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Social franchising: A systematic review

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ABSTRACT

Social franchising is starting to garner more interest among researchers and practitioners as a replication approach used to help address a growing array of societal issues in both developed countries and emerging economies. While there has been a proliferation of experimentation with social franchising that is occurring on the global stage, the knowledge base remains fragmented. A comprehensive review of the empirical and practitioner literature has not been done. This article fills the void by reviewing the past decade of literature and will be of interest to governments, non-governmental organizations (NGOs), philanthropists, social impact investors, corporations devoted to social goals, and other key players who support the scaling up or replication of ventures that strive to address societal ills by creating pathways to health and prosperity.

Introduction

Societies remain on an unabated march toward continued poverty, famine, and a veritable panoply of diseases and health maladies in spite of private, governmental, and nonprofit efforts to curb the trend. Non-governmental organizations (NGOs) rally resources from a myriad of spectrums to mount crusades against injustice, discrimination, and social inequalities through in-country programing, educational forums, and political lobbying (Grünhagen, 2010; Prata, Montagu, & Jefferys, 2005). The growing cost of deploying their strategies drives these organizations to innovate by considering business and commercial approaches in attempts to squeeze more value from their always-limited, often-diminishing coffers. Similarly, social enterprises tackle health, social, and environmental problems but are quickly hampered by the lack of sufficient resources to scale their initiatives. Within this context, NGOs and social enterprises are adapting the business format franchise model (e.g., McDonalds and Subway) as a channel strategy to generate capital for sustainability, improve quality, and expand reach in the quest to address societal problems (Alur, 2013; du Toit, 2014). This relatively new model, termed *social franchising*, operates with commercial principles, but focuses on social versus financial goals (du Toit, 2014).

There is a growing body of research suggesting a scholarly interest in the concept of social franchising (Alur & Schoormans, 2011). Furthermore, there is a proliferation of experimentation with social franchising that is occurring on the global stage, with franchise coalitions and associations escalating their involvement in these efforts. The objective of this article is to synthesize the intellectual territory that has been explored in the literature over the last decade. The first section of the article discusses our methodology, explaining the characteristics of what literature was selected. We then review definitions of the concept and offer examples of different forms of social franchising. Next we categorize the empirical studies by variables studied. This enables us to frame and interpret the findings, as well as assist with the presentation of the body of work on social franchising. Within the empirical literature, five distinct areas surfaced: (a) why the use of the franchise business model emerged in the context of solving social problems; (b) general theories used to explain the emergence; (c) franchisor selection practices; (d) motivations to become a social franchisee; and (e) outcomes from these interventions. The article continues with implications for research and practice. The final section provides our conclusions, as well as limitations of this work. This review will be of interest to governments,

NGOs, philanthropists, social impact investors, corporations devoted to social goals, and other key players who support the scaling up or replication of ventures that strive to address societal ills by creating pathways to health and prosperity.

Method

To provide an overview of the knowledge base, this article synthesizes the literature on social franchising. We targeted an integrative literature review approach (Torraco, 2005). Electronic databases used in the search included Academic Search Premier, Business Source Premier, and Google Scholar. Data sources were abstract queried using the key terms *social franchising* and *social franchise* and limited to articles with these terms appearing in the abstract or title. Although the topic has only started to emerge in the last decade, to ensure seminal studies would be included, the search time frame began in 1995. Excluded in the database search were the terms *social media, social networks*, and social *aspects*. Also excluded were articles not published in English. A total of 126 articles were obtained from this search (see Table 1). Next a spreadsheet was created that contained all 126 titles, first author, year, and source. Duplicate titles were then eliminated ($n = 20$).

From this point we went to review the 106 abstracts or executive summaries to ascertain their relevance (Torraco, 2005). Several decisions were made regarding the criteria for inclusion. Because social franchising is still relatively new, both published and gray literature were included for full review if they addressed our research questions. When studies of outcomes were reported in prior literature reviews, we opted to report the findings from these reviews. Next, critical analysis of the strengths and weaknesses of each piece in its entirety was considered with respect to our research questions. In Figure 1, the articles are shown divided into two categories, empirical studies and other (conceptual, working papers, practitioner, etc.) with an overview of how articles on social franchising netted inclusion.

Literature review

There have been multiple interpretations around "social," as the term has been paired with enterprise, and entrepreneurship, as well as franchising over the last several years. With respect to social entrepreneurship and social enterprise, common features include an innovative or novel activity that has at its core a "social" versus a "commercial" goal (Austin, Stevenson, & Wei-Skillern, 2006). Alter (2007) argues that social enterprise is merely an institutional expression of the term social entrepreneur. Social franchising, on the other hand, is the business-format that a social enterprise or a social entrepreneur might adopt to facilitate expansion and/or the replication of a delivery model. While social entrepreneurs may have the idea and be able to launch the initiative, scaling up involves another skill set and access to resources these individuals are less apt to have. In their capacity as change agents (Kidd et al., 2015), it is not surprising that social entrepreneurs expanded their thinking to experiment with the franchise business model as a replication strategy. As evidence of such, the U.K.'s Social Enterprise Coalition (Temple, 2011) created a book, *The Social Franchising Manual*, with the goal of helping organizations with a social purpose understand how to replicate using a franchise format.

How franchising works

Franchising is a contractual arrangement where one individual or an organization pays another firm for the right to sell that firm's product or service and uses that organization's trademark and business format in a specific location for a specified period of time (Lafontaine & Blair, 2008). Within the sphere of franchising, there are trademark and business format franchisors. The models differ in that within the

Table 1. Number of selected articles by database source.

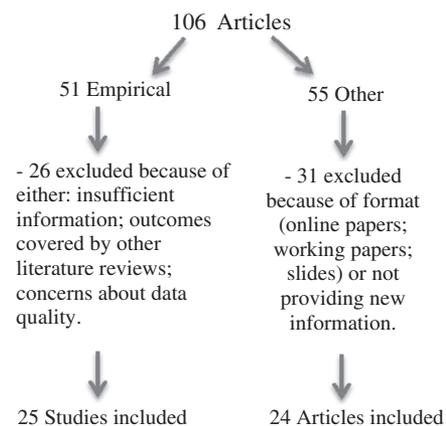| Database	"Social Franchise" or "Social Franchising" contained in abstract or title
Business Source Premiere	21
EBSCO Academic Search Premiere	21
Google Scholar (English)	84 (Title only)
Total	126
Duplicate ($N = 20$)	106 (Remaining)

Figure 1. Flowchart of articles included based on criteria.

business format franchise, the common form of payment to the franchisor is the initial entry fee, ongoing fees, typically referred to as royalties, and advertising fees (Justis, Chan, & Kedia, 2015). Trademark franchisors, meanwhile, secure their profit from the distribution process (Lafontaine & Blair, 2008). Within the business-format franchising arena there are further distinctions as firms may opt to use direct franchising, area franchising, or master franchising strategies (Preble & Hoffman, 2006).

In the United States, franchising is regulated by the Federal Trade Commission (FTC) *through* the Federal Trade Commission Rule[1] referred to as the Franchise Rule. This applies on the offer and sale of a franchise and, to a much lesser extent to investigation of consumer claims of franchisor fraud or misrepresentation. The Franchise Rule identifies the following elements before a firm is classified as a franchise:

> (h) *Franchise* means any continuing commercial relationship or arrangement, whatever it may be called, in which the terms of the offer or contract specify, or the franchise seller promises or represents, orally or in writing, that: (1) The franchisee will obtain the right to operate a business that is identified or associated with the franchisor's trademark, or to offer, sell, or distribute goods, services, or commodities that are identified or associated with the franchisor's trademark; (2) The franchisor will exert or has authority to exert a significant degree of control over the franchisee's method of operation, or provide significant assistance in the franchisee's method of operation; and (3) As a condition of obtaining or commencing operation of the franchise, the franchisee makes a required payment or commits to make a required payment to the franchisor or its affiliate.

