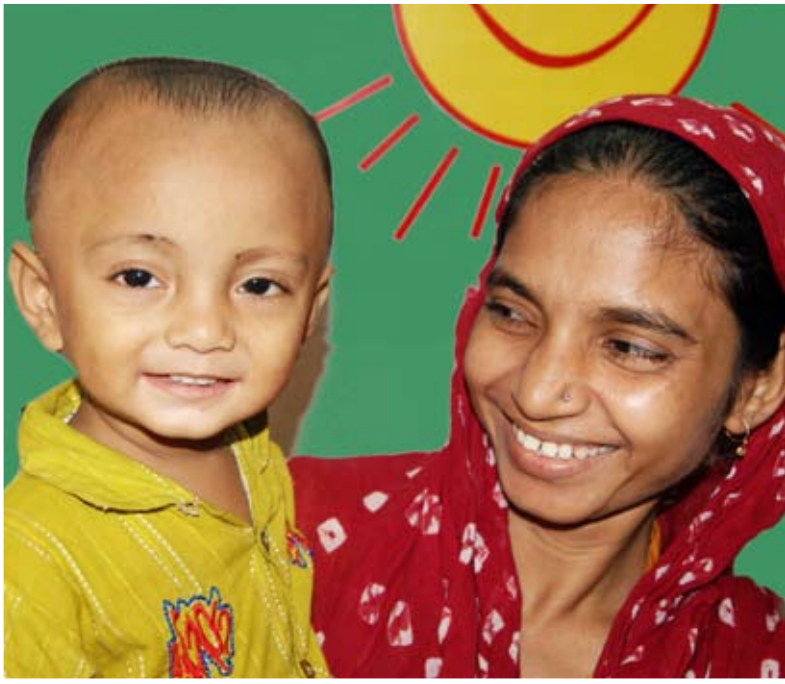
Social Franchising Evaluations

A scoping review



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Contents

List of abbreviations

ANC	Antenatal care
CMS	Commercial Marketing Strategies
DHS	Demographic and Health Survey
DOTS	Directly observed therapy
EPOC	Effective Practice and Organization of Care
FP	Family planning
ICDDR,B	International Centre for Diarrheal Diseases Research, Bangladesh
IUD	Intra-uterine device
LIC/LMIC	Low-(and middle-)income countries
NGO	Non-governmental organisation
NTP	National Tuberculosis Programme
MDG	Millennium Development Goals
PSI	Population Services International
RCT	Randomised controlled trial
RH	Reproductive health
SQH	Sun Quality Health
STI	Sexually transmitted infections
TB	Tuberculosis
USAID	United States Agency for International Development
WFMC	Well-Family Midwife Clinics

Abstract

Background

Social franchising developed as a possible means of improving the provision of non-state-sector health services in low- and middle-income countries. The objective of this systematic review was to examine the scope and nature of existing research literature on social franchising interventions, including reach, implementation, sustainability and goals, in health service delivery.

Methods

A rigorous search strategy was run in nine major databases, including Medline, Embase and CINAHL. Grey literature was also searched. All types of evaluative study designs were eligible for inclusion. Existing data abstraction and analysis tools were used. The AMSTAR measurement tool was applied to assess the quality of included systematic reviews. Framework analysis was chosen for synthesising qualitative and quantitative research.

Results

Twelve studies were included in this review: three systematic reviews and nine primary studies. Social franchising has been evaluated in Asia and Africa, particularly from low-income countries. Most studies focused on reproductive health and family planning. We found a paucity of rigorous study designs, so the evidence supporting social franchising is weak. Across settings, the government continues to have the highest volume of clients for family planning and other services; however, franchises do better than non-franchised private providers in terms of client volume. The clients of social franchises are satisfied with the quality of care and consistently report an intent to return.

Conclusions

Given that social franchising remains an area of great interest and investment, we recommend evaluations of implementation processes and sustainability, and more rigorous evaluations of the effects of different models.

Executive summary

Background

There is growing agreement and a sense of urgency that the non-state sector must be further engaged in the provision of health services in low- and middle-income countries, if the ambitious objectives set by the Millennium Development Goals are to be achieved. One approach for contracting health services from the non-state sector is social franchising. In recent years policy makers, health sector leaders and donors have focused increasing attention on social franchising as a solution in primary care, reproductive and sexual health, TB and HIV/AIDS diagnosis and care.

However, despite the enthusiasm within the donor community and serious attention within the literature, a systematic review of these models found that no rigorous evidence existed as to the effect of social franchising on access to and quality of health services in low- and middle-income countries. No conclusions could be drawn about the effectiveness of social franchising on health outcomes, quality of service, access or satisfaction.

Objectives

The purpose of this scoping review is to assess the size and nature of the available research literature addressing the research questions:

What is the scope of the literature addressing the reach (adoption by franchisees and service users), implementation (adherence and integrity), sustainability and effects of social franchising?

Does this literature describe in detail testable models of social franchising, their theoretical bases and measures of social franchising activities and goals?

The review can be used to judge which areas of the social franchising literature may be the focus of further, more detailed systematic reviews that appraise the quality of the studies and synthesise their findings. It identifies gaps in the literature and provides a basis for planning future research in the area of social franchising.

Methods

Reports were eligible for inclusion if they evaluated social franchises delivering health services by health professionals in low- and middle-income countries.

We searched major electronic databases including Medline, CINAHL and Science Citation Index. We also searched minor databases, web sites and other sources for primary studies, including Google Scholar, Marie Stopes International and the World Bank. Search strategies for electronic databases were developed using the methodological component of the Effective Practice and Organization of Care (EPOC) search strategy combined with selected MeSH terms and free-text terms related to social franchising.

Two reviewers screened abstracts and/or titles separately to determine provisional eligibility for inclusion in the review, then agreed their conclusions. Full texts for the selected documents were obtained, and two reviewers made a final determination on inclusion.

Framework analysis was chosen as the appropriate method for synthesising qualitative and quantitative research with the aim of learning for informing policy.

Details of the included studies

Twelve studies were included in this review. Three were systematic reviews and nine reported primary research. Only one review, which evaluated the literature of the non-state sector for health services through an equity lens, found studies eligible for inclusion.

The nine primary studies were set primarily in low-income countries and dealt primarily with reproductive health and family planning. Most studies were based on surveys of clients or providers. One study looked at tuberculosis using a pseudo-interrupted time series design.

Synthesis results

1. Seven studies addressed aspects of reach primarily through access to services. Social franchising was not related to increases in client volume across settings or to increased use of STI (sexually transmitted infection) treatment. However, there were mixed outcomes for changes in unmet need for family planning.
2. Five studies addressed quality of care issues. The studies showed that franchise providers were more likely to be trained than non-franchise private providers but that training was associated with government service rather than the franchise. Patient perceptions of quality of care were mixed, although in one post-intervention survey, franchise providers were more likely to be described as having a caring manner.
3. Six of the studies attempted to measure the impact of social franchising on health and health-related behaviour outcomes. Three studies showed an improvement in knowledge and use of modern family planning methods among franchise clients.
4. Seven studies contained elements of equity analysis. They presented mixed results for franchises reaching the young, the poor and the illiterate across settings. Also, clinics set in low-income urban areas did not necessary serve the target low-income group.

Conclusions and recommendations

Social franchising has been evaluated in South and South East Asia and Africa, particularly in low-income countries. No reports could be found from Central Asia or South America. Most studies were of social franchises for reproductive health and family planning issues. We found a paucity of rigorous study designs for assessing impact, so the overall existing evidence supporting social franchising is weak.

At present the literature on social franchising does not address issues of implementation such as adherence to service protocols or sustainability of the franchise. With this proviso, existing evidence appears to show that across settings, the government continues to have the highest volume of clients for family planning and other services; however, franchises do better than non-franchised private sector providers in terms of client volume. Across studies, the clients of social franchises are satisfied with the quality of care received through the franchise and consistently report an intent to return for future health services.

Given that social franchising remains an area of great interest as a model for engaging the non-state sector in the provision of health services in developing country settings, we recommend more rigorous evaluations of both the implementation aspects and the effects of different models of social franchising.

1. Background

There is growing agreement and a sense of urgency that the non-state sector must be further engaged in the provision of health services in low- and middle-income countries if the ambitious objectives set by the Millennium Development Goals are to be achieved (Bennett et al. 2005, Bloom et al. 2008, Hanson et al. 2009, Mills et al. 2000, Mills et al. 2002). Non-state sector usage for service provision in low- and middle-income countries is high. For instance, in sub-Saharan Africa, more than 60 percent of healthcare spending is out-of-pocket, private sector payments are most pronounced in the poorest countries (International Finance Corporation 2007, Sekhri 2006) and in South Asia upward of 75 percent of health services are provided in the non-state sector, particularly among the poorest (Larson et al. 2006, Rockefeller Foundation 2008, World Bank 2004). Despite this urgency, there is a lack of agreement and lack of evidence as to which mechanism is best suited for engaging the non-state sector to achieve health goals (Patouillard et al. 2007, Walker et al. 2008, Waters et al. 2003).

One approach for contracting health services from the non-state sector is social franchising. In recent years policy makers, health sector leaders and donors have focused increasing attention on social franchising as a solution in primary care, reproductive and sexual health, TB and HIV/AIDS diagnosis and care (Jefferys 2004, Makinen and Leighton 1997, Montagu 2002, Perrot 2006, Peters et al. 2004, Ruster 2003, Smith 2002, WHO and USAID 2007). Social franchising is defined as a system of contractual relationships 'usually run by a non-governmental organisation which uses the structure of a commercial franchise to achieve social goals' (Montagu 2002). The overarching difference between social and commercial franchising is that social franchising seeks to fulfil a social benefit whereas commercial franchising is driven by profit (WHO and USAID 2007). The definition can further be expanded to mean:

> an adaptation of a commercial franchise in which the developer of a successfully tested social concept (franchiser) enables others (franchisees) to replicate the model using the tested system and brand name to achieve a social benefit. The franchisee in return is obligated to comply with quality standards, report sales and service statistics, and in some cases, pay franchise fees. All service delivery points are typically identified by a recognizable brand name or logo (WHO and USAID 2007).

A more detailed description of social franchising is that in order to produce the desired social benefit, social franchises provide subsidised services so that the recipient of services has a lower out-of-pocket payment. The elements that typify a social franchising package are:

- training (e.g. in clinical procedures, business management)
- protocolised management (e.g. for antenatal care, childhood diarrhoea)
- standardisation of supplies and services (e.g. birthing kits, HIV tests)
- monitoring (e.g. quarterly reports to franchiser, reviews)
- branding (e.g. use of a logo on signs, products, or garments)
- network membership (e.g. more than one franchisee in the organisation).

Social marketing programmes are similar but focus on health products alone, rather than delivery of health services (WHO and USAID 2007). Franchising for health services (clinical franchising) can be further categorized according to model and the strength of the network:

- stand-alone model practices established to provide exclusively franchise-supported services or commodities
- fractional model: franchise services are added to existing practices
- first-generation franchising, where the franchiser offers a territory and use of franchising within the guidelines

- second-generation franchising, which includes the elements of first generation franchising and further includes active monitoring and control (creating a tighter, more structured, more regulated network) (Stephenson et al. 2004).

These models of social franchising may differ in their effects and contexts. Modifying factors to the success or failure of a franchising scheme may include the type of franchiser (government, donors or NGOs), the services they deliver (TB, sexual and reproductive health, primary care, HIV/AIDS care); the type of health care professionals engaged (physician, nurse, community health worker, paramedic); the study setting (rural versus urban); or the socio-economic status of the study population, provider or country (ultra-poor, low-income, middle-income, high-income).

However, despite the enthusiasm within the donor community and serious attention within the literature, a systematic review of these models found that no rigorous evidence existed as to the effect of social franchising on access to and quality of health services in low- and middle-income countries (Koehlmoos et al. 2009). No conclusions could be drawn about the effectiveness of social franchising on health outcomes, quality of service, access and satisfaction. The review recommended integral, high quality, prospective evaluations of social franchising operations and a refocused review of the literature to find those models of social franchising that appear promising and are ready for rigorous testing of their effects. Such a review is required because the non-state sector is fragmented and consists of small organisations which tend to learn by doing within the boundaries of their own experience (Bloom et al. 2008). To facilitate learning across these experiences, there is a need to identify those models for which there are sound theoretical bases for causal assumptions, detailed descriptions of the franchising model, good evidence of reach (adoption by franchisees and service users) implementation (adherence and integrity) and maintenance (or sustainability) and agreement on measurable and testable social franchising activities and goals.

1.1. Objectives

The purpose of this scoping review is to assess the size and nature of the available research literature addressing the research questions. It can be used to judge which areas of the social franchising literature may be the focus of further, more detailed systematic reviews that appraise the quality of the studies and synthesise their findings. It identifies gaps in the literature and provides a basis for planning future research in the area of social franchising.

It is not the intention of this review to provide a comprehensive catalogue of all studies, particularly as many of them are published as standalone reports rather than in indexed journals readily identified in bibliographic databases. The objective was to illustrate the range of social franchising models that have been evaluated and therefore perhaps provide lessons about their applicability in different contexts.

We asked the following research questions:

- What is the scope of the literature addressing the reach (adoption by franchisees and service users), implementation (adherence and integrity), maintenance (or sustainability) and effects of social franchising?

- Does this literature describe in detail testable models of social franchising, their theoretical bases and measures of social franchising activities and goals?

2. Methods used in the review

2.1 User involvement

For over three decades, the World Health Organization has encouraged the involvement of individuals and communities in the planning and implementation of their health care (WHO 1978). In line with this principle, people with an expertise in social franchising, as franchisers, franchisees, public authorities, donor organisations, researchers and members of civil society, were invited to guide this work. The consultation took place virtually for global input as well as locally to build consensus within the home country of the authors (TK, SH and RG). They were asked to comment on the work in progress, identify reports that might be eligible for inclusion and consider the emerging findings and their implications. The timeframe for this review was July 2009–May 2010.

2.2 Identifying and describing studies

2.2.1 Criteria for including studies in this review

The types of participants, interventions and outcome measures are the same as those for the earlier systematic review of effects of social franchising which found no relevant studies (Koehlmoos et al. 2009).

Types of studies
All types of evaluations were included in this review. Randomised and non-randomised trials, controlled before and after studies and interrupted time series were considered potentially suitable for assessing the effects of interventions. Observational studies such as surveys, cohort studies, case-controlled studies and case studies (with or without economic or equity analyses) were considered potentially suitable for assessing reach, implementation and maintenance.

Opinion pieces, policy documents and non-systematic reviews were excluded.

Types of participants
All levels of health care delivery were eligible.

All types of patients/consumers and healthcare professionals/providers in low-and middle-income countries were eligible (World Bank 2007).

Studies set in high-income countries were excluded (World Bank 2007).

Types of interventions
Social franchises were considered for inclusion in this review if their health professionals delivered health care services to the clients.

Further, the overarching aim behind the implementation of the social franchise had to be one of social benefit, for instance the extension of health service delivery or improving the quality of health service delivery, rather than commercial benefit.

To be included, an intervention needed to contain all of the following elements:

- a franchiser and franchisees
    - The franchiser must be an NGO or government
    - There must be multiple franchisees of independent providers/sites/locations that deliver care by health professionals
- standardisation of supplies, delivery processes, and management, including training, monitoring and protocols
- branding.

In addition, there might be other marketing strategies, including advertising (using mass media or personal media).

Studies were excluded if they did not include a social franchise for the delivery of health services.

We further excluded studies of services limited to delivering messages (health promotion or education) or commodities (e.g. condoms, bed nets) alone, which are more commonly described as social marketing.

We excluded studies of lay health worker interventions or peer educators, which are examples of services that are not delivered by health professionals.

2.2.2 Identification of potential studies: search strategy

The databases searched and the results are detailed in Appendix 2.2.

