

AUGUST 2019

Engaging India

*Guide to Developing Health Care
Partnerships with States*

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A Report of the CSIS WADHWANI CHAIR IN U.S.-INDIA POLICY STUDIES

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CSIS | CENTER FOR STRATEGIC &
INTERNATIONAL STUDIES



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Introduction

India's 2017 National Health Policy ushered in a national dictate to expand and align the role of the private sector with public health goals.¹ The policy envisages broader partnerships with a range of non-governmental stakeholders to address critical gaps in care. In addition, the 14th Finance Commission recommendations gave Indian states more fiscal power to allocate health expenditures.² In response, states are undertaking new partnerships and creating policy environments that foster innovation and entrepreneurship in the health sector.

EXAMPLE OF STATE SUPPORT

Goa has actively sought collaborations to address the population's most urgent health needs: partnering with Novo Nordisk to address diabetes and cardiac issues; inviting private hospitals to join the state's ST-Elevation Myocardial Infarction (STEMI) program to expand access to cardiac treatment; and signing a memorandum of understanding with the University of Miami to treat stroke.

These efforts to support partnerships are a welcome opportunity for stakeholders looking to impact health care more broadly. Given the Indian government's outsized role in shaping and delivering health services, partnering with the public sector is often critical for success, enabling stakeholders to access new revenue sources, patient networks, and an extensive health care infrastructure. Yet

stakeholders often find these partnerships challenging, reporting difficulty throughout the collaboration process.

To help stakeholders navigate these difficulties, Innovations in Healthcare at Duke University launched the Indian State Health Innovation Partnership project in partnership with the Center for Strategic and International Studies. Previously, the research team interviewed and surveyed health care leaders in the public and private sectors to identify health care priorities and areas ripe for collaboration across Indian States. The report *Indian State Priorities for Health Innovation Partnerships* summarizes the findings.³

1. Ministry of Health and Family Welfare, Government of India, *National Health Policy, 2017* (New Delhi: 2017), https://www.nhp.gov.in/NHPfiles/national_health_policy_2017.pdf.

2. Anit Mukherjee, "India's Budget for Health Puts the Ball in States' Court," Center for Global Development, March 1, 2016, <https://www.cgdev.org/blog/indias-budget-health-puts-ball-states-court>.

3. Rick Rossow et al., *Indian State Priorities for Health Innovation Partnerships* (Washington, DC: CSIS, 2019), <https://www.csis.org/analysis/indian-state-priorities-health-innovation-partnerships>.

In the next phase of the project, the research team interviewed 20 stakeholders from multi-national organizations, small to medium social enterprises, private health systems, and U.S.-based universities who have successfully formed partnerships with Indian state governments in the past. The team followed the “data saturation method,” collecting data until no new themes emerged.⁴ The paper which follows is a result of this research. It is designed to help stakeholders—institutions, innovators, commercial actors, researchers, or practitioners—understand the bureaucratic, political, and administrative complexities of Indian states. Though there is no silver bullet for success, the lessons learned through this project can act as guideposts for organizations that seek to work with Indian state governments.

4. Benjamin Saunders et al., “Saturation in qualitative research: exploring its conceptualization and operationalization” *Quality & Quantity* 52, no. 4 (2018): 1893-1907, <https://link.springer.com/article/10.1007/s11135-017-0574-8>.

Developing Strategic Approaches

Be prepared to navigate a complex—and often slow—bureaucratic system. Stakeholders pointed to complex bureaucratic, political, and administrative processes as top factors hampering partnerships. As Figure 1 depicts, health care governance in India is hierarchical and bifurcated between the national and state governments. Though the Ministry of Health and Family Welfare is responsible for health policy, regulation and oversight is dispersed across many governing institutions, often with overlapping remit. This has created a compartmentalized and fragmented system, leaving stakeholders unclear on which departments and officials to approach. The center-state balance can also be difficult to reconcile. During our interviews, a few state health agencies noted that forging international partnerships required the assent of the central government, while other states did not indicate such assent was required. As one stakeholder described, the public sector feels like a “massive opaque structure.” Some states, such as Uttar Pradesh and Bihar, recognize these challenges and are designing integrated public health projects that cut across different verticals. These reforms are promising but may be slow to materialize. In the meantime, be prepared to seek many layers of approval across various governmental entities to move a project forward.