The U.S. franchise rule is transparent, and while there is no parallel regulatory system globally, over 30 countries have enacted laws aimed to protect franchisees (Buchan, 2014). Still, as Buchan (2014) notes, what is defined as franchising will vary by country. Furthermore, franchising continues to evolve, with new forms of franchising (e.g., social franchising, micro-franchising, tandem franchising) adding complexity and creating new legal and policy challenges (Buchan, 2014).

NGOs use of the franchise format

While social franchising might at first be viewed as an outgrowth of social enterprise, the concept of social franchising has been evident in the nonprofit sector for many years (Oster, 1996), In her study of 61 nonprofit organizations, Oster (1996) identified 41 organizations that operated using a franchise model. These organizations include well-known names such as Planned Parenthood, The American Cancer Society, YMCA, and the United Way. Furthermore, Oster's study found that the larger the organization and the more labor intensive the sector, the more likely it was to have monitoring problems and therefore turn to franchising, for which monitoring is a core tenet. While nonprofits may have embraced the franchise model, the courts have been inconsistent in how they interpreted their status, leaving unresolved whether these nonprofits are regulated by the same laws and regulations as their for-profit counterparts (Crawford-Spencer, 2015).

What constitutes social franchising

The expansion of franchising into the social realm has implications for global development and may impact the lives of millions of individuals. It is not surprising, however, that the relatively new field of social franchising has struggled with definitional issues. Viewing the concept broadly, the term social franchising would apply to any activity that is addressing a social need where there is an independent coordinating network that supports network members (Bishai, Shah, Walker, Brieger, & Peters, 2008). Taking a more narrow view, Bartilsson's (2012) definition suggests that the social franchisor and social franchisees are "social enterprises (i.e., businesses that trade and have a social purpose) sharing the same values" (p. 6). This more restrictive definition of social franchising precludes traditional nonprofits and licensing arrangements.

Crawford-Spencer (2015) conducted an exhaustive literature review of the multiple definitions offered of the construct and she suggests eight indicators can provide the litmus test. These include

- the granting of a license or right;
- using another's business model, system, marketing plan, and trademark;
- the payment of a fee;
- a level of control is exercised or assistance is provided by the sponsoring entity;
- the social purpose prevails over shareholder gain;
- there is decentralization;
- collaboration prevails over competition; and
- complexity exists in the involvement of stakeholders or customers.

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[1]Disclosure Requirements and Prohibitions Concerning Franchising, 16 C.F.R. pt. 436 (2012) Bus. Franchise Guide (CCH) 6010-26.

Applying the indicators above would suggest that social franchising might operate within multiple contexts. One context within a developed economy could be a franchise company that wants to participate in a socially responsible endeavor may simply grant a license to a nonprofit entity. The International Franchising Association's (IFA) 2004 report on nonprofit franchising listed 11 franchise organizations with nonprofits operating in their systems. A well known example is Ben & Jerry's PartnerShop Program, whereby franchisees are community based nonprofit organizations.

In the UK well over 95 social franchises are reported to operate, and these take a variety of forms, including private limited companies, registered charities, community interest companies, companies limited by guarantee, and industrial and provident societies (Richardson, Berelowitz, & The International Center for Social Franchising Report, 2012). One of the largest UK nonprofits that embraces social franchising is Marie Stopes International (MSI). MSI began franchising in 2001 and is considered one of the leading providers of sexual and reproductive healthcare services, operating franchises in 17 countries in Asia and Africa (Thurston, Chakraborty, Hayes, Mackay, & Moon, 2015). A non-health example from the charitable sector would be Green-Works (GW), established in 2000 to collect office furniture which can be resold at low cost to small businesses and other social enterprises (Mavra, 2011). GW has multiple franchisees across the UK, aided in part by the corporate clients who contract with GW to provide an environmentally friendly method for furniture disposal (Mavra, 2011).

In developing economies, social franchising has proliferated over the last several years (Thurston et al., 2015). In this context, the social franchise may serve as a means of addressing societal problems such as population control, education, health, vision care, water-supply, and food production (Amies, 2000; Daley, 2014). Population Services International (PSI) is a global nonprofit organization that has been using the social franchise model for over 20 years. PSI's network spans multiple countries, has over 16,000 social franchisees, and is dedicated to improving the health of people in the developing world by focusing on challenges such as HIV/AIDS, malaria, contaminated water, and threats to maternal and child health (Thurston et al., 2015). A non-clinical example is Aflatoun, an NGO originating in India that used the social franchise concept to expand its social and financial training program for school children.

The organization now operates at over 21,000 sites in 103 countries (Amar & Munk, 2014).

Social franchising does not just involve NGOs and social enterprises; the concept has also been used to a limited degree in the public sector (Hanson et al., 2008). Such an example in health care is Green Star, a family planning franchise. Green Star began as a coordinated network between PSI, Social Marketing Pakistan (SMP) the PSI franchisor, and the government of Pakistan. The Green Star Network, initially funded by the government, used a coordinated network to deliver training to private sector health providers to make family planning services and products more widely available and affordable to low-income people in Pakistan (McBride & Ahmed, 2001). In Vietnam, Alive and Thrive is a social franchise that established a partnership with the National Institute of Nutrition (NRN) and local health authorities who act as sub-franchisors. Outside of the clinical social franchise spectrum, local municipalities in South Africa have been partnering with social franchises to develop and operate water sanitation projects (Wall et al., 2013). Despite more limited data on these public for-profit relationships, Hanson et al. (2008) points to "widespread enthusiasm" for public structures that incorporate private providers via social franchising as a means to improve efficiency and equity for underserved populations.

In addition to a variety of actors and funders (private, nonprofit, and public) involved in social franchising efforts, there are two principle models, and each of the models has variations (McBride & Ahmed, 2001). First, there is the stand-alone social franchise model. In this model the franchisor may provide the infrastructure, equipment, training, subsidized products or simply products at a lower cost due to volume discounts, while the franchisees deliver the services or products. The other model is the fractional social franchise; here individuals operating an existing venture add a franchised service or product to their business for added income (Montagu, 2002).

Alter (2007) suggests social enterprises may exist on a continuum between those that are mission centric to those that are commercially driven. We use Alter's (2007) continuum of organizational types to demonstrate how social franchising can be deployed across the spectrum of organizational formats (see Figure 2).

We turn next to examine reasons firms choose franchising as their replication model. We then review theoretical perspectives that have been offered to explain the phenomenon.
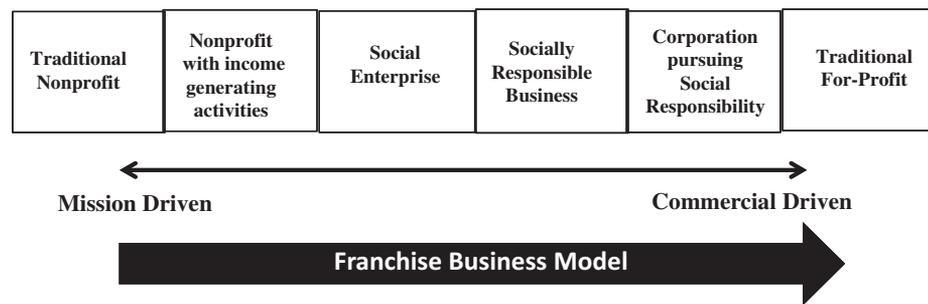
Traditional Nonprofit	Nonprofit with income generating activities	Social Enterprise	Socially Responsible Business	Corporation pursuing Social Responsibility	Traditional For-Profit

Mission Driven ←——————————————————→ **Commercial Driven**

Franchise Business Model ➤

Figure 2. Alter's (2007) *Typology of Social Enterprise*. Reprinted with author's permission. Permission to reuse must be obtained from the rightsholder.