Search strategies for electronic databases were developed using the methodological component of the search strategy employed by the Cochrane Review Group for Effective Practice and Organization of Care combined with selected MeSH terms and free -text terms related to social franchising. The following broad strategy was adopted, adapted for each databases.

Terms related to franchising

AND

Terms related to developing countries

AND

Terms related to EPOC methodology (human limits) filter.

2.2.3 Selection of the studies

Two reviewers (TK and MR) screened the titles and abstracts (where available) of all articles obtained from the search, using EPPI-reviewer software to manage the information electronically (Thomas and Brunton 2006). The numbers of titles from each search appear in Appendix 2.2. The reviewers determined independently if studies met the inclusion criteria. Differences were resolved through consultation with RG.

2.3 Analytical approach

Framework analysis was chosen as the appropriate method for synthesising qualitative and quantitative research with the aim of learning about effecting change. This allows the combination of issues important to policy makers, practitioners and service users; it is sufficiently flexible to allow amendments to the analysis in light of the emerging literature; and it leads to learning specifically linked to explicit principles driving activities and their contexts (Oliver et al. 2008).

A conceptual framework was constructed to accommodate the characteristics of social franchising, the study designs appropriate for drawing conclusions about implementation, reach, maintenance and effects of social franchising, and key issues raised by policy makers, practitioners or service users or emerging from the literature in the course of the review.

2.3.1 Detailed description of studies

Reviewers extracted the data from all studies using a standardised form. Data relating to the following items was extracted from all included studies:

1. Participants were health providers and service users. For health providers this included the number of providers and information on type of health care provider. For service users, this included the number of users and the health problems/treatment received, age, demographic details and cultural background.
2. Health care setting (rural, formal urban settlement, informal urban settlement (slum)) and country. Countries were classified as low income, lower-middle income or upper-middle income.
3. Study design and the key features of studies. To include but not limited to: randomised and non-randomised trials, controlled before and after studies, interrupted time series, surveys, cohort studies, case-controlled studies and case studies (with or without economic or equity analyses).

4. Description of social franchise: generation of franchise, health conditions served by the franchise, partial versus full franchise, number of social franchises within the network.
5. Intervention (specific training, ongoing monitoring, branding, network affiliation, standardisation of supplies and services, protocolised treatment guidelines) and health care services performed within the social franchise. Attempts were made to extract a full description of the intervention.
6. For process evaluations addressing implementation: types of activity measures (duration and frequency of specific training, ongoing monitoring, branding, network affiliation, standardisation of supplies and services, protocolised treatment guidelines, sustainability and the proportion of staff trained).
7. For outcome evaluations, outcomes including reach (e.g. access, affordability, utilisation, client volume, attendance); health outcomes; quality of care (e.g. compliance with guidelines, case notification for TB); cost of the service (from a societal perspective or the perspective of the franchiser, franchisee or patients); patient satisfaction (e.g. intent to return); provider satisfaction; adverse effects (in addition to undesirable impacts on any of the above outcomes, e.g. undesirable impacts on existing public or private services, inappropriate use of services, distortions in the provision of services); any other outcome described in the literature.
8. For all evaluations, measures of equity, such as equitable access or utilisation (distribution of access across socio-demographic characteristics).
9. For all evaluations, economic evaluation measures were included.

2.3.2 Assessing quality of studies

Conclusions about effectiveness were only drawn from systematic reviews that had assessed the quality of included studies of the effects of social franchising. We applied the Assessment of Multiple Systematic Reviews (AMSTAR) measurement tool to assess the methodological quality of the systematic reviews. The AMSTAR assessment includes eleven possible items and has been judged to have content validity for measuring the quality of systematic reviews (Shea et al. 2007).

For primary studies of reach, implementation and sustainability, in addition to describing their study design, we assessed their quality. There is no standardised tool to assess the quality of primary studies in a scoping review in part because of the great heterogeneity of study designs. In order to assess the nine primary studies, we created a quality assessment checklist based on quality assessment items described within the seminal systematic review for the social sciences guide book and within previous review examples (Hayman et al. 2011, Petticrew and Roberts 2006, Public Health Resource Unit 2006, Rees et al. 2009, Thomas et al. 2003, Waddington et al. 2009). Studies were not excluded based on their quality, but rather the quality was used to determine the strength of the evidence so that the strength of recommendations could be appropriately tempered.

We asked five overarching questions about:

1. the independence of the study
2. the robustness of reporting on the model of social franchising
3. the robustness of reporting on the study design and methods
4. the robustness of the data analysis
5. the reporting on confounding factors.

Answers were categorized as Yes, No or Unclear. A full guide to the questions can be found in Appendix 2.3.2.

2.3.3 Synthesis of evidence

A series of tables was prepared to describe the evaluative literature in terms of the characteristics of the social franchises and their context and the focus of their evaluation (reach, implementation, maintenance or effects). The research evidence about social franchising was described in terms of the populations served and the details of the

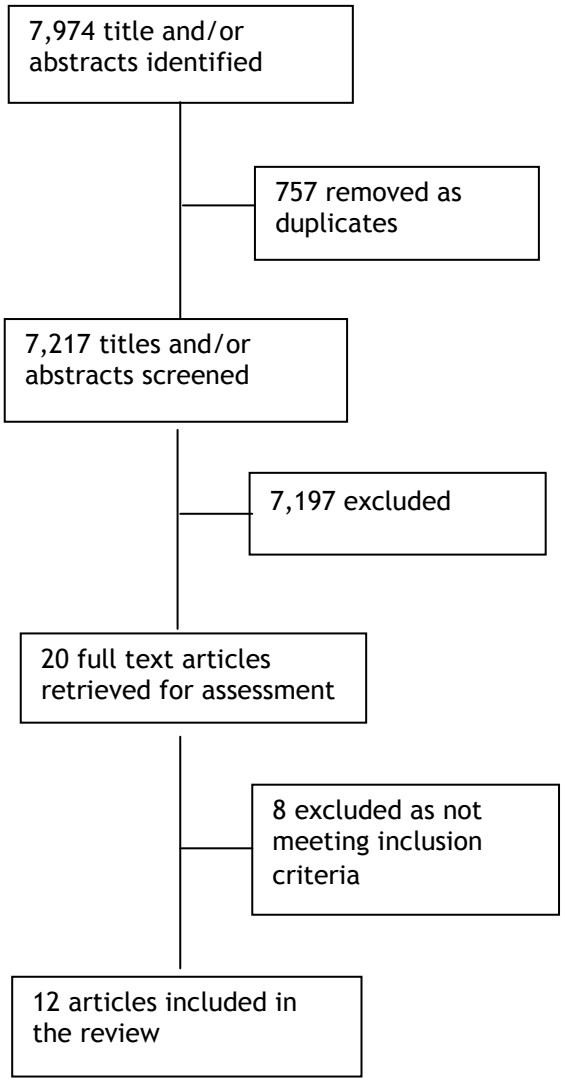
interventions (Appendix 4.1), as well as of the outcomes addressed and equity and economic analyses (Appendix 4.2).

3. Search results

3.1 Studies included from searching and screening

The search strategy was implemented from August through October 2009. The initial search of electronic databases produced 7,327 titles and/or abstracts and the search of additional databases produced 647 titles and/or abstracts, making a total of 7974 titles. After removal of 757 duplicates, 7217 titles were screened. After double screening, 20 full text articles were considered for inclusion and ultimately 12 met the inclusion criteria for this review (Figure 3.1). A list of included studies appears in Section 6.1. A description of abstracts that appeared to address social franchising but were later excluded and the reasons for their exclusion appears in Appendix 3.1. When more information was required about the included studies, TK and SH attempted to contact authors of those studies.

Figure 3.1 Filtering of papers from searching to map to synthesis



3.2 Systematic reviews

Three out of twelve included studies were systematic reviews (Koehlmoos et al. 2009, Patouillard et al. 2007, Peters et al. 2004). Two of these gave clear definitions of social franchising. The current review's definition of social franchising is drawn from the earlier review by Koehlmoos et al. (2009). Patouillard et al. (2007) include additional elements of price control and minimum sales volume.

All three reviews sought studies in low- and middle-income countries. Peters et al. (2004) addressed the role of the private sector in improving access to sexual and reproductive health (Peters et al. 2004). The two other included reviews were open to all types of franchising interventions.

Two of the systematic reviews did not identify any primary studies of social franchising either because the review was restricted to rigorous studies of impact (Koehlmoos et al. 2009) or because relevant studies were not published until after the review was completed (Peters et al. 2004). The review by Patouillard et al. (2007) includes three primary studies covering six franchising interventions. Each of those primary studies met the criteria for inclusion in this current review and is included in the analysis of primary studies below.

The three systematic reviews were assessed for quality using the eleven point AMSTAR scoring mechanism. The review by Koehlmoos et al. (2009) received six points but since this review located no studies eligible for inclusion four of the items were not applicable to the review, so its score was six out of seven. Patouillard et al. (2007) scored seven out of eleven and the review by Peters et al. (2004) scored six out of eleven (Table 3.2). All of the reviews were of average quality. For example, each included a priori design and a search of the unpublished literature; however none assessed the risk of publication bias.

Table 3.2 AMSTAR scores

Item	**Koehlmoos et al. 2009**	**Peters et al. 2004**	**Patouillard et al. 2007**
1. Was an 'a priori' design provided?	Y	Y	Y
2. Was there duplicate study selection and data extraction?	Y	N	N
3. Was a comprehensive literature search performed?	Y	N	Y
4. Was the status of publication (i.e. grey literature) used as an inclusion criterion? (Includes published & unpublished literature)	Y	Y	Y
5. Was a list of studies (included and excluded) provided?	Y	N	N
6. Were the characteristics of the included studies provided?	NA	Y	Y
7. Was the scientific quality of the included studies assessed and documented?	NA	Y	N
8. Was the scientific quality of the included studies used appropriately in formulating conclusions?	NA	Y	Y
9. Were the methods used to combine the findings of studies appropriate?	NA	Y	Y
10. Was the likelihood of publication bias assessed?	N	N	N
11. Was the conflict of interest stated?	Y	N	Y
	6/7	6/11	7/11

3.2.1 Outcomes

Outcomes addressed by these reviews were: engagement of the private sector in sexual and reproductive health (Peters et al. 2004); access to and quality of health services as well as cost factors and health outcomes (Koehlmoos et al. 2009); and the quality of health care services, particularly for the poor (Patouillard et al. 2007). Only Patouillard et al. (2007) found studies of social franchising. Between them, the three included primary studies addressed six interventions in five countries. However, the evidence of impact on utilisation and quality of services was mixed, as described in detail in the following section on equity. Furthermore, the overall rigour of the primary studies for private sector interventions was judged to be poor.

3.2.2 Equity

The systematic review by Patouillard et al. (2007) applied an equity lens to investigate the impact of various private sector interventions on utilisation of quality health service by the poor. Poverty was assessed using various tools, including low- or lower-income status, low education and/or living in disadvantaged areas. The review looked for studies measuring poverty as a relative term, considering that in many low-income countries a majority of the population might be poor. The quality of the studies was poor and results were mixed. One study from Nepal reported benefit to a poorer population; however, in low-income, urban settings in Pakistan, a franchise targeting the poor actually served groups with higher income and higher education levels.

3.3 Primary studies

3.3.1 Study designs

The nine included primary studies used a range of study designs. Three were controlled before and after studies (Agha et al. 2007b, Hennink and Clements 2005, Plautz et al. 2003). There was one uncontrolled pre and post-test (Agha et al. 2007a) and three studies that used surveys of various levels of facilities, providers and/or users (Decker and Montagu 2007, Quereshi 2004, Stephenson et al. 2004). Two studies took innovative approaches to applying publicly available data combined with programme data in order to attempt to measure the impact of the intervention. Kozhimannil and colleagues (2009) compared national demographic and health surveys from the Philippines in a faux-pre- post-test design that estimated outcomes based on possible exposure to the intervention by geographic location and density of franchises. Another study reviewed routine data from public services in townships with and without the intervention over time, but Lonnroth et al. (2007) do not report a denominator for TB prevalence and fall short of an attempt at an interrupted time series. This study from Myanmar relies on the contribution of case notification from franchisees, which gives an equivocal measure of completeness of notification. As no randomized controlled trials, non-randomized controlled trials or interrupted time series were identified in this review (similar to the results of Koehlmoos et al. 2009), it is not possible to draw conclusions about the impact of social franchising.

3.3.2 Study quality

In order to assess the quality of primary studies we applied the tool described in Section 2.3.2 and outlined in Appendix 2.3.2. The results of the nine primary studies appear in Appendix 3.3. In general there was a lack of independence either of study authors and/or study funders. Several studies did not report any steps for ensuring the rigour of their data collection; this may be a gap in reporting rather than a flaw in the study. Most of the studies adequately described the social franchising intervention. The vast majority of the studies clearly described their objectives, sampling method and limitations. There was mixed reporting of limitations, alternative explanation for the results and external factors that may have affected the conclusions.

3.3.3 Populations

All of the included studies focused on franchising interventions in developing countries (low-income and lower-middle-income countries as defined by the World Bank). Most

studies were conducted in South or South East Asia (India, Myanmar, Nepal (2), Pakistan (3) and the Philippines), with only three interventions taking place in Africa (Ethiopia, Kenya, Madagascar). There was a mix of studies that focused on franchising in urban areas and in rural areas. Only one study exclusively focused on the urban poor; Hennink and Clements (2005) looked specifically at franchises placed in six poor, urban areas of Pakistan.

Potential intervention users varied from study to study. Lonnroth et al. (2007) focused on low-income populations in township areas of Myanmar with a chronic cough or tuberculosis. In the Philippines the Well-Family Midwife Clinics opened its first clinics targeting disadvantaged populations in and around Manila (Kozhimannil et al. 2009). Low-income family planning and/or reproductive health users, both male and female, were the target of the interventions in Nepal (Agha 2007a and b), Pakistan (Hennink and Clements 2005, Qureshi 2004, Stephenson et al. 2004). In Kenya and Madagascar the reproductive health programmes targeted youth aged 15-24 years (Plautz et al. 2003, Decker and Montagu 2007).

Franchisees included a broad range of health workers. The two studies by Agha (2007a and b) included 64 nurses and paramedics. Decker and Montagu (2007) included 102 certified clinicians or nurses with a common focus on family planning and/or abortion, where as Lonnroth and colleagues (2007) attempted to capture the impact of 220 licensed general providers who were involved in tuberculosis diagnosis and case notification. Kozhimannil and colleagues (2009) looked at an undisclosed number of midwives operating out of more than 200 clinics. Qureshi (2004) looked at 1,113 family planning providers. Hennink and Clements (2005) and Stephenson et al. (2004) took a mixed provider and/or facility-based approach; the former evaluated clinics that contained a mix of clinic managers, physicians, nurses and lady health visitors and family planning counsellors, while Stephenson et al. (2004) looked at three different franchising interventions in three different countries but in each setting looked at a range of reproductive health providers to include physicians, midwives, community health workers as well as facilities.

3.3.4 Models of social franchising

One primary study looked at tuberculosis-related diagnosis, treatment and case notification (Lonnroth et al. 2007). However, the rest of the primary studies (eight) dealt with interventions to improve reproductive health services

In terms of understanding the models of social franchising, none of the papers discussed or described the intervention in sufficient detail to assess whether the franchise was first or second generation, although Stephens and colleagues introduce the phrase in the background section of the study. Six of the studies provided sufficient information to determine that the franchise was fractional versus a stand-alone model. In Nepal, SEWA is a fractional franchise (Agha et al. 2007a and b). The Green Star network includes stand-alone clinics in Pakistan (Hennink and Clements 2005, Qureshi 2004, Stephenson et al. 2004); Well Family Midwife Clinics in the Philippines were stand-alone clinics (Kozhimannil et al. 2009). This aspect of the franchising model was less clearly described in the other primary studies.

