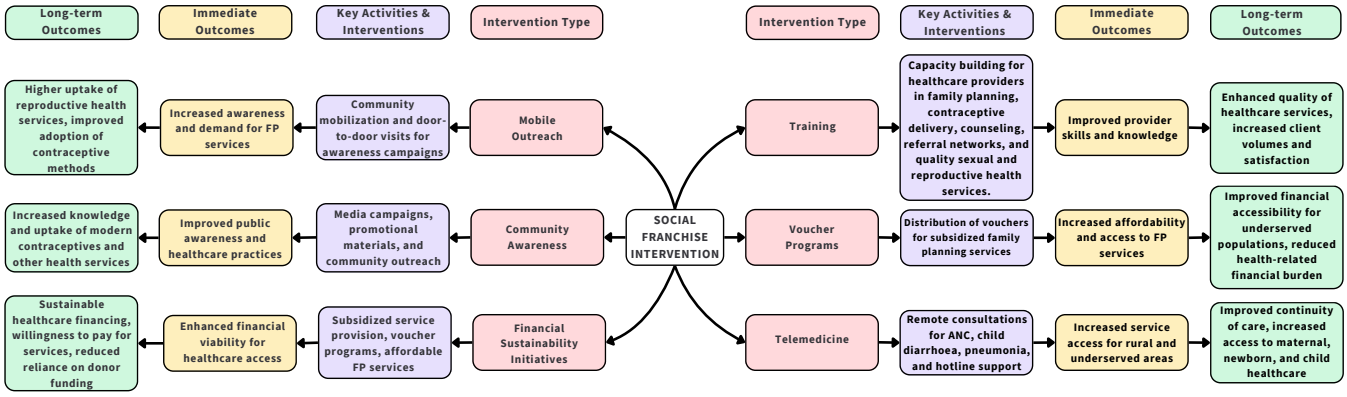

Figure 4 Conceptual framework for social franchise's impact pathway.

paper reported that it is crucial to involve local mid-level providers in expanding contraceptive coverage in underserved areas.[20]

From both the demand and programme sides, social franchises faced significant challenges. In rural communities, myths, misconceptions and health concerns continued to impede healthcare initiatives.[58] Programme implementation issues were evident in Uganda's social franchising programme in the private maternal health sector, where discrepancies between the official profile and actual operations highlighted potential gaps.[26] A comprehensive evaluation of the long-term impact and sustainability of contraceptive programmes on a national scale is necessary to ensure continued success.[48] Child health outcomes also faced limitations, with little progress made in treating diseases like child diarrhoea and pneumonia.[45] This underscores the importance of conducting rigorous impact evaluations before expanding new healthcare delivery programmes to ensure effectiveness and sustainability.[45] Details are in table 1, figure 4, and online supplemental material 4.

Financial viability and sustainability

Franchising in healthcare has shown significant financial and operational benefits for providers, clients and the healthcare system. The membership in a franchise network presented financial gain for the providers.[48 59] However, in some cases, providers did not experience financial improvements despite increased client flows for FP services, underscoring the need for continued funding to sustain subsidised FP services.[20 60] Clinics made minimal financial compromises and minimal investments in franchise members in maternal health service.[26] By expanding the number of FP service outlets, franchises enhanced access to contraceptive services.[38 52] These expansions were further supported by a consistent supply of low-cost FP commodities and high-quality client–provider relationships, embedding subsidised FP services within communities.[20 60]

The voucher programmes and subsidised service provision were highly popular among social franchises and played a significant role in reducing the health-related financial burden on patients. Vouchers played a crucial role in overcoming financial constraints, increasing awareness, access to FP and choice of contraceptive services.[18 48] The voucher FP programme was also considered affordable and cost-effective for the national healthcare system.[24] Vouchers not only alleviated financial constraints but were also found to be cost-effective in preventing diarrhoeal deaths.[32] Social franchises in the private sector provided highly subsidised TB care, reducing the financial burden on patients, particularly those from low-income backgrounds, due to relatively low treatment costs.[29] Free FP services were also offered to clients unable to pay.[27 52]

For financial sustainability, few social franchises implemented initiatives for long-term viability. For example, social franchises demonstrated efficiency by fostering widespread willingness to pay for nutrition counselling, suggesting potential financial sustainability.[40] Active follow-up approaches in LARC services showed promise for long-term financial sustainability by optimising resource utilisation and reducing the need for reintervention.[23]

