eHealth AFRICA × Dala Africa

Insights Learning Forum 2026

Report and Learning Brief

Theme: Insights. Partnerships. Inclusion. Interoperability. Investment.

"Where Digital Health Moves from Conversation to Commitment"

CONVENED BY
eHealth Africa & EHA Group, in strategic partnership with the Africa HealthTech Summit (AHTS) and Dala Africa

REPORT CO-AUTHORED BY
eHealth Africa & Nigeria Health Watch

NIGERIA HEALTH WATCH
Informed commentary, intelligence and insights on the Nigerian health sector

Powered by: EHA GROUP

Strategic Continental Partner: AFRICA HEALTHTECH SUMMIT

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Insights Learning Forum 2026

Executive Summary

The Insights Learning Forum (ILF) 2026, convened by eHealth Africa and EHA Group in strategic partnership with the Africa HealthTech Summit (AHTS) and Dala Africa, brought together government, private sector, development partners, innovators, academia, and civil society for two days at the Abuja Continental Hotel. Themed around five words: Insights, Partnerships, Inclusion, Interoperability, Investment. ILF 2026 marked the Forum's fourth edition and its first as an explicitly continental convening, expanding from a one-day national event into a two-day platform spanning African markets, financing, and health-technology leadership.

Across two days and two parallel breakout tracks, the Forum carried a national policy announcement (Nigeria's National Health Technology and Data Analytics Office), the launch of a continent-wide innovation prize (Villgro Africa's Snakebite Innovation Prize), a structured technical pathway for African hardware-medical-device innovators (the IBE Playbook), government-announced state financing incentives, an EHA Clinics investment moment, and a closing Commitment Session in which government, development partners, and private-sector organizations each made individual, named, trackable commitments, with a public accountability report promised within 30 days and progress due to be reviewed publicly at ILF 2027.

Insights Learning Forum 2026

2 DAYS
28–29 July 2026

02
CONTINENTAL PARTNERS
AHTS & Dala Africa

4th Edition
1st continental

421
IN-PERSON DELEGATES
298 Day 1 · 236 Day 2 check-ins
Unique participant list

30
SESSIONS
across both days

11
NAMED PARTNER COMMITMENTS
Commitment Session, tracked to ILF 2027

220
VIRTUAL ATTENDEES
242 unique joins · 10-min+ floor applied
Deduplicated across both days

What's New in 2026: From National Gathering to Continental Platform

First continental edition. ILF began as a single-day national convening; 2026 is the first edition run jointly with the Africa HealthTech Summit (AHTS) and Dala Africa, expanding the Forum's reach from Nigeria to a continental delegate and partner base.

Two full days, two parallel tracks. Where 2025 ran as a single-track, single-day agenda, 2026 ran two simultaneous breakout tracks on Day 2 alongside Main Hall proceedings, roughly doubling the Forum's session count.

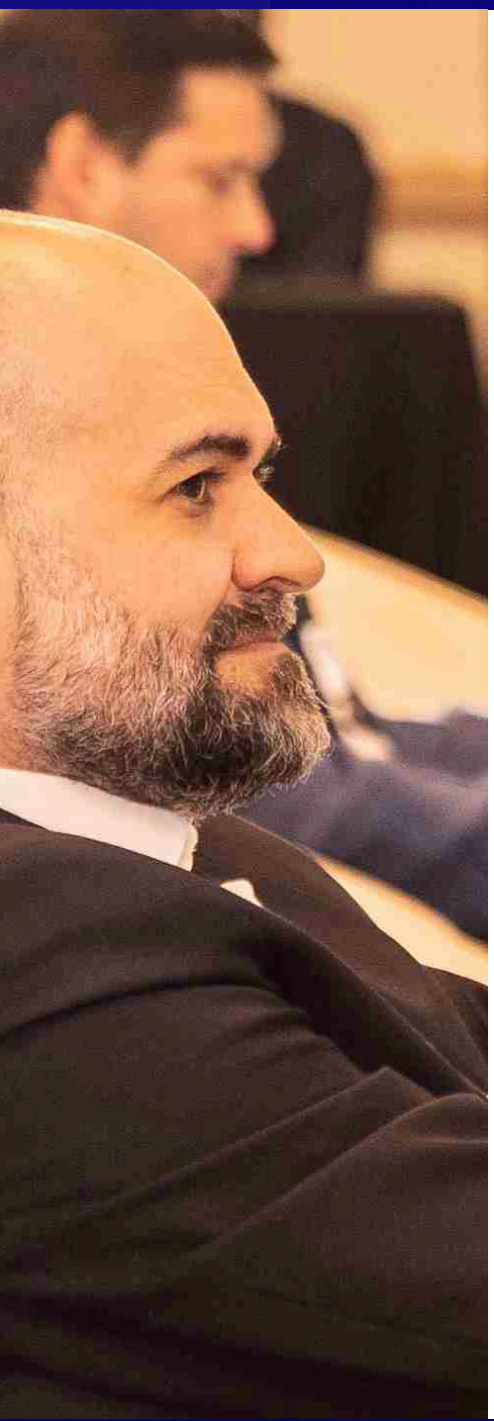
A named Commitment Session, not general pledges. Eleven institutions made individual, specific, trackable commitments from the stage, with a public accountability report due within 30 days of the Forum and a progress review scheduled for ILF 2027.