3.3.5 Sustainability of social franchising

Only seven studies provided information about the duration of the franchise being evaluated. Evaluations were conducted approximately one year (Lonnroth et al. 2007, Stephenson et al. 2004), or eighteen months to two years (Hennink and Clements 2005; Plautz et al. 2003; Agha et al. 2007a and b) after franchise services were introduced. Two studies conducted the evaluation four to five years after the introduction of the intervention (Kozhimannil et al. 2009, Stephenson et al. 2004).

Many of the primary studies named the agency funding the development of the project. These agencies included USAID (Kozhimannil et al. 2009, Agha et al. 2007 a and b); the Bill and Melinda Gates Foundation and the Packard Foundation (Hennink and Clements 2005, Stephenson et al. 2004). Franchisers or implementing agencies included John Snow International (Kozhimannil et al. 2009), the Futures Group (Stephenson et al. 2004), Population Services International (PSI) (Lonnroth et al. 2007), Commercial Marketing Strategies (CMS) (Agha et al. 2007a and b) and Marie Stopes International (Hennink and Clements 2005). One primary study briefly mentions the establishment of an organisation to

support the franchisees after the end of donor funding but no details are provided as to the scope, sources or success of this initiative (Kozhimannil et al. 2009).

3.3.6 Elements of social franchising

The amount of detail available about each element of the franchises varied from study to study. The following section details each of the elements of social franchising as presented in the primary studies.

Seven of the studies described the use of training toward the use of protocolised management within the social franchise interventions; however, the amount of detail description varies across studies. Quereshi (2004) and most other interventions focused on the protocolised management of various aspects of reproductive health and family planning. In both of the Agha studies, providers received a seven-day package of orientation to the franchises approach to basic reproductive health services like ante-natal care (ANC), the provision of clinical and non-clinical contraception, the identification of high risk pregnancy and sexually transmitted infections (STI), as well as procedures on how to prevent infection among the health providers. Hennink and Clements (2005) state that in Pakistan the franchise provided orientation to its package of contraception methods, pregnancy testing and termination and how to provide advice on sexual health. In Ethiopia, the Biu Tesfa (Ray of Hope) franchise provided training in HIV/AIDS counselling in addition to the previously mentioned reproductive health services available in social franchises elsewhere (Stephenson et al. 2004). In the Philippines, the Well-Family Midwife Clinics franchise added childbirth and infant and child care to a package of reproductive health and family planning services (Kozhimannil 2009). Providers working on tuberculosis in Myanmar were expected to follow the National Tuberculosis Programme (NTP) guidelines and maintain the NTP treatment card for each patient, appoint a treatment supporter and report all treatment defaulters. Private labs participating in the franchising programme in Myanmar received 2-3 days of training.

In terms of business and management training, the two studies led by Agha (2007a and b) contained the most insight into the content of these sessions. Network members received two days of services marketing training to build empathy, promote outreach and to develop the concept of valuing quality service around the client–provider interaction. Other studies by Stephenson et al. (2004), Lonnroth et al. (2007) and Decker and Montagu (2007) mention that this sort of business practice training took place but did not provide details.

The standardisation of supplies is another element of a social franchising intervention that is described in detail in five of the primary studies. In the Nepal studies (Agha 2007a and b) the franchiser created a link to a local social marketing company to ensure a steady supply of subsidised family planning products for the franchisees. Decker and Montagu reported that regular delivery of contraceptive supplies and the provision of some clinical equipment were part of the KMET intervention in Kenya. In Myanmar, the monthly visits by SQH franchise officers ensured a resupply of products, many of which were SQH's own brand, although TB drugs were provided by the NTP but delivered to the franchisees free of charge (Lonnroth et al. 2007). Stephenson and colleagues (2004) noted that in Pakistan, the franchiser for Green Star (Social Marketing Pakistan, SMP) delivered high quality contraceptives to network members at wholesale prices.

The role of branding and marketing was addressed in six of the primary studies (Agha et al. 2007a and b, Hennink and Clements 2005, Kozhimannil et al. 2009, Lonnroth et al. 2007, Plautz 2003, Stephenson et al. 2004). Most primary studies mentioned the name of the brand like the Well-Family Midwife Clinic (Kozhimannil et al. 2009), Green Star/Green Key (Quereshi 2004, Stephenson et al. 2004), Ray of Hope and Janani (Stephenson et al. 2004). Three studies provided detail about the extent of branding. The Sewa franchise was described in both of the studies from Nepal (Agha 2007a and b). This franchise employed a brand name logo, leaflets, an external marketing campaign, radio advertisements and billboards. Furthermore, each Sewa provider had a white jacket/shirt with the Sewa logo to wear in the clinic. The Sun Quality Health (SQH) franchise in Myanmar had its own label on medical products used in the clinics and these products and the clinics were promoted using leaflets and signboards (Lonnroth et al. 2007). Further, television advertising was used to promote tuberculosis advocacy and Directly Observed Therapy (DOTS); SQH as well as other non-state providers incorporated the public sector DOTS symbol into their TB-

related advertising materials. The Plautz study specifically addressed programme exposure, including having attended peer education or the franchise clinics and having seen a film about STIs, visited a mobile video unit or heard television or radio spots.

The monitoring function of franchisers of the franchise clinics was described in four of the studies. In Nepal, the SEWA franchise featured monthly visits by field co-ordinators to each franchise in order to make observations and complete a checklist evaluating service quality, the availability of supplies and the interaction between clients and providers (Agha 2007a and b). Decker and Montagu (2007) described a system in which facilities must meet cleanliness and privacy standards, although the mechanism and frequency of monitoring is not available. Last, the SQH franchise monitored its clinics with monthly visits and periodic mystery client surveys (Lonnroth et al. 2007).

The final element of social franchising is network membership. Although all of the primary studies mentioned that a network of franchises existed, only three of the studies detailed the cost and benefits of network membership. Joining the Sewa network cost US$1.4 and there was an annual membership fee of US$9. The KMET network providers paid a membership fee and were eligible to receive low-interest loans for facility improvement (Decker and Montagu 2007). The cost of membership in the SQH network was not stated, but Lonnroth et al. (2007) noted that franchisees who failed to meet basic quality standards could be dissociated from the network.

4. Synthesis of findings

Between them, the primary studies focused on access, quality of care and health outcomes. Several studies incorporated elements of equity analysis and one study evaluated the economic impact of the social franchise. Absent from the literature are the results of studies on sustainability of the franchising mechanism and of implementation factors such as adherence to service protocols (Table 4.1).

Table 4.1 Focus of the social franchising literature for reach, implementation, sustainability and effects

Study	Reach	Implementation	Sustainability	Satisfaction	Effects
Agha 2007a	Yes	No	No	Yes	No
Agha 2007b	No	No	No	No	Yes
Decker 2007	Yes	No	No	Yes	Yes
Hennink 2005	Yes	No	No	No	Yes
Kozhimannil 2009	Yes	No	No	No	Yes
Lonnroth 2007	No	No	No	No	Yes
Plautz 2003	Yes	No	No	No	Yes
Qureshi 2004	Yes	Yes	No	No	No
Stephenson 2004	Yes	No	No	Yes	No

4.1 Outcomes

4.1.1 Reach

Client volume is one measure of reach that has been used to evaluate social franchising. Quereshi (2004) analysed cluster data generated by provider interviews and found that compared to franchise clinics, client volume was higher in the government and NGO settings and lower in the non-franchise private sector; however the paper reported little about ensuring rigour in data collection, nor did it consider possible limitations of the study, or confounding factors or alternative explanations of the findings. Comparisons of information generated by surveys of facilities, providers and patients also found that client volume was higher for family planning in the government establishments than in franchised clinics across all settings in Ethiopia, India and Pakistan (Stephenson et al. 2004). An internal evaluation found that a fractional franchise for reproductive health in Nepal constituted less than 15 percent of the provider's overall clients (Agha et al. 2007a).

Several studies measured changes in levels of service utilisation across various family planning and reproductive health services. Changes in levels of service utilisation were part of the assessment of TOP Réseau, by making pre/post test comparisons from population-level surveillance; thus Plautz et al. (2003) found that among males with symptoms of sexually transmitted infections (STIs), those with high message exposure from the social franchise were not more likely than those with low message exposure to seek STI treatment.

In Kenya, KMET youth clients versus non-KMET youth were statistically significantly more likely to learn where to get family planning information and services from friends and neighbours and from family planning providers (Decker and Montagu 2007). It is unclear whether funding of this study was linked with the social franchise.

Data from two rounds of demographic and health surveys were employed in a pre/post-study design in the Philippines. The measure used was programme presence in the region, defined as the number of facilities of Well-Family Midwife Clinics (WFMC) per 10,000 births in comparison to the presence in a region of the national health insurance programme (PhilHealth) per 10,000 births. This independent study showed that the increased presence of the national insurance programme (PhilHealth) was associated with an increased chance of receiving four ante-natal care visits starting in the first trimester, but the social franchising (WFMC) intervention was not associated with this change. However, the presence of the WFMC was associated with increased odds of delivery in a private facility, although for both the national health insurance and for the WFMC there was no statistically significant increase in the odds of giving birth in a facility (Kozhimannil et al. 2009).

Surveys implemented in a pre/post-test design of ever-married women living within a 2-3 kilometre radius of a franchise clinic showed that the franchise clinics had little impact on overall contraceptive prevalence in five poor urban areas of Pakistan but did produce an eight percent increase in use of female sterilisation, which was offset by a seven percent decline in condom use so that the contraceptive prevalence rate was stagnant (Hennink and Clements 2005). Changes in the unmet need for family planning varied across study sites so that two sites in a less conservative province saw statistically significant declines but the three other sites in more conservative provinces had only marginal decreases.

4.1.2 Implementation

Quality of care has been assessed primarily through the use of provider and client interviews and in one instance through changes in case notification. The proportion of providers who have received training can be considered a measure of quality of care. Using cluster data generated by provider interviews, Qureshi (2004) was able to make a comparison between government, franchise and non-franchise private sector providers and found that having ever worked for the government increased the likelihood of the provider being trained; however, providers in the franchise reported having received more training then non-franchise, private sector providers and that was related to a significant increase in client volume across settings. In India, Ethiopia and Pakistan, Stephenson and colleagues (2004) analysed surveys of facilities, patients and providers and found mixed results on client perceptions of quality compared to non-franchised services and hence mixed results on intent to return to the franchise for treatment.

Client exit interviews in Nepal demonstrated that the type of provider (physician, nurse or paramedic) was not associated with perceived expertise in delivery of health services (Agha et al. 2007a). Further, as SEWA is a fractional franchise for reproductive health and woman-focused, women were more likely to report elements of client loyalty than men, who were not the target of the intervention. To that end, there was a 9.5 times increase at the end point of clients choosing the facility based on the provider's caring manner. In Kenya, client and household interviews of youth demonstrated that they considered the most important traits in selecting a provider to be privacy and respectful treatment, but these variables were not related to the franchising intervention. Also, an independent study showed that KMET providers were five times more likely to provide family planning counselling to youth than non-KMET providers (Decker and Montagu 2007).

The study of the SQH franchise in Myanmar is the only study to look at tuberculosis. It measured quality of care by measuring changes through two mechanisms: 1) case notification data from the quarterly reports of the implementing agency (PSI) and from the National Tuberculosis Programme (NTP) for the Yangon Division; and 2) client surveys collected in a pre/post design. The authors concluded that average case notification was higher in the seven periods after the introduction of the TB package of services at SQH than in the seven previous periods. However, the interpretation did not use averages but rather changes over time; this suggests an increasing notification rate before the introduction and a stabilized rate afterwards. Thus the franchise may not have been successful (Lonnroth et al. 2007).

4.1.3 Health and health-related behaviour

Six of the studies attempted to measure the impact of social franchising on health outcomes through rounds of large-scale health and demographic surveillance and through

purpose-built surveys comparing use of family planning methods across users and non-users of social franchises. Without comparable control groups, their findings report correlations rather than impact. In addition to perceptions of risk and confidence in seeking treatment, Plautz et al. (2003) used population level data from the 2000 and 2002 Madagascar Adolescent Reproductive Health Surveys in a pre- and post-design to evaluate several measures of programme activities based on message exposure. Among female franchise clients, those with high message exposure were more likely to use modern methods of family planning. Furthermore, youth who were clients of TOP Réseau clinics were no more likely to use condoms; thus a combination of messages and clinic visits or any two elements in the programme are necessary to create behaviour change.

In Nepal, Agha and colleagues (2007b) used exit interviews of male and female franchise clients and household interviews in a controlled before and after design in order to discover that that the franchising intervention resulted in no statistical difference for family planning use among married women, use of ante-natal care during their last pregnancy, or the number of women receiving ante-natal care from a medical store or pharmacy. However, the intervention period was short (two years) and there were delays in delivering the intervention due to civil unrest, which may have hampered its effectiveness.

In Kenya, client and household interviews of youth found that KMET youth clients were more likely than non-KMET youth to use any form of family planning and to use modern methods of family planning. Some 44 percent of KMET providers versus 30 percent of non-KMET providers offered youth-targeted services (Decker and Montagu 2007). The study of urban franchising clinics in Pakistan found that they were responsible for a 5 percent increase in overall knowledge of family planning methods including a 15 percent increase in knowledge of female sterilisation and a 7 percent increase in knowledge about the IUD (Hennink and Clements 2005).

4.2 Equity

Seven of the primary studies contained elements of equity analysis, as did one of the systematic reviews. The influences of gender, age, parity, education and economic status are all addressed in the social franchising literature. Economic evaluation was limited to one study from Myanmar.

Gender is one aspect of equity analysis. One primary study investigated the gender of providers. Quereshi (2004) found that male family planning providers in low-income, urban settings in Pakistan had significantly smaller clientele than female family planning providers (Quereshi 2004). However, confidence in these findings is reduced by the poor reporting of study methods. More frequently, equity was approached from the perspective of the users rather than the providers. In Nepal, more women than men reported that they were likely to make repeat visits to the social franchise (Agha 2007a).

Another equity dimension is education. In the Stephenson et al. (2004) multi-country study, the equity analysis revealed conflicting results. In Bihar illiterate people were significantly less likely to use the social franchise but there was no association based on literacy status in Pakistan or Ethiopia.

Age and parity are other equity dimensions. In Pakistan, a study observed a significant decline in franchise use that was associated with increased parity. This observation did not hold across the two other countries in the study, Bihar (India) and Ethiopia (Stephenson et al. 2004). In Nepal older clients were more likely to report that they would make a repeat visit to the franchise clinics (Agha 2007a). Decker and Montague's (2007) analysis focused specifically on 18-24 year-old users of family planning services. They determined that youth use rates of all family planning methods were lower than adult use rates, and that social stigma was the greatest barrier to youth accessing family planning services. Youth (aged 15-24 years) were also the target of the study by Plautz et al. (2003), which found that between 2000 and 2002, youth perceived more support for adolescent condom use and faced fewer barriers to accessing reproductive health services; however, this was not necessarily associated with the use of the social franchise or exposure to franchising messages.

Economic status is another dimension of equity. Hennink and Clements (2005) found that despite placing clinics in poor, urban areas with the goal of serving the poor population, the social franchise clients were more likely to be from other groups that were younger, had a relatively higher standard of living (determined by a proxy assets measure), had low parity and were primarily interested in birth spacing. However, this analysis only included female clients. In Myanmar, 68 percent of TB patients accessing care through the social franchise were from the two lowest wealth quintiles (Lonnroth et al. 2007).

4.3 Economics

Economic evaluation only appears in the study by Lonnroth and colleagues (2007) set in Myanmar. The study found that the average cost for lower socio-economic groups across the whole population using all providers was equivalent to 68 percent of their annual per capita household income versus a median of 28 percent. The SQH franchises were found to provide lower cost treatment compared to other sectors/providers; users from the lower socio-economic groups were spending 3 percent of their annual per capita income on tuberculosis treatment as compared to 11 percent of the mean. All patients appeared to have paid despite services being no cost at the point of care and drugs being 'free'. Thirty-eight percent of patients from the lower socio-economic groups had to borrow money during their treatment. The author mentioned a planned full economic evaluation but this evaluation had not appeared in the literature at the time of this review.