However, social franchises struggled to reach the poorest populations for ANC and FP services due to high fees, competition from free public services and increased out-of-pocket payments. For ANC, the poorest women often struggled to afford private sector fees, which limited their access to services. Competition social franchises faced from free or subsidised public sector services further restricted franchises from reaching the poor.[49] For instance, franchised clinics faced higher costs and attracted fewer clients from the poorest quintile compared with non-franchised private clinics in FP services.[57] Despite recruitment targets, social franchise providers achieved low market share in the competitive ANC market.[46] Additionally, concerns arose about the cost of care in franchise clinics and increased out-of-pocket payments for health services that were not price-controlled by the franchise, highlighting the need to prevent the commercialisation of services as social franchises mature in FP services and TB care.[29 59]

Reliance on vouchers and donor funding threatens the long-term financial sustainability of social franchises. There were also challenges in maintaining child diarrhoea, pneumonia and contraceptive programme sustainability over time and reliance on vouchers and external funding posed financial viability challenges.[45 48] Free nutrition counselling services need a sustainable financing mechanism like user fees or health insurance for long-term viability.[40] Assessments of health outcomes and cost-effectiveness were recommended to understand reproductive and FP service effectiveness in LMICs.[42] Details are in table 1, figure 4, and online supplemental material 4.

Innovative strategies and technologies

Information and telecommunication technology (ICT) and mobile outreach enhanced FP services by improving quality monitoring, maintaining schedules and effectively reaching rural areas, while telephone follow-ups and web-based systems ensure better data collection and client satisfaction. For example, ICT has supported quality monitoring in FP programmes by gathering and analysing data for tailored supervision of franchisees.[38] Mobile outreach teams-maintained client appointments using call centres, while active telephone follow-ups ensured satisfactory continuation of LARC and proved as effective as traditional home visits.[23 52] A web-based management information system captured detailed contraceptive service delivery statistics.[22] Additionally, franchises extended FP services to rural areas through mobile outreach teams.[61]

Franchises implemented several digital technologies to enhance reproductive and child healthcare, most commonly telemedicine and call centres. Telemedicine services were provided for ANC visits and were reported to improve access to maternal healthcare and were well-received by the community.[46 47 49] Telemedicine technology was also used to provide remote consultations for child diarrhoea and pneumonia, with trained physicians.[45] Additionally, one call centre offered 24/7 information to women on menstrual regulation, with affordable call charges and free callbacks available.[28] One franchise ran a hotline to resolve clinical issues and shared information across the franchisee network for TB care.[29]

However, in ANC, telemedicine consultations were often delayed, and women experienced long wait times for telemedicine due to poor internet connection and glitches, making it frustrating to use.[46 47] The franchise that ran a call centre for menstrual regulation consultations reported challenges maintaining the quality of services as call volumes increased.[28] Details are in table 1, figure 4, and online supplemental material 4.

Awareness and demand generation

Papers reported that franchise programmes, community mobilisation and outreach, door-to-door visits, marketing, branding, promoting modern contraceptives, health provider communities outreach and social marketing played a pivotal role in enhancing the popularity of modern and long-acting contraceptive methods, significantly raised awareness and increased uptake among women.[18–20 22 33 50 53 58] In addition to awareness-raising activities, FP programmes addressed demand-side barriers, such as service pricing, to enhance accessibility and affordability.[52] Exposure to information pamphlets was reported to contribute to women's likelihood of adopting intrauterine devices (IUDs), with many expressing a willingness to use IUD services in the future if needed.[25 33]

Community awareness and media campaigns improved public awareness and healthcare practices in other healthcare areas. For instance, providing malaria information decreased the demand for unnecessary malarial drugs by increasing awareness.[56] Similarly, promotional materials and media campaigns boosted awareness of IYCF practices.[41] In reproductive healthcare, call centre interventions improved the information quality for menstrual regulation users, reducing self-medication risks.[28]

Efforts to enhance child growth and FP services encountered obstacles, primarily due to ineffective branding and insufficient public awareness. Specifically, initiatives such as mass media campaigns and community mobilisation struggled to yield improvements in child growth outcomes. Additionally, these strategies faced significant challenges in integrating new FP methods into the already busy service delivery infrastructures, as they were unable to effectively engage the target populations or integrate seamlessly with the existing health service routines.[41 61] The ineffectiveness of demand generation and awareness efforts led to weak referral linkages between antenatal and delivery care, as well as poor quality of care, due to low service utilisation and insufficient community trust in the franchise.[46] Low franchise brand recognition and client attrition highlighted the need for enhanced branding efforts in reproductive healthcare programmes.[60] Limited awareness and demand for specific methods like Levonorgestrel Intrauterine System (LNG IUS) further underscored the need for improved community awareness of the franchise.[61] Addressing these challenges and enhancing demand generation for practices such as IYCF were reported as crucial for achieving the full impact of healthcare programmes.[43] Details are in table 1, figure 4, and online supplemental material 4.