Africa Digital Health Network (ADHN) becomes a standing platform. Rather than a one-off convening, ILF 2026 formalized ADHN as the continuing engagement structure between Forum editions, with eHealth Africa's seed investment already funding ADHN's first Executive Director and a new Nairobi office.

A confirmed date for ILF 2027. 27–28 July 2027, announced from the stage at close, alongside an internal framing of the next edition as "ILF at 5."

Immediate Outcomes

The outcomes below are organized in two parts: results eHealth Africa, EHA Group, and named partners delivered or launched directly, followed by figures and developments announced from the stage by government speakers and other participants as context for the Forum.



Delivered by eHealth Africa, EHA Group & Named Partners

- eHealth Africa's Women Vendor Directory launched with results already achieved, not targets: 262 women-owned businesses trained across 15 states over two completed cohorts, 176 contract awards secured across 58 of those businesses, combined procurement value exceeding $1M, and women-owned businesses now accounting for over 22.5% of eHA's total procurement engagements.

- EHA Group's own procurement diversification is underway in practice, not policy alone: roughly 300 female-owned vendor companies were added to the Group's procurement base within about six months, per Adam Thompson's own account of the initiative's origin.

- eHealth Africa's Planfeld microplanning tool has supported planning across 500,000+ settlements and contributed to reaching 20 million+ children with vaccines in the past year.

- The Climate Health Vulnerability Assessment Tool (CHAT), an eHealth Africa tool, is a nationally adopted, DHIS2-mainstreamed instrument, not a pilot awaiting government buy-in.

- Villgro Africa's Invention-Based Enterprises (IBE) Playbook officially launched (a real, adoptable resource, not a concept), with a live, working case study already deployed in the field: the Kidney Wallet screening device, operating out of a dedicated dialysis clinic in Hadejia.

- EHA Impact Ventures (EIV) formalized a $1.25M reinvestment in EHA Clinics, marked by an on-stage certificate presentation from the EHA Group CEO and the Director of Partnerships and Programs: EIV's third completed investment round into the organization.

- The Africa Digital Health Network's seed investment from eHealth Africa is deployed and operational: ADHN's first Executive Director is hired and its Nairobi office is running, confirmed directly by ADHN Chairman Jean Philbert Nsengimana from the stage.

- Eleven institutions, plus eHealth Africa's own accountability pledge, each made an individual, specific, named commitment from the stage during the Commitment Session, tracked in full later in this report as pledges to be measured at ILF 2027, not as completed outcomes.

- eHealth Africa's promise to publish a full accountability report against every named commitment is itself time-bound and already in motion: due within 30 days of the Forum's close, with public review scheduled for ILF 2027.

- ILF 2027 dates were announced from the stage before the Forum closed: 27–28 July 2027.

Announced From the Stage, Government & Partner Context.

The items below were stated by named speakers and are reported here as their claims, accurately attributed, not as eHealth Africa's or ILF's own verified outcomes. Several government figures below are best understood as economic and programmatic context for why the Forum's themes matter, not results ILF produced.

- Nigeria's National Health Technology and Data Analytics Office, announced by the Federal Government roughly four weeks before the Forum, with Dr Obi Adigwe appointed pioneer National Coordinator. A real national policy development, independently confirmed; not an eHealth Africa outcome.

- Nigeria's adoption of the Africa CDC Youth Engagement Strategy, and the "one patient, one health record" architecture standard, were both stated on stage as government positions, reported here as such.

- The Minister of State for Health cited a $500M USD state financing incentive under the Nigeria Health Sector Renewal Compact, and a cluster of other government figures (see the Ministerial Keynote session summary for the full list).