4.4 Summary of results of synthesis

1. Seven studies addressed aspects of access to services. Social franchising was not related to increases in client volume across settings or to increased use of STI treatment. However, there were mixed outcomes for changes in unmet need for family planning.
2. Five studies addressed quality of care issues. The studies showed that franchise providers were more likely to be trained than non-franchise private providers but that training was affiliated with government service as opposed to the franchise. Further, franchise providers were more likely to be selected for their caring manner after the intervention in one study but in general there were mixed results on patient perception of improvement in quality of care.
3. Six of the studies attempted to measure the impact of social franchising on health and health-related behaviour outcomes. Although authors reported an improvement in knowledge and use of modern family planning methods among franchise clients, their study designs were not rigorous enough to measure impact.
4. Seven studies contained elements of equity analysis presenting mixed results for franchises reaching the young, the poor and the illiterate across settings. Also, clinics set in low-income urban areas did not necessarily serve the target low-income group.

5. Conclusions

5.1 Strengths and limitations of the review

Unlike previous reviews of social franchising and the non-state sector, this review's strength was its comprehensive search of major and minor databases without the use of restrictive methodology filters, which resulted in the inclusion of three reviews and nine primary studies.

This review would be strengthened by the inclusion of social franchising literature in languages other than English (e.g. French). Further, much of the evidence supporting social franchising rests on satisfaction surveys, which are commonly unreliable due to courtesy bias (Bernhart et al. 1999, Williams et al. 2000). Similarly, health behaviour outcomes were dependant on exit interviews and household client interviews, which suffer from similar weaknesses. Specifically for exit interviews, participation bias may have caused some clients to avoid being asked to participate. Furthermore, in any study that relies upon self-reporting, there may be recall bias on some issues and for customer satisfaction, the issue of cultural biases towards pleasing the interview could impact on disclosure.

5.2. Conclusions and recommendations

5.2.1 Conclusions

Social franchising has been evaluated in South and South East Asia and Africa. No reports could be found from Central Asia or South America. Further, franchising literature was almost exclusively from low-income countries with the exception of one franchise covered from the Philippines and another from India (Kozhimannil et al. 2009 and Stephenson et al. 2004). Most studies were of social franchises for reproductive health and family planning issues.

Similar to the reviews led by Koehlmoos (2009) and Patouilliard (2007), we found a paucity of rigorous study designs, so the overall existing evidence supporting social franchising is weak. The studies led by Lonnroth et al. (2007), Kozhimannil et al. (2009) and Plautz et al. (2003) perform analysis on population-level data rather than employing custom-built evaluation designs, which would have provided the evidence needed to make definitive conclusions as to the effectiveness of social franchising.

At present, the literature on social franchising does not address issues of implementation such as adherence to service protocols or sustainability of the franchise. This casts doubt on the meaningfulness of reports about reach and satisfaction. With this proviso, existing evidence appears to show that across settings, the government continues to have the highest volume of clients for family planning and other services; however, franchises do better than non-franchised private sector providers in terms of client volume (Quereshi 2004, Stephenson et al. 2004). Across studies, the clients of social franchises are satisfied with the quality of care received through the franchise and consistently report an intent to return for future health services (Agha et al. 2007b, Stephenson et al. 2004). Little information is available about implementation, with the exception of one study from Nepal, which noted that civil unrest delayed the implementation of an external marketing campaign (Agha et al. 2007a) and no information is available about the maintenance of franchising operations. Further there is a dearth of evidence on sustainability and of interventions.

There is a dearth of economic evaluations in the field of social franchising. As by its nature, franchising consists of a financial investment both on the side of the franchisee and the franchiser, the economic aspects of this mechanism should be more fully evaluated before recommendations toward future implementation or scaling up can be made.

For much of the work, there was a substantial lag between the time of the intervention being studied and the results being published. The range was two to seven years with an average delay of around four years.

Thus, decision makers in the health sector have been making health programme and policy decisions with less than complete information.

5.2.2 Recommendations

Given that social franchising remains an area of great interest as a model for engaging the non-state sector in the provision of health services in developing country settings, we recommend more rigorous evaluations of the effects of different models of social franchising. At present, evidence publicly available adds little to our knowledge of the implementation or effectiveness of social franchising. This may be due in part to social franchises operating in an environment which inhibits the sharing of commercially sensitive data. There is a need for independent rigorous evaluations to collate what can be learnt from how social franchises operate and assess their effects, whilst protecting commercial interests.

Models to be evaluated should have sound theoretical bases for improving quality of services and access by poorer populations and be evaluated for their implementation (adherence and integrity), adoption by franchisees, service users' utilisation and satisfaction, sustainability, and agreement on measurable and testable social franchising activities and goals. Some examples of activities and goals might include changes in use of family planning services and ante-natal care/skilled birth attendance; changes in case notification for HIV or tuberculosis; and changes in training of providers and provider client volume.

There is a need to evaluate such franchising of clinical services in Africa, Central Asia and South America as have been established, as a majority of the studies included in this review are from South and South East Asia, and to evaluate franchising on service delivery areas other than reproductive health, especially family planning.

Moreover, future evaluations of social franchising could include measures of the impact of the intervention on health outcomes, not only client and provider satisfaction. Similarly, the 'social' in social franchising lends itself well to the future inclusion of PROGRESS-Plus or other equity analysis tools in evaluations of franchising in order to more accurately and consistently capture the benefit to targeted sections of society, particularly women and the poor.

Researchers evaluating social franchising interventions should be supported to bring their findings to the appropriate international audience promptly.

Further systematic reviews of social franchising are not recommended at the present time. However, it is likely that the body of primary literature evaluating social franchising will grow in the years ahead. There is a real need for rigorous prospective and/or concurrent evaluations with timely sharing of findings. The growth in the body of evidence should be monitored and a fresh review of social franchising may be called for two to three years hence.

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Appendices

Appendix 1.1: Authorship

Authorship of this review

TK: Designed and implemented the study, conducted the analysis and wrote the report.
SH: Designed and implemented the search strategy, assisted with the analysis and with writing the report.
RG: Assisted with designing the study, conducted the analysis and reviewed drafts of the report
MR: Assisted with implementing the study and conducting the analysis.

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Conflict of interest

The authors report no conflicts of interest.

Appendix 2.1: Inclusion and exclusion criteria

Types of studies

All types of evaluations were included in this review. Randomised and non-randomised trials, controlled before and after studies and interrupted time series were considered potentially suitable for assessing effects of intervention. Observational studies such as surveys, cohort studies, case-controlled studies and case studies (with or without economic or equity analyses) were considered potentially suitable for assessing reach, implementation and maintenance.

Opinion pieces, policy documents and non-systematic reviews were excluded.

Types of participants

All levels of health care delivery were eligible.

All types of patients/consumers and healthcare professionals/providers in low-and middle-income countries were eligible (World Bank 2007).

Studies set in high-income countries were excluded (World Bank 2007).

Types of interventions

Social franchises were considered for inclusion in this review if their health professionals delivered health care services to the clients.

Further, the overarching aim behind the implementation of the social franchise had to be one of social benefit, for instance the extension of health service delivery or improving the quality of health service delivery, rather than commercial benefit.

To be included an intervention needed to include all of the following elements:

- a franchiser and franchisees:
    - the franchiser must be an NGO or government
    - there must be multiple franchisees of independent providers/sites/locations that deliver care by health professionals
- standardisation of supplies, delivery processes, management, including training, monitoring and protocols
- branding.

In addition, there may be other marketing strategies, including advertising (using mass media or personal media).

Studies were excluded if they did not include a social franchise for the delivery of health services.

Appendix 2.2: Sources searched electronically and by hand

Source databases	Date of search	# of Hits
Major databases		
CINAHL/EBSCO	17/09/2009	1392
Cochrane Central Library Register	11/08/2009	161
Econlit/Ovid	11/08/2009	560
EMBASE/Ovid	11/08/2009	754
Medline/PubMed	09/08/2009	3648
Science Citation Index Expanded (SCI-expanded) and Social Sciences Citation Index (SSCI)	11/08/2009	389
Sociological Abstracts	11/08/2009	423
Total major databases		**7327**
Duplications removed		757
Total screened		**6570**
Minor databases + Hand search		
Abt. Associates	14/09/2009	2
Bio Med Central	14/09/2009	4
Chemonics	07/09/2009	2
Department for International Development, UK	05/09/2009	36
Eldis (Institute of Development Studies)	05/09/2009	15
Google Scholar	13/09/2009	179
German Technical Corporation (GTZ)	05/09/2009	4
Management Science for Health Services	05/09/2009	61
Marie Stopes International (MSI)	05/09/2009	44
Population Services International	05/09/2009	67
Rockefeller Foundation	07/09/2009	2
USAID	05/09/2009	51
WHOLIS	05/09/2009	8
World Bank	03/09/2009	97
World Health Organization (WHO)	05/09/2009	75
Total screened		**647**

Appendix 2.3.1: Search strategies for electronic databases

Major Databases	
Cochrane Library No. of records obtained: 161	#1 (outsourc*):ti,ab,kw in Clinical Trials #2 (private NEXT enterprise*):ti,ab,kw or (social NEAR enterprise*):ti,ab,kw or (nonprofit NEAR enterprise):ti,ab,kw or (non-profit NEAR enterprise):ti,ab,kw in Clinical Trials #3 (public private cooperation):ti,ab,kw in Clinical Trials #4 (public private partnership):ti,ab,kw in Clinical Trials #5 (contract services):ti,ab,kw in Clinical Trials #6 (health AND marketing):ti,ab,kw in Clinical Trials #7 (franchis*):ti,ab,kw in Clinical Trials #8 (social franchising):ti,ab,kw in Clinical Trials #9 (sponsor* NEAR service*):ti,ab,kw in Clinical Trials #10 (profit* OR nonprofit*):ti,ab,kw and (organisat*):ti,ab,kw in Clinical Trials #11 (profit* OR nonprofit*):ti,ab,kw and (organizat*):ti,ab,kw in Clinical Trials #12 (non-profit*):ti,ab,kw and (organizat*):ti,ab,kw in Clinical Trials #13 (non-profit*):ti,ab,kw and (organisat*):ti,ab,kw in Clinical Trials #14 'not for profit':ti,ab,kw and (organisat*):ti,ab,kw in Clinical Trials #15 'not for profit':ti,ab,kw and (organizat*):ti,ab,kw in Clinical Trials #16 (branding):ti,ab,kw in Clinical Trials #17 (brand names):ti,ab,kw in Clinical Trials #18 (brand imag*):ti,ab,kw in Clinical Trials #19 (brand name):ti,ab,kw in Clinical Trials #20 (non state):ti,ab,kw and (contract*):ti,ab,kw in Clinical Trials #21 (non governmental):ti,ab,kw and (contract*):ti,ab,kw in Clinical Trials #22 (nongovernmental):ti,ab,kw and (contract*):ti,ab,kw in Clinical Trials #23 (nonstate):ti,ab,kw and (contract*):ti,ab,kw in Clinical Trials #24 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23) #25 MeSH descriptor Outsourced Services, this term only #26 MeSH descriptor Marketing of Health Services explode all trees #27 MeSH descriptor Delivery of Health Care, this term only with qualifier: MT #28 MeSH descriptor Delivery of Health Care, this term only with qualifier: OG #29 MeSH descriptor Delivery of Health Care, this term only with qualifier: ST #30 MeSH descriptor Delivery of Health Care, this term only with qualifier: UT #31 MeSH descriptor Organizations, Nonprofit, this term only #32 MeSH descriptor Private Sector, this term only #33 MeSH descriptor Public-Private Sector Partnerships, this term only #34 MeSH descriptor Contract Services, this term only with qualifiers: MA,MT,OG,ST,SN,UT #35 (#24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34) #36 (#35), from 2007 to 2009
CINAHL (EBSCO) No. of hits: 1392 (The shaded lines ultimately discarded)	S1 (MH 'Contract Services') S2 (MH 'Social Marketing') S3 (MH 'Public Sector') and (MH 'Private Sector')

	S4	(MH 'Organizations, Nonprofit')
	S5	(MH 'Health Care Delivery')
	S6	TI (franchis* or outsourc* or (private W1 enterpri*) or (contract* W1 service*) or branding or (brand w1 name*) or (brand W1 imag*)) or AB (franchis* or outsourc* or (private W1 enterpri*) or (contract* W1 service*) or branding or (brand w1 name*) or (brand W1 imag*))
	S7	TI (health and marketing) or AB (health and marketing)
	S8	TI 'social marketing' or AB 'social marketing'
	S9	TI (('public sector' W6 'private sector') or ('public sectors' W6 'private sectors') or (public W6 private W6 sector*)) or AB (('public sector' W6 'private sector') or ('public sectors' W6 'private sectors') or (public W6 private W6 sector*))
	S10	TI ((social or profit* or nonprofit*) and enterpri*) or AB ((social or profit* or nonprofit*) and enterpri*)
	S11	TI ((profit* or nonprofit*) and (organization* or organisation*)) or AB ((profit* or nonprofit*) and (organization* or organisation*))
	S12	TI ((state or governmental) and contract*) or AB ((state or governmental) and contract*)
	S13	TI (sponsor* and service*) or AB (sponsor* and service*)
	S14	S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13
	S15	S1 or S2 or S3 or S4 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13
	S16	(MH 'Developing Countries')
	S17	(MH 'Africa+')
	S18	(MH 'Central America+')
	S19	(MH 'Latin America')
	S20	(MH 'South America+')
	S21	(MH 'West Indies+')
	S22	(MH 'Asia+')
	S23	TI (Africa or Asia or 'South America' or 'Latin America' or 'Central America') or AB (Africa or Asia or 'South America' or 'Latin America' or 'Central America')
	S24	MW ('American Samoa' or Argentina or Belize or Botswana or Brazil or Bulgaria or Chile or Comoros or 'Costa Rica' or Croatia or Dominica or Guinea or Gabon or Grenada or Grenadines or Hungary or Kazakhstan or Latvia or Lebanon or Libia or libyan or Libya or Lithuania or Malaysia or Mauritius or Mayotte or Mexico or Micronesia or Montenegro or Nevis or 'Northern Mariana Islands' or Oman or Palau or Panama or Poland or Romania or Russia or 'Russian Federation' or Samoa or 'Saint Lucia' or 'St Lucia' or 'Saint Kitts' or 'St Kitts' or 'Saint Vincent' or 'St Vincent' or Serbia or Seychelles or Slovakia or 'Slovak Republic' or 'South Africa' or Turkey or Uruguay or Venezuela or Yugoslavia) or TI ('American Samoa' or Argentina or Belize or Botswana or Brazil or Bulgaria or Chile or Comoros or 'Costa Rica' or Croatia or Dominica or Guinea or Gabon or Grenada or Grenadines or Hungary or Kazakhstan or Latvia or Lebanon or Libia or libyan or Libya or Lithuania or Malaysia or Mauritius or Mayotte or Mexico or Micronesia or Montenegro or Nevis or 'Northern Mariana Islands' or Oman or Palau or Panama or Poland or Romania or Russia or 'Russian Federation' or Samoa or 'Saint Lucia' or 'St Lucia' or 'Saint Kitts' or 'St Kitts' or 'Saint Vincent' or 'St Vincent' or Serbia or Seychelles or Slovakia or 'Slovak Republic' or 'South Africa' or Turkey or Uruguay or Venezuela or Yugoslavia) or AB ('American Samoa' or Argentina or Belize or Botswana or Brazil or Bulgaria or Chile or Comoros or 'Costa Rica' or Croatia or Dominica or Guinea or Gabon or Grenada or Grenadines or Hungary or Kazakhstan or Latvia or Lebanon or Libia or libyan or Libya or Lithuania or Malaysia or Mauritius or Mayotte or Mexico or Micronesia or Montenegro or Nevis or 'Northern Mariana Islands' or

