Investors for Health:

Five Years of Investing in Inclusive Healthcare 2021 – 2025

Private Capital's Role in Quality Healthcare Delivery in Emerging Markets

2026

I4H MEMBER ORGANIZATIONS

Current Members (as of 2025)

AIIB Asian Infrastructure Investment Bank
AFRICINVEST
Alta Semper Capital
British International Investment
Dalberg
DFC U.S. International Development Finance Corporation
Elevar Equity
European Bank for Reconstruction and Development
finnfund
IFC International Finance Corporation World Bank Group
Impact Fund Denmark
Johnson&Johnson
KfW DEG
LeapFrog Investments
lightrock
MSD
Quadria Capital
reFrontier
Swedfund
Temasek
TVM Capital Healthcare

Past Members

abc IMPACT
Adjuvant Capital
chiratae ventures
Columbia Pacific Management
FINCA
Health Finance Institute
IFHA Investment Funds for Health in Africa
InvAscent
Medical Credit Fund
Medtronic Labs
Patria
Philips
Somerset Indus Capital Partners
Tata Capital
TEAMFund Transforming Equity and Access in MedTech
TPG
Transform Health Fund
UBS Optimus Foundation
UBS
Verge
VEROD

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LETTER FROM THE EXECUTIVE COMMITTEE

Dear I4H Community,

Five years ago, a group of like-minded investors came together around a shared conviction: that private capital, deployed responsibly and inclusively, could play a transformative role in strengthening healthcare systems in emerging markets. What began as a series of conversations in late 2018 became Investors for Health (I4H)—a community of practice that has since grown into one of the most distinctive platforms in the global health investment landscape.

Over the past half-decade, our community has expanded from 19 founding members to more than 25 organizations, representing development finance institutions, private equity and venture capital funds, and corporate investors. Together we have convened over 30 events across four continents, published five reports and dozens of thought leadership pieces, and—most importantly—collectively represent billions of dollars in healthcare investments that are reaching tens of millions of patients across emerging markets.

This report looks back at what we set out to do, what we accomplished, and what we learned. It also looks ahead—because the need for inclusive, high-quality healthcare in emerging markets has never been greater, and the opportunity for private capital to make a difference has never been clearer.

We are proud of what I4H has achieved, grateful to every member who contributed their time, expertise, and capital, and optimistic about the future of inclusive healthcare investment.

With gratitude,

The I4H Executive Committee
Dr. Amit Varma & Anjli Kaushal, Quadria Capital
Dr. Stephen Sammut & Afsane Jetha, Alta Semper Capital
Zeynep Kantur Ozenci & Silven Chikengezha, IFC
Ken Gustavsen, MSD
Kusi Hornberger & Lily Chhatwal, Dalberg

EXECUTIVE SUMMARY

In 2020, 19 impact-minded healthcare investors formed Investors for Health (I4H) around a shared conviction: that private capital, deployed responsibly and in partnership with public systems, could help close the vast healthcare access gaps in emerging markets. Five years later, this report examines what the community set out to do, what it accomplished, and what it learned.

The results are encouraging. I4H grew from 19 founding organizations to more than 25, bringing together development finance institutions, private equity and venture capital funds, and corporate investors across four continents. Over 80 executive and investing leaders participated in the community, with a remarkably stable backbone of 28 individuals from 11 organizations sustaining engagement across all five years. The community convened more than 30 events, published 25+ knowledge products, and created a trusted space for investors who rarely sit in the same room to share deal intelligence, co-invest, and learn from one another.

The investment data tells a compelling story. Consistent members' healthcare assets under management grew 83% over five years, from $7.5 billion in 2021 to $13.8 billion in 2025. The number of active investments more than doubled (+122%), reaching 553 for consistent members and 705 for the full community. Sector allocation evolved meaningfully: while hospitals and medical distribution remained the largest categories, digital health and telemedicine rose sharply to become the top planned sector for 2026. In self-assessments, I4H members rated their own performance higher than the broader ecosystem across every dimension—AUM growth, investment volume, patients served, and marginalized populations reached.

Five lessons emerged from the community's collective experience, each grounded in real portfolio evidence. First, private capital does indeed fill critical gaps—as demonstrated by NephroPlus, which brought dialysis access to 520+ centres across four countries, 77% in underserved Tier 2 and Tier 3 cities. Second, public-private collaboration is essential—as demonstrated by IFC's partnership with Biovac to build Africa's first end-to-end multi-vaccine manufacturing facility, and by the Africa Medical Equipment Facility's innovative equipment-as-a-service model. Third, technology is an enabler for scale when built on operational trust—Penda Health's AI clinical copilot and WhatsApp-based outreach exemplify this principle. Fourth, patient and catalytic capital remains necessary for the hardest-to-reach

populations—MYDAWA's transformation in Kenya, where a $3 million Gates Foundation grant proved a telemedicine-to-pharmacy model that Alta Semper then commercialized to reach millions of patients annually, demonstrates how catalytic capital can unlock commercially viable models. And fifth, measuring outcomes is essential to demonstrate results and attract follow-on investment, as Mamotest's 87% early detection rate across 750,000 patients powerfully illustrates. Across all five lessons, a unifying thread emerged: the acute shortage of healthcare talent—clinicians, technicians, managers, and leaders—remains one of the most binding constraints on progress, and the strongest portfolio companies are those that build workforce capacity as a core business function rather than an afterthought.

The report also looks ahead. Despite meaningful progress, the healthcare financing gap in emerging markets remains vast, and new challenges—from climate-driven health burdens to geopolitical disruption of supply chains—continue to reshape the landscape. Section 4 lays out a forward-looking agenda, arguing that the next five years must be defined by deeper public-private integration, bolder capital mobilization, strengthened health value chains, systematic investment in the healthcare talent that makes everything else possible, and a relentless commitment to measuring what matters. The evidence from five years of I4H demonstrates that inclusive healthcare investing is not just morally imperative—it is commercially viable. The task now is to scale what works. The strongest message emerging from these five years is that neither public systems nor private capital succeeds without the other—partnership rather than polarity is the defining insight of the I4H experience.

01.

WHAT WE SET OUT TO DO AND WHY

By **Kusi Hornberger**, Partner and Senior Leader
Finance & Investment Practice at Dalberg Advisors

The Healthcare Gap in Emerging Markets

Healthcare systems across emerging markets face enormous access, affordability, and quality gaps. Half the world's population lacks access to essential health services, and the financing shortfall to achieve Universal Health Coverage is projected to reach $371 billion annually by 2030. In sub-Saharan Africa, there are fewer than 2 physicians per 10,000 people—compared to 35 in OECD countries. In South Asia, out-of-pocket health expenditure pushes roughly 60 million people into poverty each year.

Yet the private sector is already a major—and in many cases the dominant—provider of healthcare in these regions. In Africa, private providers deliver more than 40% of healthcare services. In South Asia, the figure exceeds 80%. This is not a temporary phenomenon; it reflects structural realities in how healthcare is financed and delivered across the developing world. The

The Challenge of Investing in Healthcare in Emerging Markets

question is not whether private capital plays a role in emerging-market healthcare, but whether it can be channeled more effectively toward inclusive, high-quality outcomes.

Despite the scale of opportunity, numerous structural barriers make investing in healthcare in emerging markets particularly challenging. Business model risk is acute: many healthcare enterprises serve low-income populations with limited ability to pay, requiring innovative pricing, cross-subsidization, or blended finance structures to achieve viability. Regulatory fragmentation across countries—and often within countries—creates compliance burdens that raise costs and slow expansion.

Weak infrastructure compounds these challenges. Unreliable electricity, limited cold-chain logistics, and poor digital connectivity hamper the delivery of everything from diagnostics to pharmaceuticals. Talent scarcity is equally limiting: healthcare systems in emerging markets face chronic shortages of doctors, nurses, technicians, and healthcare managers. These constraints do not make healthcare uninvestable, but they do demand a different kind of investor: one with patience, local knowledge, and a genuine commitment to impact along with returns.

The Birth of I4H

In this context, in 2020, 19 impact-minded healthcare investors formed Investors for Health (I4H). The founding vision was ambitious, yet grounded: to build a community of practice where investors could work together to ensure that private and public capital is deployed to achieve impact and to help build inclusive healthcare systems in emerging markets.

In its inaugural flagship report in March 2022, the I4H community articulated a framework for inclusive and sustainable healthcare investment that has become the intellectual backbone guiding the community's work ever since. The framework is built on this dual premise: that healthcare investments in emerging markets are inclusive when they fill gaps in the healthcare landscape, are complementary to the public sector, and are deployed responsibly; and that such investments are sustainable when the addressable market is large, returns are attractive, and a clear path leads to maturity and exit.

Figure 1: Framework for Investing in Healthcare in Emerging Markets

The framework identified ten archetypes for private-sector healthcare investing—spanning diagnostic services, hospitals, primary care clinics, pharmaceutical distribution, digital health, and insurance products—and mapped where private capital was best positioned for positive impact. This dual lens of inclusivity and sustainability has served as the community's shared language for evaluating investments and measuring progress.

The Five-Year Question

Now, as we stand at the five-year mark, this report looks back and asks: **has the I4H community delivered on its original vision?** And further: **what has been learned that should shape private capital's continued engagement with health systems in emerging markets?**

The answers, as the following sections demonstrate, are encouraging—but also sobering. I4H members have collectively deployed billions of dollars into healthcare, built a trusted network that fostered collaboration and co-investment, and generated real-world evidence that inclusive healthcare investment can work at scale. At the same time, **the community's experience has revealed the limits of what any single group of investors can achieve and underscored the critical importance of public-private collaboration, patient capital, human resources, technology, and rigorous impact measurement.**

02.

WHAT WE DID

Over five years, I4H has demonstrated that a purpose-built community of investors can meaningfully advance inclusive healthcare. The community built trust, fostered collaboration, and generated collective investment activity that outpaced the broader ecosystem.

Building the Network and Community

Over the years, more than 80 executive and investing leaders have been members of the I4H community, representing more than 35 leading DFIs, private equity/VC funds, and corporate venture funds, as seen in Figure 2. The community brought together investors who rarely sit in the same room—development finance institutions alongside emerging-market PE funds, corporate venture arms alongside impact-first vehicles—and created a space where candid exchange was the norm.