DISCUSSION

Our findings revealed a diverse and multifaceted landscape, with significant variations in implementation, outcomes and effectiveness of social franchises across different regions and health areas. The high prevalence of social franchises in LMIC countries highlights a strategic targeting of regions with significant healthcare challenges. These franchises are aligned with pressing health needs and align with global health priorities, addressing unmet FP demands; enhancing sexual, reproductive and maternal health services; and tackling communicable

diseases like TB and malaria and child nutrition. This strategic focus is in line with previous reviews that emphasise the pivotal role of social franchising in improving reproductive health services in LMICs.[5 12 13 62 63] However, health areas such as chronic disease and primary healthcare were significantly underrepresented in the social franchises we analysed.

Social franchises employed various interventions, primarily focusing on training and capacity building, service provision and increasing access to care, as identified in other systematic reviews.[10 64] By addressing supply and demand-side barriers, they enhanced both the availability of health services and individuals' ability to access them. However, there was comparably limited emphasis on promotion, demand creation, quality assurance and monitoring within these franchises.

We found that social franchises predominantly focused on health areas such as sexual and reproductive health and FP services, consistent with findings from other review studies.[5 10 12 64] In contrast, another systematic review revealed that the majority of studies concentrated on HIV.[63] Nevertheless, social franchises' predominant focus on sexual and reproductive health services and FP could be due to the high demand and limited access in LMICs, as we found in our analysis. However, other important health issues, such as infectious diseases, non-communicable diseases and mental health, might receive less attention and funding in social franchise implementation. This can lead to an imbalance in healthcare delivery, where only certain aspects of health are improved, potentially creating inequities in care. Therefore, attention to other critical health areas is essential for a comprehensive and equitable healthcare approach.

In examining the landscape of social franchising, MSI and Private Sector Franchised and Affiliated Clinics stand out for their substantial role in the global delivery of FP services. This study's method of analysing each franchise independently ensures that MSI's and Private Sector Franchise's wide reach does not skew the overall findings. Despite these franchises' extensive impact, their broad-scale approach might not fully address the nuanced health needs specific to local communities. In contrast, smaller franchises such as the World Health Partners and the Sustainable Healthcare Foundation demonstrate a more localised focus, tailoring their services to meet urgent community-specific health challenges. These organisations have made significant contributions to local healthcare by improving access to essential drugs and healthcare services, showcasing the effectiveness of adaptive strategies that respond directly to local needs.

Most social franchises collaborated in some way with governments to integrate services into national health systems. Integrating franchise providers into local health infrastructure enhances programme sustainability, while public–private partnerships (PPPs) optimise resources and service continuity. However, for long-term impact, there is a growing argument to either integrate social franchises more deeply into government health systems or eventually transition operational control to the government itself. This strategic shift could ensure sustained support and scalability of healthcare services beyond the initial franchise interventions, promoting enduring health improvements across communities.

Healthcare franchising has shown mixed results in terms of impact and healthcare utilisation, with some franchises reporting increased client volumes, satisfaction and improved FP knowledge, while others struggled to reach target populations and maintain high utilisation rates among lower socioeconomic groups. Similarly, two reviews reported that while social franchising was positively associated with increased client volume and client satisfaction, it faced limitations in achieving health equity.[5 12 62] This variability underscores the complexity and contextual sensitivity of healthcare interventions, highlighting that success hinges not just on the franchise model itself but also on the specific socio-economic, cultural and infrastructural environment in which it is implemented. Such findings align with other systematic reviews that emphasise the critical role of local implementation and support mechanisms.[10 11]

Positive health service outcomes, including improved access to healthcare and enhanced quality of care, highlight the potential of social franchising to significantly enhance healthcare delivery. Similar improvements in access to care through social franchising have been reported in other systematic reviews.[5 10] However, contrasting evidence from another review indicates that being located in economically disadvantaged areas does not necessarily lead to equitable access across different wealth groups.[12] While one review suggests that social franchising positively impacts the quality of care,[10] others reported that franchising did not improve the overall quality of healthcare, cost-effectiveness or equity.[5 12 14] However, our findings, along with those of other studies, indicate a lack of conclusive evidence to determine whether social franchising effectively improves the quality of healthcare.[5 10 12 62] Nevertheless, the quality of healthcare in these initiatives can be further enhanced by advancing monitoring through the strategic use of digital technology and systematically integrating client feedback and evaluation mechanisms into continuous service improvement.[38 65]