		Oman or Palau or Panama or Poland or Romania or Russia or 'Russian Federation' or Samoa or 'Saint Lucia' or 'St Lucia' or 'Saint Kitts' or 'St Kitts' or 'Saint Vincent' or 'St Vincent' or Serbia or Seychelles or Slovakia or 'Slovak Republic' or 'South Africa' or Turkey or Uruguay or Venezuela or Yugoslavia)
	S25	MW (Albania or Algeria or Angola or Armenia or Azerbaijan or Belarus or Bhutan or Bolivia or Bosnia or Herzegovina or 'Cape Verde' or Cameroon or China or Colombia or Congo or Cuba or Djibouti or 'Dominican Republic' or Ecuador or Egypt or 'El Salvador' or Fiji or Gaza or Georgia or Guam or Guatemala or Guyana or Honduras or 'Indian Ocean Islands' or Indonesia or Iran or Iraq or Jamaica or Jordan or Kiribati or Lesotho or Macedonia or Maldives or 'Marshall Islands' or Micronesia or 'Middle East' or Moldova or Morocco or Namibia or Nicaragua or Palestin* or Paraguay or Peru or Philippines or Samoa or 'Sri Lanka' or Suriname or Swaziland or Syria or 'Syrian Arab Republic' or Thailand or Tonga or Tunisia or Turkmenistan or Ukraine or Vanuatu or 'West Bank') or TI (Albania or Algeria or Angola or Armenia or Azerbaijan or Belarus or Bhutan or Bolivia or Bosnia or Herzegovina or 'Cape Verde' or Cameroon or China or Colombia or Congo or Cuba or Djibouti or 'Dominican Republic' or Ecuador or Egypt or 'El Salvador' or Fiji or Gaza or Georgia or Guam or Guatemala or Guyana or Honduras or 'Indian Ocean Islands' or Indonesia or Iran or Iraq or Jamaica or Jordan or Kiribati or Lesotho or Macedonia or Maldives or 'Marshall Islands' or Micronesia or 'Middle East' or Moldova or Morocco or Namibia or Nicaragua or Palestin* or Paraguay or Peru or Philippines or Samoa or 'Sri Lanka' or Suriname or Swaziland or Syria or 'Syrian Arab Republic' or Thailand or Tonga or Tunisia or Turkmenistan or Ukraine or Vanuatu or 'West Bank' Albania or Algeria or Angola or Armenia or Azerbaijan or Belarus or Bhutan or Bolivia or Bosnia or Herzegovina or 'Cape Verde' or Cameroon or China or Colombia or Congo or Cuba or Djibouti or 'Dominican Republic' or Ecuador or Egypt or 'El Salvador' or Fiji or Gaza or Georgia or Guam or Guatemala or Guyana or Honduras or 'Indian Ocean Islands' or Indonesia or Iran or Iraq or Jamaica or Jordan or Kiribati or Lesotho or Macedonia or Maldives or 'Marshall Islands' or Micronesia or 'Middle East' or Moldova or Morocco or Namibia or Nicaragua or Palestin* or Paraguay or Peru or Philippines or Samoa or 'Sri Lanka' or Suriname or Swaziland or Syria or 'Syrian Arab Republic' or Thailand or Tonga or Tunisia or Turkmenistan or Ukraine or Vanuatu or 'West Bank') or AB (Albania or Algeria or Angola or Armenia or Azerbaijan or Belarus or Bhutan or Bolivia or Bosnia or Herzegovina or 'Cape Verde' or Cameroon or China or Colombia or Congo or Cuba or Djibouti or 'Dominican Republic' or Ecuador or Egypt or 'El Salvador' or Fiji or Gaza or Georgia or Guam or Guatemala or Guyana or Honduras or 'Indian Ocean Islands' or Indonesia or Iran or Iraq or Jamaica or Jordan or Kiribati or Lesotho or Macedonia or Maldives or 'Marshall Islands' or Micronesia or 'Middle East' or Moldova or Morocco or Namibia or Nicaragua or Palestin* or Paraguay or Peru or Philippines or Samoa or 'Sri Lanka' or Suriname or Swaziland or Syria or 'Syrian Arab Republic' or Thailand or Tonga or Tunisia or Turkmenistan or Ukraine or Vanuatu or 'West Bank')
	S26	MW (Afghanistan or Bangladesh or Benin or 'Burkina Faso' or Burundi or Cambodia or 'Central African Republic' or Chad or Comoros or Congo or 'Cote d'Ivoire' or Eritrea or Ethiopia or Gambia or Ghana or Guinea or Haiti or India or Kenya or Korea or Kyrgyz or Kyrgyzstan or Lao or Laos or Liberia or Madagascar or Malawi or Mali or Mauritania or Melanesia or Mongolia or Mozambique or Burma or Myanmar or Nepal or Niger or Nigeria or Pakistan or Rwanda or

	'Salomon Islands' or 'Sao Tome' or Senegal or 'Sierra Leone' or Somalia or Sudan or Tajikistan or Tanzania or Timor or Togo or Uganda or Uzbekistan or Vietnam or 'Viet Nam' or Yemen or Zambia or Zimbabwe) or TI (Afghanistan or Bangladesh or Benin or 'Burkina Faso' or Burundi or Cambodia or 'Central African Republic' or Chad or Comoros or Congo or 'Cote d'Ivoire' or Eritrea or Ethiopia or Gambia or Ghana or Guinea or Haiti or India or Kenya or Korea or Kyrgyz or Kyrgyzstan or Lao or Laos or Liberia or Madagascar or Malawi or Mali or Mauritania or Melanesia or Mongolia or Mozambique or Burma or Myanmar or Nepal or Niger or Nigeria or Pakistan or Rwanda or 'Salomon Islands' or 'Sao Tome' or Senegal or 'Sierra Leone' or Somalia or Sudan or Tajikistan or Tanzania or Timor or Togo or Uganda or Uzbekistan or Vietnam or 'Viet Nam' or Yemen or Zambia or Zimbabwe) or AB (Afghanistan or Bangladesh or Benin or 'Burkina Faso' or Burundi or Cambodia or 'Central African Republic' or Chad or Comoros or Congo or 'Cote d'Ivoire' or Eritrea or Ethiopia or Gambia or Ghana or Guinea or Haiti or India or Kenya or Korea or Kyrgyz or Kyrgyzstan or Lao or Laos or Liberia or Madagascar or Malawi or Mali or Mauritania or Melanesia or Mongolia or Mozambique or Burma or Myanmar or Nepal or Niger or Nigeria or Pakistan or Rwanda or 'Salomon Islands' or 'Sao Tome' or Senegal or 'Sierra Leone' or Somalia or Sudan or Tajikistan or Tanzania or Timor or Togo or Uganda or Uzbekistan or Vietnam or 'Viet Nam' or Yemen or Zambia or Zimbabwe) S27 TI ('developing country' or 'developing countries' or 'developing nation' or 'developing nations' or less* W1 'developed country' or less* W1 'developed countries' or less* W1 'developed nation' or less* W1 'developed nations' or 'third world' or 'under developed' or 'middle income' or 'low income' or 'underserved country' or 'underserved countries' or 'underserved nation' or 'underserved nations' or 'under served country' or 'under served countries' or 'under served nation' or 'under served nations' or 'underserved population' or 'underserved populations' or 'under served population' or 'under served populations' or 'deprived country' or 'deprived countries' or 'deprived nation' or 'deprived nations' or poor* W1 country or poor* W1 countries or poor* W1 nation* or poor* W1 population* or lmic or lmics) or AB ('developing country' or 'developing countries' or 'developing nation' or 'developing nations' or less* W1 'developed country' or less* W1 'developed countries' or less* W1 'developed nation' or less* W1 'developed nations' or 'third world' or 'under developed' or 'middle income' or 'low income' or 'underserved country' or 'underserved countries' or 'underserved nation' or 'underserved nations' or 'under served country' or 'under served countries' or 'under served nation' or 'under served nations' or 'underserved population' or 'underserved populations' or 'under served population' or 'under served populations' or 'deprived country' or 'deprived countries' or 'deprived nation' or 'deprived nations' or poor* W1 country or poor* W1 countries or poor* W1 nation* or poor* W1 population* or lmic or lmics) S28 S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 S29 S14 and S28 # 3575 S30 S15 and S28 # 1392
Econlit/Ovid Technologies, Inc. No. of Hits: 560	Search Strategy: ---------- 1 (health or healthcare or patients or preventive medicine).mp. [mp=heading words, abstract, title, country as subject] (46979) 2 (social adj5 enterprise?).mp. [mp=heading words, abstract, title, country

	as subject] (266) 3 (franchis$ or marketing or private enterprise? or nonprofit organi#at$ or nonprofit organi#at$ or branding or brand name$ or brand imag$).mp. [mp=heading words, abstract, title, country as subject] (26097) 4 (non-profit adj5 enterpris$).mp. [mp=heading words, abstract, title, country as subject] (10) 5 (nonprofit adj5 enterpris$).mp. [mp=heading words, abstract, title, country as subject] (525) 6 (nonprofit$ adj3 organi#at$).mp. [mp=heading words, abstract, title, country as subject] (915) 7 (non-profit$ adj3 organi#at$).mp. [mp=heading words, abstract, title, country as subject] (158) 8 6 or 4 or 5 (1155) 9 (contract adj2 service?).mp. [mp=heading words, abstract, title, country as subject] (36) 10 (non-state adj2 contract$).mp. [mp=heading words, abstract, title, country as subject] (1) 11 (nonstate adj2 contract$).mp. [mp=heading words, abstract, title, country as subject] (0) 12 (nongovernment$ adj2 contract$).mp. [mp=heading words, abstract, title, country as subject] (1) 13 (non government$ adj2 contract$).mp. [mp=heading words, abstract, title, country as subject] (0) 14 (sponsor$ adj2 service$).mp. [mp=heading words, abstract, title, country as subject] (8) 15 private sector.mp. [mp=heading words, abstract, title, country as subject] (6546) 16 (public adj2 private).mp. [mp=heading words, abstract, title, country as subject] (11166) 17 nonprofit institution?.mp. [mp=heading words, abstract, title, country as subject] (2903) 18 6 or 11 or 3 or 7 or 9 or 17 or 12 or 2 or 15 or 14 or 4 or 16 or 13 or 10 or 5 (38316) 19 1 and 18 (2148) 20 limit 19 to africa (59) 21 limit 19 to asia (170) 22 limit 19 to 'latin america and the caribbean' (60) 23 limit 19 to oceania (41) 24 22 or 21 or 23 or 20 (321) 25 (developing countrie$ or less developed countr$ or third world countr$ or under developed countr$ or underdeveloped countr$ or developing nation? or less developed nation? or third world nation? or underdeveloped nation? or under developed nation? or developing countr$ or low income countr$ or low income nation? or middle income countr$ or middle income nation? or lmic or lmics or Africa or Asia or Mexico or South America or Latin America).mp. [mp=heading words, abstract, title, country as subject] (64078) 26 (Afghanistan or Bangladesh or Benin or Burkina or Burundi or Cambodia or African or Chad or Congo or Cote$ or Eritrea or Ethiopia or Gambia or Ghana or Guinea$ or Haiti or Kenya or Korea? or Kyrgyz$ or Lao? or Liberia or Madagascar or Malawi or Mali or Maurit$ or Mozambique or Myanmar or Nepal or Niger or Nigeria or Pakistan or Rwanda or Papua or Sao or Senegal or Sierra$ or Melanes$ or Somalia or Tajik$ or Tanzania or Togo or Uganda or Uzbek$ or Viet$ or Yemen or Zambia or Zimbabwe or Burma or Solomon or Albania or Algeria or Angola or Armenia or Azerbaijan or Bhutan or Bolivia or Bosnia).mp. [mp=heading words, abstract, title, country as subject] (33501) 27 (Cameroon or Cape Verde or China or Colombia or Dijbouti or Dominican or Ecuador or Egypt or El Salvador or Georgia or Guatemala or Guyana or Honduras or India or Indonesia or Iran or Iraq or Jordan or Kiribati or

	Lesotho or Macedonia or Indian Ocean or Micronesia or Moldova or Mongolia or Morocco or Namibia or Swaziland or Syria or Thailand).mp. [mp=heading words, abstract, title, country as subject] (46822) 28 (Timor or Tong$ or Tunisia or Turk$ or Ukraine or Vanuatu or West Bank or Gaza or Maldives or Marshall or Palestine or Syrian or Samoa or Argentina or Belize or Belarus of Botswana or Brazil or Bulgaria or Chile or Costa or Croatia or Cuba or Dominica or Fiji or Gabon or Grenada or Jamaica or Kazakhstan or Latvia or Lebanon or Libya or Lithuania or Malaysia or Mayotte or Mauritius or Mexico or Montenegro or Palau or Panama or Poland or Romania or Russia or Seychelles or Slovakia or Lucia or Serbia or Suriname or Uruguay or Venezuela or Yugoslavia or Libia or libyan or Mariana or Russian or Kitts or St Vincent or Grenadines).mp. [mp=heading words, abstract, title, country as subject] (49081) 29 27 or 25 or 28 or 26 (154948) 30 19 and 29 (472) 31 30 or 24 (560) 32 from 31 keep 1-560 (560) 33 from 32 keep 1-560 (560)
EMBASE/OVID SP Number of hits: 754 754 records obtained (lines 34, 56, 58, 63) as the search was carried out in stages.	1 outsourc$.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (630) 2 (health adj3 marketing).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (395) 3 (private adj2 enterpris$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (78) 4 (social adj7 enterpris$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (61) 5 (non-profit adj5 enterpris$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (4) 6 (non?profit adj5 enterpri$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (2) 7 'public private co?operation'.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (13) 8 'public private partnership'.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (143) 9 (contract adj2 services).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (154) 10 ('not for profit' adj5 organi?at$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (131) 11 (non-profit$ adj5 organi?at$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (1951) 12 (non?profit$ adj5 organi?at$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (460) 13 (non?state adj2 contract$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (0) 14 (non?governmental adj2 contract$).mp. [mp=title, abstract, subject

	headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (2) 15 (sponsor$ adj20 service$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (402) 16 franchis$.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (110) 17 branding.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (112) 18 (brand adj1 imag$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (14) 19 (brand adj1 names).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (170) 20 (brand adj1 name$).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (708) 21 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 (5047) 22 developing country/ (22122) 23 ('less developed countr$' or 'developing countr$' or 'third world countr$' or 'under?developed countr$' or 'under developed countr$' or 'developing nation?' or 'less developed nation?' or 'less-developed nation?' or 'third world nation?' or 'under developed nation?' or 'under?developed nation?').mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (32796) 24 ('low income countr$' or 'low income nation?' or 'middle income countr$' or 'middle income nation?' or 'low and middle income' or lmic or lmics).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (1542) 25 (Africa or Asia or Mexico or 'South America' or 'Latin America').mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (76165) 26 (Afganistan or Bangladesh or Benin or 'Burkina Faso' or Burundi or Cambodia or 'Central African Republic' or Chad or 'Democratic Republic of Congo' or 'Cote d'Ivoire' or 'Ivory Coast' or Eritrea or Ethiopia or Gambia or Ghana or Guinea or Guinea-Bissau or Haiti or Kenya or 'Korea Dem Rep' or 'Korean Democratic Republic' or Kyrgyzstan or Laos or Liberia or Madagascar or Malawi or Mali or Mauritania or Mozambique or Myanmar or Nepal or Niger or Nigeria or Pakistan or 'Papua New Guinea' or Rwanda).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (124550) 27 ('Sao Tome and Principe' or Senegal or Sierra Leone or Melanesia or Somalia or Tajikistan or Tanzania or Togo or Uganda or Uzbekistan or Vietnam or Yemen or Zambia or Zimbabwe or Burma or Congo or Kyrgyz or Lao or 'North Korea' or 'Sao Tome' or 'Viet Nam' or 'Solomon Islands' or 'Central African Republic' or 'Sierra Leone' or Albania or Algeria or Angola or Armenia or Azerbaijan or Bhutan or Bolivia or Bosnia or Cameroon or 'Cape Verde' or China or Colombia or Djibouti or 'Dominican Republic' or Ecuador or Egypt or 'El Salvador' or Georgia or Guatamala or Guyana or Honduras or India or Indonesia or Iran or Iraq or Jordan or Kiribati or Lesotho or Macedonia or 'Indian Ocean Islands').mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer

	name] (139671) 28 (Micronesia or Moldova or Mongolia or Morocco or Namibia or Nicaragua or Paraguay or Peru or Philippines or Samoa or 'Sri Lanka' or Sudan or Swaziland or Syria or Thailand or 'East Timor' or Tonga or Tunisia or Turkmenistan or Ukraine or Vanuatu or 'West Bank' or Gaza or Maldives or 'Marshall Islands' or Palestine or 'Syrian Arab Republic' or 'Timor-Leste' or Samoa or Argentina or Belize or Belarus or Botswana or Brazil or Bulgaria).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (61979) 29 (Chile or 'Costa Rica' or Croatia or Cuba or Dominica or Fiji or Gabon or Grenade or Jamaica or Kazakhstan or Latvia or Lebanon or Libya or Lithuania or Malaysia or Mayotte or Mauritius or Montengro or Palau or Panama or Poland or Romania or Russia or Seychelles or Slovakia or 'Saint Lucia' or Serbia or Suriname or Turkey or Uruguay or Venezuela or Yugoslavia or Libia or Libyan or Mariana or 'Russian Federation' or Serbia or 'St Kitts' or 'St Lucia' or 'St Vincent' or Grenadines).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (64356) 30 27 or 28 or 26 or 29 (370618) 31 25 or 22 or 24 or 23 (105661) 32 Grenada.mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name] (67) 33 32 or 30 or 31 (445274) 34 21 and 33 (629) 35 from 34 keep 1-200 (200) 36 from 34 keep 201-400 (200) 37 from 34 keep 401-600 (200) 38 from 37 keep 1-200 (200) 39 from 34 keep 601-629 (29) 40 from 39 keep 1-29 (29) 41 from 35 keep 1-200 (200) 42 from 36 keep 1-200 (200) 43 health care delivery/ or 'health care facilities and services'/ or health care manpower/ or health care organization/ or health care planning/ (97186) 44 exp marketing/ (8291) 45 non profit hospital/ or non profit organization/ (2057) 46 'organization and management'/ (55037) 47 financial management/ (24777) 48 46 or 45 or 43 or 44 or 47 (173661) 49 33 and 48 (15693) 50 (43 or 44 or 45) and 33 (10768) 51 (44 or 45 or health care delivery/ or health care organization/) and 33 (8593) 52 (health care organization/ or 45) and 33 (4182) 53 limit 52 to human (2862) 54 45 and 33 (290) 55 54 not 34 (6) 56 from 55 keep 1-6 (6) 57 (47 or 46) and 44 (1648) 58 (57 and 33) not 34 (68) 59 from 58 keep 1-68 (68) 61 33 and 43 and 44 (61) 62 61 not 34 (51) 63 from 62 keep 1-51 (51)
Medline/PubMed Number of hits: 3648	1. (Outsourc*[tw]) OR ((Outsourced services[MeSH])) OR (('Marketing of health services'[MeSH])) OR ((Health[tw] AND Marketing[tw])) OR

	((‘Delivery of Health Care/methods’[Majr:noexp] OR ‘Delivery of Health Care/organization and administration’[Majr:noexp] OR ‘Delivery of Health Care/standards’[Majr:noexp] OR ‘Delivery of Health Care/utilization’[Majr:noexp])) OR ((‘Organizations, Nonprofit’[Majr:noexp] OR (‘Organizations, Nonprofit/organization and administration’[Majr:noexp] OR ‘Organizations, Nonprofit/utilization’[Majr:noexp]))) OR ((Private Sector[Majr:noexp])) OR ((private enterprise*[tw])) OR ((social[tw] AND enterprise[tw])) OR ((nonprofit[tw] AND enterprise[tw])) OR ((non-profit[tw] AND enterprise[tw])) OR ((Public private sector partnership[Majr:noexp])) OR ((Public private cooperation[tw])) OR ((Public private partnership[TW])) OR ((‘Contract Services/manpower’[Majr:noexp] OR ‘Contract Services/methods’[Majr:noexp] OR ‘Contract Services/organization and administration’[Majr:noexp] OR ‘Contract Services/standards’[Majr:noexp] OR ‘Contract Services/statistics and numerical data’[Majr:noexp] OR ‘Contract Services/utilization’[Majr:noexp])) OR ((Contract services[TW])) OR (((profit*[tw] OR nonprofit*[tw]) AND (organisat*[tw] OR organizat*[tw]))) OR (((‘not for profit’[tw]) AND (organiz*[tw] OR organis*[tw]))) OR (((non state[tw] OR non governmental[tw]) AND contract*[tw])) OR ((Sponsor*[tiab] AND service*[tiab])) OR ((social franchising[tiab])) OR ((franchis*)) OR (Branding[tw] OR brand names*[tw] OR brand imag*[tw]) 2. (‘Developing Countries’[Mesh]) OR (less developed countr*[tiab]) OR (third world countr*[tiab]) OR (under developed countr*[tiab]) OR (underdeveloped countr*[tiab]) OR (developing nation*[tiab]) OR (less developed nation*[tiab]) OR (third world nation*[tiab]) OR (under developed nation*[tiab]) OR (underdeveloped nation*[tiab]) OR (developing countr*[tiab]) OR (low income countr*[tiab]) OR (low income nation*[tiab]) OR (middle income countr*[tiab]) OR (middle income nation*[tiab]) OR (low and middle income OR limc OR lmics[tiab]) OR (Africa south of the sahara[MeSH]) OR Asia, western[Mesh] OR (‘Asia, southeastern’[Mesh]) OR (‘Asia, central’[Mesh]) OR (‘Mexico’[Mesh]) OR (‘South America’[Mesh]) 3. (Afghanistan OR Bangladesh OR Benin OR Burkina Faso[MeSH] OR Burundi OR Cambodia OR Central African Republic[MeSH] OR Chad OR ‘Democratic Republic of the Congo’ OR Cote d'Ivoire[MeSH] OR Eritrea OR Ethiopia OR Gambia OR Ghana OR Guinea OR Guinea-Bissau[MeSH] OR Haiti OR Kenya OR ‘Korea Dem Rep’ OR Kyrgyzstan OR Laos OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mozambique OR Myanmar OR Nepal OR Niger OR Nigeria OR Pakistan OR Papua New Guinea[MeSH] OR Rwanda OR ‘Sao Tome and Principe’ OR Senegal OR Sierra Leone[MeSH] OR Melanesia[MeSH] OR Somalia OR Tajikistan OR Tanzania OR Togo OR Uganda OR Uzbekistan OR Vietnam OR Yemen OR Zambia OR Zimbabwe)) OR ((Burma[Text Word] OR Burkina Faso[Text Word] OR Congo[Text Word] OR Kyrgyz[Text Word] OR Lao[Text Word] OR North Korea[Text Word] OR Sao Tome[Text Word] OR Viet Nam[Text Word] OR Solomon Islands[Text Word] OR Central African Republic[Text Word] OR Cote d'Ivoire[Text Word] OR Guinea-Bissau[Text Word] OR Sierra Leone[Text Word])) OR ((Albania OR Algeria OR Angola OR Armenia OR Azerbaijan OR Bhutan OR Bolivia OR ‘Bosnia and Herzegovina’ OR Cameroon OR Cape Verde[MeSH] OR China OR Colombia OR Congo OR Djibouti OR Dominican Republic[MeSH] OR Ecuador OR Egypt OR El Salvador[MeSH] OR ‘Georgia’ OR Guatemala OR Guyana OR Honduras OR India OR Indonesia OR Iran AND (Islamic Republic) OR Iraq OR Jordan OR Kiribati OR Lesotho OR ‘Macedonia (Republic)’ OR ‘Indian Ocean Islands’[MeSH] OR Micronesia OR Moldova OR Mongolia OR Morocco OR Namibia OR Nicaragua OR Paraguay OR

	Peru OR Philippines OR Samoa OR Sri Lanka[MeSH] OR Sudan OR Swaziland OR Syria OR Thailand OR East Timor[MeSH] OR Tonga OR Tunisia OR Turkmenistan OR Ukraine OR Vanuatu OR 'West Bank and Gaza'))) OR ((Bosnia[Text Word] OR Cape Verde[Text Word] OR Dominican Republic[Text Word] OR 'Egypt Arab Republic'[Text Word] OR El Salvador[Text Word] OR Gaza[Text Word] OR 'Georgia Republic'[Text Word] OR Kiribati[Text Word] OR Macedonia[Text Word] OR Maldives[Text Word] OR Marshall Islands[Text Word] OR Palestine[Text Word] OR Sri Lanka[Text Word] OR Syrian Arab Republic[Text Word] OR West Bank[Text Word] OR Timor-Leste[Text Word] OR 'West Bank and Gaza'[Text Word]))) OR ((American Samoa OR Argentina OR Belize OR Belarus OR Botswana OR Brazil OR Bulgaria OR Chile OR Costa Rica OR Croatia OR Cuba OR Dominica OR Fiji OR Gabon OR Grenada OR Jamaica OR Kazakhstan OR Latvia OR Lebanon OR Libya OR Lithuania OR Malaysia OR Mayotte OR Mauritius OR Mexico OR Montenegro OR Palau OR Panama OR Poland OR Romania OR Russia[MeSH] OR Seychelles OR Slovakia OR South Africa[MeSH] OR Saint Lucia OR Serbia OR Suriname OR Turkey OR Uruguay OR Venezuela OR Yugoslavia))) OR ((Guinea[Text Word] OR Libia[Text Word] OR libyan[Text Word] OR Mayotte[Text Word] OR Northern Mariana Islands[Text Word] OR Russian Federation[Text Word] OR Samoa[Text Word] OR Serbia[Text Word] OR 'St Kitts and Nevis'[Text Word] OR St Lucia[Text Word] OR 'St Vincent and the Grenadines'[Text Word] OR South Africa[Text Word])) 4. # 2 OR # 3 5. # 1 AND # 4
Science Citation Index Expanded Number of records obtained: 389	Search strategy: SCI-Expanded + SSCI # 1 TS=outsourc* # 2 TS=(sponsor* SAME service*) # 3 TS=(health SAME marketing) # 4 TS=('private enterprise' OR 'private enterprises') # 5 TS=(social SAME enterprise) # 6 TS=(nonprofit SAME enterprise) # 7 TS=(non-profit SAME enterprise) # 8 TS=(public SAME private SAME cooperation) # 9 TS=(public SAME private SAME partnership) # 10 TS=(contract services) # 11 TS=franchis* # 12 TS=(('non governmental') AND contract*) # 13 TS=(('nongovernmental') AND contract*) # 14 TS=(('nonstate') AND contract*) # 15 TS=(('non state') AND contract*) # 16 TS=(branding OR 'brand names' OR 'brand name' OR 'brand imag*') # 17 TS=(profit* SAME organi*at*) # 18 TS=(non profit* SAME organi*at*) # 19 TS=(nonprofit* SAME organi*at*) # 20 #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1 # 21 TS=('less developed countr*' OR 'third world countr*' OR 'under developed countr*' OR 'underdeveloped countr*' OR 'developing nation*' OR 'less developed nation*' OR 'third world nation*' OR 'under developed

	nation*' OR 'underdeveloped nation*' OR 'developing countr*' OR 'low income countr*' OR 'low income nation*' OR 'middle income countr*' OR 'middle income nation*' OR 'low and middle income' OR limc OR lmics OR 'developing countries') # 22 TS=(Afghanistan OR Bangladesh OR Benin OR Burkina Faso OR Burundi OR Cambodia OR 'Central African Republic' OR Chad OR 'Cote d'Ivoire' OR Eritrea OR Ethiopia OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Haiti OR Kenya OR 'Korea Dem Rep' OR Kyrgyzstan OR Laos OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mozambique OR Myanmar OR Nepal OR Niger OR Nigeria OR Pakistan OR 'Papua New Guinea' OR Rwanda OR 'Sao Tome and Principe' OR Senegal OR Sierra Leone) # 23 TS=(Melanesia OR Somalia OR Tajikistan OR Tanzania OR Togo OR Uganda OR Uzbekistan OR Vietnam OR Yemen OR Zambia OR Zimbabwe OR Burma OR Burkina Faso OR Congo OR Kyrgy* OR Lao OR 'North Korea' OR 'Sao Tome' OR Viet Nam OR 'Solomon Islands' OR Albania OR Algeria OR Angola OR Armenia OR Azerbaijan OR Bhutan OR Bolivia OR Bosnia OR Cameroon OR Cape Verde OR China OR Colombia OR Congo OR Djibouti OR Dominican OR Ecuador OR Egypt OR Salvador OR Georgia OR Guatemala OR Guyana OR Honduras OR India OR Indonesia OR Iran OR Iraq OR Jordan OR Kiribati) # 24 TS=(Lesotho OR Macedonia OR Micronesia OR Moldova OR Mongolia OR Morocco OR Namibia OR Nicaragua OR Paraguay OR Peru OR Philippines OR Samoa OR Sri Lanka OR Sudan OR Swaziland OR Syria OR Thailand OR East Timor OR Tonga OR Tunisia OR Turkmenistan OR Ukraine OR Vanuatu OR Macedonia OR Maldives OR Marshall Islands OR Palestine OR Syrian Arab Republic OR West Bank OR Timor-Leste OR Gaza OR American Samoa OR Argentina OR Belize OR Belarus OR Botswana OR Brazil OR Bulgaria OR Chile) # 25 TS=(Costa Rica OR Croatia OR Cuba OR Dominica OR Fiji OR Gabon OR Grenada OR Jamaica OR Kazakhstan OR Latvia OR Lebanon OR Libya OR Lithuania OR Malaysia OR Mayotte OR Mauritius OR Mexico OR Montenegro OR Palau OR Panama OR Poland OR Romania OR Russia OR Seychelles OR Slovakia OR South Africa OR Saint Lucia OR Serbia OR Suriname OR Turkey OR Uruguay OR Venezuela OR Yugoslavia OR Guinea OR Libia OR libyan OR Mayotte OR 'Northern Mariana Islands' OR 'Russian Federation' OR Samoa OR Serbia OR 'St Kitts and Nevis' OR St Lucia OR 'St Vincent and the Grenadines' OR 'South Africa') # 26 #21 AND #20 # 27 #22 AND #20 # 28 #23 AND #20 # 29 #24 AND #20 # 30 #25 AND #20 # 31 #26 OR #27 OR #28 OR #29 OR #30 # 32 TS=(health OR healthcare OR patients OR 'preventive medicine')