Figure 2: Members of the community by function and number of years of membership

ExCo	**Afsane Jetha,** Alta Semper **Amit Varma,** Quadria Capital **Anjli Kaushal,** Quadria Capital **Chris McCahan,** IFC	**Ilaria Benucci,** BII **Ken Gustavsen,** MSD **Kusi Hornberger,** Dalberg **Leandro Cuccioli,** BII	**Lily Chhatwal,** Dalberg **Max Ateba,** Dalberg **Silven Chikengezha,** IFC **Dr. Stephen Sammut,** Alta Semper	**Zeynep Kantur Ozenci,** IFC
5 years	**Audrey Obara,** Alta Semper **Bryan Lim,** Temasek **Caitlin Bristol,** JJIV **DI Fu,** Temasek **Dustin Higgins,** JJIV **Eliza Foo,** Temasek	**Erin Barringer,** Dalberg **Hala Sherif,** IFC **Helmut Schuehsler,** TVM **Holly Radel,** TVM **Irina Schmidt,** DEG **Isabel Thywissen,** DEG	**Jide Olanrewaju,** TPG **Monisha Ashok,** USDFC **Nadia Karkar,** TPG **Nafisa Jiwani,** USDFC **Rachel Fong,** abcIMPACT **Sarah Mullane,** JJIV	**Valaray Omamo,** Swedfund **Vikrant Parashar,** Quadria Capital **Zachary Fond,** Alta Semper
4 years	**Amie Patel,** Elevar Equity	**Liliane Kidane,** Dalberg	**Markus Pentikainen,** Finnfund	**Nate McLemore,** Columbia Pacific
3 years	**Aicha Zakraoui,** AfricInvest/THF **Anahitaa Bakshi,** Dalberg **Bernardo Cantu,** Dalberg **Dorien Mulder,** Medical Credit Fund	**Emil Siercyzski,** IFD **Faisal Jiwa,** AfricInvest/THF **Hela Triki,** AfricInvest/THF **Klaus Prebensen,** IFD	**Lisbeth Erlands,** IFD **Marissa Leffler,** UBS Optimus **Milinda Wasalathanthri,** IFD **Milinda Wasalathanthri,** IFD	**Noorin Mawani,** AfricInvest/THF **Noorin Mawani,** AfricInvest/THF
2 years	**Anne Stake,** Medtronic Labs **Biju Mohandas,** LeapFrog **Bianca Samson,** Dalberg **Carl Nicholas Ng,** Verge **Clinton Watson,** AIIB **Danladi Verjeijen,** Verod	**Eddine Bahaa Sarroukh,** Philips **Eshani Shah,** LeapFrog **Felix Olale,** LeapFrog **Joseph Mocanu,** Verge **Kashvi Trivedi,** Dalberg **Kelvin Hul,** AIIB	**Kristina Yu,** AIIB **Lucie Gareton,** Dalberg **Matias Loening,** EBRD **Michael Jelinske,** LeapFrog **Nonnie Waiyaki,** Lightrock **Omer Imtiazuddin,** FINCA	**Ramesh Kannan,** Somerset Indus **Ranhith Menon,** Chiratae **Ruchika Singhal,** Medtronic Labs **Sarvesh Singh,** Dalberg **Shakir Merali,** Lightrock **Vera Siesjo,** AIIB
1 year	**Abdul Lediju,** HFI **Chris Haynes,** TEAMFund **Curt Laird,** reFrontier	**Daniel Streckfuss,** reFrontier **Harl Buggana,** Invascent **Jenny Yip,** Adjuvant	**Katrina Aitken Laird,** reFrontier **Martina Sampo,** Dalberg **Menka Shah,** IFHA	**Norberto Jannuzzi,** Patria **Tara Wright,** Dalberg **Visalakshi,** Tata Capital

Several patterns in the community's evolution stand out. The backbone was remarkably stable: 28 individuals from 11 organizations—including Johnson & Johnson Impact Ventures (JJIV), Temasek/ABC Impact, DEG, IFC, Swedfund, USDFC, and Dalberg—have remained engaged for all five years, providing continuity and institutional memory. Combined with the 13-member Executive Committee, roughly half the community has participated for the full duration of I4H. In year three, a significant wave of expansion brought in 30 new participants from 15 organizations, many of them private equity and venture capital firms such as LeapFrog, Lightrock, Chiratae, and

Verod, as well as multilateral newcomers like AIIB, EBRD, and AfricInvest. This influx diversified the community beyond its DFI-heavy origins and brought investors with deeper emerging-market operational experience.

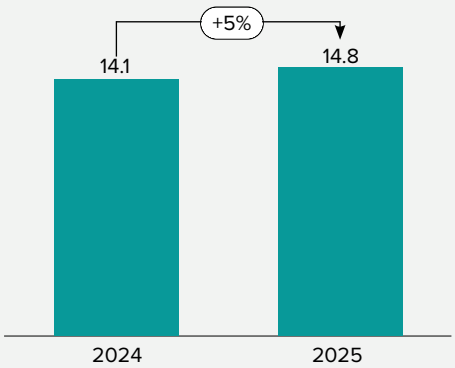
COMMUNITY ENGAGEMENT	KNOWLEDGE & IMPACT
15 Virtual Member Meetings covering digital health, oncology, diagnostics, pharmaceuticals, home care, impact measurement, mental health, and climate-health **15+ In-Person Events** in London, New York, Singapore, Cape Town, Nairobi, Washington DC, Bogota, and Davos **12+ New Partnerships** and co-investments fostered within the network, bridging corporates, venture capital and PE firms, sovereign wealth funds, and development finance institutions (DFIs).	**5 Annual Activity Reports** documenting investment trends, sector shifts, and community sentiment across the full five-year period **25+ Thought Leadership Pieces** published in ImpactAlpha and other outlets, plus knowledge series on 9+ topics from health-tech valuations to climate-health investing **NPS Above 33%** every year—reflecting sustained member satisfaction with the community's programming and value proposition

Investment Activity: Outpacing the Ecosystem

As investors, I4H members' investing activity grew significantly over five years, specifically on key metrics like AUM (assets under management) and number of investments made per year. The data below draws from the I4H Annual Survey, tracking 11 consistent members who responded to all five surveys alongside the full community of members active in 2025.

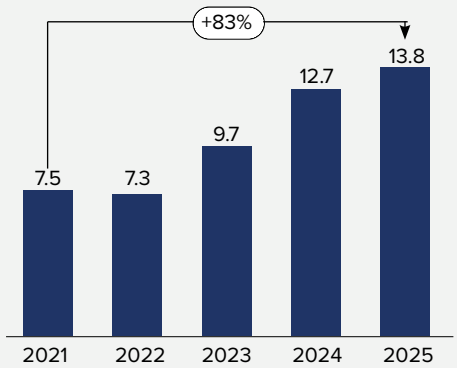
Figure 3: Healthcare AUM Growth - All Members (2024–25) and Consistent Members (2021–25)

Value of all* I4H members AUM in healthcare by year 24–25, $ billions



Notes: (*) 15 members participated in the 2025 survey

Value of consistent I4H members AUM in healthcare by year 21–25, $ billions**

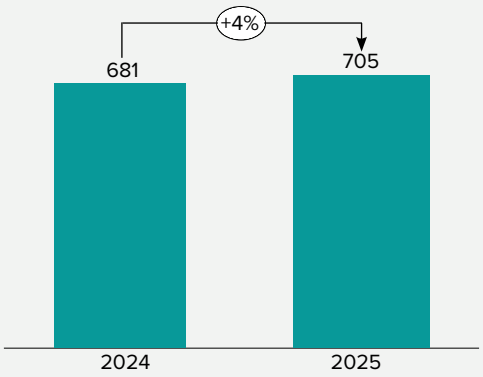


Notes: (**) 11 consistent members responded to survey across all five years: Alta Semper, BII, DEG, DFC, Elevar Equity, FinnFund, IFC, MSD, Quadria, Swedfund and TVM

Consistent members' AUM grew 83% over five years, from $7.5 billion in 2021 to $13.8 billion in 2025. The full community stewards $14.8 billion, up 5% year-over-year. Growth was strongest in 2023–2024 (+31%) before moderating in 2025, reflecting a shift from rapid deployment to portfolio management and value creation.

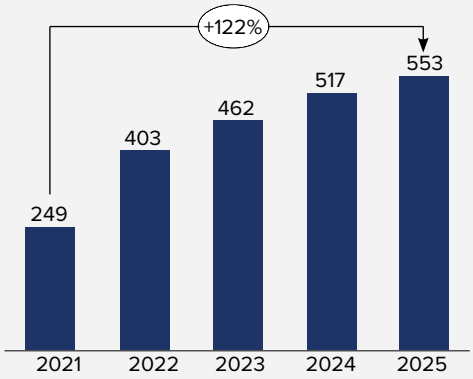
Figure 4: Investment Volume Growth—All Members (2024–25) and Consistent Members (2021–25)

Volume of all* I4H members AUM in healthcare by year 24–25, # of investments $ billions



Notes: (*) 15 members participated in the 2025 survey

Volume of consistent I4H members AUM in healthcare by year 21–25, # of investments**

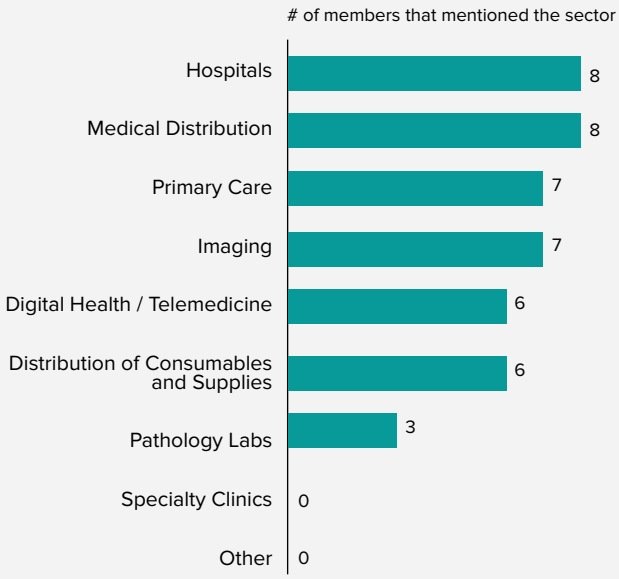


Notes: (**) 11 consistent members responded to survey across all five years: Alta Semper, BII, DEG, DFC, Elevar Equity, FinnFund, IFC, MSD, Quadria, Swedfund and TVM

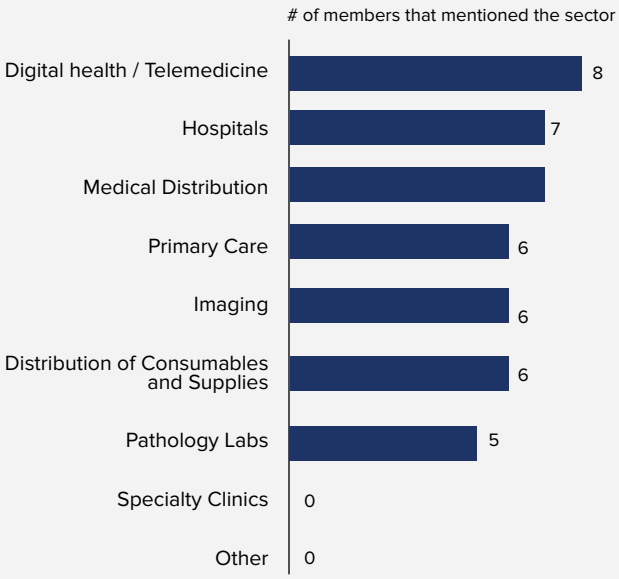
The number of active investments grew even faster: +122% for consistent members (from 249 to 553) and 705 total for the full community, up 4% year-over-year. In 2025, collectively the community managed $14.8 billion in healthcare AUM and made 705 individual investments in hospitals, primary and specialty care, medical distribution, imaging, and digital health solutions.

Figure 5: Sector Allocation—2025 Investment Activity and 2026 Plans

In what sectors did you invest during 2025, # of survey respondents (n = 15)



In what sectors do you plan to invest during 2026, # of survey respondents (n = 15)



Sector allocation has evolved meaningfully. Hospitals and medical distribution remain the most common investment areas, but digital health and telemedicine have risen sharply in members' forward-looking plans—becoming the top planned sector for 2026. Members intend to make an average of five new investments per year, signaling continued confidence and pipeline strength.

The following vignettes were selected to illustrate two dimensions of the I4H framework. Each represents a company that is sustainable—demonstrating a viable business model with strong unit economics and a path to commercial returns—while also being inclusive, reaching underserved populations in geographies or clinical areas where access gaps are most acute. Together, they reflect the breadth of I4H members' investment strategies across sectors, geographies, and stages.

Spotlight: Notable 2025 Investments by I4H Members

The breadth of I4H members' investment activity in 2025 illustrates the diverse ways private capital is reaching underserved populations. The following vignettes highlight five investments made by community members that exemplify inclusive healthcare investing across different geographies and subsectors:

DCDC Kidney Care —ABC Impact / Temasek

DCDC KIDNEY CARE | abc IMPACT | TEMASEK

- DCDC operates over 200 dialysis centers across India, delivering nearly 100,000 dialysis sessions monthly to economically weaker populations with end-stage renal disease. ABC Impact (backed by Temasek) invested approximately $18 million in 2025 to expand the network by 150 new clinics, addressing critical gaps in dialysis access in a country where over 1.5 million patients require regular treatment. The investment exemplifies inclusive healthcare by making life-sustaining kidney care accessible to underserved populations through affordable clinic-based models and public-private partnerships.