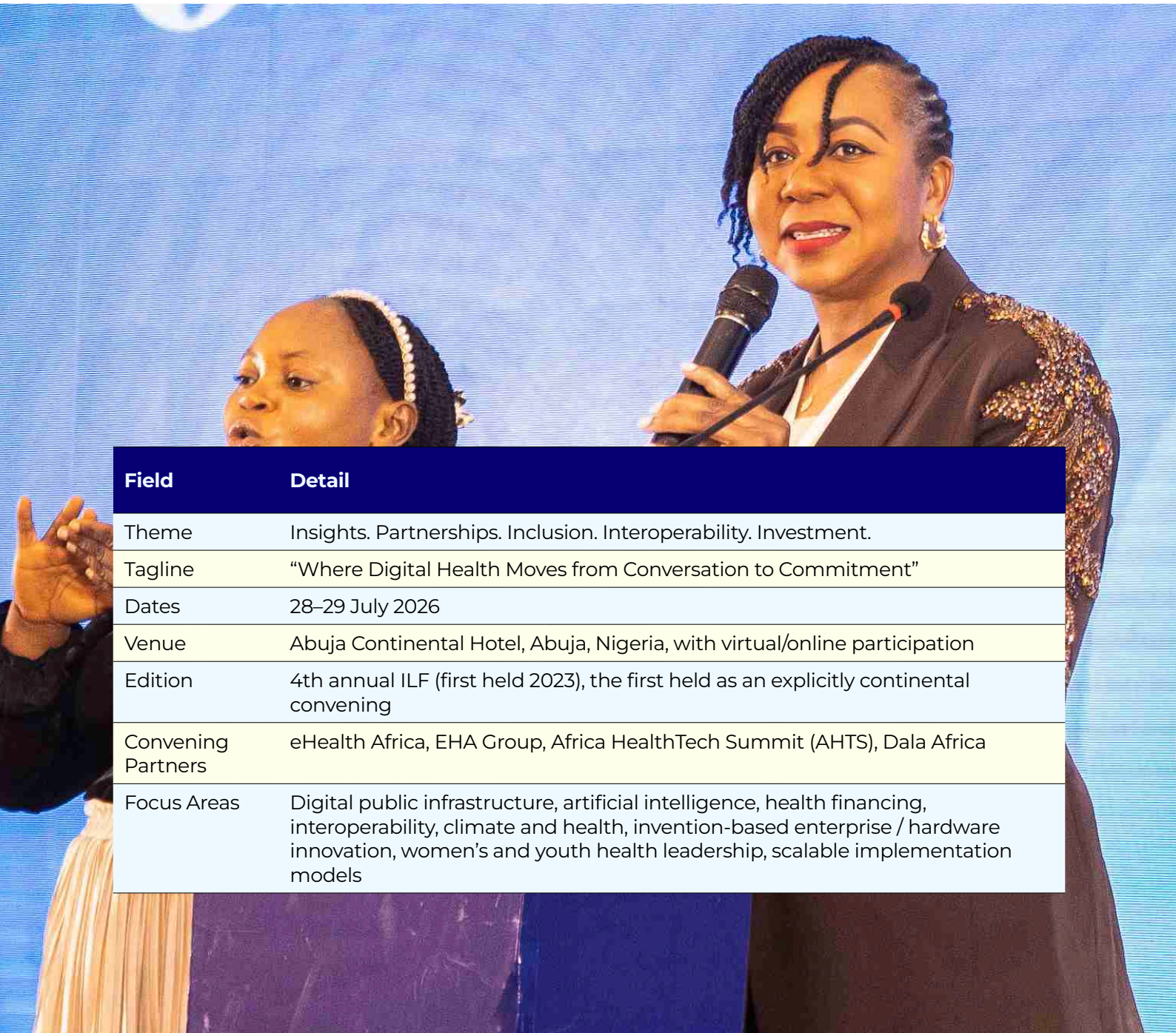
- NPHCDA cited a series of national program figures from the stage, including a campaign described as reaching very large numbers of children, reported in the relevant session summary as NPHCDA's own claim. Where independent sources describe this as a campaign target rather than a completed count, that distinction is noted in place.

- KanInvest, the Rural Electrification Agency, and Kano State's own rural development plan each cited investment and delivery figures from the stage (renewable energy investment attracted and pipelined, healthcare electrification projects completed, a state development budget): government- and agency-stated figures, reported as such in the relevant session summaries, not eHealth Africa outcomes.