	# 33 #32 AND #31 = 389
Sociological Abstracts /CSA Illumina Number of records obtained: 423	(KW=health OR healthcare OR patients OR healthcare OR patients OR 'preventive medicine') and (((DE=('brand names' or 'collectives' or 'enterprises' or 'financial support' or 'nongovernmental organizations' or 'nonprofit organizations' or 'private sector' or 'public sector private sector relations' or 'sponsorship')) or(TI=franchis* or AB=franchis*) or(TI=outsourc* or AB=outsourc*) or(TI=(private enterprise*) or AB=(private enterprise*)) or TI=(branding) or AB=(branding) or TI=(brand name) or TI=(brand names) or TI=(brand imag*) or AB=(brand name) or AB=(brand names) or AB=(brand imag*)or (KW=marketing) or(TI=(social AND enterprise) or AB=(social AND enterprise)) or(TI=(social AND enterpris*) or AB=(social AND enterpris*)) or(TI=(nonprofit AND enterpris*) or AB=(non-profit AND enterpris*)) or(KW=(Public private cooperation) or KW=(Public private partnership)) or(KW=(contract* service*)) or(KW=(profit* OR nonprofit*) and KW=organisat*) or(KW=(profit* OR nonprofit*) and KW=organizat*) or(KW=('not for profit') and KW=(organization* OR organisation*)) or(KW=(non state OR non governmental) and KW=contract*) or(KW=(nonstate OR nongovernmental) and KW=contract*) or(KW=sponsor* and KW=service*)) and (((DE=('latin america' or 'cuba' or 'dominica' or 'dominican republic' or 'grenada' or 'haiti' or 'jamaica' or 'saint kitts nevis' or 'saint lucia' or 'saint martin' or 'saint vincent' or 'central america' or 'afghanistan' or 'africa' or 'algeria' or 'angola' or 'asia' or 'azerbaijan' or 'bangladesh' or 'belize' or 'benin' or 'bhutan' or 'botswana' or 'burkina faso' or 'burma' or 'burundi' or 'cambodia' or 'cameroon' or 'cape town south africa' or 'cape verde islands' or 'central african republic' or 'central asia' or 'chad' or 'china' or 'commonwealth of independent states' or 'comoro islands' or 'costa rica' or 'democratic republic of congo' or 'djibouti' or 'east timor' or 'egypt' or 'el salvador' or 'eritrea' or 'ethiopia' or 'far east' or 'gambia' or 'georgia republic of' or 'ghana' or 'guatemala' or 'guinea' or 'guinea bissau' or 'himalayan states' or 'honduras' or 'india' or 'indochina' or 'indonesia' or 'iran' or 'iraq' or 'ivory coast' or 'johannesburg south africa' or 'jordan' or 'kazakhstan' or 'kenya' or 'korea' or 'kyrgyzstan' or 'laos' or 'lebanon' or 'lesotho' or 'liberia' or 'libya' or 'macao' or 'madagascar' or 'malawi' or 'malaysia' or 'mali' or 'mauritania' or 'mauritius' or 'mexico' or 'middle east' or 'mongolia' or 'morocco' or 'mozambique' or 'myanmar' or 'namibia' or 'nepal' or 'nicaragua' or 'niger' or 'nigeria' or 'north africa' or 'north korea' or 'pakistan' or 'palestine' or 'panama' or 'papua new guinea' or 'peoples republic of china' or 'philippines' or 'pretoria south africa' or 'republic of the congo' or 'rwanda' or 'sao tome and principe' or 'senegal' or 'seychelles' or 'sierra leone' or 'somalia' or 'south africa' or 'south america' or 'south asia' or 'south korea' or 'southeast asia' or 'sri lanka' or 'sub saharan africa' or 'sudan' or 'swaziland' or 'syria' or 'tajikistan' or 'tanzania' or 'thailand' or 'togo' or 'tunisia' or 'turkey' or 'turkmenistan' or 'uganda' or 'union of soviet socialist republics' or 'uzbekistan' or 'vietnam' or 'yemen' or 'zambia' or 'zimbabwe')) or(DE=('uzbekistan' or 'albania' or 'american samoa' or 'argentina' or 'armenia' or 'bolivia' or 'bosnia herzegovina' or 'brazil' or 'bulgaria' or 'caroline islands' or 'central america' or 'chile' or 'colombia' or 'croatia' or 'ecuador' or 'gilbert and ellice islands' or 'guyana' or 'honduras' or 'kosovo' or 'latin america' or 'latvia' or 'lithuania' or 'macedonia' or 'mariana islands' or 'marshall islands' or 'micronesia' or 'moldova' or 'montenegro yugoslavia' or 'paraguay' or 'peru' or 'poland' or 'romania' or 'samoa' or 'slovak republic' or 'solomon islands' or 'south america' or 'suriname' or 'tonga' or 'uruguay' or 'vanuatu' or 'venezuela' or 'wake island' or 'yugoslavia')) or(DE=('developing countries' or 'albania' or 'american samoa' or 'argentina' or 'armenia' or 'bolivia' or 'bosnia herzegovina' or 'brazil' or

	'bulgaria' or 'caroline islands' or 'central america' or 'chile' or 'colombia' or 'croatia' or 'ecuador' or 'gilbert and ellice islands' or 'guyana' or 'honduras' or 'kosovo' or 'latin america' or 'latvia' or 'lithuania' or 'macedonia' or 'mariana islands' or 'marshall islands' or 'micronesia' or 'moldova' or 'montenegro yugoslavia' or 'paraguay' or 'peru' or 'poland' or 'romania' or 'samoa' or 'slovak republic' or 'solomon islands' or 'south america' or 'suriname' or 'tonga' or 'uruguay' or 'vanuatu' or 'venezuela' or 'wake island' or 'yugoslavia')) or(DE=('fiji islands' or 'solomon islands' or 'vanuatu' or 'albania' or 'american samoa' or 'argentina' or 'armenia' or 'belarus' or 'bolivia' or 'bosnia herzegovina' or 'brazil' or 'bulgaria' or 'caroline islands' or 'central america' or 'chile' or 'colombia' or 'croatia' or 'developing countries' or 'ecuador' or 'gabon' or 'gilbert and ellice islands' or 'guyana' or 'honduras' or 'kosovo' or 'latin america' or 'latvia' or 'lithuania' or 'macedonia' or 'mariana islands' or 'marshall islands' or 'micronesia' or 'moldova' or 'montenegro yugoslavia' or 'paraguay' or 'peru' or 'poland' or 'romania' or 'samoa' or 'slovak republic' or 'south america' or 'suriname' or 'tonga' or 'uruguay' or 'venezuela' or 'wake island' or 'yugoslavia')) or(TI=(Afghanistan OR Bangladesh OR Benin OR Burkina Faso OR Burundi OR Cambodia OR 'Central African Republic' OR Chad OR Cote d'Ivoire OR Eritrea OR Ethiopia OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Haiti OR Kenya OR 'Korea Dem Rep' OR Kyrgyzstan OR Laos OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mozambique OR Myanmar OR Nepal OR Niger OR Nigeria OR Pakistan OR Papua New Guinea OR Rwanda OR 'Sao Tome and Principe' OR Senegal OR Sierra Leone OR Melanesia OR Somalia OR Tajikistan OR Tanzania OR Togo OR Uganda OR Uzbekistan OR Vietnam OR Yemen OR Zambia OR Zimbabwe OR Burma OR Burkina Faso OR Congo OR Kyrgy* OR Lao OR North Korea OR Sao Tome OR Viet Nam OR Solomon Islands OR Albania OR Algeria OR Angola OR Armenia OR Azerbaijan OR Bhutan OR Bolivia OR Bosnia OR Cameroon OR Cape Verde OR China OR Colombia OR Congo OR Djibouti OR Dominican OR Ecuador OR Egypt OR Salvador OR Georgia OR Guatemala OR Guyana OR Honduras OR India OR Indonesia OR Iran OR Iraq OR Jordan OR Kiribati OR Lesotho OR Macedonia OR Micronesia OR Moldova OR Mongolia OR Morocco OR Namibia OR Nicaragua OR Paraguay OR Peru OR Philippines OR Samoa OR Sri Lanka OR Sudan OR Swaziland OR Syria OR Thailand OR East Timor OR Tonga OR Tunisia OR Turkmenistan OR Ukraine OR Vanuatu OR Macedonia OR Maldives OR Marshall Islands OR PalestineOR Syrian Arab Republic OR West Bank OR Timor-Leste OR Gaza OR American Samoa OR Argentina OR Belize OR Belarus OR Botswana OR Brazil OR Bulgaria OR Chile OR Costa Rica OR Croatia OR Cuba OR Dominica OR Fiji OR Gabon OR Grenada OR Jamaica OR Kazakhstan OR Latvia OR Lebanon OR Libya OR Lithuania OR Malaysia OR Mayotte OR Mauritius OR Mexico OR Montenegro OR Palau OR Panama OR Poland OR Romania OR Russia OR Seychelles OR Slovakia OR South Africa OR Saint Lucia OR Serbia OR Suriname OR Turkey OR Uruguay OR Venezuela OR Yugoslavia OR Guinea OR Libia OR libyan OR Mayotte OR Northern Mariana Islands OR Russian Federation OR Samoa OR Serbia OR 'St Kitts and Nevis' OR St Lucia OR 'St Vincent and the Grenadines' OR South Africa)) or(AB=(Afghanistan OR Bangladesh OR Benin OR Burkina Faso OR Burundi OR Cambodia OR 'Central African Republic' OR Chad OR Cote d'Ivoire OR Eritrea OR Ethiopia OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Haiti OR Kenya OR 'Korea Dem Rep' OR Kyrgyzstan OR Laos OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mozambique OR Myanmar OR Nepal OR Niger OR Nigeria OR Pakistan OR Papua New Guinea OR Rwanda OR 'Sao Tome and Principe' OR Senegal OR Sierra Leone OR Melanesia OR Somalia OR Tajikistan OR Tanzania OR Togo OR Uganda OR Uzbekistan OR Vietnam OR Yemen OR Zambia OR Zimbabwe OR Burma OR Burkina Faso OR Congo OR Kyrgy* OR Lao OR North Korea OR Sao Tome OR Viet Nam OR Solomon Islands OR Albania OR Algeria OR Angola OR Armenia OR Azerbaijan OR Bhutan OR Bolivia OR Bosnia OR Cameroon OR Cape Verde OR China OR

	Colombia OR Congo OR Djibouti OR Dominican OR Ecuador OR Egypt OR Salvador OR Georgia OR Guatemala OR Guyana OR Honduras OR India OR Indonesia OR Iran OR Iraq OR Jordan OR Kiribati OR Lesotho OR Macedonia OR Micronesia OR Moldova OR Mongolia OR Morocco OR Namibia OR Nicaragua OR Paraguay OR Peru OR Philippines OR Samoa OR Sri Lanka OR Sudan OR Swaziland OR Syria OR Thailand OR East Timor OR Tonga OR Tunisia OR Turkmenistan OR Ukraine OR Vanuatu OR Macedonia OR Maldives OR Marshall Islands OR PalestineOR Syrian Arab Republic OR West Bank OR Timor-Leste OR Gaza OR American Samoa OR Argentina OR Belize OR Belarus OR Botswana OR Brazil OR Bulgaria OR Chile OR Costa Rica OR Croatia OR Cuba OR Dominica OR Fiji OR Gabon OR Grenada OR Jamaica OR Kazakhstan OR Latvia OR Lebanon OR Libya OR Lithuania OR Malaysia OR Mayotte OR Mauritius OR Mexico OR Montenegro OR Palau OR Panama OR Poland OR Romania OR Russia OR Seychelles OR Slovakia OR South Africa OR Saint Lucia OR Serbia OR Suriname OR Turkey OR Uruguay OR Venezuela OR Yugoslavia OR Guinea OR Libia OR libyan OR Mayotte OR Northern Mariana Islands OR Russian Federation OR Samoa OR Serbia OR 'St Kitts and Nevis' OR St Lucia OR 'St Vincent and the Grenadines' OR South Africa))) or(TI=(less developed countr* OR third world countr* OR under developed countr* OR underdeveloped countr* OR developing nation* OR less developed nation* OR third world nation* OR under developed nation* OR underdeveloped nation* OR developing countr* OR low income countr* OR low income nation* OR middle income countr* OR middle income nation* OR low and middle income OR limc OR lmics) OR AB=(less developed countr* OR third world countr* OR under developed countr* OR underdeveloped countr* OR developing nation* OR less developed nation* OR third world nation* OR under developed nation* OR underdeveloped nation* OR developing countr* OR low income countr* OR low income nation* OR middle income countr* OR middle income nation* OR low and middle income OR limc OR lmics))))

Appendix 2.3.2: Quality assessment checklist for primary studies

1. Independence of the study	**Response**
Is study author a donor or recipient or linked to project? *Does the study specify whether all or any of the author(s) are employed by or affiliated to the donor behind the intervention or the recipient receiving the support?*	Yes No Unclear
Was the study funded by a donor or recipient? *Is it clear who funded the study?* *Was that funder a donor agency, implementing agency or recipient government associated with the intervention?*	Yes No Unclear
2. Reporting on the model of social franchising	
Is there a clear description of the franchising intervention?	Yes No Unclear
3. Reporting on the study design and methods [This section concerns items reported in the study without making value judgements about the nature of the study design or methods]	
Are study aims and methods clearly described?	Yes No Unclear
Was the method of sampling reported?	Yes No Unclear
Were steps taken to increase the rigour of data collection reported? *Here the use of data triangulation is looked upon as a sign of rigour.*	Yes No Unclear
Is the control group reported? [This question is only applicable to causal studies]	Yes No Unclear
Are the study limitations discussed?	Yes No Unclear
4. Robustness of the data analysis [This section looks for convergence between a study's qualitative conclusions and the quantitative data presented in the study]	
Do the data support the study conclusions?	Yes No Unclear
5. Reporting on confounding factors [This section is concerned with what is reported in the study]	
Does the study report confounding factors? *E.g. intervening variables which might affect the findings, such as literacy rates, other health factors, poverty levels*	Yes No Unclear
Is the study clear about possible alternative explanations for the results?	Yes No Unclear
Does the study report external events or factors which have affected conclusions? *E.g. factors beyond the control of the intervention, such as natural disasters/civil unrest or the impact of new government policy*	Yes No Unclear

Appendix 3.1: Table of excluded studies

Anderson (2008)	Opinion piece
Barber (2006)	Not social franchising
Lapido et al. (1990)	Not social franchising
Mills et al. (2004)	Not social franchising
Montagu (2002)	Not an evaluation or observational study (overview)
Prata et al. (2005)	Not an evaluation or observational study (overview)
Sharma (2009)	Not social franchising
Smith (2002)	Not an evaluation or observational study (overview with case descriptions)

Appendix 3.2: Quality assessment of primary studies

	Independence of the study		**Model of social franchising**	**Reporting on the study design and methods**					**Robustness of the data analysis**	**Reporting on confounding factors**		
	Is study author a donor or recipient or linked to project?	Was study funded by a donor or recipient ?	Is there a clear description of the franchising intervention?	Are study aims and methods clearly described?	Was the method of sampling reported?	Were steps to increase the rigour of data collection reported?	Is the control group reported?	Are the study limitations discussed	Do the data support the study conclusions?	Does study report confounding factors?	Is study clear about possible alternative explanations behind results?	Does study report external events or factors which have affected conclusions?
Agha 2007a	Yes	Yes	**Yes**	**Yes**	**Yes**	**Yes**	--	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Agha 2007b	Yes	Yes	**Yes**	**Yes**	**Yes**	**Yes**	Yes	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Decker 2007	**No**	Unclear	**Yes**	**Yes**	**Yes**	No	--	**Yes**	**Yes**	No	No	No
Hennink 2005	Unclear	Unclear	**Yes**	**Yes**	**Yes**	Yes	Yes	No	**Yes**	**Yes**	**Yes**	No
Kozhimannil 2009	**No**	**No**	**Yes**	**Yes**	**Yes**	No	--	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Lonnroth 2007	Yes	**No**	**Yes**	**Yes**	**Yes**	No	--	**Yes**	No	Yes	No	No
Plautz 2003	Yes	Yes	**Yes**	**Yes**	**Yes**	Yes	--	**Yes**	**Yes**	**Yes**	**Yes**	No
Qureshi 2004	**No**	**No**	No	**No**	**Yes**	No	--	No	**Yes**	No	No	No
Stephenson 2004	Yes	Yes	No	**Yes**	**Yes**	No	--	**Yes**	**Yes**	**Yes**	**Yes**	No

The shading highlights the outliers in each column.