Identify and continuously engage the right national institutions. For instance, at the national level, the Department of Biotechnology and the Department of Science and Technology (both under the Ministry of Science and Technology) can serve as important supporters of new technologies. One Indian enterprise advised staying in contact with these entities during product development, particularly as they are willing to support innovative startups.

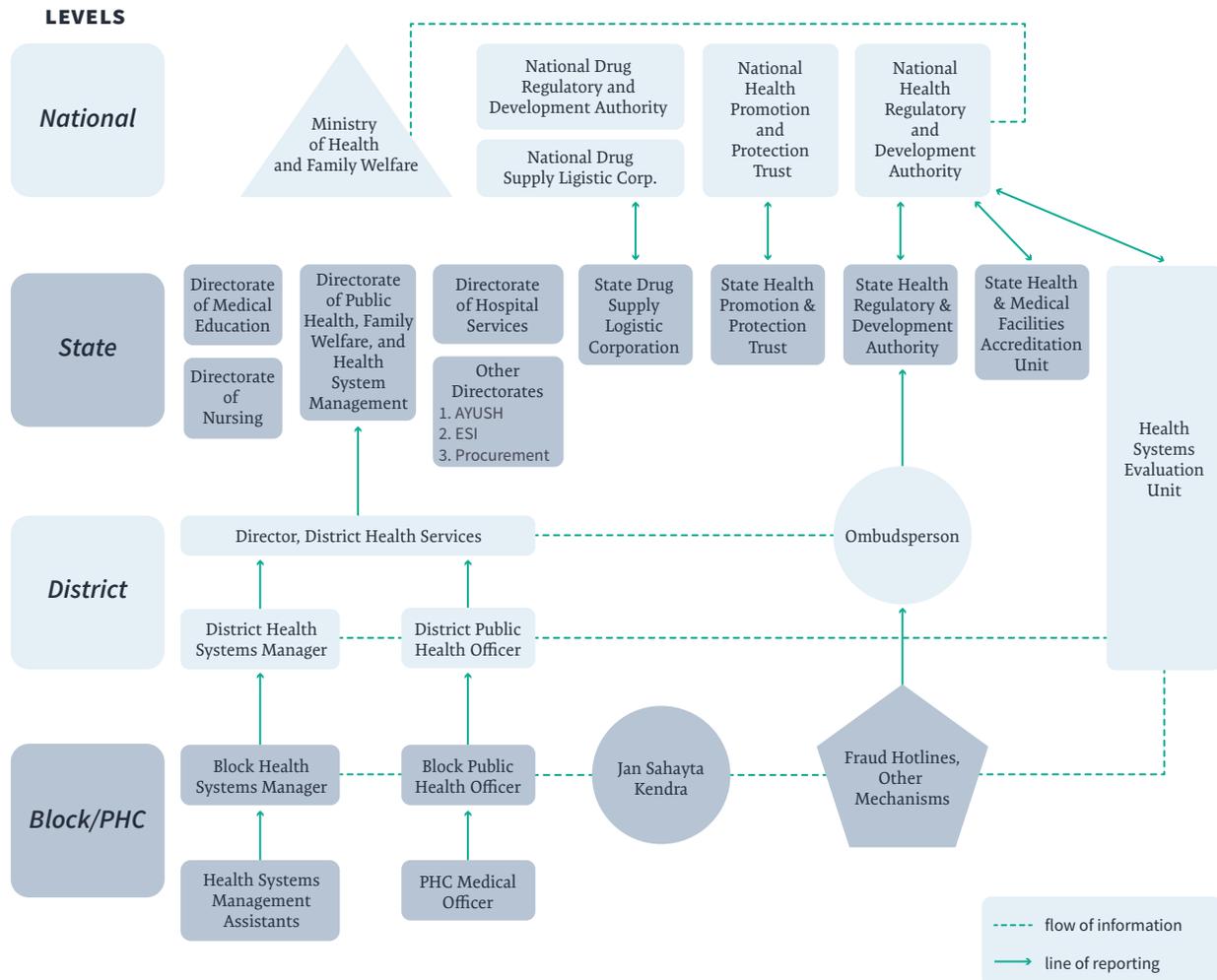
“If the individual has the vision, it can be rolled out quickly. If they get transferred, then the next person may not have the vision”

– from an interviewee

Target the right state- and district-level officials. It is critical to have support from the principal secretary of Health and the director of the National Health Mission in any state of operation. However, the intricacies of the approval and implementation process will differ from state to state. Approval from a

senior-level official is a necessary step, but a lower-level technocrat will ultimately be charged with implementation. Project success hinges on their continued engagement and

Organization of the Health System in India



Source: Planning Commission of India, 2011.