Why does social franchising exist?

Mavra (2011) study for the Social Enterprise Coalition in the UK investigated reasons why social enterprises opted for different approaches to replication. Interviewing respondents from 22 organizations, Mavra found three replication strategies operating: social franchising, social licensing, and partnership agreements. Interviewees indicated their preference for the franchise model because it (1) provided a blueprint for delivering the enterprise into another context (whether geographically or with another organization), (2) offered a "business in a box", and (3) allowed trusted local people to deliver the service. Similar motivations were uncovered by Lambie (2011) in her study of the UK's Trussell Trust Foodbank Network. The food bank, a social franchise with 148 food banks across the UK, selected franchising as a replication strategy based on the desire to achieve rapid expansion, maintain quality control, and ensure a community-owned approach (Lambie, 2011).

Practitioners in the social franchising arena reinforce these same reasons for the existence of this replication strategy. Daley (2014) suggests that one key benefit is to help quality control "just like Subway or McDonald's control for the quality of food" (p. 95). Amies (2000) suggests that efficiency is the driving factor for social franchising to become a model replication strategy. He argues that while governments, nonprofits, and foundations offer ways to alleviate problems, they lack a replication strategy for passing on best practices. Amies states "wherever there are multiple customers who need to be served from multiple locations, franchising can help to make delivery more cost effective" (p. 39). The chairman of the International Franchise Association (IFA) task force on social franchising, Michael Seid, maintains that the "most promising development in recent years is the use of franchising' to address health and quality of life issues (Seid, 2009, p. 34). Finally, another rationale for social franchising is the desire by for-profit franchisors to participate in socially responsible endeavors to support local communities where they conduct business (Litalien, 2006).

In summary, social franchising has been viewed as an organizational format that offers the ability to attract capital, capture economies of scale, facilitate faster replication, and exploit network alliances. In the next section, we explore what theories have been applied to social franchise studies and how they have been applied.

What theories explain social franchising?

Still in its nascent stage, there is only minimal academic research that links general theoretical perspectives from business literature to social franchising. While a good theory can help us make sense of a phenomenon, in this case, social franchising, it requires clarity around how to define the concept. As noted earlier in this article, there are numerous types of social franchises. The lack of clear boundaries may be hampering theory application and development. Furthermore, much of the research to date has been program evaluation oriented, aimed at offering insight as to the ability of social franchises to effectively deliver outcomes, apparently superseding the need for providing theoretical understanding of the emergence of this phenomena. We review first the application of general theories that have been applied in social franchising studies to explain the motivation behind the formation of these types of alliances. We then offer an integrative framework as a building block to guide future scholarly research.

Through our literature search, only five scholarly articles (Beckmann & Zeyen, 2014; Tracey & Jarvis, 2007; Volery & Hackl, 2010; Zafeiropoulou & Koufopoulos, 2013, 2014) propose theoretical frameworks to explain why social franchising is chosen as a strategy for scaling up. Not surprisingly, scholars at this stage have relied on case studies as evidence to

support their propositions. Two of the studies (Beckmann & Zeyen, 2014; Tracey & Jarvis, 2007) use illustrative cases, while Volery and Hackl (2010) and Zafeiropoulou and Koufopoulos (2013, 2014) adopted qualitative research designs employing case study methodology. We begin by discussing each theory linked to social franchising and then offer a framework for integration.

Agency theory

While there remains debate in the commercial franchising literature as to which theory best explains why firms choose to franchise, agency theory has been cited frequently. As organizations (the principal) choose to expand, they rely on other parties (agents). One of the core assumptions of agency theory is that each party is motivated by self-interest and different attitudes toward risk resulting in different decision-making preferences (Eisenhardt, 1989). Geographical distance of the agent from the principal contributes to information asymmetries between the agent and principal, and since the principal cannot create contracts specifying every possible situation that could occur, they either have to monitor the agent or create incentive mechanisms to ensure their own goals are met (Eisenhardt, 1989). Scholars have argued that when the organization makes a decision to expand, the agency costs are lower for opting to use franchisees versus salaried managers (Rubin, 1978).

Agency costs, however, are evident in social franchising, one of which is adverse selection (Tracey & Jarvis, 2007). Adverse selection has dramatic, long-term effects on the relationship and is manifested in brand issues, compliance issues and relational issues. With respect to brand issues in social franchising, some franchisees may refuse branding because they do not want to deter clients by appearing overly upscale (Eldridge, 2011). Compliance issues can occur in social franchising as well. McBride and Ahmed's (2001) case study of the Green Star franchise in Pakistan found that PSI's franchisor, SMP, initially struggled with wide variances in delivery quality, varying levels of franchisee skills and low franchisee engagement. Despite the issues, SMP was reluctant to enforce standards and hold the franchisees compliant. This supports the moral hazard issue within agency theory as franchisees tend towards noncompliance when franchisors are not willing or capable of enforcing system standards (Barthélemy, 2011). Finally the franchisor and franchisee relationship is at risk of *shirking*, which is the propensity of the franchisee to fail to meet the expectations and *free-riding*, which is the value gained by the franchisee from the brand value of the system overall (Elango & Fried, 1997). These issues that plague commercial franchising are also evident in some social franchises. Much will depend on whether the social franchisee was motivated to become a franchisee based on extrinsic economic rewards or a desire to serve others.

Volery and Hackl's (2010) examination of three social franchise ventures that relied on individual franchisees found that two core aspects of agency theory were operating. First, in each of the three cases, the franchisees supported the belief that an important aspect was compensation for their work. A classic tenet in principal/agency theory is that the franchisee is motivated by extrinsic remuneration. Second, in each of the cases, control mechanisms were instituted to reduce uncertainty. The mechanisms used by the social franchisors ranged from customer surveys, training of franchisees, data reporting for benchmarking purposes, and on-site inspections.

Similarly, Tracey and Jarvis (2007) illustrative case of the UK's first social franchise systems offered agency theory as one of two frameworks to explain why a social enterprise pursued a franchising model. Tracey and Jarvis (2007) traced the rise and fall of Aspire, a social enterprise designed to provide jobs for those who find it difficult to access employment. These scholars found goal incongruence between franchisees and the franchisor, supporting agency theory's assumption about self-serving human behavior, which results in the need for close monitoring of franchisees and the creation of incentive structures that align the interests of franchisors and franchisees. A notable difference in this study, however, was that the franchisees were non-profit organizations, as opposed to individuals.

Both Volery and Hackl (2010) and Tracey and Jarvis (2007) suggest agency theory offers an incomplete picture of the relatively new and still forming phenomenon of social franchising. Similarly, Beckmann and Zeyen's (2014) conceptual article argues that the principal-agent dilemma of disparate goals does not exist in a social franchise relationship, making agency theory less applicable to social franchising than commercial franchising.

Resource scarcity theory

Oxenfeldt and Kelly (1969) suggested resource scarcity theory could explain a firm's decision to pursue a commercial franchise replication strategy. The argument is made that younger organizations seeking to expand often lack the financial capital, the local

geographic knowledge, or the capacity to attract a talented labor pool (Combs & Ketchen, 1999). A growth strategy using franchising allows rapid expansion of the concept by relying on the capital of franchisees, their knowledge of the market and their ability to attract labor, mitigating the risks associated with growth (Kaufmann & Dant, 1999; Shane, 1998).