Cloudphysician
—Elevar Equity

- Cloudphysician provides AI-powered ICU monitoring and ambient intelligence technology that enhances critical care delivery across Indian hospitals, extending partnerships to over 200 facilities across 23 states. The platform's AINA AI Video Co-pilot helps reduce ICU mortality rates by up to 40% while easing workloads for doctors and nurses in resource-constrained settings. Elevar Equity led the pre–Series A round of $4 million, recognizing the platform's potential to democratize access to high-quality intensive care where specialist physicians are scarce.

Crown Healthcare
—IFD (Impact Fund Denmark)

- Crown Healthcare is a Kenyan medical products distributor and pharmaceutical manufacturer combating Africa's counterfeit medicine crisis, which claims over 100,000 lives annually on the continent. IFD invested $10 million to help build East Africa's largest integrated pharmaceutical manufacturing and medical devices facility, with planned capacity to employ over 1,000 professionals. The investment addresses a systemic vulnerability: 70 to 80% of African medicines are imported and subject to dangerous counterfeiting, making local manufacturing critical for healthcare security.

Hewatele
—AfricInvest / Transform Health Fund

- Hewatele is a Kenyan medical-grade oxygen producer addressing a critical shortage across East Africa, where over 70% of existing oxygen generation plants are nonoperational or produce substandard purity levels. AfricInvest's Transform Health Fund invested $10.5 million to build a large-scale production facility capable of generating 20 tonnes of oxygen daily at 99.6% purity, serving 300+ healthcare facilities. The investment tackles a fundamental infrastructure gap—medical oxygen is essential for treating respiratory infections, childbirth complications, and trauma—that directly impacts maternal and child mortality.

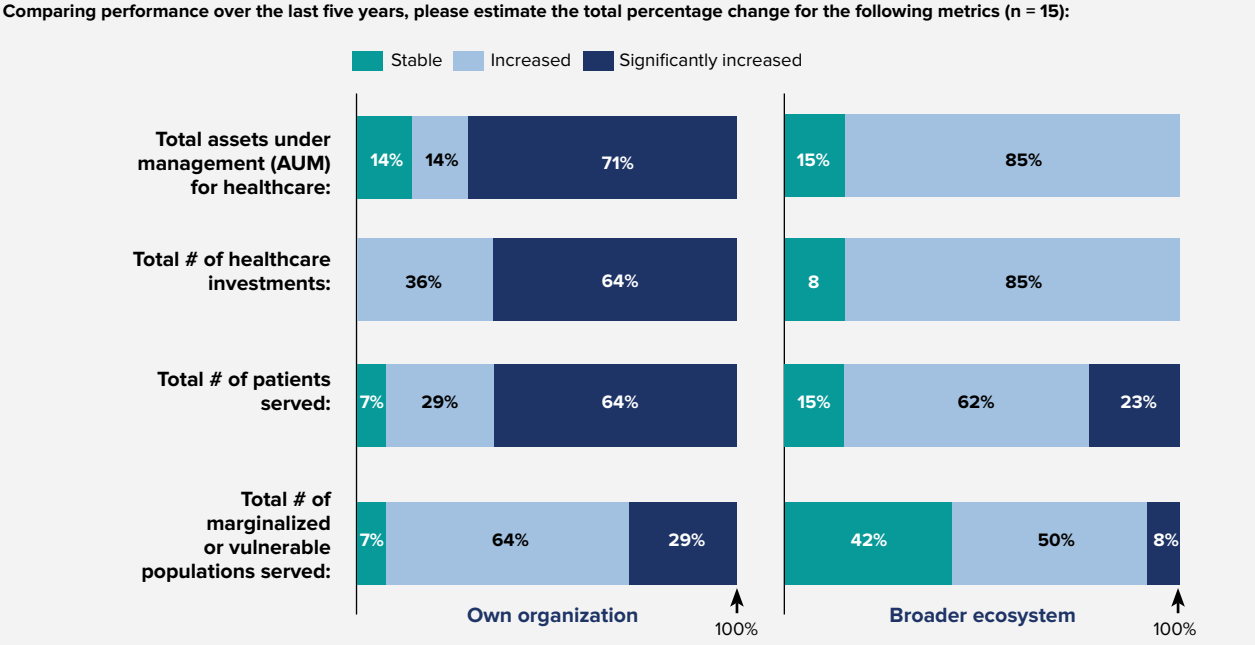
Baraya Extended Care —TVM Capital Healthcare

Baraya Extended Care provides comprehensive long-term care and rehabilitation services in Saudi Arabia, addressing the Kingdom's rapidly aging population and rising chronic disease burden. TVM Capital Healthcare led a Series B round bringing total capital raised to $124 million, with plans to operate 650+ beds in long-term care hospitals by 2026. Aligned with Saudi Arabia's Vision 2030 health transformation, the investment exemplifies how private capital can shift emerging-market health systems from acute-only models to the full continuum of care including post-acute rehabilitation and home services.

Outperforming the Ecosystem

A distinctive feature of the 2025 survey was a self-assessment asking members to compare their own five-year performance against the broader healthcare investment ecosystem. The results reveal a community that believes it is investing with greater intentionality and achieving stronger impact outcomes than the market at large. Despite headwinds such as COVID-19 disruptions, rising interest rates, and global ODA cuts for public health, the majority of members also believe that their own investment activity and contributions to access, quality, equity, and outcomes were significant or very significant over the five-year period.

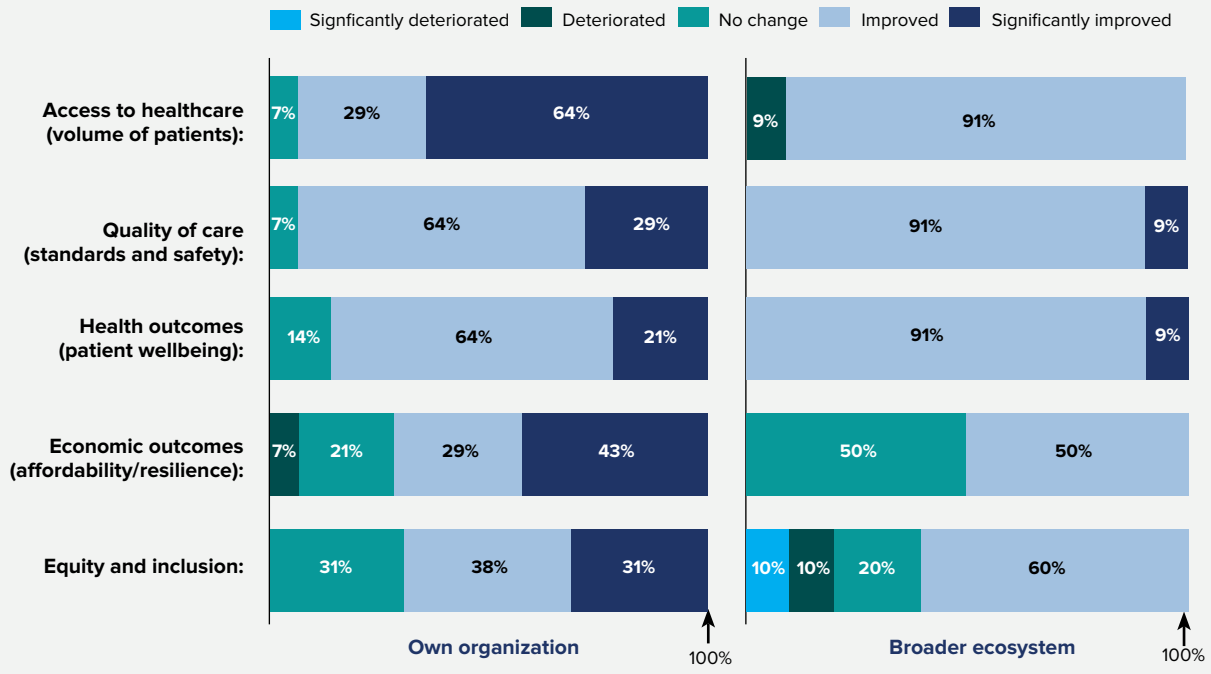
Figure 6: Majority of I4H members believe they have increased investment activity and patients served more than the broader ecosystem



Across all four metrics—AUM growth, investment volume, patients served, and marginalized populations reached—I4H members rated their own performance higher than their assessment of the broader ecosystem. The most striking gap was in patient reach: 93% of members reported increased or significantly increased numbers of patients served by their own organizations, compared to 85% for the ecosystem. These are, of course, self-assessments—members evaluating their own performance—and should be interpreted with that limitation in mind. Yet the consistency of the pattern across metrics and across years is itself revealing: it suggests that investors who organize intentionally around inclusive healthcare, guided by a shared framework and peer accountability, perceive meaningfully stronger outcomes than they observe in the broader market. Whether that perception reflects actual outperformance or the sharper self-awareness that comes from measurement discipline, the implication is the same: intentionality matters.

Figure 7: I4H members believe they have contributed more impact across access, quality, health and economic outcomes as well as on equity and inclusion than the broader ecosystem

How would you rate improvements in the underserved markets you operate in across the following impact performance dimensions over the last five years (n = 15):



Access to healthcare (volume of patients) stands out as the strongest area: 93% of members reported improvements in their own portfolio, compared to 91% for the broader ecosystem. Quality of care and health outcomes also scored strongly, at 93% and 85%, respectively. Economic outcomes (affordability and resilience) and equity and inclusion showed somewhat lower self-assessments—reflecting the reality that while solutions may be more accessible to an overall population, reaching the most marginalized communities and achieving systemic affordability remain the hardest challenges in inclusive healthcare.

03.

WHAT WE LEARNED

Over five years, I4H has generated unique insights into what it takes to invest inclusively in healthcare. Five lessons stand out, each illustrated below by a case study drawn from the community's portfolio and accompanied by reflections from Executive Committee members who lived these lessons firsthand.

> "Bringing healthcare to where patients live, rather than having patients come to where healthcare exists."
>
> —Dr. Amit Varma, Quadria Capital

LESSON #1: PRIVATE CAPITAL DOES INDEED FILL CRITICAL GAPS

When I4H was founded, a central question was whether private capital could genuinely serve underserved populations without inevitably gravitating toward the affluent. Five years of evidence suggests the answer is emphatically yes, but with caveats. Private investors have financed dialysis networks reaching patients in tier-2 and tier-3 cities, built primary care clinics in peri-urban areas, and scaled diagnostic services across rural communities. The key has been business models that combine affordability with scale—achieving unit economics through volume rather than price. Critically, these models also require investing in people: NephroPlus's in-house academy has trained almost 400 dialysis technicians, turning workforce development from an externality into a core business function—a pattern that recurs across the strongest I4H portfolio companies.

The experience of NephroPlus illustrates this dynamic. Backed by Quadria Capital, NephroPlus has grown to 520+ dialysis centers serving more than 36,000 patients, the vast majority of whom lacked access to affordable renal care through the public sector. By standardizing operations, investing in technology-enabled monitoring, and negotiating partnerships with government insurance schemes, NephroPlus demonstrates that inclusive healthcare delivery and commercial viability can coexist—but only when the investor is willing to take a long-term view and actively support operational excellence.

Case Study: NephroPlus—Quadria Capital

NephroPlus is the largest dialysis network in South Asia, operating more than 520 centers across India and internationally and serving over 36,000 patients. The company's model combines standardized clinical protocols with hub-and-spoke distribution, enabling it to reach patients in smaller cities where dialysis access was previously unavailable. Quadria Capital's investment supported the company's expansion from a regional player to a continent-spanning network, demonstrating that private capital can fill critical gaps in chronic disease management at scale.