Indrani Gupta and Mrigesh Bhatia, "The Indian Health Care System," *International Health Care System Profiles, The Commonwealth Fund, 2017*, <https://international.commonwealthfund.org/countries/india/>.

interest. However, be aware that new projects are an additional duty for them. To reduce their workload burden, identify areas of alignment between new projects and current responsibilities.

Find a well-connected advocate with institutional knowledge. Stakeholders emphasized the importance of partnering with individuals, officials, or institutions who can navigate the political and bureaucratic system and identify, access, and effectively communicate with appropriate government officials. These individuals have often worked in government previously, have maintained positive relationships with public officials, and are persistent and meticulous in their interactions. Government officials can also serve as advocates and will often introduce and champion successful organizations to other states. Some interviewees recommend partnering with larger established international

organizations (like the U.S. Agency for International Development) to provide smaller unknown enterprises with credibility and access to government officials, as well as greater commercial reach. Local non-profits with long-standing community ties can also help outside organizations build trust with government officials.

There is no perfect recipe to picking the right state. Stakeholders chose states using a range of criteria, from favorable political and regulatory environment, existing need, or existing funders. For instance, one respondent noted the importance of political alignment between the state and the national government. If the central and state political parties are the same, states can more easily find resources for projects. For other organizations, having a champion to shepherd new projects is the most important factor for guiding partnerships. For instance, Noora Health ascribes part of their success to secretaries of health interested in health education. In other cases, public-sector officials helped expedite and steward projects through the approval process. However, as the vice president of one multi-national company stated, “all of the criteria I would have thought were relevant to choosing a partner state don’t necessarily apply . . . it is more a question of if our technology is a fit between what they want to do.”

CASE STUDY: APOLLO TELEHEALTH

Apollo TeleHealth (ATHS) is a multispecialty telehealth division of Apollo Hospitals, a large private hospital chain in India that has operated in South Asia for over 35 years. In 2000, Apollo began using telemedicine services, launching India’s first virtual hospital in Aragonda, Andhra Pradesh. ATHS provides cost-effective telemedicine services to patients in remote areas, ranging from general consultations to advanced services such as intensive care, emergency care, and telementored surgeries. Through public-private partnerships (PPP) and corporate social responsibility projects across multiple states, ATHS has touched nearly 8 million lives and delivered more than 800,000 teleconsultations.

With support from the Himachal Pradesh state health secretary, ATHS launched its first PPP, providing tele-emergency services in Himachal Pradesh, a rural and mountainous state with limited transportation and acute physician shortages. One year after its launch, the ATHS-Himachal Pradesh PPP was evaluated by the National Health Systems Resource Centre, an institute within the Ministry of Health that provides technical assistance and capacity building. The favorable assessment led to numerous partnerships with other states. ATHS quickly developed two PPPs with the government of Andhra Pradesh, operating and maintaining 183 electronic urban primary health centers and running 115 vision centers via tele-ophthalmology. Examples of other state partnerships include Jharkhand, where ATHS has converted 100 Primary Health Centers into digital dispensaries, and Uttar Pradesh, where ATHS has equipped 134 Community Health Centers with tele-radiology services and 120 centers with specialty telemedicine services. According to ATHS, they are now connected to over 300 million Indians remotely and operate over 700 tele-clinics through PPPs.

Vikram Thaploo, CEO of Apollo TeleHealth, credits the public sector with extending AHS's reach to underserved populations. State governments provide access to a large and regular user base, creating consistent demand that can be critical for scale. To develop state-level partnerships, Thaploo recommends perseverance and focus: identify and target one challenge single-mindedly.

Building Long-Term Relationships

Elections in India are frequent and can have an outsized influence on the success of an enterprise, quickly upending relationships that took time to cultivate. Below are steps organizations took to address this challenge.