Tracey and Jarvis (2007) study of Aspire found that franchising was chosen as a replication strategy based on resource considerations. Aspire did not have the financial capital to expand and it was decided that the franchise business model could be used by inviting nonprofit organizations to be franchisees. In order to attract nonprofits to become franchisees, however, Aspire helped with the startup costs as opposed to the more traditional model where franchisees pay the franchisor a rights fee. Tracey and Jarvis also found the resource scarcity assumption with respect to local knowledge and access to managerial capital also applied. The nonprofit organizations that signed on as franchisees had experience dealing with marginalized groups and legitimacy in the local market.

Social capital theory

Beyond the traditional theories from economics (agency theory; resource scarcity theory), relational research paradigms have also been used to explain interfirm alliances such as franchising. Interfirm relationships represent social capital and resources are embedded within and available from the relationships between the parties (Burt, 1997; Nahapiet & Ghoshal, 1998). The ties between the franchisor and franchisee enable them to share information and knowledge to create entrepreneurial opportunities (Koka & Prescott, 2002). Interactions also create norms of expectations that function as social mechanisms driving greater cooperation (Koka & Prescott, 2002).

Using social capital theory as a framework in social franchising, the relationship serves as a bridging function (access to more resources) as well as a bonding function (willingness to follow the rules) (Volery & Hackl, 2010). In the three illustrative cases examined, Volery and Hackl (2010) found the legal agreement was less instrumental in the cooperation between the parties, rather it was the social relationships between the people involved. Similar to commercial franchising, the relationship between franchise and franchisor serves to both bridge and bond, and this is an important factor for social franchises (Volery & Hackl, 2010). While the cases did not demonstrate a high level of horizontal trust between franchisees, they did indicate a high level of vertical trust between headquarters and the franchisees (Volery & Hackl, 2010).

Also, using a relational theoretical lens as opposed to economic, Zafeiropoulou and Koufopoulos (2013, 2014), studied four social franchise cases in the UK, and found relational embeddedness played a central role in the governance and performance of these franchises. These scholars argue that since network organizations are not organized on centralized hierarchical controls, it must be the strength of the relationship that governs the system.

Applying social capital theory to franchise management suggests that involvement and trust are key components between franchisor and franchisee and where there is more of a collectivist culture evident, there is less focus on command and control, and contracts are likely less detailed (Volery & Hackl, 2010). This idea of a symbiotic relationship, while attractive, has risks as well. One of the risks is the franchisor will need to provide a high level of attention that involves frequent communication and the ability to nurture the relationship. Since social franchisors have little recourse to discipline franchisees for low quality they must cajole and encourage to maintain standards and ensure compliance (Bishai et al., 2008).

An alternative relationship based theory for social franchising is offered by Beckmann and Zeyen (2014). These scholars rely on Hayekian perspective to explain why social franchising is a suitable scaling up strategy. Austrian philosopher, August von Hayek, argues that individuals must navigate two types of social interactions, small groups where there is strong face-to-face relationships with shared goals, and big groups where anonymous interactions occur and people are directed by their own needs (Beckmann & Zeyen, 2014). Using small group versus big group logic, Beckmann and Zeyen (2014) suggest social franchising offers the advantage of scaling without forcing organizational growth. Social franchising "duplicates the original organization thereby replicating small-group conditions locally" (p. 16). Furthermore, under this framework, social franchising addresses resource scarcity issues and avoids opportunistic behavior because the relationship between the actors creates strong self-monitoring effects for the system (Beckmann & Zeyen, 2014). These scholars rely on an illustrative case to support their proposition.

Conclusions: What theories explain social franchising

There remains limited empirical work and no agreement on which theory best explains why social franchising has
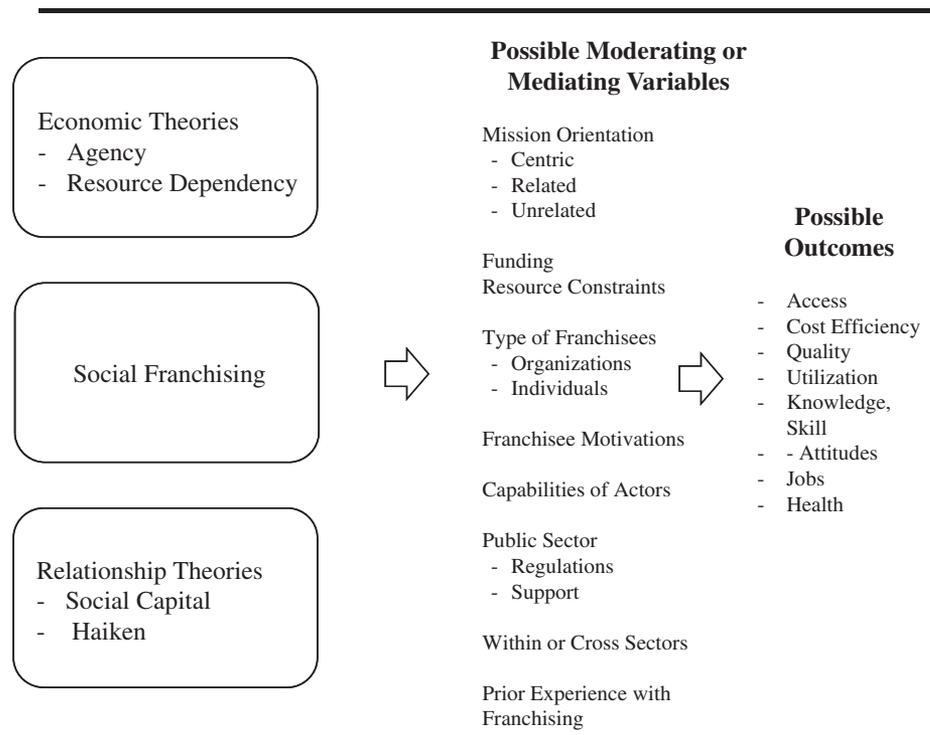
Figure 3. Conceptual framework for theoretical exploration.

been adopted as a channel strategy. The theoretical propositions to date use the lenses of (1) economics or (2) relationships. We maintain that both the economic view and the relationship view provide complimentary insights into the inter-organizational forms of social franchising. The integration of economic and relational theories allows for a wider range of theoretical lenses and introduces the pairing concept for scholars investigating the social franchise nexus. Our framework (see Figure 3) suggests that future scholars examine social franchising using at least one theory related to economics and one related to relationships. Such an integrative approach may be more capable of providing satisfactory explanations for the breadth of social franchise formats. We underscore what prior studies have thus far demonstrated. While Resource Dependency Theory and Agency Theory may elucidate economic reasons, and Social Capital and Hayekian Theory may explain the relationship rationale, each is insufficient on their own to fully explain the construct. Incorporated in the framework are possible factors that could serve to mediate or moderate social franchising outcomes. We believe our framework can be useful as a tool to identify potential influencing factors on performance evaluation. We do not suggest this as an exhaustive model, but as a means to use an integrative lens and guiding framework to which other theories and variables can be added in the future. We offer this as a building block that future scholars may

use to explore the construct in a more systematic manner.

