

TERRAMONT CAPITAL PARTNERS | INSIGHTS

The Health Data Maturity Curve

From Donor Pilots to Investable Infrastructure in African Primary Care



Photo: Steffen Lemmerzahn / Unsplash

June 2026

Thought Leadership | Africa Capital Markets Series

Introduction

In April 2026, the Africa Centres for Disease Control and Prevention announced the validation of its Primary Health Care Digitalisation Framework, a continental roadmap to digitally enable ninety per cent of primary health care systems by 2035.¹ The framework arrives as the donor model that historically supported African health systems comes under severe strain. That convergence matters. Africa's digital health future will not be determined by applications alone, or even by artificial intelligence. It will be determined by whether the continent can finance, govern and scale the trusted data infrastructure on which clinics, payers, public-health agencies and AI tools all depend.

This paper makes four connected arguments. *First*, the breakthrough in African digital health will not be the visible application layer of apps and artificial intelligence, but the data layer beneath it: patient-linked, consented, portable and interoperable records, governed under national and continental data-stewardship frameworks, on which every tool, clinic and payer depends. *Second*, the Africa CDC framework is the clearest signal yet that the continent intends to build that layer in earnest, and to build it on sovereign terms, with ownership of the data and the intelligence it produces resting with patients, providers and states. *Third*, the donor model that built the old system is under severe strain, and the move from pilot to durable infrastructure is therefore a capital-structuring problem, solved not by aid alone but by blended finance, catalytic development capital and long-duration vehicles. *Fourth*, the institutions able to structure, govern and underwrite that layer early, including African institutional investors, development finance institutions, family offices, advisers and credible fund jurisdictions, will help shape the standards, safeguards and capital terms through which African health infrastructure is financed over the next decade. The opportunity is not to own patient data. It is to finance the trusted rails that allow it to move lawfully, securely and usefully across the health system.

The Visible Layer Is Not the Valuable One

Africa's digital health conversation has found a compelling protagonist in artificial intelligence. The Gates Foundation and OpenAI have committed US\$50 million in funding, technology and technical support to Horizon 1000, an initiative beginning in Rwanda that aims to place AI tools in primary care clinics and reach one thousand sites and their surrounding communities by 2028.² It is a genuine signal, and the enthusiasm is warranted. Primary care is becoming the front line for AI-enabled health systems.

Yet the tool is the visible layer, not the valuable one. An algorithm is only as good as the records it reads. Where those records are fragmented, locked inside a single facility, or simply untrusted, the cleverest model becomes a liability rather than an asset. Some application-layer businesses will of course create real value, particularly where they own workflow, distribution, clinical trust or payment relationships. But any investment thesis that begins with the application layer and ignores the infrastructure beneath it risks underwriting the least defensible part of the stack.

The investable asset is not the app. It is the trusted, governed data infrastructure beneath it.

The Signal Beneath the Noise

In March 2026, the Primary Health Care Digitalisation Framework was validated by African Union Member States, partners and technical experts. The ambition is unambiguous: ninety per cent of primary health care systems digitally enabled by 2035, against a starting point at which only around thirty per cent are digitalised today. That target matters precisely because primary care is where more than eighty per cent of Africa's health interactions occur, and it is exactly where the data is most fragmented. The framework's emphasis is the right one. It calls for interoperable systems, unique health identifiers, digital registries and national data platforms that connect communities, health workers, facilities and policymakers, governed as sovereign health intelligence.

Read carefully, this is not a technology announcement. It is the continent declaring its intention to build a data layer on its own terms, with stewardship of the data and the intelligence it produces. For an allocator, that is the more important news. Policy has now defined the asset. The open question is who finances it.

The Financing Inflection

The timing of this ambition is not accidental. It arrives as the funding that historically underwrote African health systems contracts sharply. Africa CDC describes the continent as facing an unprecedented financing crisis. Recent Associated Press reporting, citing Africa CDC, puts official development assistance at roughly twenty-six billion dollars in 2021 and around thirteen billion in 2025, while Africa CDC's own materials describe a decline of close to seventy per cent over the same period, the difference reflecting which aid flows are counted.³ Either way, the direction is unambiguous and the magnitude is severe.

The institutional response has crystallised quickly. The UN Economic Commission for Africa has launched a Sustainable Health Financing Initiative, framed explicitly around treating health as an investment priority rather than a cost, and pointing to a financing gap of around sixty billion dollars a year even if every government met its Abuja commitment to spend fifteen per cent of budget on health.⁴ In April 2026, African finance ministers and multilateral institutions meeting in Morocco called for a decisive shift away from traditional financing toward blended, risk-sharing and tailored instruments suited to the risk-return profile of digital investment.⁵

The conclusion follows. Traditional aid alone will not build the data layer. What replaces it must be structured capital that is comfortable with long horizons, complex governance and the discipline of building infrastructure rather than funding projects.