EXPERT TIPS

Noora Health, a non-profit educational platform, has successfully operated across four states in India. They recommend staying aware of power dynamics, carefully choosing which employee interacts with key officials. Experienced individuals have more clout and are more likely to achieve greater results than junior staff. Also, individuals should focus on maintaining a positive rapport. “How can you help them [government officials] make their work easier?” recommends Shahed Alam, Noora Health president and co-founder. Alam points to patience and perseverance as key to Noora’s success. It took almost one year of consistent engagement with one government official to gain their support. “Timing matters most,” advises Alam.

Be the first one in the door and be mindful of political trends. Once a new government is in place, proactively establish relationships to ensure that your ideas and initiatives are considered after the dust settles. To do so, some stakeholders timed partnerships according to election schedules, choosing states with distant elections. Administrations are also more willing to partner immediately after elections, given the longer political horizon.

Keep close tabs on and adjust to political trends, even outside of election cycles. If a political administration turns over, tailor your proposal to align with new political priorities. This may not be always be

feasible. To blunt the effects of unpredictable political trends, some organizations bank on the strengths of their product by demonstrating the effectiveness of their model. As one individual stated, “The trick is how to set up something quickly and earn a good name so [administrations] that follow will continue it.”

Heed election regulations. The Election Code of Conduct prohibits external entities from entering into a contract with state governments during election time. This occurs the moment the Election Commission of India announces the election date, which varies but is typically two months before voting begins. During this time, negotiations on significant projects with the government—that could be seen as politically helpful to the incumbent government—must stop until the post-election government is formed. In the best case, this is a temporary delay. In the worst case, organizations may need to restart negotiations with a new governing party. Note that new governing parties may oppose or re-prioritize the policies and projects of the previous administration—sometimes merely

out of political expediency—regardless of the proven efficacy of a project or venture. To mitigate this, some organizations choose to work in states with consistent policies. As an example, stakeholders cited Tamil Nadu’s stable development initiatives, which have led to flourishing private-sector partnerships.

Demonstrating Credibility

Develop a convincing “pitch.” Once you have identified the right state and public official to target, craft a customized and persuasive pitch. To do so, understand the state’s current needs or other information that may be most compelling to that particular official. Evidence of success can be powerful in a pitch as public officials are often risk averse and not likely to endorse new, untested ventures. However, be prepared to make a long-term investment to gain buy-in. Trust is typically accrued incrementally over time.

Show evidence of success. Government officials value evidence of success, which can allay concerns about backing new ventures. There is no uniform assessment criteria or process across states. For instance, in Tamil Nadu, all proposals must include an independent technology assessment, a cost benefit analysis including cost of treatment, and a Disability Adjusted Life Years calculation.⁵ Stakeholders mentioned that some states have specific committees that formally evaluate technologies, influencing the state purchasing agencies to update existing tenders. Though the evaluation process can take up to two years, innovators have found it beneficial to demonstrate impact to public-sector officials.

What officials value—cost-effectiveness, scalability, operability, or patient outcomes—varies. According to one public servant, officials tend to lean on evidence that supports their existing biases. It is therefore important to understand which metrics are important to which government official. In the experience of one individual, “Every person had some sort of question about the program and some evidence or detail they needed. These were not standardized . . . You have to build the organizational capacity to address that.” Ultimately, we found cost be the most important and common factor guiding an official’s decisionmaking. Organizations factor this in to make a bid competitive. Noora Health, for instance, supports staff and operational costs while the states allocate funds for program implementation.

Showcase prior work. State officials value products of services that have been implemented and scaled previously. To do so, some organizations shoulder upfront costs for a pilot project. Several stakeholders also emphasized the importance of attributing and highlighting the state’s role in a project’s success. Doing so can be an important lever to getting buy-in from other state officials. It also increases visibility, with officials likely to showcase a pilot with a demonstrated record of success.

5. Darez Ahamed, “Session - Improving Health through Collaboration: Partnerships between India and the United States,” Duke University India Health Conference: Innovation, Policy and Research, December 13, 2018.

Target and include the right people. Some organizations recommend approaching the central government first to get approval and referral to state officials. This can help open discussions, but it is important to maintain focus on courting state officials who ultimately have control. Additionally, public officials value “homegrown” organizations with local roots. According to several interviewees, non-Indian organizations should hire a mix of international and Indian staff for relationship building. In the experience of one foreign entrepreneur, having an Indian-based business and staff with local connections was vital to their success.