Social franchisor selection practices

In social franchising, as in commercial franchising, the franchisee may be an individual or an organization. Mavra's (2011) report for the Social Enterprise Coalition notes that constraints to social franchising include selection of the wrong partner. This mirrors commercial franchising, especially cross-border franchising. The critical role of franchisees, both individuals and organizations, has just begun to be studied in the context of social franchising. Three articles were found that investigated franchisors' criteria for selecting franchisees; all used qualitative designs, but two journal articles reported results using the same data (see Table 2). Alur and Schoormans' (2011) work was part of a larger study aimed at understanding awareness and perceptions of social franchising amongst healthcare nonprofits operating in India. Using in-depth interviews, these scholars found smaller NGOs in India were not aware of social franchising. Of the two organizations using social franchising, only Population Services International (PSI) had a clear method of choosing doctors for the clinics they operate. PSI's criteria for selecting franchisees included a clinic location, patient profiles, doctors' interest in

Table 2. Studies of franchisor selection.

Source	Location	Methods	Sample; Response rate	Conclusions
Franchisor selection				
Alur and Schoormans (2011)	India	Exploratory Study using a multiple case studies format with in-depth interviews	8 NGOs	Two out of the eight used social franchising. One had clear and multiple criteria for choosing doctor's for branding the clinics with the franchisor's name and the other franchisor only required the franchisee to follow pricing guidelines.
Schlein, De La Cruz, Gopalakrishnan, and Montagu (2013)	Global study	Qualitative Study using self reported program data, scoping telephone interviews, in-depth field interviews and clinic visits	50 social franchise managers	Found evidence to support the 2002 conceptual model of social franchising that proposed assurance of quality was one of the three core goals of all social franchises. While quality assurance is incorporated in all areas of operation, the systems of measurement are not optimal.
Sivakumar and Schoormans (2011)	India	Exploratory Study using a multiple case studies format with in-depth interviews	8 NGOs	Lack of understanding about social franchising, apprehension about locating franchisees, concern about the ability to monitor and control to ensure quality.
Franchisor–franchisee relationship				
Nijmeijer et al. (2015)	Holland	Sequential Mixed Methods Study using observations, document analyses, semi-structured interviews, and cross sectional survey	3 Dutch Healthcare Systems (96 interviews); Cross sectional survey across 19 systems with 346 respondents	Franchisees experience more satisfaction working in the franchise when there is partnership with the franchisor, when they are informed, and have autonomy to fit the care to local needs. These types of relationships help ensure survival and quality of care.
Amar and Munk (2014)	India	Case Study Profile	1 Case	This case profile reflected on the critical nature of the franchisor-franchisee relationship. Findings from this case profile suggest command and control does not work and partnership is the better option.

PSI's area specialization, patient load, as well as doctors' willingness to be trained, maintain a level of quality and pricing per the contract (Alur & Schoormans, 2011). Sivakumar and Schoormans (2011) findings, using the same eight NGOs as Alur and Schoormans (2011) study, focused on reasons why the six organizations had not selected franchising. While six organizations expressed interest in social franchising after learning about the concept, the two main apprehensions for pursuing this channel strategy revolved around securing qualified franchisees and being able to control for quality.

Schlein et al. (2013) in-depth study of 13 clinical social franchises operating in Asia and Africa found that, among high performing franchises, the franchisors only recruited healthcare providers with a valid operating license and who offered a facility that allowed for privacy, a functioning toilet, hand washing facilities, and adequate drug storage. These scholars found that a few franchisors went even further and rated the clinic on ventilation, lighting, cleanliness, and adequate supplies of disinfectants and sterilizing equipment.

Though not an empirical study, Thurston et al. (2015) documented how both MSI, with 17 franchise networks, and PSI with 25 social networks, recruit providers. Given the limited number of qualified medical personnel, targeting potential franchisees is challenging. Records and site visits helped identify prospects. On the site visits, both organizations assess

Table 3. Studies of franchisee motivations to join.

Source	Location	Methods	Sample; Response rate	Conclusions
Franchisee motivation to join				
Huntington et al. (2012).	Myanmar	Uncontrolled facility based random sample using financial data, observations and interviews	228 franchisee interviews	Most common reason for physicians to join was access to high quality, inexpensive drugs, followed by feelings of helping the poor. Availability of training also rated high. Just over half reported their income increases after joining.
O'Connell et al. (2011)	Myanmar	Qualitative (focus groups)	12 focus groups (6–8 per group)	Non-monetary incentives emerged as drivers for joining (access to high quality drugs and the ability to helpt the poor). Initial concern that income would decrease from joining did not materialize.
Sieverding et al. (2015).	Ghana and Kenya	Qualitative study (in-depth interviews, qualitative exit surveys	47 franchisee interviews	Training found to be the main motivation to join the system. Another benefit was the consistent supply of commodities.

capacity using a standardized tool that is customized to the country of origin (Thurston et al., 2015). Some of MSI's franchise networks even create opportunities for prospective franchisees to speak with current franchisee providers in group settings. This form of exchange is used to ensure the prospect fully understands the benefits of membership (Thurston et al., 2015).

Given the importance of recruitment, greater understanding of how franchisees are selected is needed, along with studies that investigate attrition rates and the consequences of attrition. Furthermore, research that delves into the franchisor-franchisee relationship might also help identify factors that could help improve performance. To date, only one study was located that focused specifically on the franchisor-franchisee relationship. Nijmeijer, Fabbricotti, and Huijsman (2015) used a multi-embedded case study of three Dutch healthcare franchises using both a survey and interviews to investigate the impact of the relationship. These scholars found that trusting, cooperative relationships between the parties, along with low levels of conflict and opportunistic behavior helped to "ensure satisfaction, survival, and quality of care" (p. 1). A case study profile of Aflatoun, a social franchise that provides financial education or school children, suggests that the key to this organization's success is the relationship between the franchisor and franchisees (Amar & Munk, 2014). Understanding the importance of training, rather than using a centralized

hub approach, the Aflastoun model opted to train the franchisees "best trainers" at their own expense and then leverage that local expertise to train others in their region. In this organization, franchisees are referred to as partners and the organization creates opportunities for sharing of knowledge across regions.

Franchisee motivations to join

The social franchise concept is not possible without a franchisee. Prospective franchisee participants must see value in joining the franchise network (Thurston et al., 2015). Several prior empirical works have investigated the decision-making processes used by individuals to join a social franchise network. Two of these studies were from Asia and the other in Africa; all three studies relied on qualitative design (see Table 3).

A series of focus groups among PSI's Sun Quality Health franchisee providers in Myanmar explores provider incentives to join the network (O'Connell, Hom, Aung, Theuss, & Huntington, 2011). These individual franchisees initially reported the expectation of decreased earnings, though they found this did not materialize. Their incentive to join the network centered on serving the poor, increasing their own self-confidence, greater access to better medicines, training opportunities, and professional networking with other providers. Subsequently, several of the researchers in the above study conducted interviews with 228 franchisee providers in Myanmar to gain additional

insights on why physicians joined the Sun Quality Health franchise. The study reported that 96% of the providers indicated access to high quality and lower cost medicine was the attraction to join, while 95% were motivated by a sense of social responsibility. Furthermore, the study found access to training courses (87.7%) and professional networking (55.7%) also emerged as important considerations as well (Huntington, Mundy, Hom, Li, & Aung, 2012).

The final study we located on motivations to join a franchise network used semi-structured interviews of franchisees operating within three franchised networks in Africa operated by the two largest NGOs (MSI and PSI). Across the three networks, training was indicated as the main motivator for joining the network at the time of recruitment (Sieverding, Briegleb, & Montagu, 2015). A consistent commodity supply was also shared as a motivator by all three systems. In Ghana, providers indicated social value was an additional reason, while in Kenya the ability to have a wider network to provide support was valued. Few providers mentioned branding, a benefit frequently associated with commercial franchising (Sieverding et al., 2015).

While Azmat, Mustafa, et al.'s (2013) qualitative study of family planning in Pakistan focused on clients, in their research they also interviewed providers (franchisees). The providers reported an increase in their client base after partnering with the franchisor, and greater confidence in their ability to serve the community due to the medical training provided.

