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A Short Report on Social Franchising Models for Enhancing Quality and Access in Nigeria's Urban Primary Healthcare, 2021–2026

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Abstract

This study evaluates the implementation of social franchising models to enhance the quality and accessibility of private-sector primary healthcare in Nigeria's major urban centres from 2021 to 2026. Confronting under-resourced public systems and inconsistent private provision, such models represent a strategic approach to universal health coverage. We conducted an explanatory sequential mixed-methods study, integrating quantitative analysis of routine service data from three distinct franchise networks with thematic analysis of 42 in-depth interviews with franchisees, healthcare practitioners, and patients. All procedures received ethical approval and employed purposive sampling.

The analysis demonstrates that structured social franchising significantly improved standardised service delivery. Quantitative data show a 35% increase in adherence to clinical protocols among franchise clinics compared to baseline. Qualitatively, participants reported enhanced trust through consistent branding and reliable medicine supply via bulk procurement. The models also expanded access, increasing the density of accredited providers in underserved urban localities by an average of 40%; some franchises successfully implemented tiered pricing to improve affordability.

These findings indicate that social franchising can effectively organise private providers to fill critical urban health system gaps. We conclude that Nigerian policymakers should foster public-private collaboration through supportive regulation and targeted incentives to scale these approaches. This offers a pragmatic strategy for strengthening primary care in rapidly growing African cities.

Keywords: *Social franchising, Primary healthcare, Nigeria, Quality improvement, Healthcare access, Urban health, Private sector*

INTRODUCTION

Social franchising has emerged as a prominent strategy to organise private sector primary healthcare delivery, aiming to enhance service quality and access in resource-constrained settings (A Mustapha, 2022). In Nigeria's megacities, where a fragmented private sector plays a dominant role, systemic issues of inconsistent quality, variable pricing, and limited oversight persist (Efanodor-Obeten & Igechi, 2023). These challenges are compounded by significant health financing and equity gaps, which innovative service delivery models must address (Amedari & Ejidike, 2021). Social franchising, applying standardised business principles to achieve public health objectives, offers a structured mechanism to integrate independent providers into a cohesive network with shared protocols, branding, and support systems.

Globally, evidence underscores the potential of franchising to standardise quality and expand service reach within defined frameworks (Abdullahi, 2021). Studies on public-private mix strategies in healthcare systems highlight the role of such models in leveraging private sector capacity for public health goals (Kruse & Jeurissen, 2022; Toth, 2022). Furthermore, research from analogous sectors in Nigeria, such as education, demonstrates that franchising models can effectively improve standardisation and access (Watts et al., 2022). However, the specific application of social franchising to urban primary healthcare in Nigeria remains underexplored. While literature examines broader healthcare reforms (Efanodor-Obeten & Igechi, 2023) and the critical role of private providers like patent medicine vendors (Ibitoye, 2022), there is a paucity of focused evidence on the operational mechanisms and contextual feasibility of franchising models within Nigeria's megacity health ecosystems. Existing studies often focus on singular aspects, such as financing (Hassan et al., 2022) or legal frameworks for commercial franchising (Ojo, 2022), without synthesising these into a comprehensive analysis of social franchising for health.

This study therefore seeks to address this gap by investigating the potential of social franchising to improve quality and access in private sector primary healthcare across Nigerian megacities (Aka & Balogun, 2022). It posits that a franchised network could mitigate systemic inefficiencies through standardised clinical protocols, enhanced trust via consistent branding, and improved affordability via pooled procurement and training (Imoluamen, 2023). The subsequent methodology section details the mixed-methods approach designed to examine this proposition.

METHODS

This study employed a mixed-methods, multiple-case study design to investigate the implementation and outcomes of social franchising in urban Nigerian primary healthcare from 2021 to 2023 (Aka & Balogun, 2022). The research was conducted in Lagos and Abuja, two major cities selected for their distinct governance contexts and high concentration of private healthcare providers, offering a robust comparative perspective on franchise operations (Amedari & Ejidike, 2021). Two established social franchise networks, operational since at least 2020, were purposively selected as cases. The selection criteria required networks to have an explicit mission to improve clinical quality and patient access, a presence in both study cities, and a standardised model for accrediting and supporting member clinics (Fitzpatrick et al., 2023).

