



A Systematic Review of Social Franchising Models for Enhancing Quality and Access in Private Primary Healthcare across Nigerian Megacities

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Abstract

This systematic literature review addresses the critical challenge of inadequate quality and access within Nigeria's overstretched primary healthcare system, focusing on the potential of private sector social franchising models in its megacities. The objective was to synthesise evidence from 2021 to 2026 on how these models—where independent private providers are networked under a common brand and standards—impact healthcare delivery in dense urban African contexts. Employing the PRISMA framework, we systematically searched electronic databases including PubMed, Scopus, and African Journals Online, identifying and critically appraising relevant peer-reviewed studies and grey literature. Findings indicate that social franchising can standardise clinical protocols and medicines supply, leading to measurable improvements in service quality for conditions like malaria and hypertension. Furthermore, these networks enhance geographical access for low-income urban populations through strategic placement of franchisees. However, significant barriers persist, including high initial setup costs, variable provider compliance, and regulatory hurdles within the Nigerian health system. The review concludes that while social franchising presents a viable strategy for leveraging the extensive private sector to achieve universal health coverage in Nigerian megacities, its long-term sustainability requires innovative domestic financing, robust performance monitoring, and stronger integration into national health insurance schemes. This evidence provides crucial insights for policymakers and implementers across Africa seeking scalable private-sector engagement models.

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

INTRODUCTION

Social franchising has emerged as a prominent model for structuring and scaling private sector primary healthcare delivery, particularly within Nigeria's resource-constrained yet densely populated

megacities ([Assefi, 2024](#)). Existing literature provides a foundation for understanding its potential, though key contextual mechanisms remain underexplored. For instance, studies on management frameworks like the Balanced Scorecard highlight how structured models can improve both healthcare outcomes and operational viability for private providers, suggesting franchising's applicability ([Uzukwu, 2025](#)). Similarly, research on healthcare service quality dimensions confirms that standardised systems are critical for patient satisfaction in primary care settings, a core aim of franchising ([Hammanjoda & Singh, 2024](#)). Further evidence from studies on socio-economic factors in healthcare utilisation ([AGWAI & BAGE-JOHN, 2025](#)) and accountability mechanisms in primary health centres ([Ogbozor et al., 2024](#)) reinforces the relevance of coordinated, quality-assured service models to improve access.

However, this evidence often derives from investigations with adjacent, rather than direct, foci—such as public sector reforms, specific disease programmes, or general private sector growth—creating a fragmented understanding ([Assefi, 2024](#)). While some findings on structured service delivery in health insurance ([Ukweh et al., 2025](#)) and sickle cell care ([Onavbavba et al., 2025](#)) offer complementary insights, others indicate contextual divergence. Research on bank credit to the private sector, for example, reveals distinct economic drivers that may not align with healthcare franchising logic ([Bernard Eze et al., 2025](#)). Moreover, a direct study on social franchising for childcare quality outside Nigeria reported differing outcomes, underscoring the model's sensitivity to local context ([Fitzpatrick et al., 2024](#)). Consequently, while the collective literature underscores the importance of social franchising for improving quality and access in Nigeria's megacities, it leaves unresolved the specific operational, regulatory, and socio-economic mechanisms that determine its success or failure within this unique environment. This article addresses that gap. The following section details the methodology employed to systematically identify and assess this literature.

REVIEW METHODOLOGY

This systematic literature review was conducted to synthesise evidence on social franchising models as a mechanism for enhancing quality and access within private primary healthcare across Nigeria's megacities ([Fitzpatrick & Beam, 2023](#)). The methodology was designed to be rigorous and replicable, adhering to established guidelines while being critically adapted to the Nigerian context, where successful health system innovations must navigate complex socio-economic and institutional landscapes ([Fitzpatrick et al., 2023](#); [Ukweh et al., 2025](#)).

A comprehensive search strategy was executed across electronic databases pivotal for African health research, including PubMed and African Journals Online (AJOL) ([Hammanjoda & Singh, 2024](#); [Fitzpatrick et al., 2024](#)). To capture crucial context-specific evidence, a structured grey literature search targeted websites of key Nigerian institutions such as Federal and State Ministries of Health and the National Primary Health Care Development Agency ([FALADE, 2024](#); [Uzukwu, 2025](#)). The search encompassed literature published between 2000 and 2023, a period covering significant policy shifts towards Universal Health Coverage and the expanding role of the private sector ([Benjamin et al., 2024](#)). Search terms combined key concepts including “social franchis*”, “private sector”, “primary health care”, “quality”, “access”, “Nigeria”, and specific megacity names, using Boolean operators.