Social franchising outcomes

Since social franchising first emerged in Pakistan and Nepal to provide family planning access to the poor in the early 1990s (Montagu, Ngamkitpaiboon, Duvall, & Ratcliffe, 2013), it is not surprising that most of the empirical studies on the topic have been conducted in developing countries and have focused on health products and services. Four literature reviews have been conducted that summarize the empirical studies on outcomes of healthcare social franchising. Table 4 summarizes the four literature reviews, including the studies these reviews included, the types of social franchises, countries involved, methodologies used within the studies, main findings and limitations of the review. All of the studies in these four reviews were conducted between 2001 and 2013. After discussing these reviews we discuss an additional 9 studies conducted between 2013 and 2015.

The first systematic review (Patouillard, Goodman, Hanson, & Mills, 2007) investigated the impact of various private sector interventions (one being social franchising) on both perceived quality of service in franchised clinics and the franchised clinics' likelihood of serving the poorest groups. Patouillard et al.'s (2007) literature review found only three primary studies that used social franchising. These studies were in Africa, the Middle East, and Asia. With respect to client satisfaction with the quality of the franchised clinics, one study reported greater satisfaction, one study less satisfaction among customers, and one study showed no difference. Similarly, evidence of usage of franchise clinics benefiting the poorest segments of the population was also mixed. Patouillard et al.'s (2007) work has been criticized for including studies that lacked a high level of rigor (Koehlmoos, Gazi, Hossain, & Rashid, 2011). We offer the opinion that conducting research in developing countries is not a simple task and the scholars attempting these studies likely had a difficult path in obtaining data.

In 2009, Koehlmoos, Gazi, Hossain, and Zaman (2009), attempted a systematic review of social franchising's effect on access to and quality of health services in low-and middle-income countries. Criteria for study inclusion required Randomized Control Trials, Non-Nandomized Control Trials, Interrupted Time Series, and Controlled Before and After Studies. After a search of 2210 abstracts, these scholars found no study met their inclusion criteria. They reported that given the lack of rigorously defined studies in the field, no conclusions could be drawn about the impact of social franchising. Two years later, however, Koehlmoos et al.'s (2011) modified their inclusion criteria to allow observational studies (surveys, cohorts, case-controlled studies) and nine primary studies met the standard and were included in their subsequent systematic review. The amount of information in each of the nine studies varied with respect to core elements that comprise a franchising model. Out of the nine studies, seven described training franchisees, six mentioned branding, five discussed standardization and four described monitoring by the franchisor. This suggests that how the franchising model is delivered may vary. Koehlmoos et al. (2011) conclusion, based on a review of the nine primary studies, was that social franchising did not increase client volume, but franchise providers were more likely to be trained. Patient perceptions' of quality of care were mixed as was whether franchised clinics are more likely to reach the most needy populations. With respect to whether social franchising impacts the health-related

Table 4. Systematic reviews of healthcare franchising.

Authors	Empirical sources	Social franchise sector	Countries involved	Methodologies	Main findings	Comments
Patouillard et al. (2007)	3 Studies	Reproductive Health	India; Ethiopia, Madagascar; Nepal; Pakistan	Qualitative (Interviews); Quasi-Experimental	Utilization mixed; Quality of health services mixed; Equity mixed.	First study to clearly identify social franchising interventions. Rigor of the studies subject to question.
Koehlmoos et al. (2009)	NA	NA	NA	No study met criteria	Scholars indicated lack of rigor in studies made it impossible to judge efficacy of social franchising	Literature Review chose to disregard studies that these same scholars later used.
Koehlmoos et al. (2011)	9 Studies	Reproductive Health; TB; Family Planning; Prenatal Care	Ethiopia; India; Kenya; Madagascar; Myanmar; Nepal; Pakistan; Philippines	Randomized Controlled Trials; Non-Randomized Controlled Trials; Interrupted Time Series; Surveys; Case Studies; Analysis of public data to program deliverables.	Volume not increased. Franchise providers more likely to be trained but mixed perception of quality of care. Improvement in health related behaviors with respect to family planning. Mixed results for equity.	Broadening methodologies enabled scholars to provide some preliminary evidence on social franchising outcomes. Provided a comprehensive review and critique of studies.
Beyeler et al. (2013)	23 Studies	Reproductive Health; Child Health; Family Planning; TB	Ethiopia; India; Kenya; Madagascar; Myanmar; Nepal; Pakistan; Philippines; Vietnam	Quasi-Experimental: Cluster Randomized Trial; Cohort Study; Cross-sectional survey; Pre-post surveys; Case study	Positive impact on quality. Increases volume; and in some cases improves client health knowledge and behavior. No evidence it improves equity.	Broader number of studies included. Data shown and compared by outcomes.
Nijmeijer (2014)	15 Studies	Reproductive Health; Pharmacy; TB; Prenatal care; Family Planning	Canada; Ethiopia; India; Kenya; Myanmar; Nepal; Pakistan; Philippines; USA; Vietnam	Pre-post non experimental design, Survey; Pre-post quasi experimental design; Cross-sectional; Longitudinal; Quasi-experimental; Archival case	Positive or no effect on perceived quality of service; positive for quality of facilities and supplies. Client satisfaction mixed, as was access to services. Positive or no evidence on effect on preventive care, but no relation with utilization of healthcare.	Studies from developing countries also included. Scholars reluctant to draw conclusions, but suggest patterns emerge that indicate healthcare franchises perform better or at least as well as non-franchised healthcare entities on physical accessibility, utilization, client volumes and quality of service.

behavior of the population, Koehlmoos et al. (2011) concluded that the studies were not rigorous enough to make that assessment.

The third systematic review of franchising in a clinical context, conducted by Beyeler, York De La Cruz, and Montagu (2013), examined the impact on health services in low and middle-income countries. These scholars included empirical work that used Randomized Trials, Cohorts, Quasi-Experimental Designs, and Cross-Sectional Survey Studies. The 23 studies that met the reviewers' criteria were segmented by five outcomes: quality, health knowledge, increased utilization, cost effectiveness, and equity. These scholars found no studies that evaluated health outcomes, rather they found studies focused on client satisfaction, perceived quality, client volume, and utilization. Contrary to Koehlmoos et al.'s (2011) findings, Beyeler et al.'s (2013) review of primary studies suggested some support that social franchising increases client volume and client satisfaction, and in some settings improves client health knowledge. From their analysis, Beyeler et al. (2013) concluded that social franchising: (1) is an effective intervention in some contexts, specifically where there are a large number of unregulated private clinics; (2) is an efficient way to introduce new services in existing private practices; and (3) should be expanded to arenas other than reproductive health care, such as child health and TB services.

The most recent systematic literature review of empirical studies on healthcare, Nijmeijer's (2014), identified 15 primary studies for analysis. Both qualitative and quantitative studies were included, but to qualify for inclusion the studies had to compare franchise and non-franchise pre-post franchise or different franchise systems. The studies also had to focus specifically on franchising. Unlike prior reviews by Koehlmoos et al. (2011) and Beyeler et al. (2013), Nijmeijer's (2014) review did not limit empirical work from only low and middle-income countries, and studies from the US and Canada were also included. Nijmeijer (2014), similar to prior work, also acknowledges that the body of empirical knowledge has methodological limitations. She does suggest that evidence supports the fact that franchising can be valuable to healthcare practices, particularly those in low-and-middle income economies. Furthermore, healthcare franchisees "appear to perform better or at least as well as non-franchise healthcare entities on physical accessibility, utilization, client volumes and quality of services as it relates to facilities and suppliers, the provider and client satisfaction" (p. 38).