- The global £6.25M Wellcome Snakebite Innovation Prize, delivered by Challenge Works, was featured at the Forum to promote regional participation ahead of the 16 September 2026 application deadline. This regional spotlight highlighted the ongoing global open call, which launched on 17 June 2026 with support from partners including Villgro Africa.

About ILF 2026

The Insights Learning Forum is eHealth Africa's flagship annual convening, designed to bring policymakers, innovators, financiers, and implementers together to examine what it actually takes to move African digital health from isolated pilots to interoperable, financed systems at scale. What began in 2023 as a national, single-day gathering has, across four editions, evolved into a two-day, continental platform for cross-sector knowledge-sharing, investment matchmaking, and public commitment.



Field	Detail
Theme	Insights. Partnerships. Inclusion. Interoperability. Investment.
Tagline	"Where Digital Health Moves from Conversation to Commitment"
Dates	28–29 July 2026
Venue	Abuja Continental Hotel, Abuja, Nigeria, with virtual/online participation
Edition	4th annual ILF (first held 2023), the first held as an explicitly continental convening
Convening Partners	eHealth Africa, EHA Group, Africa HealthTech Summit (AHTS), Dala Africa
Focus Areas	Digital public infrastructure, artificial intelligence, health financing, interoperability, climate and health, invention-based enterprise / hardware innovation, women's and youth health leadership, scalable implementation models

Key Outcomes at a Glance

- Nigeria's Federal Government announced the creation of a National Health Technology and Data Analytics Office, a new coordinating platform for health data and technology, built on three guiding principles: security, interoperability, and sovereignty.
- The Forum hosted a regional promotion for the global £6.25M Wellcome Snakebite Innovation Prize (delivered by Challenge Works), featuring regional partner Villgro Africa to drive West African applications ahead of the September deadline and support the global target of a 50% reduction in snakebite deaths by 2030.
- Villgro Africa officially launched the Invention-Based Enterprises (IBE) Playbook, a structured, five-phase technical-readiness pathway for African hardware medical-device innovators from concept through market entry, illustrated live with a Nigerian kidney-health screening device case study.
- EHA Impact Ventures (EIV) formalized a $1.25M reinvestment in EHA Clinics on stage with a certificate presentation, citing 20,000+ additional patients served annually, three new facilities, and 100% growth in antenatal-care attendance since the prior round.
- eHealth Africa officially launched its Women Vendor Directory: 262 women-owned businesses trained across 15 states, securing 176 contract awards worth over $1M, with women-owned businesses now accounting for 22.5%+ of the organization's procurement engagements.
- The Minister of State for Health cited a $500M USD Nigeria Health Sector Renewal Compact financing incentive for states that align fastest with the national digital health architecture, the Minister's own claim, reported here as government context rather than an eHealth Africa or ILF outcome.
- Nigeria was confirmed as the first African country to formally adopt the Africa CDC Youth Engagement Strategy, with a domestication and implementation committee already forming.
- The ILF 2026 Commitment Session closed the Forum with eleven individual, named commitments from government, development partners, private sector, and implementing partners, alongside eHealth Africa's own accountability pledge, with a public accountability report promised within 30 days and progress to be reviewed at ILF 2027.
- ILF 2027 was formally announced at the close of the Forum: 27–28 July 2027.
- 421 in-person guests registered for the Forum, with 298 checked in on Day 1 and 236 on Day 2. A further 220 unique participants joined virtually, meeting a minimum 10-minute attendance threshold across both days.

Forum Structure

ILF 2026 was designed as a two-day, multi-format event, reflecting its expanded continental scope:

Day 1: Main Hall, single track. Opening ceremony, a continental keynote, government and donor addresses, an innovation-prize regional announcement, two Flagship Dialogue panels, and a dedicated eHA × AHTS breakout on intelligent health systems, followed by three parallel evening breakout sessions (Pathfinder International, , EHA Clinics).

Day 2: Two parallel breakout rooms through the morning, converging into Main Hall for the afternoon. Breakout Room 1 carried the Villgro IBE Playbook launch, an AMCE fireside chat, and the NCDC–HFN–roundtable; Breakout Room 2 carried a climate-health technology demo and panel, and the Day 2 Ministerial Keynote. The afternoon Main Hall carried a Flagship Dialogue, a special address on rural health financing, a CEO fireside chat, a panel on women's and girls' health, an investment announcement, a youth panel, the Commitment Session, the Women Vendor Directory launch, and the Forum's formal close.

Continuous threads across both days: named commitments were requested and tracked, invention-based and hardware innovation had a dedicated pathway (not just a pitch slot), and every major session was framed around one or more of the Forum's five theme words.