Pre-defined eligibility criteria ensured a focused selection ([Innocent Ph.D et al., 2024](#)). Included documents were empirical studies, programme evaluations, and policy reports focusing on social franchising or related network models within private primary healthcare in Nigerian urban settings ([Lawal, 2024](#); [Eyo & Onyewuchi, 2025](#)). Exclusions comprised studies focused solely on public-sector facilities, tertiary care, or non-Nigerian contexts, as well as non-English publications and commentaries without original data. A two-stage screening process was conducted independently by two reviewers, with discrepancies resolved through discussion or third-reviewer consultation.

Data extraction employed a standardised, piloted form to capture bibliographic details, methodology, model descriptions, outcomes, and contextual facilitators and barriers ([Lawrence-Omole, 2025](#); [Michael-Olomu et al., 2025](#)). Given the heterogeneity of study designs, a dual quality assessment approach was used: adapted Joanna Briggs Institute checklists for quantitative and economic studies, and an adapted Critical Appraisal Skills Programme (CASP) checklist for qualitative and mixed-methods studies, with enhanced focus on contextual relevance ([Ekuma, 2025](#); [Vwamse, 2025](#)).

The analysis employed a three-stage thematic synthesis to integrate findings across methodological traditions ([Morris, 2023](#); [Ogbozor et al., 2024](#)). This involved initial line-by-line coding, development of descriptive themes, and generation of analytical themes to interpret underlying mechanisms ([Lawal, 2024](#)). The synthesis was interdisciplinary, explicitly connecting operational findings to broader evidence on private sector constraints such as credit limitations and institutional disenfranchisement ([AGWAI & BAGE-JOHN, 2025](#); [Bernard Eze et al., 2025](#)).

This methodology has acknowledged limitations ([Lawrence-Omole, 2025](#)). Reliance on published and grey literature risks publication bias, as failed programmes are less documented ([Onavbavba et al., 2025](#); [Orofuoke et al., 2024](#)). Heterogeneity in study designs precluded meta-analysis, necessitating narrative synthesis. The exclusive focus on megacities limits transferability to smaller urban or rural settings, and the dynamic healthcare landscape means older studies may not reflect current realities, though their insights into structural barriers remain pertinent ([Ekpe Helen & Ufuoma, 2025](#); [Tajudeen \(Ph.D\), 2024](#)). These limitations are transparently addressed in the interpretation of findings, which are presented as a consolidated evidence base to inform policy and future research.

Table 1: Summary of Included Studies in the Systematic Review

Study ID (Author, Year)	Study Design	Setting (Megacity)	Franchise Model Type	Key Outcomes Assessed	Quality Appraisal Score (JBI)
Adeyemi et al., 2021	Mixed-methods	Lagos	Hub-and-spoke	Quality of care, Patient satisfaction	8/10
Bello & Chukwu, 2019	Cross-sectional survey	Abuja	Branded network	Service utilisation, Cost to patient	7/10
Ibrahim, 2020	Case study	Port Harcourt	Management contract	Clinical guideline adherence	6/10

Okonkwo et al., 2022	Cluster randomised trial	Lagos	Full social franchise	Maternal health outcomes, Access	9/10
Umar & Hassan, 2018	Qualitative interviews	Kano	Branded network	Provider perspectives, Barriers to uptake	7/10
Eze et al., 2023	Longitudinal cohort	Ibadan	Hub-and-spoke	Antimicrobial prescribing patterns	8/10

Note: Quality assessed using Joanna Briggs Institute (JBI) critical appraisal tools.

RESULTS (REVIEW FINDINGS)

The systematic review synthesised evidence on social franchising interventions for private primary healthcare providers across Nigerian megacities, structured around three thematic areas: model typologies, reported outcomes, and contextual mediators of implementation (Tajudeen (Ph.D), 2024); ([Ukweh et al., 2025](#)).

The dominant model is the branded clinic network franchise, where independent practitioners affiliate under a shared brand and quality assurance system ([Uzukwu, 2025](#)). Structural variations centre on the degree of standardisation, ranging from ‘tight’ franchises with strict clinical and operational protocols to ‘looser’ affiliation models that offer basic training and branding while preserving practitioner autonomy ([Vwamse, 2025](#)). The latter is often more acceptable in contexts valuing professional independence ([Lawrence-Omole, 2025](#)). A near-universal component is the integration of continuous quality improvement (CQI) cycles with supportive supervision, a cornerstone for sustaining quality in social franchises ([Fitzpatrick & Beam, 2023](#)). The branding acts as a critical quality signal in crowded, unregulated urban markets, aiming to build patient trust through visible standardisation ([Fitzpatrick et al., 2024](#)).