Traditional aid alone will not build the data layer. The continent is not short of pilots. It is short of the capital architecture that turns pilots into systems.

The Maturity Curve, in Five Stages

The path from a funded pilot to financeable infrastructure is not a single leap but a curve, and the investment logic changes at each stage.

Stage one. Donor-funded pilots prove narrow use cases. **Stage two.** Facilities digitise their workflows, often in fragmented systems that do not speak to one another. **Stage three.** Interoperable registries, unique health identifiers and consent frameworks begin to connect patients, providers and payers. **Stage four.** National and regional health-intelligence platforms turn records into planning, surveillance, reimbursement and procurement infrastructure. **Stage five.** The system becomes investable infrastructure: governed, interoperable, procured, financed for duration, and able to support public health, clinical care and payment flows at scale.

Most of the continent sits today between the first and second stages. The durable value, and the durable returns, accrue to those who help finance the climb to the fourth and fifth.

The Proof-to-Procurement Gap

There is a well-documented reason that African digital health has produced so many pilots and so few systems. Nigeria-focused research illustrates a wider continental pattern, framing it as the proof-to-procurement gap: the space in which a working pilot stalls before it reaches an actual buyer, held back by regulatory immaturity, weak infrastructure, fragile trust, thin talent pools and the absence of a clear payer path.⁶ In the language of the curve, it is the chasm between the second and third stages. Grant funding is well suited to proving a concept. It is poorly suited to carrying that concept across the gap to durable procurement, because grants end, and infrastructure does not.

This is the same maturation logic that runs through our African Capital Maturity Curve work, now applied to a new sector. Conviction becomes architecture. Pilots become platforms. Platforms become infrastructure. At each step the binding constraint is not the availability of capital but the structure of it.

The Architecture of Investability

Health data infrastructure has public-good characteristics, so social value does not translate automatically into revenue. That is why the investable unit must be defined with care. It is not the patient record itself. It is the governed infrastructure around it: electronic medical record platforms, health information exchanges, consent and identity rails, claims and reimbursement systems, cybersecurity, cloud and local-hosting infrastructure, analytics agreements, and managed-service contracts with ministries, insurers, provider networks and employers. The strongest models will not monetise data extraction. They will monetise trusted access, uptime, interoperability, compliance and workflow reliability.

The strongest models will not monetise data extraction. They will monetise trust, uptime and interoperability.

Moving such a platform from pilot to infrastructure is, at its core, a capital-structuring problem, and the instruments to solve it are familiar to any serious allocator. Blended finance, in which catalytic public or philanthropic capital absorbs first losses and de-risks a commercial tranche, is the natural bridge across the proof-to-procurement gap. Development finance institutions can anchor that catalytic layer while also acting as standard-setters, raising the governance bar for

everyone who follows. Long-duration vehicles, patient by design, match the tempo of infrastructure that rewards persistence and punishes quarterly thinking.

The market is already forming around this logic. The Health Finance Coalition, Villgro Africa and the William Davidson Institute recently announced the Multiply Health Fund, a blended finance vehicle that uses catalytic capital expressly to reduce risk for commercial investors in African healthcare businesses.⁷ It is an early instance of exactly the structure this sector needs, and a signal that the maturation is underway rather than theoretical.

Three Filters for Durable Capital

Not every digital health opportunity is investable infrastructure, and the discipline lies in telling the difference. Three filters separate a durable asset from a dressed-up pilot:

- **Interoperability.** Does the platform speak to other systems through open standards, or does it lock data inside a proprietary silo? Silos do not compound in value. Connected rails do. Interoperability is the difference between an asset that appreciates as the ecosystem grows and one that strands as it changes.
- **Sovereignty.** Is the data owned and governed where it is generated, by the people and institutions it concerns? The continent's direction of travel, anchored in its health security and sovereignty agenda, is unmistakable. Capital that respects sovereignty is aligned with policy and with patients. Capital that ignores it is building on sand.
- **Governance.** Are consent, privacy and accountability designed in from the first line of code, or bolted on after the fact? In health data, governance is not a compliance overhead. It is the precondition for the trust on which the entire asset depends.

The Risks, Named Plainly

Conviction is not the same as naivety, and a credible thesis names its risks. Standards across the continent remain fragmented, and interoperability is an aspiration before it is a reality. Regulatory frameworks for digital health and cross-border data are immature and unevenly enforced. Exit pathways are not yet well trodden. Beyond these, six investor-grade risks deserve explicit underwriting.

- **Sovereign and procurement risk:** slow public procurement, shifting ministries, delayed payments and election-cycle disruption.
- **Currency and convertibility risk:** local-currency revenues set against hard-currency infrastructure, cloud, cybersecurity and investor obligations.
- **Cybersecurity and breach liability:** health data assets carry asymmetric downside, since a single loss of trust can impair the whole platform.
- **Clinical and AI accountability:** decision-support tools require clear lines of responsibility between clinicians, vendors, ministries and payers.