INTERVIEW: NEPHROPLUS

A Conversation with Dr. Amit Varma, Quadria Capital

NephroPlus is Asia's largest dialysis network, operating more than 520 centers across India, Nepal, the Philippines, and Uzbekistan and serving more than 36,000 patients annually. Quadria Capital invested $101 million in 2024, backing a company that had taken a decade to prove its model. We spoke with Dr. Amit Varma, Managing Partner at Quadria Capital, about why kidney care became a conviction investment, what private capital made possible, and what the company's landmark IPO means for inclusive healthcare investing.

I4H: Quadria followed NephroPlus for nearly a decade before investing. Why the patience, and why did you ultimately pull the trigger?

Dr. Amit Varma: Our investing thesis has always been very dependent on forming a sectoral theme and conviction before we invest. And then, more importantly, finding reasons to get close to the company before we decide to commit. In NephroPlus's case, it took us almost ten years. The first time, we did not believe the company would achieve what they told us they would. The second time, there was a mismatch in valuation. And finally, we were lucky the third time.

The entry thesis was straightforward: dialysis is not a discretionary service. Three to four times a week, for life. In Asia, the infrastructure for patients barely exists beyond urban centers, and treatment costs almost $3,000 annually—which in our part of the world is an arm and a leg. NephroPlus was built to close that gap with pricing sessions at around $20 to $30, 40% below what large hospitals charge. But most importantly, and this was central to our thesis, without undermining the quality of clinical care.

I4H: How is NephroPlus able to deliver at that price point without sacrificing quality?

Dr. Amit Varma: Single-specialty care comes with its own innate model of efficiency. You develop clinical centers of excellence. You hire specialist teams—doctors, nurses, technicians—who are drawn to a specialist model. Your drug and consumables sourcing runs at massive volumes, so you can negotiate deep discounts and narrow the supply chain to two or three providers. And as you get better with volume throughput, the base cost of providing service comes down.

NephroPlus is a classic example of staying in the kidney space. EBITDA margins sit at about 24% healthy for a low-cost, high-volume business. The company is not getting propped up by deployment capital—it is generating its own momentum. Since our investment, the revenues have nearly doubled, and the company went from debt to net cash positive position.

I4H: You emphasize that 77% of NephroPlus centers are in Tier 2 and Tier 3 cities. Why does that matter?

Dr. Amit Varma: This is central to our thesis: bringing healthcare to where patients live, rather than having patients come to where healthcare exists. Dialysis was pretty much unavailable in most of these centers before NephroPlus came in. And given the three big deficits in healthcare in emerging markets—lack of talent, lack of clinical technology, and affordability—we believe NephroPlus is the prototype of how all three can be addressed simultaneously.

We have an academy within NephroPlus that has trained almost 400 dialysis technicians, which helps address the clinical talent bottleneck but also provides employment. In 2024, we ran the largest ever kidney health screening campaign—almost 5,000 people across 26 cities. We don't believe this is an investor relations exercise. This is what a business should look like when affordability is a structural design principle rather than an afterthought.

I4H: What role has Quadria played beyond providing capital?

Dr. Amit Varma: Quite honestly, this is a very well-run company with a management team that has hung around for 10 to 15 years. They've been very receptive to deficits we've pointed out in their business model, especially in operations and where technology could play an added role. But the main role we are playing is helping them expand their geographical footprint.

Beyond India, Nepal, the Philippines, and Uzbekistan, we are now taking them into Indonesia, Malaysia, Vietnam, and—interestingly—Saudi Arabia. The GCC is going through a massive healthcare shift where the era of paying high-cost dollars to Western providers is under strain. They are looking for solutions that are far more capital efficient. And that is something we should be able to crack, provided you can reproduce the highest clinical quality standards repeatedly. That is something this company has done really well.

I4H: NephroPlus went public in December 2025. What did that moment mean?

Dr. Amit Varma: The IPO was oversubscribed 14 times overall—27 times among qualified institutional buyers with anchor participation from marquee global and domestic investors. It was one of the firm's fastest turnarounds, delivering returns to our Fund III investors just seven months after the final close. This was our third successful oversubscribed healthcare listing in India in two years, following Concord Biotech and Akums.

And here's what I think matters most: despite all the geopolitical turbulence and the broader market taking a tumble, NephroPlus is 35% above its listing price. Which tells you that if you are high quality, the capital markets tend to recognize it. That's the proof point for this community—inclusive healthcare and commercial returns are not in tension.

I4H: Looking back over your five years with I4H, what trends define this period for you?

Dr. Amit Varma: I'd highlight five. First, noncommunicable disease is a permanent demand driver—not a cycle. NCDs are responsible for 62% of deaths across South and Southeast Asia, and critically, 52% of those deaths occur before age 70. This is a mid-life, working-age crisis. Second, the China supply chain disengagement has created India's decade—70% of global biotech is struggling with Chinese suppliers, and the China+1 strategy is playing out in our favor.

Third, there's a clear trend toward single-specialty care delivery, now 20% of market share and growing at 10% CAGR, with PE deals rising from 10% to 30% of the space. Fourth, capital markets have validated the healthcare investing thesis—APAC healthcare PE is growing at 21% CAGR. And fifth, digital health is expanding the addressable market, not replacing physical care. AI is an enabler—it will transform drug discovery, radiology, and preventive care at price points that were never imaginable.

Interview conducted for the I4H Five-Year Flagship Report, May 2026

> “Private healthcare is an essential complement—working alongside and complementing public provision, not replacing it.”
>
> —Chris McCahan, IFC

LESSON #2: PUBLIC-PRIVATE COLLABORATION IS ESSENTIAL

Perhaps the clearest lesson from five years of I4H is that private capital alone cannot solve the healthcare access challenge. The most impactful investments have been those that work with—rather than around—public health systems. Public-private partnerships (PPPs) in healthcare take many forms: government co-financing of private clinics, insurance schemes that cover private provider services, regulatory frameworks that encourage quality standards, and blended finance structures that de-risk private investment.

INTERVIEW: IFC

A Conversation with Chris McCahan, International Finance Corporation

The International Finance Corporation (IFC), the private sector arm of the World Bank Group, has been investing in healthcare in emerging markets for over 25 years—longer than almost any other development finance institution. Its portfolio spans health services, pharmaceuticals, and medical technology across every developing region, guided by a mandate to expand quality, access, and affordability. We spoke with Chris McCahan, who helped build IFC’s healthcare practice and was instrumental in the creation of the Investors for Health community, about what IFC has learned about public-private collaboration and why it remains the essential ingredient for closing healthcare delivery gaps.

I4H: IFC has been investing in healthcare for a quarter century. What is the core thesis?

Chris McCahan: IFC uses a three-pronged lens when we look at healthcare: quality, access, and affordability. We invest across health services, medical technology, and pharmaceuticals, and that lens shifts depending on the subsector—but fundamentally, we are looking to strengthen health systems by investing in affordable, high-access, high-quality care.

Our early efforts really started in Latin America about 25 years ago. The rationale was straightforward: governments were not providing universal access, the private sector was stepping in, and the question became—why wouldn't we support affordable, quality private healthcare where it makes sense from a systems perspective? A unit was formed, it grew into a global practice, and healthcare is now seen within the World Bank Group as foundational "human" infrastructure—as important as physical infrastructure and a prerequisite for job creation. You cannot expand agribusiness, you cannot grow manufacturing, you cannot build an economy unless you have healthy citizens.

I4H: The World Bank Group recently set a target of reaching 1.5 billion patients. What does that mean for how IFC invests?

Chris McCahan: The Health 1.5 target is now the organizing principle. The World Bank Group aims to provide access to 1.5 billion patients, facilitated through compacts with governments, and providing a north star to help us prioritize within each subsector. In pharmaceuticals, we are promoting low-cost, affordable drugs but also local manufacturing—particularly on the African continent. In medical technology, it is about affordable, useful devices for low-resource settings at scale, again with a push for local production. And in health services, the sweet spot is tech-enabled primary care.

Critically, this requires ensuring that the private sector operates with a clear lens of mixed health systems—working alongside and complementing public delivery frameworks rather than in isolation.

But the real shift is in how we think about our catalytic role. There is a huge push within IFC, and the World Bank Group overall, around private capital mobilization. We have always seen part of our role as de-risking investments in challenging markets so that other investors can follow. Now that is even more central to what we do, whether through co-investment, advisory work on health quality and ethical principles, or upstream policy and regulatory engagement that makes the environment more conducive to private capital.

IFC SENIOR LOAN

DOSES ANNUALLY

DOSES DELIVERED SINCE 2003

SKILLED JOBS CREATED

I4H: Biovac in South Africa is one of IFC's signature healthcare investments. What does that deal illustrate about public-private collaboration?

Chris McCahan: Biovac is a powerful example of exactly the kind of public-private convergence we believe is essential. Biovac is a South African vaccine manufacturer established in 2003 in partnership with the South African government. It supplies the country's routine pediatric vaccines and has delivered more than 450 million vaccine doses to countries across Southern Africa. In April 2026, IFC led a major financing package—a $20 million senior loan with further mobilization underway—alongside a €75 million quasi-equity investment from the EIB Group, backed by the European Commission and the Gates Foundation. This will fund Africa's first end-to-end multi-vaccine manufacturing facility in Cape Town, with capacity to produce 30 to 40 million doses annually of vaccines for cholera, polio, pneumonia, and meningitis.

What makes Biovac distinctive is the structure of the partnership. This is not IFC acting alone—it is a coalition of multilateral development banks, European institutions, and philanthropic partners working alongside a company that itself is a public-private partnership. And the ambition goes beyond existing products: Biovac is developing new manufacturing capabilities with international partners, positioning South Africa as a hub for vaccine production on the continent. The facility will create over 340 skilled jobs and 7,000 indirect jobs, and will address approximately 40% of the global cholera vaccine supply gap.

When you combine public policy commitment, private operational capability, and development finance willing to de-risk the investment, you can build the kind of infrastructure that makes entire health systems more resilient.

I4H: Tell us about AIM2030 and what it represents for the future of pharmaceutical manufacturing in Africa.

Chris McCahan: AIM2030 is the Africa Investment and Manufacturing 2030 initiative led by the World Bank Group together with the African Union Commission. The goal is ambitious but necessary: to double Africa's pharmaceutical manufacturing capacity by 2030. It operates across three pillars: investing in foundations like infrastructure, human capital, and digital systems; enabling policy reforms including regulatory harmonization; and mobilizing private sector investment through partnerships and blended finance.

The initiative is focused on nine countries—Egypt, Ethiopia, Ghana, Kenya, Morocco, Nigeria, Rwanda, Senegal, and South Africa—and it contributes directly to the Health 1.5 target. Biovac is an early example of the type of market-shaping investment AIM2030 is designed to support. But what is most important is the recognition that not every country will become India in pharmaceutical manufacturing. The question is where each country can position itself in the value chain based on the maturity of its workforce, its technical capacity, its regulatory environment, and other enabling factors. Some will produce finished dosage forms; others will focus on active pharmaceutical ingredients or upstream inputs. The point is that local manufacturing reduces dependency, creates jobs, and makes health systems more resilient—and it requires exactly the kind of public-private collaboration that IFC has been building for 25 years within health systems.

I4H: Over five years, what trends have defined this period in healthcare investing?

Chris McCahan: I would highlight three. First, there is much more recognition of the role of the private sector. When we started more than 25 years ago, there were not many DFIs or impact investors interested in the healthcare space. Now there is a growing realization that private healthcare is a critical part of the whole health system; not a competitor to public provision but an essential complement. More investors, including impact investors and socially conscious capital that previously shied away from healthcare, are entering the space.

Second, we have seen a proliferation of innovative models, many riding on the back of technology changes. AI-native companies are getting tremendous investor attention for their potential to scale at lower cost and reach down-market—though the jury is still out on some of these models. Technology, when combined with operational discipline and rigorous outcome measurement, can transform diagnostic delivery across entire health systems.