Insights Learning Forum 2026

DAY 01

Tuesday, 28 July 2026

eHA Innovation Spotlight: Planfeld.

Moderator: **Abubakar Shehu** (Program Manager, eHealth Africa)

Speaker: **Dayo Akinleye** (Technical Project Manager, eHealth Africa)

Opening fireside conversation ahead of the formal welcome, spotlighting Planfeld, eHealth Africa's digital microplanning tool for immunization and malaria campaigns.

- **Built for government users** (state ministries of health and donors planning vaccination or malaria campaigns), rather than as a consumer-facing tool.
- **Cuts microplan creation time** from a typical 5–7 days (in a hotel, on per diems) to under five minutes once teams are proficient, demonstrated live in Lagos in under one minute.
- **Interoperable by design:** integrates with DHIS2 and can feed dashboards such as Tableau rather than operating as a standalone system.
- **Co-designed directly with frontline health workers:** field teams spent 2–3 days each in 7+ Nigerian states building the tool alongside the people who would use it, credited as the reason for adoption, including insisting agency staff be named as co-authors on a resulting published paper.
- **Measured impact:** resource savings from eliminating multi-day in-person microplanning sessions, and team rationalization, redistributing (not just adding) vaccination teams within a state to correct over- and under-staffed areas.
- **Advice for governments and donors replicating the model:** co-design with frontline health workers from day one, and build multi-year sustainable financing into the design so government can build internal capacity before donor support ends.

Opening & Welcome

The Forum opened with a welcome cultural performance from the Abuja Cultural Troupe, followed by a standard hotel safety briefing.

Atef Fawaz (Executive Director, eHealth Africa).

- Framed ILF 2026 as a first: eHealth Africa's inaugural partnership with AHTS and Dala Africa, making this year's Forum explicitly continental rather than national in scope.
- Positioned eHealth Africa's 15+ years of operating history and project delivery across 25 countries as evidence that impact requires more than infrastructure and offices; it requires partnership and a service-delivery-first posture.
- Named the current global moment (shifting geopolitics, tightening funding) as the reason the continent needs to work together now more than in the past, framing this year's theme (Insights, Partnerships, Inclusion, Interoperability, Investment) as "the way forward."

> "Working alone did not get us anywhere."
>
> — Atef Fawaz

Context-Setting Address

Ota Akhigbe (Director, Partnerships and Programs, eHealth Africa)

An extended, substantive address, the clearest articulation offered anywhere in the Forum of why ILF exists.

- Named two things true at once about African health systems: real, measurable progress (new HIV infections down more than half since 2010 across Eastern, Southern, Western, and Central Africa; TB incidence significantly down per the WHO Africa region) alongside a harder truth, trained health workers systems can't absorb, understaffed facilities, and pilots that never find a permanent home.
- Cited WHO's own projection that external health aid dropped 30–40% last year versus 2023; 50+ countries reported health-worker job losses; some places saw maternal care, vaccination, and disease surveillance disrupted by as much as 70%.
- Argued the responsible response is clarity, not despair, protecting the gains external financing helped produce while building the domestic financing, capability, and institutional ownership that let them last.
- Confirmed ILF is now in its fourth edition (started 2023) and named the "missing middle" as the Forum's reason for existing, the unglamorous space where an insight becomes a policy decision, a pilot finds a government budget line, and financiers, regulators, implementers, and communities meet while something is still being designed, not after it's already built.
- Cited a concrete result of this approach: geospatial and digital planning tools (including Planfeld) supported planning across 500,000+ settlements last year, contributing to reaching 20 million+ children with vaccines, in partnership with NPHCDA, 36 state governments, WHO, and UNICEF.
- Announced the ILF Commitment Session for Day 2 afternoon, framed explicitly as "less is more", one honest, survivable commitment per institution, not five aspirational ones.
- Posed three standing questions carried through every session across both days: what is a credible path to institutional ownership; what financing lets this endure rather than move from one external source to the next; and who remains accountable for the system three to five years from now.

> "Digital health is not an app; it is a network of people, systems, and trust."
>
> — Ota Akhigbe

Opening & Welcome

Adam Thompson (Co-founder & Group Chief Executive Officer, EHA Group)

A long, personal address tracing the origin and structure of EHA Group, the clearest public account to date of how the organization's three arms fit together.