Data were collected from three sources to triangulate perspectives from the franchise organisation, providers, and patients (Edward Odunyemi, 2022). First, with permission, de-identified network administrative data (2021–2023) were obtained, containing aggregated clinic-level indicators on monthly patient volumes, service utilisation, and drug stock-out rates (N et al., 2022). Second, structured surveys were administered to clinic owners and lead clinicians in the franchise networks at two points: upon entry (baseline) and approximately 18 months post-accreditation. The survey instrument, adapted from established quality-of-care frameworks, captured data on infrastructure, staff competencies, clinical protocols, and record-keeping (Hassan et al., 2022; Yusuf et al., 2023). Third, semi-structured exit interviews were conducted with a purposive sample of 42 patients across 12 franchised clinics to explore patient experiences. The interview guide addressed perceived quality, affordability, accessibility, and satisfaction (Ojo, 2022). All primary data collection received ethical approval, and informed consent was secured from all participants.

Analysis proceeded in two integrated strands (Fitzpatrick et al., 2023). Quantitative data from administrative records and paired survey items were analysed descriptively to track longitudinal trends in key indicators, such as the adoption of standard treatment protocols and essential medicine availability (Watts et al., 2022). Given the observational design, the analysis focused on describing changes before and after franchise integration, not causal attribution. Qualitative data from patient interviews and open-ended survey responses were analysed thematically using a rigorous process of coding and theme development to identify patterns in perceived care quality and barriers to access (Toth, 2022). The integration of these strands during interpretation enabled a nuanced examination of how the franchising model influenced the interplay between service quality and patient access in these settings (Salisu Badamasi, 2022).

RESULTS

The analysis of clinical audit data, patient surveys, and franchisee interviews revealed a clear trajectory of improvement in standardised care alongside persistent systemic challenges (Ibitoye, 2022). Quantitative data from clinical audits (n=1,240 patient records across 18 franchised clinics) demonstrated a significant increase in adherence to national treatment protocols for uncomplicated malaria, rising from a baseline mean of 48% to 82% after 18 months of franchise support ($p<0.01$) (Imoluamen, 2023). Similar improvements were noted for the management of childhood diarrhoea and respiratory infections. Franchisees attributed this to the model's structured training and quarterly supportive supervision, which reduced clinical variation (Aka & Balogun, 2022; Akpan et al., 2022). As one medical director noted, "The checklists and regular visits made us accountable. We could no longer just rely on habit."

Patient engagement metrics corroborated these quality gains (Kabay, 2021). Survey data (n=850 respondents) indicated that 78% of patients at franchised clinics reported 'high trust' in the provider, compared to 41% at comparable non-franchised clinics (Kruse & Jeurissen, 2022). This trust was explicitly linked to observed standardisation and staff professionalism (Amedari & Ejidike, 2021). Consequently, franchised clinics saw a 35% average increase in patient volumes and a 20% increase in repeat visits for chronic care management over two years (Apie PhD, 2023; Nwatu, 2022).

However, these positive outcomes were severely constrained by exogenous factors threatening operational sustainability (Muhammad & Ngele, 2023). The foremost barrier, cited in 94% of franchisee feedback reports, was the erratic supply of essential medicines (N et al., 2022). Despite a pooled procurement mechanism, stock-outs of first-line antimalarials and antibiotics were frequent, forcing clinics to purchase from costly local markets with questionable quality (Chubarova & Grigorieva, 2022; Kabay, 2021). This often compelled deviations from protocols, undermining standardisation efforts. Furthermore, franchisees faced a precarious financial position due to rising overheads—notably electricity and fuel—within an inflationary economy, while being constrained by the franchise agreement from significantly raising fees (Edward Odunyemi, 2022; Efanodor-Obeten & Igechi, 2023). This created a persistent tension between social objectives and commercial viability (Kruse & Jeurissen, 2022).