And third—and this is perhaps the most important—there has been a real convergence of public and private. Governments are increasingly seeing the private sector not as something just to tolerate but as an important partner with which to integrate, both from a policy and regulatory perspective and through direct contracting and financing arrangements. Everything has matured. That convergence is what makes investments like Biovac and initiatives like AIM2030 possible.

I4H: What has made IFC's healthcare investments successful—and what has gone wrong?

Chris McCahan: It starts with having a business model that is relevant for the market—and a market that is ready for the business model. Then a strong management team. If you look back at our investments, the ones that have gone badly have usually been because something was wrong fundamentally with the business or clinical model, with the management team, or because that public-private arrangement did not work—for example, a social health insurance scheme fell apart, a government contract was not honored, or the enabling environment shifted.

The lesson for our I4H community is that the enabling environment matters as much as the company itself. This is why IFC invests not just capital but advisory capacity—working on health quality standards, ethical principles, and regulatory frameworks. De-risking is not just a financial exercise; it is about shaping the conditions in which private healthcare can deliver for patients and for investors.

I4H: What is the value of a community like Investors for Health?

Chris McCahan: I think there is huge value. One of the original premises was really aligning around the core principles of what should be in place to invest in private healthcare—what are the stumbling blocks, what are like-minded investors similarly facing—and instead of everyone individually trying to grapple with these challenges in isolation, working together to find the best approaches.

That still holds, especially with the enormous technology changes and with markets shifting so much across different geographies. Having a community that can raise examples, share practical learnings, and communicate those with partners, including governments, is critically important. And then there is the advocacy piece: showing the relevance and importance of private healthcare within the broader ecosystem. It is one thing if a single institution says that. It is quite another when a whole community says it. It carries real weight with policymakers and other investors who are still on the sideline.

Interview conducted for the I4H Five-Year Flagship Report, May 2026

> “Technology can accelerate scaling in healthcare… when built on a strong foundation of patient trust.”
>
> —Dana Deardorff, J&J Impact Ventures

LESSON #3: TECHNOLOGY IS AN ENABLER FOR SCALE

A recurring theme across I4H members’ portfolios is that technology—when deployed thoughtfully—can overcome the infrastructure and talent constraints that have historically limited healthcare access in emerging markets. Digital health platforms extend specialist expertise to remote areas. AI-assisted diagnostics compensate for physician shortages. Mobile-first distribution models reach patients who cannot access traditional pharmacies. But technology alone is insufficient without the human capital to implement and sustain it—a constraint that makes health workforce development inseparable from technology investment.
Penda Health exemplifies this dynamic. A Kenyan primary care network supported by J&J Impact Ventures, Penda currently operates 20+ clinics serving overhalf a million patients each year. In 2024, Penda partnered with OpenAI to develop and deploy an AI clinical copilot that assists clinicians with real-time diagnostic suggestions and treatment protocols. Early results with actual clinical implementation showed a 16% reduction in clinical errors—a meaningful improvement in settings where misdiagnosis is a leading cause of poor health outcomes. The investment illustrates how technology, combined with strong operational foundations, can improve quality and safety at scale.

Case Study: Penda Health—J&J Impact Ventures (JJIV)

- Penda Health operates 20+ primary care clinics across Kenya, which have served over two million patients with a technology-enabled, high-quality but affordable care model. In 2024, Penda partnered with OpenAI to deploy an AI clinical copilot that provides real-time diagnostic support to clinicians, achieving a 16% reduction in clinical errors in early pilots. JJIV’s investment supported Penda’s expansion from a smaller traditional clinic to a technology-forward primary care platform that demonstrates how AI can be an equalizer—bringing specialist-level clinical decision support to lower-resourced settings.

INTERVIEW: PENDA HEALTH / J&J IMPACT VENTURES

A Conversation with Caitlin Bristol and Dana Deardorff, J&J Impact Ventures

Penda Health is one of East Africa's largest outpatient healthcare networks, operating 20+ clinics across Kenya and has engaged more than two million patients. J&J Impact Ventures (JJIV), an investment fund in the Johnson & Johnson Foundation, first invested in 2022, supporting Penda's growth from a trusted community care provider into a technology-forward platform. We spoke with Dana Deardorff and Caitlin Bristol of JJIV about why they invested, what they've learned, and how technology helped with scaling.

I4H: Why did JJIV invest in Penda Health? What drew you to this company?

Dana Deardorff: The need for high-quality primary healthcare exists all around the world. But delivering that in an environment like Nairobi is extremely challenging with limited health system infrastructure, significant cost-sensitivity of patients, and competition from lower-quality providers. What drew us to Penda is that they were up for that challenge… our investment thesis focused on the belief that if anyone could make a sustainable model with high-quality affordable primary care – it was going to be this team. And not because they had everything figured out already, but because they were willing to address the hard questions and build a solid foundation of rigorous business and clinical operations while still putting patients first and earning their trust.

It was on this foundation that we saw the potential for them to scale more efficiently with technology integration, even before AI models were so common. Our role was to provide catalytic capital and other support to help them grow from a traditional clinic model into a tech-enabled healthcare platform.

I4H: You've spoken about technology as an "enabler." What does that mean in Penda's case?

Dana Deardorff: In healthcare, technology is often not the whole solution by itself. We have seen more failures than successes from companies pushing a pure technology approach onto customers instead of truly understanding patient needs and how to embed solutions within the complexity of clinical care. But for companies that have a clear value proposition, especially those grounded in patient trust, technology can enable acceleration of that value delivery at scale.

And that's what happened at Penda.They didn't start with a telehealth app, or an AI tool, or even a digital EMR. They started with consistently caring for patients, building trust in the communities they served. Once that was established, the technology integration then became a more natural evolution that helped to amplify the work and scale more efficiently.

I4H: Can you give us a concrete example of how technology has changed outcomes at Penda?

Caitlin Bristol: There are two strong examples. The first is patient engagement through Turn.io, which is actually another JJIV portfolio company. Turn.io powers Penda's WhatsApp-based outreach—culturally contextualized health messaging that meets patients where they already are. When Penda switched from SMS to WhatsApp, response rates jumped from about 3% to 20%, and they saw a 25 to 30% lift in patient retention. That's a massive change in a market where keeping patients engaged with preventive care is one of the hardest challenges.

The second is the partnership with OpenAI. Penda deployed an AI clinical decision support copilot that's fully integrated into all their clinics and electronic health records. It runs in the background during every patient visit and acts as a real-time safety net, flagging potential issues or diagnostic gaps and making treatment recommendations. In the first real-world study of its kind with 40,000 patient visits, it reduced diagnostic errors by 16%. That's a significant improvement in quality of care - not by replacing doctors and nurses, but making them better at what they already do taking care of patients.

CLINICS ACROSS KENYA

PATIENTS ENGAGED

FEWER DIAGNOSTIC ERRORS

I4H: JJIV talks a lot about "beyond capital." What did that look like with Penda?

Caitlin Bristol: Our support went well beyond the check. We have a secondment program at Johnson & Johnson, where we place employees with our portfolio companies for six-month engagements contributing 20 to 40% of their time on defined projects. Penda was able to benefit from multiple secondments of talented employees in areas like pricing strategy, business process automation, and HR and payroll systems. This type of pro bono support can be very helpful to a smaller company like Penda that has resource constraints as they are trying to scale.

And the Turn.io and Penda connection is a great example of how our portfolio companies can reinforce each other. Turn.io powers the WhatsApp channel that keeps patients engaged, and Penda is the care platform that delivers on the promise of that engagement. That kind of portfolio synergy is something we are actively working to cultivate as investors.

I4H: What does the Penda story tell us about investing in healthcare in emerging markets?

Dana Deardorff: I think the main thing it tells us is this type of investing can be very challenging but also very rewarding. It's challenging in the time and effort required to build effective solutions for the complex problems with healthcare in emerging markets. Penda's success has certainly not come overnight, and they worked hard to build the operational foundation that could then be scaled. But definitely rewarding to see the impact – both in terms of the patients reached but also in the value creation for the business. Which is why we would like to see more investors in this space. Imagine if each of us who is active in healthcare impact investing brings in just one more investor over the next year—someone sitting on the sidelines, or maybe investing in other sectors—to double the number in the space. That could change the trajectory of healthcare access in emerging markets.

Interview conducted for the I4H Five-Year Flagship Report, April 2026

> "Catalytic capital should be a jumpstart, not a perpetual safety blanket."
>
> —Afsane Jetha, Alta Semper Capital

LESSON #4: PATIENT AND CATALYTIC CAPITAL IS STILL NEEDED

Despite the growth in commercial healthcare investment, the I4H experience has reinforced that patient and catalytic capital remains essential, particularly for business models that serve the hardest-to-reach populations. Inclusive healthcare enterprises often operate on extended timelines because they must simultaneously build demand, trust, infrastructure, and regulatory legitimacy before scale becomes possible. Investing early in robust infrastructure and regulatory compliance ensures that, as these platforms scale, they achieve both meaningful social impact and strong financial returns.

One of the most persistent misconceptions in impact investing is that capital alone is sufficient. In reality some of the most important healthcare innovations emerge in markets where commercial incentives are weakest, purchasing power is lowest, and infrastructure is least developed. In such settings, patient and catalytic capital are not substitutes for commercial investment; they are often prerequisites for it.

MYDAWA, a Kenyan digital pharmacy platform backed by Alta Semper Capital, illustrates both the promise and the patience required. MYDAWA has reached 1.8 million patients through a “bricks-and-clicks” model that combines an online pharmacy with physical dispensing points, achieving 30%+ annual revenue growth. Unlike traditional e-commerce, pioneering a new frontier in digital healthcare requires a deliberate, strategic approach, requiring Alta Semper to provide patient capital and active board engagement to navigate regulatory complexity, build consumer trust, and develop the logistics infrastructure needed for last-mile pharmaceutical delivery. As Afsane Jetha frames it, catalytic capital should be “a jumpstart, not a perpetual safety blanket”—the goal is to de-risk innovations that private capital can then scale, not to subsidize business models indefinitely. The Gates Foundation’s telemedicine grant to MYDAWA exemplifies this principle: it provided a $3 million investment that proved a new care delivery model, which Alta Semper then commercialized to reach millions of patients annually.

The MYDAWA experience suggests a broader principle: catalytic capital is most effective when it does not replace markets but creates them. Its purpose is to absorb uncertainty that commercial investors cannot justify bearing alone, thereby enabling business models that can ultimately stand on their own. Behind the investment thesis lies a public-health reality: millions of patients face a choice between unaffordable medicine and unreliable medicine. MYDAWA’s significance lies not only in lowering costs but in increasing trust in the pharmaceutical supply chain itself.

Case Study: MYDAWA—Alta Semper Capital

- MYDAWA is a Kenyan digital pharmacy platform that has served 1.8 million patients through its integrated online-and-offline "bricks-and-clicks" model, achieving over 30% annual revenue growth. The platform makes genuine, affordable pharmaceuticals accessible to patients who previously relied on informal markets with high counterfeit risk. Alta Semper's investment required patient capital and active operational support, navigating Kenya's evolving pharmaceutical regulations, building last-mile delivery infrastructure, and investing in consumer education, demonstrating that catalytic capital can unlock scalable, commercially viable models in underserved markets.

INTERVIEW: MYDAWA / ALTA SEMPER

A Conversation with Afsane Jetha, Alta Semper Capital

MYDAWA, founded in 2017, is Africa's largest online pharmacy and telemedicine platform. Operating across Ethiopia, Kenya, Mozambique, Tanzania, and Uganda, it has served millions of patients through a model that integrates pharmaceutical e-commerce, free telemedicine consultations, laboratory services, and chronic disease management—delivering medication 20 to 60% cheaper than high street pharmacies. Alta Semper Capital, a thematic investor focused exclusively on healthcare in Africa, first invested in MYDAWA in 2021 through a convertible during COVID. We spoke with Afsane Jetha, Managing Partner and CEO of Alta Semper, about why patient capital matters, what catalytic funding can and cannot do, and what the MYDAWA story reveals about filling healthcare delivery gaps in emerging markets.