- eHealth Africa was founded in 2009 by Adam Thompson and co-founder Evelyn Castle, originally focused purely on digital systems for public health programs. The founders' early lesson was that digital alone "wasn't enough" without the surrounding infrastructure, human capital, and logistics (power, plumbing) to make systems work, which led eHA to build that supporting ecosystem itself.
- Cited Ebola response and polio eradication work as the moments this lesson "came to fruition": the deciding factor in saving lives was not strategy or data alone, but how fast money and equipment could physically move.
- EHA Clinics began as eHealth Africa's own investment in primary care, originally built for eHA's own staff, after a personal experience: Thompson described struggling to get urgent care for his wife in Kano despite eHA's extensive healthcare-system network, which he cited as the trigger for finally building it. Deliberately kept non-scalable at first, to learn what worked before scaling. Now led by Dr Ifunanya Ilodibe.
- Noted EHA Clinics changed how private-sector partners (named Novartis and Pfizer) engaged with eHA: approaching them as a business rather than an NGO seeking grants changed the nature of the conversation.
- EHA Impact Ventures launched with a raised endowment specifically because EHA Clinics' own fundraising experience as a private-sector health startup was so difficult ("constantly getting rejected by investors... told that's not a real business model"): EIV exists to be the investor that says yes to African health entrepreneurs working in mental health, nutrition, and other under-funded areas.
- EHA Group itself was formed to integrate what had become three standalone organizations (eHealth Africa, EHA Clinics, EHA Impact Ventures) after recognizing a lack of cross-learning between them. Now building shared services (finance, HR, procurement) and a cross-organization research team, roughly six months old and already having hit its research fundraising goal, with six publications in progress.
- Described the current phase explicitly as a "proving ground", testing whether the integrated-group model delivers more impact, not presenting a finished formula.

Continental Address.

From Abuja to Kigali: Advancing Africa's Digital Transformation, Interoperability, and the Africa CDC/AHTS Pathway.

Jean Philbert Nsengimana (Chairman, Africa HealthTech Summit (AHTS) & Africa Digital Health Network (ADHN); Chief Digital Health Advisor, Africa CDC)

Opened with greetings from Kigali, Addis Ababa (Africa CDC headquarters), and Canada, having flown in that morning on a Toronto → Abuja → Kigali circuit later used to illustrate the pace of continental engagement.. Structured around three themes: integration, collaboration with action, and acceleration.

Origin of the eHA / AHTS / Dala Africa partnership

- **October 2025:** Atef Fawaz and Ota Akhigbe attended the Africa HealthTech Summit in Kigali, which Nsengimana chairs. eHealth Africa subsequently made a $50,000 anchor/seed investment into the Africa Digital Health Network (ADHN), the structure AHTS built to sustain momentum between summits.
- **May 2026:** Ota Akhigbe and Atef Fawaz returned to Kigali for the Africa CEO Forum, where the invitation for Dala Africa (AHTS's organizing partner in Kigali) to co-host ILF 2026 in Abuja was extended.
- **Nsengimana attended ILF 2026 in a triple capacity:** AHTS Chairman, ADHN Chairman/ "Chief Curator," and by extension representing Dala Africa's co-hosting role.

Investment data presented

- Continental digital health investment share: Kenya leads (33%), followed by South Africa, Egypt, Nigeria, and the rest of the continent.
- Nigeria: roughly 240M population, with digital-sector investment "close to $600M", framed as a small fraction of potential relative to Korea, India, or the US, which invest in the billions. Nigeria has the continent's most dynamic startup market by count, but is not yet attracting proportionate capital share.

"Pilotitis", integration, and data sovereignty

- Named the core continental barrier as "pilotitis", successful innovations failing to scale domestically or across borders, reframed as an

> "Nigeria needs Africa, and Africa needs Nigeria."
>
> — Jean Philbert Nsengimana

integration problem, not merely an interoperability one. Called for infrastructure that lets startups and founders scale faster, and for solving donor dependency, fragmentation, and weak integration into public health delivery platforms.

- Argued AI trained on African population data, customized to the continent's own biological and cultural characteristics, requires Africa to protect and integrate its data space as a continent, not only country by country, starting at the national level.

Closing / AHTS invitation

- Announced AHTS's 5th edition in Kigali, citing 2,500 participants in 2025, including 300+ who travelled from Nigeria, among them named past attendees Dr Mories Atoki, Ota Akhigbe, Atef Fawaz, Dr Ahmed Ogwell, and Dr Iziaq Kunle Salako.