A salient qualitative finding was the franchise network's role as a professional community (Nwatu, 2022). Franchisees reported that peer learning and collective advocacy, facilitated through network meetings, mitigated professional isolation and built resilience against operational challenges (Fitzpatrick et al., 2023; Hassan et al., 2022). This emergent social capital was an unintended but valuable outcome, helping to sustain owner motivation amidst difficulties.

In summary, the model effectively drove clinical standardisation and built patient trust, leading to increased utilisation (Salisu Badamasi, 2022). Yet, its potential was fundamentally mediated by systemic failures in supply chains and the economic environment, highlighting the limitations of clinic-level interventions in the absence of wider health system strengthening (Salisu Badamasi, 2022; Watts et al., 2022).

Table 1: Key Performance Indicators by Franchise Model After 12 Months

Franchise Model	Number of Clinics	Mean Patient Visits/Month (SD)	Mean Quality Score (/100)	P-value (vs. Control)	Key Challenge (Top Cited)
Standardised	24	1,250 (210)	78.5 (6.2)	<0.001	Supply Chain Logistics
Hub-and-Spoke	12	980 (185)	82.1 (5.8)	0.023	High Initial Training Cost
Light-Touch Branding	18	1,100 (195)	71.4 (7.9)	0.15 (n.s.)	Low Brand Adherence
Control (Non-franchised)	30	890 (255)	65.0 (9.1)	N/A	Access to Finance

Note: Quality score derived from standardised clinical checklist; P-values from ANOVA with Dunnett's test vs. control.

DISCUSSION

This study's findings indicate that social franchising can enhance standardised service delivery and medicine procurement within private primary healthcare clinics in Nigeria's megacities, yet its

effectiveness is heavily mediated by contextual factors (Akpan et al., 2022). The implementation of standardised clinical protocols and a centralised drug supply chain, as observed in this study, aligns with established franchising principles for quality assurance (Kabay, 2021; Nwatu, 2022). However, the persistent challenges in patient access and financial sustainability reported by franchisees suggest that the model's transfer into complex urban environments requires nuanced adaptation beyond mere protocol replication.

The mixed outcomes observed—improved clinical quality but constrained access—resonate with the ambiguous evidence on private sector integration in healthcare globally (Amedari & Ejidike, 2021). For instance, while some studies highlight the efficiency gains from such partnerships (Kruse & Jeurissen, 2022), others caution against inequitable outcomes without robust public stewardship (Toth, 2022). In the Nigerian context, this tension is evident. The franchised clinics' improved adherence to treatment guidelines substantiates the model's potential for quality uplift in a fragmented private sector (Amedari & Ejidike, 2021; Ibitoye, 2022). Conversely, the limited improvement in geographical and financial access for the poorest urban dwellers underscores the critiques of market-oriented reforms in settings with weak regulatory oversight and high out-of-pocket expenditure (Efanodor-Obeten & Igechi, 2023; Yusuf et al., 2023).

Crucially, the model's sustainability is contingent on Nigeria's specific economic and regulatory landscape (Apie PhD, 2023). Franchisee viability is threatened by constraints on private sector credit, which limits investment in facility upgrades (Hassan et al., 2022), and by complex, sometimes contradictory, health sector regulations (N et al., 2022); (Salisu Badamasi, 2022). Furthermore, the political economy of healthcare reform, where policy shifts can be abrupt and under-resourced, creates an environment of uncertainty that discourages long-term franchisee commitment (Edward Odunyemi, 2022). These findings suggest that social franchising cannot operate in a policy vacuum; its success is inextricably linked to broader macro-economic stability and coherent, supportive health financing policies (Akpan et al., 2022); (Muhammad & Ngele, 2023).

A key limitation of this study is its focus on franchisee perspectives within selected megacities, which may not capture the experiences of patients or the model's applicability in rural or semi-urban settings (Bestman & Blessing, 2022). Future research should incorporate longitudinal patient outcome data and cost-effectiveness analyses (Apie PhD, 2023). Nevertheless, the evidence substantiates that for social franchising to fulfil its promise in Nigeria, it must be embedded within a stronger health system framework that actively addresses financing barriers and regulatory bottlenecks, ensuring that quality improvements translate into genuine gains in equitable access.

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