Meet the states where they are. State governments are usually not looking to build new systems. In interviews, public officials clearly preferred technical assistance in response to real needs. As one stakeholder noted, “If you want to scale in India, you need to be flexible with the needs and processes of [your government] partners.” The standard approach is to identify requests for proposals (RFP), which are published regularly on state and national ministry websites. Unsurprisingly, obtaining government support for unsolicited proposals is more difficult. One approach is to proactively develop projects with the government. RTI International, for instance, found success in actively building partnerships with governments by both applying to RFPs and co-creating projects with government stakeholders.

CASE STUDY: SEVAMOB

Sevamob is a social enterprise that provides comprehensive primary care through a subscription-based model. Care includes general health, vision, dental, nutrition, cardio-metabolic, infectious disease, ENT, and more. They offer consultation, diagnostic services, and treatment, onsite and remotely. The service incorporates the use of technologies like artificial intelligence. Several factors have contributed to Sevamob’s success:

- Sevamob works directly with individual districts, a unique approach that requires numerous distinct contracts but allows them to quickly reach a large number of patients. “While national guys have big budgets, sales cycles are longer. District-level guys often have small discretionary budgets and shorter sales cycles,” says Shelley Saxena, Sevamob’s founder and CEO.
- Flexibility is critical to success. Sevamob first piloted a program at the district-level for a nominal fee. The pilot was successful, piquing the interest of other districts. Sevamob catered to each district’s needs, knowing that initial users are critical for spread. “If you are able to satisfy the first couple of sponsors, it snowballs into much bigger deals. Even if something is not part of the original scope or if they ask for a deeper discount, it is a good trade-off if you get a good customer reference from them,” Saxena says.
- Sevamob collaborates with other public-sector industries. For instance, Sevamob provides care for Indian Oil (a state-owned utility company) employees, which offers steady revenue and a large customer base.

- Sevamob works with other local partners that hold their own contracts with district-level authorities. This simplifies the regulatory process and helps Sevamob connect with the appropriate officials. “If someone already has a relationship and you are a vendor through that relationship then you can go forward more easily. If you are cheaper, then they have the incentive to work with you.”
-

Ensuring Financial Stability

TIPS FOR FINANCIAL SUSTAINABILITY

- Use sustainability frameworks to design and evaluate your project, which can help demonstrate evidence of success to state officials.
- Consider co-hosting workshops or co-writing publications with state officials to gain buy-in.
- Work with officials to incorporate findings from existing programs, such as improved health outcomes and cost-effectiveness, into state-level health policy and programs.

State health care budgets are often unpredictable.

The national government distributes health care funding to states through annual fiscal transfers. While the federal government has increased the percentage of “uncommitted” transfers to the states, funding is often earmarked, with clearly defined stipulations to which states must adhere.⁶ Due to bureaucratic and administrative challenges, states typically underutilize funding for both committed and uncommitted transfers,

with unspent balances ranging between 40 to 76 percent for some programs.⁷ However, committed funding has better utilization rates than uncommitted expenditures, meaning funding for novel initiatives is less likely.⁸ Unspent funding can be returned to the central government, re-allocated for other purposes, or carried over to the next financial year.⁹

These challenges shape how a state chooses to invest its money. For instance, funding may be disbursed late in the fiscal year, limiting a state’s ability to fully expend an account. Because the timing and amount of funding is often unpredictable, states are less willing to invest in multi-year projects. As a result, states tend to prioritize routine expenditures like salaries and deprioritized funding for “complicated” or “innovative” projects. To hedge against this unpredictability, states also keep rainy day accounts, accruing savings at the expense of funding programs for exigent health needs.