> "Yesterday we were in Toronto, today we are in Abuja, and tomorrow we'll be in Kigali."
>
> — Jean Philbert Nsengimana

NPHCDA Address: National Progress on Primary Healthcare Revitalization

Dr Muyi Aina (Executive Director / Chief Executive Officer, National Primary Health Care Development Agency (NPHCDA))

The Presidential Compact & four pillars

Referenced a compact signed by the President with states around 2024, subsequently expanded to development partners, local governments, and traditional leaders, coordinated by Prof. Muhammad Ali Pate (Coordinating Minister of Health and Social Welfare) via a sector-wide approach, built on four pillars: governance, accountability and data; access to quality healthcare (primary care and NHIA); the healthcare value chain and supply chain, positioning health as a driver of GDP rather than a cost line; and health security (NCDC).

Primary healthcare functionality

- A "functional" PHC is defined as: decent, dignified infrastructure; 24-hour operation via reliable power (typically solarization); and a minimum of six skilled birth attendants on rotating shifts, or four where on-site staff accommodation exists.
- At baseline, roughly 8,300 PHCs were already receiving Basic Healthcare Provision Fund support, but fewer than 20% met the functionality bar. Since then: roughly 3,600 completed, 800–900 in progress, against a target of 8,800 fully functional "Level 2" facilities and 17,600 functional overall.
- A public dashboard on the NPHCDA website now tracks facility-level status by name and location.

Workforce

- Target: retrain 120,000 frontline health workers in integrated primary care, roughly 78,000 completed to date.
- Shift underway from ad hoc, program-funded hiring toward permanent civil-service employment: 19,000+ skilled birth attendants and 3,000–4,000 community-based health workers moved to permanent roles.

Maternal and newborn mortality: MAMII

- Data-led targeting: 172 of Nigeria's 774 LGAs identified as contributing 55% of maternal deaths nationally.
- 500,000+ pregnant women enrolled with assigned case managers, ensuring access to required diagnostics, ultrasound, and specialist referral for high-risk pregnancies.
- Free emergency obstetric care has reached 40,000+ women over the past 12–18 months; the NEMSAS emergency transport voucher scheme is now active in 32–33 states.

> "It's not a federal drive, it's not a state drive, it's all of us moving in one direction in an integrated way."
>
> — Dr Muyi Aina

Immunization

- The "Identify, Enumerate, Vaccinate" (IEV) approach targeting zero-dose children is active in 14 states, with tracking methodology evolving from self-reported data to GPS team tracking to household-level digital tracking.
- HPV vaccine reach: 17M+ adolescents. Malaria vaccine active in 4 states. An integrated measles-rubella campaign (combined with polio, malaria, and NTD delivery in select states) was cited on stage as reaching 100–102 million children aged birth to 14. Independent sources consistently describe this campaign's 106 million figure as a target, not a confirmed completed count as of the Forum.

Financing

- Basic Healthcare Provision Fund (BHCPF) disbursement is being digitized for visibility, now live in 14+ states and growing.
- Facility-level payments: a baseline of ₦600,000 per quarter, with top-quartile facilities by service delivery receiving ₦800,000 per quarter.
- Performance and Financial Management Officers (PFMOs) are being deployed per local government; a "PHC Jubilee Fellows" program with the Office of the Vice President was referenced as upcoming. The federal government is in advanced stages of increasing (reportedly doubling) its BHCPF contribution, alongside incentives for states to add their own resources.

Gates Foundation Address

Dr Yusuf Yusufari (Deputy Director, Immunization and Disease Control, Gates Foundation)

- Framed the Foundation's three goals (attributed to a stated pledge of over $200 billion of resources over the next 20 years) as reducing preventable maternal and child mortality, a world without infectious disease, and poverty reduction.
- Positioned donor contribution as one of three things any partner brings: advocacy for high-impact interventions, technical assistance, or catalytic resourcing, always in support of, not replacement for, government-led programs.
- Committed the Foundation to continued work with the Nigerian government and implementing partners on last-mile vaccine delivery.

Dr Yusufari also spoke as a panelist in ILF Flagship Dialogue I, with more extensive remarks on sustainability and domestic resource mobilization.

KanInvest: Turning Data into Investment

Nazir Halliru (Director General / CEO, Kano State Investment Promotion Agency (KanInvest))

- Cited a geospatial mapping of Kano industries, conducted in partnership with eHealth Africa, roughly 3,600 industries mapped, of which about 800 identified as candidates for revitalization.
- That revitalization pipeline would require roughly 500MW of electricity, against current average daily dispatch of about 150MW to Kano, framed as both the core constraint and the core investment opportunity for renewable energy.
- Reported $150M+ already attracted in renewable energy investment, with a pipeline exceeding $800M across renewable energy, agriculture, manufacturing, and infrastructure. Cited Kano's GDP at roughly $20B, said to exceed the GDP of some African countries.
- Announced an approved Public-Private Partnership policy framework for Kano State, naming healthcare-sector investment opportunities specifically: diagnostic centres, pharmaceutical/drug manufacturing, medical consumables production, hospital infrastructure, and digital health.
- Closed with an open invitation for private-sector and development-partner investment in Kano, framing the state as a gateway to Niger Republic, Chad, and Sudan markets.