Appendix 4.1: Details of studies included in the review: description of interventions

Systematic reviews

Study (timing)	Standardised description of intervention
Koehlmoos 2009 (2007 search)	**Intervention providers:** Any **Intervention users:** **Setting:** LMIC **Training:** Yes **Protocolised management:** Yes **Standardisation of supplies:** Yes **Branding:** Yes **Monitoring:** Yes **Network membership:** Yes **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** All eligible
Patouillard 2007 (2006 search)	**Intervention providers:** Private, not for profit **Intervention users:** 'the poor' **Setting:** LMIC **Training:** Yes **Protocolised management:** Yes **standardisation of supplies:** Yes **Branding:** Yes **Monitoring:** Yes **Network membership:** Yes **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** No
Peters 2004 (2003 search)	**Intervention providers:** Private providers **Intervention users:** Low and lower-middle-income country populations **Setting:** LMIC **Training:** No **Protocolised management:** No **Standardisation of supplies:** No **Branding:** No **Monitoring:** No **Network membership:** No **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** No

Primary studies

Study (timing)	Standardised description of intervention
Agha 2007a (2001-2)	**Intervention providers:** 64 nurses and paramedics **Intervention users:** male and female clients (486 pre-test, 617 post-test), averaging 32 years, two-thirds living more than 10 minutes from clinic, more than half with less than secondary education **Setting:** LIC, Nepal, rural and urban **Training:** Services marketing training (build empathy; mass marketing; outreach; value of quality service; importance of word of mouth), 2 days **Protocolised management:** Yes, basic reproductive health training (ANC; provision of contraceptive non-clinical and clinical; identification of high-risk pregnancy, identification of sexually transmitted infections (STIs), 7 days **Standardisation of supplies:** No special discount but franchiser created a link to a local social marketing company to ensure a steady supply of subsidised FP products **Branding:** External marketing campaign, brand name, logo, leaflets, brochures, radio advertisement, billboards (hoarding boards) – experienced delays due to Maoist insurgency until just before end-line survey **Monitoring:** monthly visits by field co-ordinator/observations and checklist **Network membership:** SU$1.4 joining fee, SU$ 9 annual fee. SEWA, Monthly newsletter to providers **Other:** Strengthening of referral linkages to internal trained providers for IUDs and to external physicians and government for complex problems **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** No
Agha 2007b (2001 baseline, 2002-3 endline)	**Intervention providers:** 64 nurses and paramedics **Intervention users:** Males and females **Setting:** LIC, Nepal, rural and urban **Training:** Same as above: loyalty and client-provider interaction **Protocolised management:** Yes, infection prevention (for provider), availability of essential equipment, temporary contraceptive methods, reproductive health, STIs **Standardisation of supplies:** Same as above **Branding:** Same as above **Monitoring:** Same as above; including service statistics **Network membership:** Same as above, detailed contract specifies training, monitoring of quality, referral system and marketing support **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available
Decker 2007 2000 (pers.	**Intervention providers:** 102 KMET providers (out of 204): certified clinicians or nurses focusing on family planning or abortion

comm.)	**Intervention users:** Women and older youth (18-24 years) **Setting:** LIC, Kenya (Western) **Training:** Yes, no details **Protocolised management:** Not available **Standardisation of supplies:** Yes, regular delivery of contraceptive supplies; received some equipment **Branding:** Not available **Monitoring:** Yes, facilities must meet standards for cleanliness and privacy **Network membership:** Yes, KMET were paid a membership fee, received low-interest loans for facility improvement **Other:** No **Model of social franchise: Stand-alone/fractional, 1st/2nd gen:** Not available
Hennink 2005 (1999-2000 baseline, 2001-2 End line)	**Intervention providers:** 6 total staff within each clinic: clinic manager, physician, lady health visitor, several nurse assistants, FP counsellor and small team (6-8) community-based distribution workers **Intervention users:** ever-married women (ages 15-45) residing in a 2-3 km radius of clinic. Baseline: 5,338, endline: 5502 **Setting:** LIC, Pakistan, 6 urban areas **Training:** N/A **Protocolised management:** Yes, contraceptives (IUD, injectables, pills, condoms), pregnancy test and termination, advice on sexual health **Standardisation of supplies:** No **Branding:** Yes **Monitoring:** No **Network membership:** No **Other:** Fee for service (less than general private sector) with subsidies for the poor **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Stand-alone
Kozhimannil 2009 (DHS 1998 and 2003)	**Intervention providers:** Midwives **Intervention users:** Target high priority or disadvantaged areas (and easy to reach – the first clinic sites were in and around Manila) **Setting:** Lower-MIC, Philippines **Training:** Not available **Protocolised management:** Yes, ANC, childbirth, post-natal care, FP, reproductive health, , infant and child care **Standardisation of supplies:** Not available **Branding:** Well-Family Midwives Clinics (WFMC) **Monitoring:** Not available **Network membership:** Yes **Other:** Births in WFMC may be covered by the national health insurance

	programme if the provider is a certified recipient **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available
Lonnroth 2007 (2002-5)	**Intervention providers:** 220 licensed general providers **Intervention users:** Low income population; offer FP, STI, some malaria and since 2004 TB **Setting:** LIC, Myanmar, townships **Training:** Yes, 2-3 days for providers and training for private labs **Protocolised management:** Yes, following National Tuberculosis Programme (NTP) guidelines, GP maintains NTP 'treatment card' **Standardisation of supplies:** Yes, monthly visits by franchise officers to ensure re-supply of products. SQH has own branded products; TB drugs provided by NTP **Branding:** Yes, posters, leaflets, signboard promotion of SQH products, TV spots, promoting TB and DOTS **Monitoring:** Yes, mystery client surveys, monthly follow-up visits to GPs to ensure supply of products and resolve problems; quarterly TB case reporting by franchise **Network membership:** Yes, SQH — 556 active GPs in more than 100 townships; 220 GPs in 49 townships took part in TB component **Other:** Not available **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available
Plautz 2003 (2001)	**Intervention providers:** 30 trained providers working at 17 pre-existing clinics in Toamasina town **Intervention users:** Youth ages 15-24 living in town and in the rural district of Toamasina **Setting:** LIC, Madagascar, urban and rural **Training:** No **Protocolised management:** STI diagnosis, FP and related RH counselling services to youth **Standardisation of supplies:** No **Branding:** Mass media and interpersonal communication, peer educators, televised youth debates, mobile video unit shows, radio and television spots. **Monitoring:** No **Network membership:** No **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available
Qureshi 2004 (2001)	**Intervention providers:** 1,113 family planning providers **Intervention users:** Low-income FP users **Setting:** LIC, Pakistan, urban **Training:** Yes, in FP and RH services

	Protocolised management: No **Standardisation of supplies:** No **Branding:** Green Star SF **Monitoring:** Not available **Network membership:** Green Star SF **Other:** No **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available
Stephenson 2004 (2001)	**Intervention providers:** Multiple categories of provider (doctors, midwives, community health workers) and facilities **Intervention users:** Reproductive health clients (contraception, abortion, FP, STI) **Setting:** LMIC, Pakistan, urban; Ethiopia – three regions; India – rural **Training:** Yes, not well described **Protocolised management:** Yes, not well described **Standardisation of supplies:** Yes, not well described **Branding:** Yes, not well described **Monitoring:** Yes, not well described **Network membership:** Yes, Pakistan: Green Star and Green Key; Ethiopia: Biruh Tesfa (Ray of Hope); India: Janani **Other:** Not available **Model of social franchise: stand-alone/fractional, 1st/2nd gen:** Not available

Appendix 4.2: Details of studies included in the review: evaluation of interventions

Study (timing)	Evaluation of interventions
Koehlmoos 2009 (2007, search)	**Study design:** Systematic review of RCTS, non-RCTS, Controlled Before and After and Interrupted Time Series **Outcomes addressed:** Search for all of the above outcomes **Processes addressed**: Yes **Result:** No studies eligible for inclusion **Equity analysis**: No **Economic analysis**: No
Patouillard 2007 (2006, search)	**Study design:** Systematic review of impact evaluations, pre-post, controlled, pre-post with control, with or without randomisation – studies based on national survey data were excluded **Outcomes addressed:** Quality of health care services for the poor **Processes addressed:** Processes not investigated separately **Result:** 6 interventions identified in 5 countries. Evidence of impact on utilisation and quality of services was mixed; overall the rigor of impact evaluation for private sector interventions was judged to be weak. **Equity analysis:** Mixed results: In Nepal poorer than average population. In Urban Pakistan franchises targeting the poor actually served groups with higher levels of education and income **Economic analysis**: No
Peters 2004 (2003, search)	**Study design:** Cross-sectional studies **Outcomes addressed:** Impact of strategies to engage the private sector for sexual and reproductive health **Processes addressed**: No **Result:** Out of 71 included studies, none had social franchising as the primary intervention **Equity analysis**: No **Economic analysis**: No
Agha 2007a (2001-2)	**Study design:** Pre-test/post-test client survey of a cross-section of the clinics; uncontrolled design **Outcomes addressed:** Client perception of quality of care (study tool designed to reduce 'courtesy bias'); client loyalty – repeat visits **Processes addressed**: No **Result:** Less than 15 percent of clients for reproductive services; increase in clients from greater than 10 minutes distance to clinic; 9.5 times increase at post-test showing client choosing a facility based on provider's caring manner; provider type (nurse, paramedic) not associated with perceived expertise. **Equity analysis:** Females more likely than males to return to the clinic; older clients more likely to make a repeat visit **Economic analysis**: No
Agha 2007b	**Study design**: Baseline and follow-up measurements on two non-

(2001 baseline, 2002-3 endline)	equivalent control groups; exit surveys; clinic service delivery statistics **Outcomes addressed:** Client satisfaction, return visit, service utilisation **Processes addressed:** Not in detail; however, it was stated that civil unrest in Nepal caused major delays with the intervention **Result:** No statistically significant difference for FP use among married women, use of ANC during last pregnancy, receipt of ANC from medical store/pharmacy **Equity analysis**: No **Economic analysis**: No
Decker 2007 (2000, personal comm.)	**Study design:** Survey of clients and nearby households of a cross-section of clinics **Outcomes addressed:** FP need and use, clinical services targeting youth, youth perceptions, reason behind provider choice (access, cost, provider age, skill, respectful treatment) **Processes addressed**: No **Result:** KMET youth vs non-KMET youth more likely to use any form of family planning and to use modern method of FP. 44 percent of KMET providers vs 30 percent of non-KMET providers offered youth-targeted services. Statistically significant difference in sources of family planning information with more KMET youth learning where to get FP services from friends and neighbours AND from FP providers. KMET youth consider provider choice traits to be skill, privacy and respectful treatment; cost, access and age of provider not important (no comparison) **Equity analysis:** Yes-target youth for FP services (18-24 yrs) compared to adults – but no analysis presented. However, youth cited social stigma as the greatest barrier to services. Youth use rates of all FP methods were lower than adult methods. **Economic analysis**: No
Hennink 2005 (1999-2000 baseline, 2001-2 endline	**Study design**: Controlled before and after using nearby households surveys plus exit interviews on quality of care during endline at intervention sites. **Outcomes addressed:** Patient knowledge of FP, contraceptive prevalence, whether clinic serves the urban poor, unmet need for FP **Processes addressed**: No **Result:** Knowledge of any modern FP method at the baseline was 88% in study and control sites; however, the endline survey saw an increase to 96% in the study sites which was almost 5% above the control sites (statistically significant). Knowledge of female sterilisation in study sites increased from 28.9 percent to 46.4 percent, IUD from 43.1 to 50.3 percent and both were statistically significant from the control sites; little change in contraceptive prevalence; mixed results for unmet need for FP based on province (statistically significant at three sites in a less conservative province, not statistically significant in a conservative province. **Equity analysis:** Yes, target was the urban poor, but despite placing clinics in poor areas, users were from other groups (younger, middle-income, low-parity, interested in birth spacing). **Economic analysis**: No

Kozhimannil 2009 (DHS 1998 and 2003)	**Study design:** Correlational study using two rounds of the demographic and health survey and publicly available programme reports and the Philippine national census comparing franchise to national health insurance programme – calculated measure of 'presence of facilities per 10,000 births' in a region; and 15 key informant interviews **Outcomes addressed:** Related to quality of ANC care and facility-based delivery: whether there were 4 ANC visits, whether the first ANC visit was before 4th month, number of ANC visits, gave birth in a health care facility, gave birth in a private facility **Processes addressed**: No **Result:** Increase presence of national insurance (Phil Health) associated with increase chance of receiving 4 ANC and 1st trimester ANC visit – but increase in numbers of WFMC not associated with such a change; presence of WMFC associated with increased odds of delivery in a private facility; no statistically significant increase in odds of facility delivery with both Phil Health and WFMC. **Equity analysis:** Yes, but only shown for national health insurance as a social franchise showed no significant changes in predicted probability of study outcomes by wealth quintile. **Economic analysis**: No
Lonnroth 2007 (2002-5)	**Study design: 1)** Review of routine data from public services and the franchiser in townships with and without franchisees; and 2) a survey of franchise patients **Outcomes addressed:** Contribution to TB case notification; ensuring equity in access; curing patients equitably; protecting patients from adverse financial and social consequences of TB and TB care **Processes addressed:** Reason for choosing an SQH provider **Result:** 1) that average case notification was higher in the 7 periods after introducing the TB treatment at SQH than the 7 periods before – but the interpretation did not use averages but change over time; an increasing notification rate before introducing the franchise and a stabilised rate after introduction suggest that the franchise was not successful. (This conclusion was hampered by the lack of independent data); 2) choice of clinic: it was the usual source of care for 43 percent of SQH TB users **Equity analysis:** Yes – 68 percent of the TB patients accessing care through the social franchise were from the lower socio-economic groups (bottom two quintiles) **Economic analysis:** Yes - lower SE groups in the whole population incurred average costs equivalent to 68 percent of annual per capita household income versus a median of 28 percent of annual household income. The franchise provided low-cost care compared to other sectors (only 3 percent annual per capita income for the people from lower SE groups.)
Plautz 2003 (2000, 2002)	**Study design:** Two rounds of Madagascar Adolescent Reproductive Health Surveys: before and after the establishment of the social franchise **Outcomes addressed:** Proportion of clients with low, medium and high programme exposure who reported use of contraceptive methods **Processes addressed:** Branding and marketing via peer education,

	films about STIs, mobile video units, television and radio spots. **Result:** Modern contraceptive use rate higher for women with high exposure to the intervention than those with low or medium exposure **Equity analysis**: No **Economic analysis**: No
Qureshi 2004 (2001)	**Study design**: Provider survey **Outcomes addressed**: Client volume **Processes addressed:** Having received training **Result:** Higher provider volume in government and NGO facilities, but franchise provision was higher than the non-franchise private sector. Franchise more likely to be trained than non-franchise. Training increased client volume overall. **Equity analysis:** Yes - male providers of FP had significantly smaller clientele. **Economic analysis**: No
Stephenson 2004 (2001)	**Study design :** Cross-sectional survey of facilities, their staff and clients in three countries **Outcomes addressed:** Client volume, FP client volume, other RH volume, total number of staff, number of FP brands, number of RH services, franchise attendance, affordability of services, service quality, clients' future service use intentions **Processes addressed**: No **Result:** Mixed evidence of franchise clients' intent to return to the franchise for future services, and perception of quality compared to non-franchised services and of affordability of franchised services; rather than franchised clinics leading in FP client volume, in all three settings the government establishments had a significantly higher client volume for FP services. **Equity analysis:** Yes - illiterate people were significantly less likely to use social franchising in Bihar but no association in Pakistan or Ethiopia. Significant decline in franchise use in Pakistan associated with increased parity Economic analysis: No

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