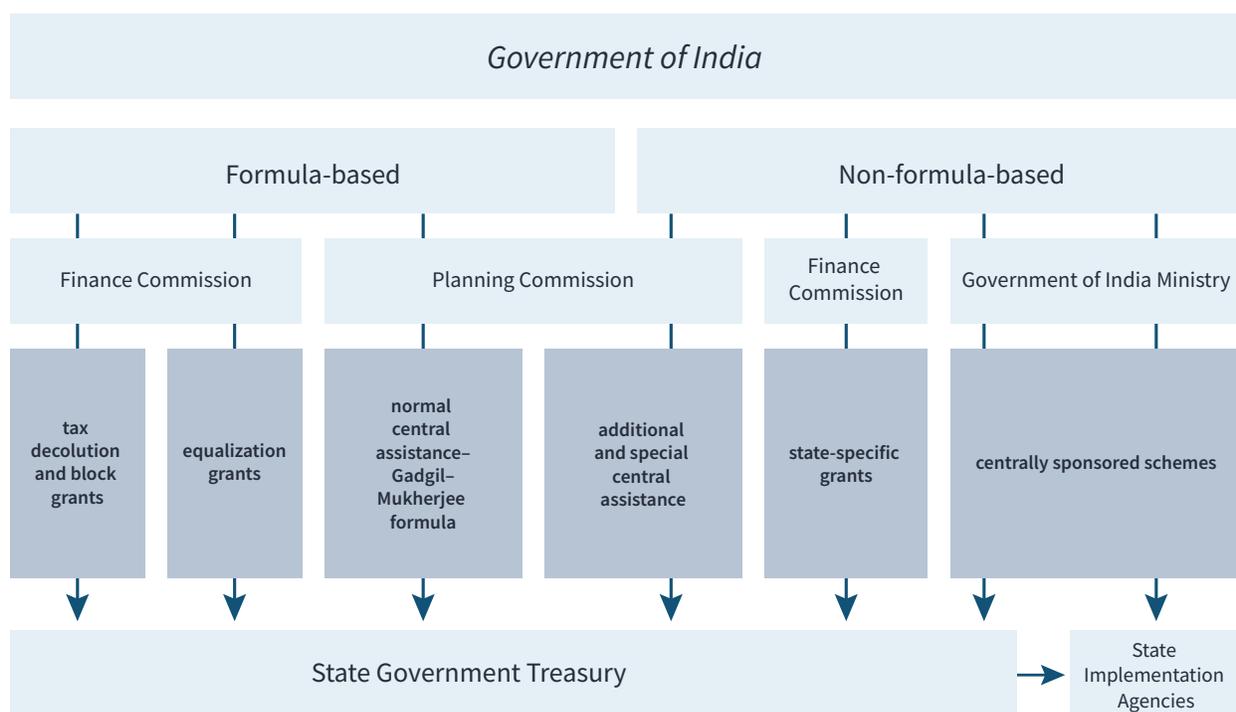
6. Intergovernmental Fiscal Transfers for Health Working Group, *Power to the States: Making Fiscal Transfers Work for Better Health* (Washington, DC: Center for Global Development, December 2015), <https://www.cgdev.org/publication/power-states-making-fiscal-transfers-work-better-health>.

7. Union Government (Civil) Ministry of Health and Family Welfare, *Report of the Comptroller and Auditor General of India on Performance Audit of Reproductive and Child Health* (New Delhi: 2017), https://cag.gov.in/sites/default/files/audit_report_files/Report_No.25_of_2017_-_Performance_audit_Union_Government_Reproductive_and_Child_Health_under_National_Rural_Health_Mission_Reports_of_Ministry_of_Health_and_Family_Welfare.pdf.

8. Peter Berman, Manjiri Bhawalkar, and Rajesh Jha, *Government financing of health care in India since 2005: What was achieved, what was not, and why?* (Boston, MA: Harvard T.H. Chan School of Public Health, February 2017), <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2031/2017/01/Government-financing-of-health-care-in-India-since-2005.pdf>.

9. Kavita Singh, “Guidelines on Committed and Uncommitted Unspent Balances under NHM,” Letter from NHM Mission Finance Director Kavita Singh to 35 States and UTs, National Health Mission, December 21, 2016.

The Architecture of Intergovernmental Fiscal Transfers in India



Source: Mukherjee, 2014.

Center for Global Development and Accountability Initiative, Centre for Policy Research, *Power to the States: Making Fiscal Transfers Work for Better Health* (Washington, DC: Center for Global Development, 2015), <https://www.cgdev.org/sites/default/files/India-fiscal-transfers-CGD-working-group-report.pdf>.

Prepare for delays in funding. The budget approval process can delay funding, with less prioritized funding released later in the fiscal year. For instance, 73 percent of districts in Uttar Pradesh received National Health Mission funding in the last quarter in 2014.¹⁰ While this lack of certainty at the state level creates funding challenges for government partners, organizations can prepare for and blunt the effects of delayed funding. For instance, one organization created a line item in their budget for working capital in cases of inconsistent funding.