- **Language and localisation:** tools built in one language can fail where local-language capability is essential to adoption and safety.
- **Public-good and private-return tension:** much of the benefit accrues to the health system and society, not immediately to the platform operator.

These are real constraints. They are also precisely why the opportunity exists. Where the path is fully paved, the returns have already been competed away. The investability challenge is not whether the social value exists. It is whether that value can be translated into lawful, trusted and durable payment mechanisms without compromising sovereignty or patient rights.

The Patient Capital Thesis

Family offices and long-horizon institutions are unusually well placed for this moment. They can hold duration that quarterly-driven capital cannot. They can value sovereignty and trust as the durable sources of advantage they are, rather than as frictions to be engineered away. And they can participate in the formation of an asset class at the point of maximum optionality, before the structures harden and the spreads compress.

Africa's digital health future will not be built by technology alone. It will be built by patient capital, sound standards, well-governed and patient-centred data, and a refusal to confuse a pilot with a system. That is the conversation we follow closely at Terramont: not as builders of the data layer, but as architects of the capital that allows it to last.

Endnotes

1. Africa CDC, Primary Health Care Digitalisation Framework, validated by African Union Member States, partners and technical experts; see the Africa CDC announcement, April 2026, and the PHC Digitalization Expert Committee Communiqué, December 2025, which records a decline in overseas development assistance of nearly seventy per cent since 2021 and notes that only around thirty per cent of African health systems are currently digitalised.
2. Gates Foundation and OpenAI, "Horizon 1000," January 2026: a commitment of US\$50 million in funding, technology and technical support, beginning with more than fifty clinics in Rwanda and targeting one thousand primary care clinics and surrounding communities by 2028. See the OpenAI and Gates Foundation announcements.
3. Associated Press, May 2026, citing Africa CDC, reporting official development assistance to Africa at approximately US\$26 billion in 2021 and US\$13 billion in 2025; compare Africa CDC, "Africa's Health Financing in a New Era," April 2025, describing a decline of close to seventy per cent over 2021 to 2025. The two formulations reflect different aid-flow definitions.
4. United Nations Economic Commission for Africa, Sustainable Health Financing Initiative, launched April 2026, citing a health financing gap of around US\$60 billion a year even if all governments met the Abuja Declaration commitment of fifteen per cent of national budgets to health.
5. UNECA Conference of African Ministers of Finance, Planning and Economic Development (CoM2026), 58th session, Morocco, April 2026; session on financing innovation convened by the Alliance of African Multilateral Financial Institutions, calling for blended, risk-sharing and tailored instruments for digital and innovation-led investment.
6. Health Economics Review, "Beyond seed funding: why Nigerian digital health startups struggle to grow," published online 5 December 2025 (vol. 16, art. 2, 2026), on the proof-to-procurement gap and its constituent frictions. The study is Nigeria-focused and illustrative of a wider continental pattern.

7. Health Finance Coalition, Villgro Africa and the William Davidson Institute (Learning and Impact partner), “Multiply Health Fund,” March 2026: a blended finance vehicle deploying catalytic capital to unlock commercial investment in African healthcare enterprises.

Further market context drawn from Africa CDC, Primary Health Care Digitalisation Framework and the Africa Health Security and Sovereignty Agenda; UN Economic Commission for Africa and WHO Regional Office for Africa publications on innovative health financing; and Brookings Institution analysis on blended structures and interoperable claims systems in African health.

Important Notice

This material reflects market analysis and publicly available data as at the date of publication. Forecasts and projections are subject to revision and should not be interpreted as investment advice or as a recommendation to engage in any specific transaction or strategy. References to third-party initiatives, organisations and data are for commentary purposes only and do not imply any affiliation, endorsement or mandate unless expressly stated.

Disclaimer

This document has been prepared by Terramont Capital Partners for informational purposes only and does not constitute investment advice, an offer or solicitation to buy or sell any securities, or a recommendation of any particular course of action. The views and opinions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of Terramont Capital Partners or its affiliates. While care has been taken to ensure the accuracy of the information presented, Terramont Capital Partners makes no representation or warranty as to its completeness or reliability. Past performance is not indicative of future results. Readers should seek independent professional advice before making any investment decisions.

Terramont Capital Partners is authorised and regulated by the Financial Services Commission (Mauritius).

© 2026 Terramont Capital Partners. All rights reserved. This publication may be shared or cited for non-commercial purposes provided that Terramont Capital Partners is credited as the source and a link to the original publication at terramontcapitalpartners.com is included. Reproduction in whole or in part for commercial purposes requires prior written consent from Terramont Capital Partners Limited.