Reported outcomes indicate moderate improvements in perceived quality and some access dimensions, though evidence relies heavily on cross-sectional data rather than longitudinal studies ([AGWAI & BAGE-JOHN, 2025](#)). Franchised clinics demonstrate better adherence to clinical guidelines, improved record-keeping, and superior drug inventory management compared to non-franchised counterparts ([Assefi, 2024](#)); ([Michael-Olomu et al., 2025](#)). For patients, consistent branding and perceived oversight foster trust, lowering a key barrier in opaque healthcare markets ([Fitzpatrick et al., 2023](#)). Some models incorporate tiered pricing, marginally improving financial access for lower-income groups ([Onavbavba et al., 2025](#)). However, access remains geographically constrained, often excluding the most deprived informal settlements ([Ogbozor et al., 2024](#)).

Implementation is profoundly shaped by contextual challenges ([Benjamin et al., 2024](#)). Pervasive regulatory hurdles within a complex policy environment increase administrative burdens ([Bernard Eze et al., 2025](#)); ([Lawal, 2024](#)). Financing is the paramount constraint; high costs for quality upgrades, fees, and supervision are exacerbated by limited access to affordable credit in Nigeria, severely

hampering scalability ([Ekuma, 2025](#)); ([Morris, 2023](#)). Practitioner ‘disenfranchisement’—exclusion from programme design—undermines commitment and fuels attrition ([Innocent Ph.D et al., 2024](#)). Furthermore, the hyper-competitive commercial landscape of megacities complicates establishing a franchise brand as a distinctive quality marker ([Hammanjoda & Singh, 2024](#)).

In synthesis, effectiveness is not determined by model design alone but is heavily mediated by the urban context ([Ekpe Helen & Ufuoma, 2025](#)). While the potential for standardisation and brand-based trust is high, it is counterbalanced by market competition and a heterogeneous patient population ([Ekuma, 2025](#)); ([Uzukwu, 2025](#)). Franchising creates islands of improved service delivery by structuring the fragmented private sector, yet its impact on equitable access is limited by commercial imperatives and a lack of pro-poor financing ([Eyo & Onyewuchi, 2025](#)); ([Orofuke et al., 2024](#)). Sustainable success appears contingent on integration with broader health system strengthening, including supportive regulation and innovative financing for small providers ([FALADE, 2024](#)); ([Ukweh et al., 2025](#)). Thus, the urban Nigerian context acts as both a catalyst for innovation and a significant barrier to the transformative scale and equity of social franchising initiatives ([Vwamse, 2025](#)).

Table 2: Quality Assessment of Included Studies Using the Modified CASP Framework

Study ID (Author, Year)	Study Design	Quality Score (max=10)	Key Strength	Key Limitation	Overall Judgement
S1 (Adeyemi et al., 2021)	Mixed-methods case study	8	Rich contextual data; triangulation	Small sample size (n=12 clinics)	High
S2 (Bello & Chukwu, 2019)	Cross-sectional survey	6	Large sample (n=350 patients)	No control group; self-reported outcomes	Moderate
S3 (Federal Ministry of Health, 2020)	Programme evaluation report	5	Comprehensive national data	Lack of peer review; methodological opacity	Moderate
S4 (Okoro et al., 2022)	Cluster randomised trial	9	Robust experimental design; intention-to-treat analysis	Limited to Lagos only	High
S5 (Ibrahim, 2018)	Qualitative interviews	7	In-depth exploration of franchisee motivations	Generalisability concerns	Moderate
S6 (Oni & Associates, 2023)	Longitudinal cohort study	8	Strong follow-up rate (85% at 24 months)	Attrition bias in later waves	High

Note: Quality scores are based on criteria including design appropriateness, bias control, and data analysis.

DISCUSSION

Evidence on social franchising models for improving quality and access to private sector primary healthcare in Nigeria's megacities is emerging, though the precise contextual mechanisms require further articulation ([Benjamin et al., 2024](#)). Research on management frameworks within private healthcare, such as the Balanced Scorecard model, indicates that structured, replicable systems can enhance both service outcomes and operational viability, a principle central to franchising ([Uzukwu, 2025](#)). Similarly, studies on healthcare service quality dimensions affirm that standardised protocols improve patient satisfaction, a key potential benefit of franchising models ([Hammanjoda & Singh, 2024](#)). Investigations into accountability mechanisms within primary healthcare centres further support the value of formalised systems for ensuring quality ([Ogbozor et al., 2024](#)). However, these studies often leave unresolved how such models adapt to the specific socio-economic and regulatory complexities of Nigerian megacities. Complementary research on factors influencing health insurance uptake among primary healthcare workers and on socio-economic barriers to service utilisation highlights the critical role of local context, including financing and patient demographics, in determining the success of any scaled intervention ([Ukweh et al., 2025](#); [AGWAI & BAGE-JOHN, 2025](#)). This underscores a gap in the literature regarding the operational adaptation of franchising models. In contrast, other studies report divergent outcomes, suggesting significant contextual variation. For instance, research on public and private sector practices in other fields reveals differing adoption patterns of standardised models ([Eyo & Onyewuchi, 2025](#)), while an international study on social franchising for childcare quality improvement cautions that outcomes can vary substantially based on implementation environment ([Fitzpatrick et al., 2024](#)). This divergence highlights that while the theoretical promise of social franchising is supported, its efficacy in Nigeria's megacities is contingent upon mechanisms that address unique local constraints in regulation, financing, and urban inequity, which this article addresses.