I4H: What drew Alta Semper to MYDAWA? What problem were you trying to solve?

Afsane Jetha: We are a thematic investor: we only invest in healthcare, consumer health, health education, and health technology. So we are always looking for business models that move forward our mission but are doing something different. The statistics are ones we all know but many others may not: Africans pay more for medication than residents of any other continent in the world, including North America, yet have a GDP per capita one-twentieth that of residents elsewhere. Also, 60 to 70% of medication on the continent is counterfeit or expired. People are overpaying for things that are pretty low quality.

The supply chain is anachronistic—decades old, not tech-enabled, heavily reliant on imports of mixed quality, and supplied by over-leveraged distributors with painful working capital cycles. Most African countries do not have large pharmacy chains or governments negotiating on behalf of consumers the way the NHS does in the UK. Then if you look at primary care access, Africa has anywhere from one-hundredth to one-thousandth the number of doctors it needs.

MYDAWA seemed to tick a lot of boxes. It was disrupting the supply chain, sourcing generics from audited factories in India, tracking the molecule from factory to end consumer with its own technology, holding its own drug distribution license. Because it was largely online with an efficient warehouse rather than fancy stores, it cut out a lot of the fixed costs. Also, it was starting to layer telemedicine on top. Today it is by far, by probably many multiples, Africa's largest online pharmacy and telemedicine business. Since our initial investment, it has grown 600% in revenues and is essentially break-even. We choose to continue investing in growth.

I4H: The Gates Foundation played a role in MYDAWA's telemedicine platform. How did that catalytic capital work in practice?

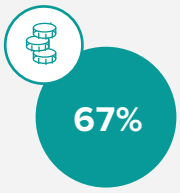
Afsane Jetha: Like many things in Africa, it was a bit of an accident of history. The Gates Foundation was trying to monitor their preventative HIV patients in Kenya and found that the programs they were funding through the government were not set up to provide patient tracking and KPIs. So they came to us and said: If we build you a telemedicine platform, you can keep it, but can we use it to track our PrEP patients? We said sure.

What we then discovered was extraordinary. If you give someone a free doctor visit, 67% of those people actually buy something from your pharmacy. They tend to be your most loyal customers, with the highest average order value. A third then need a blood test, which we refer within our network; the results get uploaded, the doctor reviews them, writes a prescription, and you get this virtuous circle of more access and more sales. We ran a trial in a semi-rural location, sent everyone a text message offering a free doctor visit. We expected 200 responses. We got 4,000. Fifty percent of those people ordered something from us, and many had not seen a primary care provider in years—most presenting with hypertension and diabetes.

The Gates grant was about $3 million in two tranches. Probably if we had allocated that capital to a small acquisition or a new warehouse, it would not have passed muster on a weighted average cost of capital basis. However, because Gates de-risked the CapEx build, we were able to commercialize the technology and massively amplify the impact. We now see millions of patients a year through telemedicine. That is what catalytic capital should do: prove a new model that private capital can then scale.

REVENUE GROWTH

CHEAPER THAN PHARMACIES



TELEMED-TO-PURCHASE CONVERSION

BRAND AWARENESS IN KENYA

I4H: You have strong views on what patient and catalytic capital should—and should not—do. Can you elaborate?

Afsane Jetha: Catalytic capital can be a jumpstart, but it cannot be a perpetual safety blanket. We talk about this a lot internally: we do not want to be "bubble wrap capital." If you wrap a critically important business—say, the largest provider of cancer care in a country, in permanent subsidy, the minute you sell it, that is a systemic risk to the whole country's healthcare system. You have an obligation to make sure a business can wash its face. The challenge for investors is not deciding whether catalytic capital should exist, but determining when it has accomplished its purpose.

There is a great role for philanthropy to support businesses, and we are actually catalytic in some instances ourselves; as a thematic fund, we are willing to take more risk than a generalist buyout fund because we know these industries deeply. What we like to do is anchor large, profitable, stable businesses and then, either with our own capital or with catalytic capital, test innovations within those business models. The Gates–MYDAWA example is perfect: MYDAWA was a stable, growing, unit-economic-positive business. Nobody knew if telemedicine was going to work. Gates stepped in and de-risked the CapEx build because it was valuable to them on the philanthropic side. Instead of owning it, they let us keep the technology, and we commercialized it.

A lot of catalytic capital should be pushed into technologies and therapies that enhance health equity but bring down the unit economic cost without compromising quality. Often we see it actually increases quality. However, you have to be very careful that catalytic capital is not being used to distort markets or perpetually subsidize business models that should be commercially viable.

I4H: Over the last five years, what trends have defined healthcare investing in Africa and other emerging markets?

Afsane Jetha: If you look at the private equity sector in Africa, it started in earnest with infrastructure and power, then telecoms, then the banking boom, then the big consumer wave. When we started Alta Semper, we were at the beginning of that consumer wave, but you were not seeing healthcare deals because people still had a mindset that African governments were consumers but not patients. No one could conceive that you could make money investing in healthcare in frontier markets.

Then investors got smarter. They looked at what had worked in emerging Asia; hospitals in India, medical devices, labs, pharmacies and a wave of CapEx-light, outpatient primary care investments began. We see that trend maturing now. What is really taking off is disruptive medtech: online pharmacy, telemedicine, AI-based imaging. The beauty of being in a frontier market is that there is nothing there to begin with, so you can invest in low-cost, disruptive technologies that are frankly better and able to reach the last mile.

We are also seeing a huge shift toward health, wellness, supplements, and nutrition, both from pharma companies whose margins are being squeezed by generics and biosimilars, and from consumer companies realizing that people do not want ultra-processed food. Also, precision medicine, where understanding the uniqueness of the individual is reshaping treatment. Africa and emerging Asia can leapfrog legacy systems entirely—that is the opportunity.

I4H: Are you seeing shifts in how limited partners think about healthcare as an asset class?

Afsane Jetha: Yes, from several directions. One of our largest DFI investors actually doubled their commitment to our fund spontaneously at the end of their due diligence. When we asked why, they said it was a policy decision: they want to stabilize regions in conflict, reduce migration, and ultimately shrink their aid budgets, and when they looked at the root causes, a lot of it is poverty driven by lack of access to healthcare.

We also have investors with explicit impact mandates who want benchmark commercial returns with real, measurable impact. They want to know how many patients you served, how many medicines you sold, how much cheaper your products are. With MYDAWA, we can provide that data—it is auditable and tangible.

However, the newest and most encouraging trend is among sophisticated investors who are starting to understand that businesses with impact embedded in their DNA are simply better businesses, less volatile and with more customer engagement, more motivated employees, and more government support. At MYDAWA, the average employee age is 28, and many have left Google, Nestlé, and Unilever to work in a mission-driven business. We have 41% unprompted brand awareness in Kenya, second only to Amazon. That kind of loyalty cannot be bought with marketing spend alone. It comes from people feeling that a business genuinely cares about them.

I4H: What has the Investors for Health community meant to Alta Semper?

Afsane Jetha: It has been encouraging, refreshing, and deeply educating. As a specialist healthcare investor, to learn from peers who have done this in different markets and different verticals and who have been very open about sharing what has worked and what has not, is invaluable. People have put us in touch with management teams, potential partners, and employees.

It has also been a different way to build relationships with the investor community. We engage with corporate members and DFIs in a setting where we are not pitching, they just hear us talk about our work and think, that makes sense. It has been very legitimizing for the asset class. There are still people who think healthcare in emerging markets is not really investable. To see credible groups like MSD, J&J Impact Ventures, Dalberg, and larger peers rallying around this as a real, legitimate, growing, attractive asset class, that carries weight. Every time we have an I4H event, I come across someone doing exactly what we are doing in a different market, and I learn something. I just wish we had more members.

Interview conducted for the I4H Five-Year Flagship Report, May 2026

The lesson from MYDAWA is not that patient capital should replace commercial discipline. Quite the opposite. Patient and catalytic capital are most effective when they accelerate the journey toward commercial sustainability. The goal is not perpetual subsidy but the creation of durable enterprises capable of delivering affordable health care at scale. In emerging markets, where the greatest needs often coincide with the greatest uncertainty, this bridge between innovation and investment remains indispensable.

The broader significance of MYDAWA extends beyond pharmacy distribution. It illustrates how sectors evolve. What begins as a philanthropic or catalytic intervention can, if the underlying economics prove sound, mature into an investable market capable of attracting mainstream capital.

> “What gets measured gets funded.”
>
> —Ken Gustavsen, MSD

LESSON #5: MEASURING OUTCOMES IS ESSENTIAL TO DEMONSTRATE RESULTS

A persistent challenge in healthcare investment is the gap between capital deployed and outcomes demonstrated. Many investors track financial returns and basic output metrics (number of facilities, patients served) but struggle to measure whether their investments actually improve health outcomes—survival rates, early detection, quality-adjusted life years, patient satisfaction. I4H’s experience suggests that rigorous impact measurement is not just a reporting exercise: it is essential to attracting new capital, holding investees accountable, and building the evidence base for inclusive healthcare investment. Mamotest, part of the Impact Venture Fund of I4H member company MSD *(known as Merck in the U.S. and Canada)*, clearly illustrates this lesson.

Case Study: Mamotest / Bolder—MSD

How Rigorous Impact Measurement Turned a Telemammography Network into a Global Diagnostic Imaging Integration Platform

Breast cancer is the most common cancer among women globally, yet in Latin America the majority of cases are detected late—when treatment is costliest and least effective. Founded in Argentina in 2013 by Guillermo Pepe, Mamotest set out to change this equation. As the first telediagnostic platform for breast cancer detection in the region, Mamotest pioneered an asset-light, data-driven model that combines AI-powered diagnostics with remote medical interpretation to bring screening to communities that had never had access. Now backed by MSD, Philips Foundation, J&J Impact Ventures, and others, Mamotest’s journey from serving a single Argentine province to reaching patients in three countries illustrates a lesson that resonates across the I4H community: measuring outcomes is not just good practice—it is what makes the difference between a promising pilot and a platform that attracts capital and scales.

“What gets measured gets funded. If you cannot show investors and partners the impact a company is having—both business impact and social impact—in hard numbers, you will struggle to move from a project to a platform.”

—Ken Gustavsen, MSD

The Diagnostic Gap

Seventy percent of clinical decisions depend on a medical image. Yet in underserved regions of Latin America, patients routinely wait 48 to 96 hours for a diagnosis, diagnostic backlogs are chronic, and service-level agreements hover at just 60 to 70%. The problem is not a shortage of radiologists—it is the maze of disconnected systems. Moving between the study and the diagnosis requires nine steps using different technologies with zero integration. Each handoff creates friction. The cumulative effect is a system that loses 30 to 35% of potential revenue to backlog and wastes roughly 18% of costs on workflow inefficiency.

From Screening Network to Diagnostic Platform

Mamotest's first insight was that the problem was not the radiologists—it was the system around them. Over 12 years operating diagnostic imaging networks in various settings—under real service-level pressure, with real patients waiting—Mamotest developed deep expertise in the end-to-end diagnostic workflow. That operational knowledge became the foundation for Bolder, an AI-powered integration layer that connects radiologists, institutions, and diagnostic workflows into a single intelligent system, deployed on top of existing infrastructure. No migration. No disruption. The results are striking: turnaround time drops from 48 to 96 hours to under 24 hours; SLA compliance jumps from 60 to 70% to above 99%; and chronic backlogs are eliminated entirely.