Diversify sources of funding. Rather than contracting directly with state governments, some organizations operate as a third-party vendor or subcontractor, which in their experience provides greater fiscal stability. Other organizations diversified their customer base across public and private entities. This cushioned against cash flow risks and increased their flexibility to conduct pilot programs.

Apply for and maintain FCRA Status. Early stage social enterprises need capital to refine business models, expand their service area, or grow their firm. This capital is often more readily accessible from sources outside of India. Unfortunately, for many social enterprises operating in India, getting access to foreign sources of funding is difficult. This

10. Berman, Bhawalkar, and Jha, *Government financing of health care in India since 2005*.

STARTUP INDIA INITIATIVE

Some organizations have received state funding through [Startup India Initiative](#), a national program developed in 2016 to drive the growth of business and employment opportunities by creating an environment that enables startups to scale. The initiative seeks to reduce regulatory burden, increase financial support and incentives to drive innovation growth, and encourage collaboration between industry and academia. Some states are developing their own policies to take the national initiative forward, though progress and implementation varies. When determining which state to work in, consider which states are advancing the national initiative.

is because of India's Foreign Contribution (Regulation) Act (FCRA), which requires those firms who wish to get foreign contributions to first apply for "FCRA status" with the government. Only after government authorization (which often takes years) can a firm be granted the approval to receive foreign funds. These firms must maintain good standing (meaning not deviate from the objectives of the firm's mission or be perceived a threat to national security) and periodically have to undergo reevaluation to maintain their "FCRA status." Having FCRA status can be an incredibly beneficial

asset to social enterprises wanting to engage in the health care sector in India, especially if domestic sources of funding continue to be unreliable.

Understand the tendering and procurement processes. Tendering for a government contract differs across states. The process is typically lengthy and complicated, driving some organizations to find alternative ways of accessing central or state funds. If participating in the tendering process, closely watch requests for proposals announced on government websites. In some cases, developing the right relationships can help find champions within the government who are willing to develop a request for proposal that matches an organization's competencies and attributes.

States differ in how they procure and test technologies and medical products. Many officials are hesitant to deviate outside of existing state protocols and usually prioritize cost over impact. In order to make it easier for officials to procure and organizations goods, stakeholders suggested the government eMarketplace, an online procurement portal which facilitates the procurement of goods and services by various government organizations and departments. If selling goods or services to the government, listing a product on the eMarketplace can increase visibility.

States prioritize initiatives listed in Programme Implementation Plans (PIP). PIPs are annual documents outlining each state's strategy for implementing national health programs and activities.¹¹ The PIP development process is complex and iterative, with the central NHM providing a general framework within which states develop their plans. While 60 percent of the NHM budget is determined by the central government, states have latitude to allocate their 40 percent apportionment but must provide a rationale for new programs, explaining how they will leverage existing resources to support new programs.¹² One organization worked with state governments to insert line items in the PIP (line items are classified into 18 categories, with a designated "Innovation" category). While

11. Department of Health & Family Welfare, MoHFW, National Health Mission, "Online Programme Implementation Plan, Budget Planning and Approval System," <http://pip.nhm.gov.in/>

12. National Health Mission, Ministry of Health and Family Welfare, Government of India, "NHM PIP Guidance Note 2018-19," <https://www.nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1235&lid=659>.

not a guarantee, being listed as a line item in a state PIP increases visibility and chances of consistent funding. Alternatively, some organizations were financed through flexible budget allocations, which has a simpler approval process. While this approach may be quicker, it is also riskier; states are less likely to renew projects not codified into budgets.

CASE STUDY: MIRACLEFEET

Every year, 35,000 children are born in India with clubfoot, a congenital birth defect wherein one or both feet are turned inwards. Founded in 2011, MiracleFeet works to increase access to treatment for children born with clubfoot. MiracleFeet partners with local health care providers to treat this condition using the Ponseti Method, which results in full correction of the feet. To do so, MiracleFeet trains health care providers in the Ponseti Method, provides braces (designed in partnership with Stanford Design School) free of cost, and develops customized materials to create awareness and improve patient outreach.

