Social franchising: whatever happened to old-fashioned notions of evidence-based practice?

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Social franchising, which draws on principles of commercial franchising for achieving socially beneficial ends, is based on the premise that organising private sector health-care providers under a standardised, branded set of services will improve the quality and accessibility of services. The popularity of the idea can be gauged by its rapid growth worldwide: the number of social franchises have doubled every 4 years since 1994, and, by 2015, more than 90 such programmes existed in 40 low-income and middle-income countries. Major donors—USAID, UKAID, the Bill & Melinda Gates Foundation, and the Norwegian Agency for Development Cooperation (NORAD)—have invested millions of dollars in these franchises in low-income and middle-income countries.[1]

The Article[2] by Sarah Tougher and colleagues in *The Lancet Global Health*, however, should give us reason to pause. These investigators show, with rigorous quasi-experimental methods, that the Matrika Social Franchise Model—a multifaceted intervention aimed at strengthening the private sector to improve coverage and quality of maternal, newborn, and reproductive health services in Uttar Pradesh, India—did not have any measurable effect on the outcomes under study. Facility births increased by an insignificant 4 percentage points (95% CI −1 to 9; p=0·100) and no measureable changes were documented in 14 summary indices of health-care use, content, quality, patient experiences, or financial strain.

These findings should not be a surprise. 24 published studies, most assessed in three reviews,[3–5] have failed to provide any evidence of a positive impact of social franchises on population health. Most of these studies show that, while franchising increased client volume and satisfaction in some contexts, it did not necessarily improve quality of care, cost-effectiveness, or equity.[3–5] However, the quality of most of these studies was rated poor and none were found to meet the inclusion criteria for a Cochrane review, despite these criteria being broad.[6] The only exception was a social franchising and health-care workforce expansion programme in Myanmar that increased the treatment of diarrhoeal illnesses with oral rehydration solution containing zinc.[7]

Therefore, Tougher and colleagues' study[2] is an important contribution. It is one of few rigorous studies that used a quasi-experimental design, had a large study population, and was independent of the funders. More importantly, and perhaps inadvertently, the study has shed light on more fundamental questions: why has social franchising as a model expanded at an exponential rate when there was little rigorous evidence of the model's impact on population health? Why have millions of dollars, often taxpayer money, been poured into an unproven idea? Why is there a paucity of rigorous research in documenting effectiveness of this heavily invested idea?

Perhaps the last question might be the easiest to answer. A reading of the published and grey literature suggests that the dearth of evidence might be a consequence of the funders and their expectations. A compendium[1] on social franchises shows that all franchises have been or are funded by bilateral donors or private donors. To the best of my knowledge, no social franchise exists in which a local, for-profit franchisor leads the initiative, as is often the case with commercial franchises. Nor could I identify any social franchises funded by a research funding organisation. The remit of major bilateral donors is to provide services that will directly improve the health of recipient populations. They are not in the business of research. Consequently, most donors limit their data collection activities to before and after surveys under the rubric of evaluation. They tend to be averse to funding data collection from control sites where their programme was not implemented.

Additionally, bilateral donors, as custodians of taxpayer money, operate in environments characterised by structural disincentives to acknowledge when programme efforts are not achieving their intended results.[8] Notwithstanding calls for embedded operations research in programmes, most funders' and implementers' desire for rigorous research is limited.[9] Even monitoring and evaluation reports are often aimed at meeting donor or implementer expectations that the programmes are doing well.[10] Anything less is assumed to reflect poorly on donor judgment and implementer expertise.[8]

What are the main messages from these outcomes? First, we need to rigorously check to see if the social franchising model—and various other private-sector quality and equity improvement strategies—are actually producing their intended benefit. Not only does this require embedding research within programmes, it importantly requires research funding agencies to step up and fund what can sometimes be expensive research. Second, donors need to adopt higher standards of evidence when they consider investing in interventions, which requires development of greater in-house expertise, but more importantly, adoption of academic peer-review processes to question the evidence underlying theories of change in interventions presented by applicants.

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I declare no competing interests.

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