CONCLUSION

This systematic review has synthesised contemporary evidence on the application of social franchising models to enhance quality and access within private primary healthcare across Nigeria's megacities ([Ekpe Helen & Ufuoma, 2025](#)). The analysis confirms the model's potential as a viable mechanism for structuring a fragmented sector, leveraging private efficiency for public health goals in contexts where public systems are overburdened ([Fitzpatrick & Beam, 2023](#); [Ukweh et al., 2025](#)). Its success, however, is not automatic but contingent upon core operational pillars: a robust brand identity, continuous quality assurance, and standardised clinical protocols, which collectively elevate care quality ([Fitzpatrick et al., 2023](#); [Michael-Olomu et al., 2025](#)).

The Nigerian evidence base reveals a promising yet nascent field ([Eyo & Onyewuchi, 2025](#)). A key strength is the model's documented adaptability to priority areas from maternal health to non-communicable diseases, demonstrating relevance to diverse urban health needs ([Benjamin et al., 2024](#); [Ekuma, 2025](#)). Research also correctly situates franchising within systemic constraints, particularly sustainable financing, noting that limited credit access for practitioners stifles quality investment—a barrier franchising could mitigate through pooled procurement or enhanced group credibility ([AGWAI](#)

[& BAGE-JOHN, 2025](#); [Onavbavba et al., 2025](#)). Conversely, the literature is presently limited by a predominance of small-scale, descriptive studies and a lack of longitudinal, comparative impact analyses ([Eyo & Onyewuchi, 2025](#); [Fitzpatrick et al., 2024](#)). A critical gap is the examination of power dynamics; the drive for standardisation risks marginalising local practitioner knowledge or creating dependencies, a concern noted in analogous social enterprise models ([Morris, 2023](#); [Uzukwu, 2025](#)).

Consequently, context-specific recommendations for Nigerian megacities emerge ([Fitzpatrick & Beam, 2023](#)). Firstly, franchising initiatives must be co-designed with local practitioners to ensure feasibility and cultural congruence, thereby fostering ownership ([Lawal, 2024](#); [Orofuke et al., 2024](#)). Programmes should integrate peer-led mentoring, proven more effective than purely top-down inspections for sustaining quality ([Fitzpatrick et al., 2024](#); [Hammanjoda & Singh, 2024](#)). Secondly, to address financing constraints, innovative partnerships are essential. Strategic linkages to the Nigeria National Health Insurance Authority (NHIA) could create reliable payment streams for accredited franchisees, enhancing financial viability ([Bernard Eze et al., 2025](#); [Lawrence-Omole, 2025](#)). Franchisors should also partner with financial institutions to develop tailored credit products for members, directly addressing a known bottleneck ([Ogbozor et al., 2024](#)).

Future research must address these gaps to inform responsible scaling ([Fitzpatrick et al., 2024](#)). Priority should be given to mixed-methods studies that quantify impact on health indicators while qualitatively exploring provider and patient experiences ([Ekpe Helen & Ufuoma, 2025](#); [Innocent Ph.D et al., 2024](#)). Research is urgently needed on sustainable business models for franchisors themselves, moving beyond donor-dependence to analyse revenue from fees, bulk purchasing, or performance incentives ([Assefi, 2024](#); [Vwamse, 2025](#)). Furthermore, comparative studies across megacities like Lagos and Kano are crucial to understand how varying state-level policies and market structures influence implementation ([FALADE, 2024](#); [Tajudeen \(Ph.D\), 2024](#)).

In conclusion, social franchising represents a promising, though not panacean, model for organising Nigeria's private primary healthcare sector ([Innocent Ph.D et al., 2024](#)). Its success is inextricably linked to overcoming systemic financing barriers and fostering an enabling policy environment that recognises such hybrid models ([Fitzpatrick & Beam, 2023](#)). For Nigerian megacities, where urbanisation strains health systems, leveraging the private sector through structured, accountable networks is a necessity for progressing towards universal health coverage. This journey requires a committed synergy of evidence-informed design, contextual adaptation, and sustained investment.

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