In India, MiracleFeet started implementing its own program, beginning with a pilot in Uttar Pradesh in 2018. In Uttar Pradesh, MiracleFeet partners with the Department of Health and Family Welfare and National Health Mission to provide free treatment for children at select district hospitals. Partnering with the National Health Mission enabled MiracleFeet to leverage the Rashtriya Bal Swasthya Karyakram (RBSK), a national child health screening and treatment program for early identification and referral of 4Ds (Diagnosis, Diseases, Disorders, and Disabilities), including children affected with clubfoot. MiracleFeet also submitted a proposal to the National Health Mission at New Delhi, which introduced MiracleFeet as a prospective partner to all state-level National Health Missions. MiracleFeet is now operating in various capacities across five states including Maharashtra, Uttar Pradesh, Madhya Pradesh, Mizoram, and Himachal Pradesh.

Working with the government has been critical for MiracleFeet's success. It allowed MiracleFeet to reach a larger number of beneficiaries than otherwise possible. Tapping into the public health infrastructure—like state hospitals, district health systems, community health clinics, and primary health clinics—expanded MiracleFeet's reach, particularly in rural areas. Through ASHA workers and the national RBSK program, MiracleFeet was able to increase awareness, improve patient identification, and expand its referral network. Moreover, partnering with the government has given MiracleFeet additional credibility, which facilitated the recruitment of physicians and other health workers.

Conclusion

In India, states play a critical role in shaping and implementing health care policies and priorities. States organize, deliver, and increasingly direct funding for health services. For organizations looking to achieve broad impact, engaging directly with states can be crucial to securing funding, infrastructure, and opportunities to scale. Yet partnering with states can be challenging. Due to bureaucratic, administrative, and political complexities, state support is often unpredictable and difficult to navigate. In this report, we highlighted lessons learned from a range of institutions that successfully dealt with these challenges. Though their approaches differed, several common trends emerged:

- Most importantly, successful organizations spent considerable time identifying and engaging the right government officials.
- Securing buy-in is foundational for success but is a lengthy process, often requiring months or years of continuous outreach.
- To develop a compelling sell, organizations aligned their pitch to state officials' needs or priorities.
- Organizations frequently pilot an initiative—shouldering the upfront cost—to validate their product.
- Lastly, to blunt the effects of inconsistent or delayed funding, organizations turned to innovative approaches, including codifying their activities in state health budgets, diversifying their customer base, or finding alternative public-sector funding.

While none of these approaches guarantee success, they reflect field-tested practices that may offer practical guidance for organizations looking to partner with Indian states.

About the Project Directors and Authors

Richard Rossow is a senior adviser and holds the Wadhvani Chair in U.S.-India Policy Studies at CSIS. In this role he helps frame and shape policies to promote greater business and economic engagement between the two countries. He joined CSIS in 2014, having spent the last 16 years working in a variety of capacities to strengthen the partnership between the United States and India.

Dr. Kartikeya Singh is a senior fellow and deputy director of the Wadhvani Chair in U.S. – India Policy Studies and senior fellow of the energy and national security program at CSIS. Over the last two years he has been leading the center’s work on engagement with India’s states. Aside from his pioneering work connecting U.S. and Indian states on energy cooperation, Kartikeya has led the charge in shaping the Hans and Ford Foundation supported Indian States Health Innovation Partnership project. He holds a doctorate in international affairs from the Fletcher School of Law & Diplomacy, and a master’s degree in environmental science from the Yale School of Forestry & Environmental Studies.

Dr. Krishna Udayakumar is the founding director of the Duke Global Health Innovation Center, focused on generating deeper evidence and support for the study, scaling, and adaptation of health innovations and policy reforms globally. He is also Executive Director of Innovations in Healthcare, a non-profit co-founded by Duke, McKinsey & Company, and the World Economic Forum, leading the organization’s work to curate and scale the impact of transformative health solutions globally. At Duke University, Dr. Udayakumar holds the rank of Associate Professor of Global Health and Medicine and is Associate Professor at Duke-NUS Medical School Singapore. His work has been published in leading academic journals such as the *New England Journal of Medicine*, *Health Affairs*, and *Academic Medicine*. Dr. Udayakumar is a Phi Beta Kappa graduate of the University of Virginia, with a bachelor’s degree in interdisciplinary studies with distinction. He received both an MD and an MBA (with a concentration in Health Sector Management) from Duke University, where he was a Fuqua Scholar. Dr. Udayakumar completed his residency training in internal medicine at Duke and served as Assistant Chief Resident at the Durham VA Medical Center before joining the faculty of Duke University.

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