PATIENTS SCREENED

EARLY DETECTION RATE

COUNTRIES

TURNAROUND TIME

Measuring What Matters

What distinguishes Mamotest (now Bolder), from other telehealth ventures is the granularity of its impact data. The company tracks not just volume—screenings performed, images read—but outcomes: early detection rates, time-to-treatment, the proportion of patients accessing care they otherwise might not obtain (estimated at 70 to 80%), and the economic value of backlog elimination. This data discipline was not an afterthought; it was a design choice from the beginning. For investors like MSD, that rigorous impact measurement is essential to demonstrating not just current value, but also for attracting follow-on capital and driving the commercial and social

value of inclusive diagnostics. The results have spoken: Bolder is now processing 24,500 studies per month with $3.1 million in annual recurring revenue, 194% year-over-year growth, and zero churn.

The Corporate Investor's Role

MSD's involvement with Mamotest reflects a broader corporate philosophy. With a $60 million Impact Venture Fund portfolio invested to advance health access and reaching more than 36 million people since 2018 in low- and middle-income countries, MSD brings not just capital but institutional credibility and a culture of evidence-based decision-making. The fact that three of the world's leading healthcare institutions—MSD, Philips Foundation, and J&J Impact Ventures—have all backed Mamotest's evolution into Bolder sends a signal to the market: when impact is measured rigorously, corporate and institutional investors will follow.

"Several institutions that understand this problem best have already committed to solutions like Mamotest / Bolder. That's not a coincidence—it's because the data makes the case." —Ken Gustavsen, MSD

Written by Ken Gustavsen, MSD, and I4H, for the I4H Five-Year Flagship Report

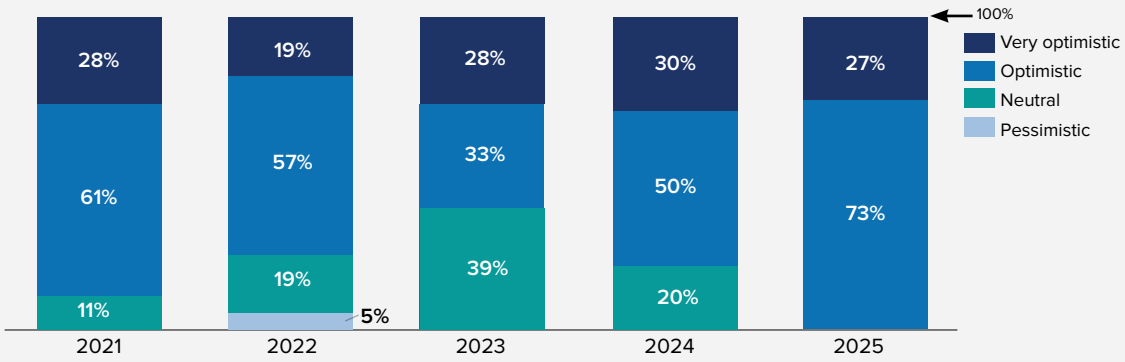
04.

LOOKING AHEAD — WHAT THEN MUST WE DO

By **Dr. Stephen M. Sammut**, Adjunct Associate Professor of Management, Senior Fellow, Health Care Management, The Wharton School, University of Pennsylvania; Operating Partner and Chairman, Industry Advisory Board, Alta Semper Capital

Figure 8: Despite turbulent era for investment I4H members remain optimistic about investment activity year after year

How optimistic are you, on a scale from one (very pessimistic) to five (very optimistic), that you will reach your healthcare investment target for the next year? % of survey respondents (n = 15)



Five years is a short time in the life of a health system, but it is long enough to test a hypothesis. When Investors for Health was formed in 2020, the question before us was straightforward but consequential: could private capital, deployed responsibly and in partnership with public institutions, meaningfully contribute to improving healthcare access, quality, and affordability in emerging markets, and at the same time advance the professionalism and welfare of the providers themselves?

The evidence assembled in this report suggests that it can. Over the past five years, members of this community have expanded healthcare assets under management, increased investment activity, and supported enterprises that now serve millions of patients across Africa, Asia, Latin America, and the Middle East. We have seen dialysis networks reach underserved cities, digital health platforms extend access to care, pharmaceutical manufacturers strengthen local supply chains, and diagnostic companies demonstrate that better outcomes can accompany commercial success.

These are important accomplishments. They demonstrate possibilities. But they do not demonstrate completion.

The healthcare gaps that motivated the formation of I4H remain substantial. Half of the world's population still lacks access to essential health services. The financing gap required to achieve Universal Health Coverage is projected to reach $371 billion annually by 2030. Climate-related health burdens are increasing. Noncommunicable diseases continue to rise. Health workforce shortages remain severe. Supply chains remain vulnerable to geopolitical disruption. And the landscape has grown more complex: climate-driven disease burdens, antimicrobial resistance, the lingering structural damage of the COVID-19 pandemic, and geopolitical disruption of pharmaceutical supply chains have all intensified.

The question before us, therefore, is no longer whether inclusive healthcare investing is possible. The question is whether we will act and deliver at the scale that the evidence now demands.

This is, in essence, the question posed by the title of this chapter. Tolstoy's famous query—What Then Must We Do?—was not fundamentally an economic question. It was a question about responsibility. Once we understand a problem and recognize that solutions are possible, what obligations follow? The past five years have given us sufficient evidence to ask that question seriously.

From Proof of Concept to Responsibility

The first phase of any new field is proving that it can work. For many years, healthcare investing in low- and middle-income countries was viewed skeptically from multiple directions. Some doubted whether commercially sustainable healthcare enterprises could serve low-income populations. Others questioned whether private investment could contribute positively to health systems at all. Still others believed that the risks were simply too great for meaningful institutional participation.

The experiences documented in this report suggest a more nuanced reality. Private capital is not a substitute for public health systems. It cannot replace governments, public financing, public health programs, or national health priorities. Nor should it attempt to do so. At the same time, the evidence increasingly suggests that private capital can play an important role in expanding healthcare capacity, improving quality, accelerating innovation, strengthening supply chains, and extending services to populations that would otherwise remain underserved.

The lesson is not that markets alone can solve healthcare challenges. The lesson is that functioning health systems require contributions from both public and private actors, each operating within their respective strengths and responsibilities.

Reasonable observers will continue to debate the appropriate role of private capital in healthcare. Such scrutiny is appropriate. Healthcare is too important to be governed by ideology of any kind, whether market ideology or anti-market ideology. The relevant question is not whether private capital should participate in healthcare. The relevant question is under what conditions it contributes most effectively to access, affordability, quality, equity, and system resilience. The experiences of the I4H community over the past five years provide several answers.

I would propose that the next phase of work for I4H and its peer communities be organized around six imperatives.

First, We Must Contribute to Building Complete Health Systems

Many healthcare investments focus naturally on providers—hospitals, clinics, diagnostic networks, and physician services. These investments are essential. Yet they represent only one part of a functioning health system.

Healthcare is ultimately an ecosystem—an extended value chain. Providers require payers. Payers require manufacturers. Manufacturers require distributors. All require infrastructure, regulatory capacity, technology, and skilled people. When any of these components are missing, the entire system suffers.

The next phase of healthcare investment in emerging markets must therefore move beyond isolated interventions toward more deliberate strengthening of healthcare value chains. The lesson emerging from companies such as NephroPlus is instructive. Clinical excellence alone would not have enabled expansion into underserved regions. Partnerships with government insurance programs were equally important. Similarly, investments in pharmaceutical manufacturing, medical oxygen production, diagnostics, and distribution networks create benefits that extend far beyond individual enterprises.

The goal should not simply be to build successful companies. The goal should be to build stronger systems—to complete the healthcare value chain. Investors should increasingly evaluate opportunities not only on their standalone merits but also on their contribution to the broader healthcare ecosystem.

Second, We Must Mobilize Capital at a Different Order of Magnitude

The I4H community today stewards nearly $14.8 billion in healthcare assets under management. This represents meaningful progress. It is also insufficient. The financing needs associated with Universal Health Coverage—workforce development, pharmaceutical manufacturing and access, digital infrastructure, climate resilience, and chronic disease management—exceed the resources of any individual fund, institution, or investor community.

The community's own data shows that members intend to make an average of five new investments per organization in 2026, suggesting continued growth but at an incremental pace. To close the healthcare financing gap, the sector needs mechanisms that bring in institutional capital at scale: blended finance structures that use catalytic and concessional tranches to de-risk commercial investment, standardized impact metrics that satisfy institutional due diligence requirements, and secondary market mechanisms that provide liquidity to early-stage healthcare investors.

The NephroPlus IPO—oversubscribed 14 times—demonstrates that public markets can validate inclusive healthcare models. The challenge is to create more exit pathways and, in doing so,

to attract the pension funds and sovereign wealth pools whose participation is essential to reaching the hundreds of billions required. Encouragingly, LP attitudes are shifting: development finance institutions are increasing commitments to healthcare funds as a strategy for regional stabilization, while sophisticated investors are recognizing that businesses with impact embedded in their DNA—such as MYDAWA, whose employees leave global corporations to work in mission-driven healthcare—often outperform on talent retention and brand loyalty.

The most important lesson from the past five years may not be the amount of capital deployed by I4H members themselves. It may be the demonstration that healthcare in emerging markets can generate both measurable impact and attractive financial returns. The task now is to transform isolated proof points into a recognized investment category. This will require better exit pathways, more sophisticated blended-finance structures, greater standardization of impact metrics, and stronger mechanisms for sharing risk across public, philanthropic, and private investors.

It will also require advocacy—not advocacy for any individual organization, but advocacy for the proposition that healthcare investment is an essential component of economic development. Every successful healthcare enterprise should be viewed not only as a portfolio outcome but as an invitation for additional capital to enter the sector.

Third, We Must Treat Technology as Infrastructure

Technology featured prominently throughout many of the investments highlighted in this report. Yet one of the most important lessons from these experiences is that technology succeeds when it strengthens systems rather than attempts to replace them.

Penda Health did not begin with artificial intelligence. It began with clinical quality, operational discipline, and patient trust. Mamotest did not begin as a software company. It began by solving real-world diagnostic bottlenecks. MYDAWA did not begin as a technology platform. It began by addressing failures in pharmaceutical distribution. In each case, technology became powerful because it was built upon operational foundations.

This distinction matters. The future of healthcare innovation in emerging markets is unlikely to be defined by technology for its own sake. It will be defined by technology that extends the reach of scarce clinical talent, integrates fragmented systems, reduces costs, improves quality, and expands access.

The relevant question is not whether technology—particularly AI—can replace healthcare professionals. The relevant question is whether it can empower them. Investors who understand this distinction will allocate capital more effectively and build enterprises that endure beyond technological cycles and market fashions.

Frontier markets offer a particular advantage: with limited legacy infrastructure to displace, they can leapfrog directly to low-cost, technology-enabled models—from online pharmacy to AI-based imaging to telemedicine—creating healthcare systems that are more efficient and accessible than those in developed markets.

Fourth, We Must Measure What Matters

Perhaps no lesson emerged more consistently from the experiences of I4H members than the importance of rigorous outcome measurement. For too long, both investors and development institutions have relied heavily on inputs and outputs. Dollars invested. Facilities constructed. Patients served. These metrics are useful. They are not sufficient.

What ultimately matters is whether patients live longer, recover more quickly, avoid disease, receive earlier diagnoses, or gain access to services that would otherwise remain unavailable. The experience of Mamotest demonstrates what becomes possible when impact measurement is designed into a business model from the beginning. Early detection rates, turnaround times, and treatment pathways provide a much richer picture of impact than simple activity measures alone.

This matters not only for accountability but also for capital formation. Investors increasingly demand evidence. Policymakers increasingly demand evidence. Patients deserve evidence. The future growth of inclusive healthcare investing will depend heavily on the sector's ability to demonstrate outcomes with the same rigor that it demonstrates financial performance.