With respect to more recent empirical studies focusing on outcomes, our literature search yielded an additional nine social franchise studies focused specifically on outcomes (access, utilization, cost efficiency, and quality of care). All of these additional empirical studies are clinical, conducted in low or middle-income economies, and published since 2013 (see Table 5). Across the nine studies, the organizations using social franchising included PSI (4), MSI (3), and Alive & Thrive (2). The empirical research methodology varied, but only three used some form of a control design (Cluster Randomized or Quasi-Experimental), with the rest relying on Record Reviews, Cross Sectional Surveys, or Interviews and Focus Groups. The findings suggest that social franchising has improved the quality of care (Azmat, Shaikh, et al., 2013; Nguyen, Kim, et al., 2014; Nguyen, Menon, et al., 2014; Sensalire, Byansi, & Akinyemi, 2015); attitudes, awareness and knowledge (Azmat, Mustafa, et al., 2013; Azmat, Shaikh, et al., 2013; Nguyen, Menon, et al., 2014; Sensalire et al., 2015); as well as access to medical care (Montagu, Sudhinaraset et al., 2013; Munroe, Hayes, & Taft, 2015; Sensalire et al., 2015). Findings regarding utilization of social franchise clinical services, on the other hand, were mixed. Two studies indicated that utilization of clinical services/products remained low (Nguyen, Menon, et al., 2014; Sensalire et al., 2015), but Azmat, Shaikh, et al. (2013) found usage of contraceptives improved. Divergent findings on client satisfaction were also noted. Munroe et al. (2015) found high client satisfaction, while Nguyen, Kim, et al.'s (2014) study found no statistical difference in satisfaction scores between franchise and non-franchise clinics.

Two of the empirical studies we located focused specifically on the cost of services. One study (Bishai et al., 2013) reported a benchmark figure for the cost of care without making a claim to the positive or negative aspect of the spending per person. That benchmark was published in 2013. Two years later, Bishai et al. (2015) reported that developing a network of franchisee providers in a social franchise was highly cost effective in terms of dollars per disability-adjusted life years (DALYs) averted. While there is no universal method to assess the health impact of social franchising, Montagu, Ngamkitpaiboon, et al. (2013) argue that using DALYs averted offers a more robust measure of health impact of social franchise endeavors than patient volume and number of outlets. One method of obtaining the data to calculate DALYs averted is through the tracking provided by the

Table 5. Clinical social franchising outcome studies from 2013 to 2015.

Source	Location	Methods	Sample; Response rate	Conclusions
Clinical – Social Franchising Outcomes				
Azmat, Shaikh, et al. (2013)	Pakistan	Quasi Experimental study design using surveys	Intervention baseline/endline survey (2,483/1,984). Control baseline/endline survey (2,509/2,019).	Social franchising along with vouchers significantly increased awareness and usage of contraceptives in rural Pakistan,
Azmat, Mustafa, et al. (2013)	Pakistan	Qualitative exploratory study using focus groups and interviews	6 Randomly selected intervention districts of 18 project districts in Sindh and Punjab	Clients reported the clinics (social franchises) were a source of information, associated the clinics with accessibility, affordability, and quality care.
Bishai et al. (2013).	Myanmar	Qualitative study using interviews with staff and analysis of financial reports	7 Staff members in the central Yangon office	Benchmark to determine spending of per care episode. PSI Myanmar is spending $2.7 per private sector medical care episode in efforts to increase quality, affordability, accessibility, and usage in its network.
Bishai et al. (2015).	Myanmar	Retrospective review of financial data	104 Village tracts matched in 52 comparable randomly assigned pair	Investing in developing a network of private sector providers and keeping them stocked with ORS-Z as is done in a social franchise can be a highly cost-effective in terms of dollars per DALY averted.
Montagu, et al. (2013).	Myanmar	Analyzed data from national TB study from the National TB Program and conducted exit interviews	375 Interviews; 739 Survey participants	Franchised clinics in Myanmar are reaching poor populations of TB patients in urban areas (increasing equity), but no difference in urban settings with respect to socio-economic status.
Munroe et al. (2015)	Africa and Asia	Exit interviews; Program monitoring data; and Clinical quality audits	Exit interviews with 4,844 clients across 14 of the 17 franchises.	Social franchising increased access to family planning services, for the general population as well as young women and the poor. High levels of client satisfaction recorded.
Nguyen, Kim, et al. (2014)	Vietnam	Cluster-randomized impact evaluation using surveys, observations, exit interviews and in-depth interviews	Facility assessment ($n = 32$), observations ($n = 137$), structured interviews with clients ($n = 137$), with health providers ($n = 96$), in-depth interviews with franchise users and non users ($n = 48$)	Incorporating elements of social franchising significantly enhances the quality of infant and young child feeding counseling services within government primary healthcare facilities. Utilization remained low, and client satisfaction not statistically different between the two groups.
Nguyen, Menon, et al. (2014).	Vietnam	Cluster-randomized impact evaluation using interviews and surveys, and observations	Interviews with franchise board members ($n = 12$) surveys with health providers ($n = 120$), counseling observations ($n = 160$), household surveys ($n = 2045$)	Findings suggest franchising increased the capacity of providers improving the quality of care for mothers, but monitoring should be improved. Mothers also showed improved knowledge, beliefs and intentions towards breastfeeding practices. While franchise utilization increased (among users) it fell below goal suggesting with that while quality of care increases and current users visit more frequently, there is still an issue in terms of increasing overall demand for services.
Sensalire et al. (2015)	Uganda	Longitudinal cross sectional survey	53 districts hosting 194 privately owned health facilities branded $n = 1,460$ (2012), $n = 1,604$ (2013).	Social franchising improved client perceptions of (1) availability of Long-Term Contraception (2) quality of care at facilities (3) improved knowledge, but did not show any increase in usage of this type of contraception.

University of San Francisco's (UCSF's) Global Health Group. This group facilitates exchange with social franchise programs in the health sector and compiles a Compendium of Clinical Social Franchising Programs operating in Asia, Africa, and Latin America (Montagu, Ngamkitpaiboon, et al., 2013). This measure encompasses a broad array of health services, enables benchmarking of an entire franchise network's performance between programs, and can be used to track cost-effectiveness. The limitation of this method is that it relies on accurate and complete service data to be reported.

In the clinical arena, the nine recent studies we reviewed, combined with the four literature reviews, reinforce that social franchising can provide a higher quality of service, allow greater access to healthcare, and impact attitudes and knowledge among local populations regarding health matters. The research, however, is less clear on the impact with respect to increasing utilization. Furthermore, cost effectiveness of social franchising remains ambiguous, as methods to evaluate are only recently emerging.

Discussion and implications

The success of the franchise model *commercially* has attracted interest *socially*. While this review has shown that the pace of research on social franchising has accelerated, there is still much to be learned. Studies on clinical social franchising have offered the most robust data to date, but these have been subject to criticism based on methodologies used. At this stage we wish to reflect on the overview of the literature used in this sample and identify future research questions. We have separated these into the themes of *implications for research* and *implications for social franchise practice*.

Implications for research

From a review of both prior conceptual and empirical literature we can readily acknowledge that social franchising covers a broad range of entities. We suggest Alter's (2007) typology offers a way for future scholars to consider social franchising as a broad umbrella that can be operationalized across a continuum of organizational formats. The defining feature of a social franchise is the presence of a managing agent (the franchisor) and providers (franchisees) who offer the service or products. The franchisor may be an NGO, a nonprofit, a social enterprise, a public agency, a for-profit organization or some combination of these

formats. It is likely that addressing a social need is a driving motivator, but the classic for-profit motive may be present (e.g., when the social franchise is used to supplement charitable donations or grants with earned revenue). Furthermore, the franchisee may be an individual or an organization and they may be either fully or only partially using the franchise concept. These numerous configurations present a challenge for researchers and suggest the need for scholars to develop a more coherent framework that classifies different forms of social franchising. A precise typology of social franchising would be a welcome addition to the literature. We suggest that in addition to a legal lens (e.g., Crawford-Spencer, 2015), other classifications such as financial, sociological, psychological, or managerial perspectives could aid in model building.