The sustainability of social franchises is a critical concern, primarily due to their high dependence on donor funding and the provision of services that are often subsidised or free. This reliance raises questions about the long-term viability of these models once external funding diminishes. Many empirical studies have reported predominantly short-term outcomes within controlled contexts, leaving the long-term sustainability and impact of these interventions uncertain, as highlighted by other studies.[10 62] This challenge underscores the need to develop innovative financing models and cost-sharing mechanisms that balance cost-effectiveness with accessibility. These models might include PPPs,

tiered pricing systems based on income levels or integrating with national health systems to share costs and resources.

Digital technologies, particularly telemedicine, call centres and ICT, improved healthcare service delivery by enhancing quality monitoring, data collection and access to care in underserved areas. However, issues such as internet connectivity problems and high demand have impacted their efficiency and user experience. These findings are consistent with broader research that highlights the potential of telemedicine to transform healthcare delivery while also emphasising the need for effective management to address digital infrastructural challenges.[66] Despite the promising benefits, previous systematic reviews have not thoroughly explored the integration of digital technologies within social franchises. Given the ongoing digital revolution, further research is needed to examine the role and impact of digital technology in health service delivery within social franchise models. This research should focus on identifying best practices for implementation, addressing technological and operational barriers and exploring how digital solutions can be optimised to enhance service quality and accessibility in social franchise.

Community mobilisation and marketing notably increased contraceptive use and healthcare awareness. However, challenges such as inadequate branding have limited their overall impact. Effective branding is crucial in social franchising, as it enhances brand recognition and consistency across health providers and facilities.[11 13] To maximise impact, it is crucial to innovate branding strategies by employing dynamic media campaigns, harnessing digital platforms for targeted outreach and using real-time data to refine branding approaches.

Upon reviewing grey literature, we encountered numerous reports, which provide evidence but lack the rigor and detail necessary for comprehensive academic analysis. The lack of rigorous peer-reviewed evidence may be due to the focus of funders on service delivery rather than research. Major donors often avoid comprehensive data collection or independent evaluation to avoid negative implications,[14] potentially indicating reporting bias. Future research on social franchising should focus on thoroughly documenting its effects and evaluating both its equity and cost-effectiveness, with an emphasis on understanding its role within the broader healthcare system and establishing a strong conceptual basis linking programme design to outcomes. To answer key questions about the feasibility and impact of social franchising, particularly regarding the equity in private sector interventions, more robust research designs are essential. Additionally, expanding research across diverse healthcare sectors and geographical regions, with attention to outcomes and trade-offs, will require global health investments aimed at filling evidence gaps and enhancing evaluation rigor.

The review faces several limitations. The reliance on diverse study designs introduces variability in methodological quality, which may affect the consistency of findings across studies. The exclusion of non-English literature and grey literature potentially limits the scope of evidence, particularly from low-resource settings where these sources might be more prevalent. Additionally, variability in outcomes across different contexts also complicates the synthesis of findings and the generalisation of recommendations.

CONCLUSION

Our findings highlight a complex and varied landscape in the implementation and outcomes of social franchising across different regions and health areas. Social franchising in healthcare improved client volumes, satisfaction and contraceptive continuation rates, addressing FP, sexual and reproductive health and communicable diseases. The adoption of long-acting modern contraceptives, increased FP brand availability and improved health services were significant achievements. Franchise also reduced maternal and child mortality and malaria-related mortality. Additionally, social franchise benefited providers and clients financially and operationally. Popular voucher programmes and subsidised services reduced patients' health-related financial burden. Technology like ICT, telemedicine and mobile outreach improved service delivery and community outreach and marketing raise awareness and modern contraceptive use.

However, social franchises struggled to reach poor populations for antenatal and FP services due to high fees, competition from free public services and increased out-of-pocket payments. Heavy reliance on donor funding and voucher programmes threatened long-term sustainability. Besides, social franchises often failed to improve FP, reproductive healthcare and child nutrition. Additionally, poor internet connections and technical issues delayed antenatal telemedicine consultations. Poor branding and community awareness hampered child growth and FP.

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