I4H is well positioned to lead on this front. The community has five years of survey data, case studies, and portfolio evidence that few peer networks can match. The next step is to codify this into a shared measurement framework—one rigorous enough to satisfy institutional investors but practical enough to be adopted by portfolio companies operating in resource-constrained environments. The I4H framework's dual lens of sustainability and inclusiveness provides the intellectual scaffolding. What is needed now is the operational architecture to populate it with data.

What gets measured gets improved. And increasingly, what gets measured gets funded.

Fifth, We Must Invest in People

No health system can function without skilled people—and the talent deficit in emerging markets remains one of the most binding constraints on progress. Sub-Saharan Africa has a physician-to-population ratio of 18 per 100,000, compared to 170 in India and 370 in France. Without the full range of physicians, nurses, and allied health professionals, the clinics that I4H members finance cannot be staffed, the technologies they invest in cannot be maintained, and the health systems they seek to strengthen cannot be led.

Every discussion of healthcare eventually arrives at the same constraint. People. Clinicians. Managers. Technicians. Engineers. Supply-chain specialists. Data scientists. Regulators. Healthcare ultimately remains a human enterprise. Across emerging markets, workforce shortages represent one of the greatest obstacles to improving healthcare access and quality. New facilities require staff. New technologies require expertise. New enterprises require leadership. Without sufficient human capital, financial capital cannot achieve its full potential.

This is a dimension of healthcare investing that our community has not yet addressed with sufficient urgency. The NephroPlus academy—which has trained almost 400 dialysis technicians—offers a model: embedding workforce development within the portfolio company itself, so that talent creation becomes a business function rather than an externality. The JJIV secondment program, which placed Johnson & Johnson professionals at Penda Health for six-month rotations, represents another approach: using the corporate investor's own human capital to fill operational gaps that would otherwise constrain growth.

But these are isolated examples. What is needed is a systematic commitment to building the next generation of healthcare leaders in emerging markets—through management education programs designed for the realities of low-resource health systems, through clinical training partnerships that keep talent in-country rather than feeding the brain drain, and through deliberate investment in the healthcare management and administration capabilities that determine whether a well-conceived business model actually translates into quality care at the point of delivery.

Having helped design and launch healthcare management MBA programs at institutions like the Indian School of Business and Strathmore University in Nairobi (and since reproduced at KNUST in Ghana and the Lagos Business School), I have seen firsthand that the appetite for this kind of education is enormous—and that the graduates it produces are exactly the leaders these health systems need.

Investors routinely discuss capital formation. We should begin discussing talent formation with equal seriousness. The strongest healthcare systems of the future will not necessarily be those that attract the most investment capital. They will be those that develop the most capable people.

Sixth, We Must Practice Stewardship

Underlying all of these priorities is a broader responsibility. Healthcare is different. A failed consumer product disappoints customers. A failed healthcare institution affects lives, families, and communities. This reality places unique obligations upon investors, operators, policymakers, and development institutions.

The most successful healthcare investors will increasingly be those who see themselves not simply as allocators of capital but as stewards of institutions. Stewardship requires a longer

time horizon. It requires balancing growth with quality. It requires strengthening public-private collaboration rather than pursuing false choices between sectors. It requires recognizing that healthcare enterprises influence not only financial outcomes but social outcomes as well.

The strongest examples in this report share this characteristic. They are not merely successful businesses. They are institutions that create capability—clinical capability, manufacturing capability, workforce capability, and system capability. Such institutions deserve patient support because they create value that extends well beyond individual investment cycles.

Stewardship is not merely a financial concept. It is a social one. The resources entrusted to investors—capital, expertise, influence, and networks—carry obligations that extend beyond individual transactions. In healthcare especially, stewardship requires recognizing that every investment ultimately touches the lives of patients, families, and communities. The question is not whether investors should seek returns. The question is how those returns are generated and whether the institutions created in the process leave health systems stronger than they found them.

A Final Reflection

In over three decades of working at the intersection of healthcare, investment, and emerging markets globally, I have observed that progress in this space is rarely linear. It comes in phases, each building on the credibility and infrastructure of the last.

The first phase is proving the concept—demonstrating that responsible private investment in healthcare is feasible and can generate both impact and returns. I4H has accomplished this. The second phase is scaling what works—moving from proof points to systemic change. This is the work that lies ahead.

It may require a leap of faith, but at every phase, responsible business and investment decisions are possible with acceptable returns of resources and profound impact. The I4H community has shown that inclusive healthcare and commercial viability are not in tension. The task now is to make that truth impossible to ignore—to build the evidence, mobilize the capital, and strengthen the systems so that the next generation of investors does not need to be convinced that this sector is worth their attention. They will simply see it in the data.

A fundamental observation from my experience working across cultures, religions, and philosophical traditions, is a recurring moral insight: human beings are not judged solely by what they know, but by what they do with what they know. Across cultures, traditions, and societies, there exists a recurring moral question. Once we understand suffering and possess the ability to alleviate it, what responsibilities follow? The answer differs in language but not in substance.

The obligation is not to solve every problem. The obligation is not to guarantee every outcome. The obligation is to act responsibly upon what we have learned.

The past five years have provided the I4H community with numerous lessons: We have learned that inclusive healthcare investing can work. We have learned that private capital can contribute meaningfully to health-system development when deployed responsibly and in partnership with public institutions. We have learned that commercial viability and social impact are not necessarily opposing objectives. And we have learned that the most durable solutions emerge when investors focus not only on financial returns but on building institutions capable of serving patients over time.

These lessons do not eliminate uncertainty. They do, however, reduce excuses for inaction.

The work ahead remains substantial. The healthcare financing gap remains vast. Workforce shortages persist. New health threats continue to emerge. Millions remain without access to essential care. But the evidence assembled over the past five years suggests that progress is possible. The first phase of this journey proved that inclusive healthcare investment could succeed. The next phase is scaling what works.

That task will require more capital, more partnership, more evidence, more talent, and greater institutional commitment. Above all, it will require the willingness to move from demonstration to transformation.

The past five years have demonstrated what is possible. The next five will determine whether those possibilities become systems.

The healthcare gaps confronting emerging markets were not created in five years, and they will not be resolved in five years. Yet history suggests that progress occurs when institutions accept responsibilities commensurate with their capabilities. The evidence assembled in this report demonstrates that private capital, when deployed responsibly and in partnership with public systems, can contribute meaningfully to that progress.

The task before us is therefore neither ideological nor abstract. It is practical, measurable, and immediate: to build stronger institutions, mobilize greater resources, develop human talent, and extend access to quality care for those who remain excluded.

The work is unfinished. The evidence is encouraging. The responsibility is clear.

That, then, is what we must do.

ANNEX

ANNEX 1

Methodology

This report draws on five years of data collection and analysis by Dalberg Advisors as I4H's knowledge partner and community manager:

- Five annual surveys (2021–2025) covering investment activity, AUM, sector allocations, performance perceptions, and community satisfaction. 11 members responded consistently across all five years; 15 members participated in 2025.
- Five years of community programming records: attendance, event summaries, and knowledge product archives spanning 15 VMMs, 15+ in-person events, and 25+ published pieces.
- Supplementary research including case study interviews with Executive Committee members, web-based research on portfolio companies, and analysis of publicly available market data.
- The preliminary analysis PPTX (2025), which synthesized five-year trends for Executive Committee review prior to this report.

All investment data is self-reported by members through the annual survey. AUM figures represent healthcare-specific assets under management. Investment counts represent active portfolio investments in healthcare. Growth rates for consistent members are calculated on a like-for-like basis across all five survey years. Self-assessment data (performance vs. ecosystem, impact dimensions) represents members' own perceptions and may not correspond to independently verified outcomes.

ANNEX 2

I4H Member Organizations

Over five years, the following organizations contributed to the I4H community. We are grateful for their commitment, engagement, and willingness to share data, insights, and case studies.

Current Members (as of 2025)

DFIs & Multilaterals	PE/VC, Impact & Corporate
AIIB	AfricInvest / Transform Health Fund
BII (British International Investment)	Alta Semper Capital
DEG	Dalberg (Community Manager)
EBRD	Elevar Equity
Finnfund	JJIV (Johnson & Johnson)
IFC (World Bank Group)	LeapFrog Investments
IFD (Impact Fund Denmark)	Lightrock
Swedfund	MSD
USDFC	Quadria Capital
	reFrontier
	Temasek / ABC Impact
	TVM Capital Healthcare

Past Members

Founding / Multi-Year	Mid-Term Members	Recent Members
Columbia Pacific	Chiratae Ventures	Adjuvant
TPG	FINCA Ventures	HFI
TVM Capital	Medical Credit Fund	IFHA
UBS Optimus	Medtronic Labs	Invascent
	Philips	Patria
	Somerset Indus	Tata Capital
	Verod Capital	TEAMFund
	Verge HealthTech Fund	

ANNEX 3

The People of I4H: Five years of community

Over five years, more than 80 individuals from 25+ organizations contributed to building the I4H community—bringing diverse perspectives from development finance, private equity, venture capital, corporate innovation, healthcare operations, and academia. The following individuals are listed alphabetically by first name:

Abdul Lediju, HFI
Emil Sierczyski, IFD
May Lo, Temasek/ABC Impact
Afsane Jetha, Alta Semper
Eshani Shah, LeapFrog
Menka Shah, IFHA
Aicha Zakraoui, AfricInvest/Transform Health Fund
Faisal Jiwa, AfricInvest/Transform Health Fund
Michael Jelinske, LeapFrog
Amie Patel, Elevar Equity
Felix Olale, LeapFrog
Milinda Wasalathanthri, IFD
Amit Varma, Quadria Capital
Hala Sherif, IFC
Monisha Ashok, USDFC
Anjli Kaushal, Quadria Capital
Hari Buggana, Invascent
Nadia Karkar, TPG
Anne Stake, Medtronic Labs
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Audrey Obara, Swedfund
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Biju Mohandas, LeapFrog
Holly Radel, TVM
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Bryan Lim, Temasek/ABC Impact
Ilaria Benucci, BII
Noorin Mawani, AfricInvest/Transform Health Fund
Caitlin Bristol, JJIV
Irina Schmidt, DEG
Norberto Jannuzzi, Patria
Carl Nicholas Ng, Verge
Isabel Thywissen, DEG
Omer Imtiazuddin, FINCA Ventures
Charles Dalton, IFC
Jide Olanrewaju, TPG
Rachel Fong, Temasek/ABC Impact
Chris Haynes, TEAMFund
Jenny Yip, Adjuvant
Ramesh Kannan, Somerset Indus
Chris McCahan, IFC
Joseph Mocanu, Verge
Ranjith Menon, Chiratae
Clinton Watson, AIIB
Katrina Aitken Laird, reFrontier
Ruchika Singhal, Medtronic Labs
Curt Laird, reFrontier
Kelvin Hui, AIIB
Sarah Mullane, JJIV
Dana Deardorff, JJIV
Ken Gustavsen, MSD
Shakir Merali, Lightrock
Daniel Streckfuss, reFrontier
Klaus Prebensen, IFD
Silven Chikengezha, IFC
Danladi Verjeijen, Verod

Kristina Yu, AIIB
Dr. Stephen Sammut, Alta Semper
Di Fu, Temasek/ABC Impact
Leandro Cuccioli, BII
Valaray Omamo, Swedfund
Dorien Mulder, Medical Credit Fund
Lisbeth Erlands, IFD
Vera Siesjo, AIIB
Dustin Higgins, JJIV
Marissa Leffler, UBS Optimus
Vikrant Parashar, Quadria
Eddine Bahaa Sarroukh, Philips
Markus Pentikainen, Finnfund
Visa Chandramouli, Tata Capital
Eliza Foo, Temasek/ABC Impact
Matias Loening, EBRD
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Martina Sampo, Dalberg
Ximena Benard-Tertrais, Dalberg

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