This review illustrates that the scholarly research on social franchising is heavily focused within the clinical arena and assesses intervention outcomes. This is likely due to the fast pace of health interventions across developing nations that have embraced social franchising as a channel strategy. Furthermore, two very large organizations using social franchising (MSI and PSI) have been in existence for over 15 years. Of the nine empirical studies published since 2013, seven involved the MSI or PSI organizations. This review found that the services and products distributed ranged from family planning counseling, tuberculosis treatment, oral rehydration education, to assistance with infant feeding practices. The research designs among these studies also varied. Finally, outcomes measured focused on either some health impact (such as awareness and usage), cost effectiveness, quality of service, or equity for poorer populations.

This leads to three key questions. The first of which is, what is the best way to secure evidence of the utility of franchising as a mechanism for solving social problems? Unlike commercial franchising where business success is typically measured with sales, profitability and longevity, in social franchising the broad array of social issues means different objectives. The second question is, how should social value be measured? In the healthcare arena there is a call for standards to address the reporting issues and agree upon metrics that offer utility in measuring outcomes (Montagu, Ngamkitpaiboon, et al., 2013; Nijmeijer, 2014). The third question is, how can social franchises integrate metrics into their management systems? We suggest that there would be value in creating at least one success criterion that is universally applicable

across social franchise endeavors. Franchisee sustainability could be a viable option.

Beyond the realm of healthcare, social franchises address other mission centric goals such as prison reentry pathways, supportive employment for significantly disabled individuals, and community economic sustainability. At best, from our overview of the literature, we found only illustrative cases of failures and successes reported in practitioner literature. Because of the variety of contexts, researchers need to delve more closely into what aspects of the franchising model are being fully used in these organizational forms and how adoption of these elements (e.g., training, branding, compliance) impacts sustainability? At present there is virtually no scholarly support for social franchisors outside the healthcare arena, leaving these organizations to learn from trial and error.

Finally, this review uncovered limited use of theory. We recommend scholars incorporate theory building to investigate the social franchising phenomenon at the organizational level, as well as the individual level. Beyond the few studies that attempt to explain the emergence of social franchising using a theoretical lens, we need research that offers theory to predict what factors influence performance and sustainability. Theory can also help make sense of existing findings and develop a record for future scholarly pursuits. Some questions that could be explored at the organizational level: are certain types of social ventures or certain contexts where social franchising is a successful scaling strategy and those where it is not; and what types of funding mechanisms predict performance and sustainability? The questions arising at the individual level include: what are the characteristics of franchisees that predict success; and what affects the relationship between the franchisor and franchisees in a social franchise? The conceptual framework we provide offers a building block for future research to investigate different forms of social franchising and provides influencing variables to consider.

Implications for practice

The long-standing and well-published success of the commercial franchise model is clearly attracting individuals and organizations. However, in the case of NGOs, public sector agencies, and nonprofit organizations there may be a lack of fundamental business and commercial acumen (Litalien, 2006; Tracey & Jarvis, 2007), as well as understanding of core franchising tenets. While not all of these organizations lack business savvy, research is replete with mission-based organizations that struggled, some to the point of complete failure, due to a lack of understanding and applying foundational business practices (Dacin, Dacin, & Matear, 2010). When organizations utilizing a social franchise strategy lack formal education on the franchise model, do not seek or hire individuals with commercial franchise experience, or do not monitor activity they elevate the risk of failure. A theme evident in this literature review is the need for knowledge and understanding about the array of franchise models and the core elements required for success. Practitioners need access to more information on different types of franchise models, including area/regional developer, master/sub-franchise and co-branded models. To date, most individuals and organizations have applied the commercial model in a limited fashion, relying primarily on the single-unit approach whereby the franchisor grants a franchise to an individual franchisee.

Based on this situation, our first implication is that organizations that support social franchising activities, including the International Center for Social Franchising (ICSF), the European Social Franchise Network (ESFN), and The Social Enterprise Coalition (SEUK) connect with franchise associations (the IFA; the British Franchise Association; the Franchise Council of Australia) or retired franchisors who are seeking to give back to society. These support organizations and retired individuals with experience in franchising could help bridge the knowledge gap. While networking across organizational boundaries is difficult, Austin et al. (2006) make the salient point that social issues require more resources than any single organization can provide.

Another theme that emerged is that social franchising struggles with recruitment of franchisees who will be able to build and sustain the model. This is due to several reasons. First, there are less stringent requirements to join as prospects may be funded by donors (Crawford-Spencer & Cantatore, 2016); second, the franchisee pool is heavily skewed toward a population from a disadvantaged background where there has been no exposure to a business culture (du Toit, 2014); and third, even when the franchisee pool is an educated population there is little knowledge of how a franchise system operates (du Toit, 2014). The literature in this review suggests that only long-standing organizations using social franchising (PSI and MSI) have formalized franchisee selection practices. Our second implication for practice, therefore, is that social franchises need to have clear criteria established

for selecting franchisees and mechanisms in place to maintain control of the brand.

The third implication is policy related. It is clear that funders are interested in supporting more efficacious approaches to addressing social issues; however, it must be in an environment that prevents fraud, abuse, and waste. To minimize problems while fostering the prospects of franchising, host governments need to consider regulations. These may be in the form of guidelines or reporting requirements, but will likely need to include some 'on-site' monitoring in the early stages. Governments will also need to collaborate with social franchisors to build networking opportunities with potential franchisees to assist with expansion, and facilitate information flows to targeted populations that help improve utilization of the services or products provided by the social franchise. With respect to protecting the franchisee, there may need to be a legal infrastructure that ensures these individuals have enough information to make an informed decision on whether to participate.

The fourth implication and challenge is the need for robust empirical evidence to optimize social franchising models. To help bridge the gap between research and practice, there needs to be more emphasis on data driven inquiry. Given the past three decades of franchise research, coupled with the proliferation in social franchise activity, a significant opportunity for new, high-valued research in social franchising has emerged. Research on the impact of funding sources, actor selection, and model integration should be moving into the fray to fill in the gaps of this burgeoning segment of activity.

Conclusion

Adoption of franchising as a channel strategy is being tested with growing frequency and this review has identified the intellectual territory that has been explored within this emerging field. Within the health arena where findings have been published, the evidence suggests that effectiveness is highly specific to the context and to particular details of how the franchise system operates. Outside of the health arena only illustrative case studies could be found to suggest the implementation of a social franchising model can effectively address societal needs such as hunger, chronic unemployment among the disadvantaged, or environmental issues that blight communities.

Based on our review, we see the need for (1) a classification system of the various forms of social franchising, (2) agreement on measures of social value, (3) theory development to aid in the generalizability of findings, (4) networking between social enterprise organizations and either franchising associations or retired franchisor executives for knowledge transfer, and (5) more empirical research to provide a suitable roadmap.

It is important to recognize some of the limitations of this literature overview. Although multiple sources were reviewed, it is likely that some relevant literature was excluded or overlooked. Furthermore, adding related search terms (e.g., tandem franchising, micro-franchising, and fractional franchising) could serve to add new information that relates to social franchising. These limitations present opportunities for future work and continued exploration of this emerging phenomenon.

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