Villgro Africa: Snakebite Innovation Prize Spotlight

Panellists: Waringa Kamau, Partnership and Stakeholder Engagement Lead, Villgro Africa · Benjamin Bauer, Project Management Lead, Villgro Africa

Opened with a case story: Ifunanya Nwangene, a young Abuja-based musician and contestant on The Voice, died in February 2026 following a snakebite, after a breakdown in her journey to care and a delay reaching a facility with the correct antivenom. Confirmed figures: an estimated 5 million snakebites occur globally each year, resulting in roughly 100,000 deaths and 400,000 disabilities. The Prize's goal is a 50% reduction in snakebite deaths by 2030.

Structure

- Funded by Wellcome; designed and delivered globally by Challenge Works; Villgro Africa serves as one of the entry-phase partners supporting innovators in Sub-Saharan Africa.
- Applications opened July 2026 and close 16 September 2026, with an in-person innovator-strengthening event in Nairobi on 10–11 August 2026 (travel grants available for selected applicants).
- Launch Track (new entrants, proof of concept): 10 finalists selected at £75,000 each; 2 of those 10 advance to further financing of £750,000 each.
- Growth Track (existing players scaling a snakebite-relevant solution): 5 initial finalists at £100,000 each, running January–November 2027; the final 2 of those 5 receive £1.75M each to scale.
- **Total fund stated on stage: £6.25M.**

Scope

Four patient-journey gaps are targeted: first-aid support at the point of bite; logistics and transport to a facility or antivenom to the patient; assessment and diagnosis on arrival; and emergency and ongoing patient care. In-scope solution types span medical technology (diagnostics, hardware), logistics and distribution, technology (telemedicine, clinical decision support), financial models (health-finance access), and social/awareness interventions.

Special Address on Behalf of the Coordinating Minister:

The National Health Technology and Data Analytics Office (NHTDAO)

Dr Obi Adigwe (Director General, National Institute for Pharmaceutical Research and Development (NIPRD); pioneer National Coordinator, NHTDAO).

The Honourable Coordinating Minister of Health and Social Welfare, Prof. Muhammad Ali Pate, was unable to attend in person due to an urgent national assignment; Dr Adigwe was asked to represent him.

Headline announcement

- Approximately four weeks before ILF 2026, President Bola Ahmed Tinubu announced the creation of the National Health Technology and Data Analytics Office, a meta-level platform to coordinate and harmonize Nigeria's existing health technology and data interventions, built on three guiding principles: security, interoperability, and sovereignty.

Framing and calls to action

- Positioned the new Office against three "concentric circles" already active in Nigeria's health system (big data, IoT, and AI/ML), citing existing EHR deployments and the SLIPTA and SORMAS systems in laboratory and surveillance work.
- Called for clarity on regulatory frameworks (e.g. telemedicine), innovation-hub development, workforce capacity to absorb new interventions, and interoperability standards, specifically referencing FHIR R4 versus the emerging R6 standard, and SNOMED CT terminology alignment.
- Referenced Nsengimana's earlier investment-ranking data (Nigeria ranked roughly 4th) as a challenge accepted on behalf of the country, drawing a comparison to Nigeria's earlier fintech leapfrogging (producing 5–6 of the continent's roughly 10 unicorns) as a precedent for what focused coordination can achieve in health tech within five years.
- Cited emerging international reference points (the US Office of the National Coordinator, Canada Health Infoway, eSwiss, and the Swedish eHealth Agency) as examples of countries that began with fragmented systems and built toward integration and data sovereignty.
- Closed with direct questions to each stakeholder group in the room (private sector, DFIs, entrepreneurs, citizens) about what they need from government to engage, framed as an open invitation rather than a finished framework. Reaffirmed continental integration as a named objective, citing cross-border effects such as Lake Chad basin environmental degradation (affecting Chad, Niger, Nigeria, and Cameroon) as the rationale for designing interventions with regional, not only domestic, reach.

ILF Flagship Dialogue I:

Financing Scalable Solutions for Inclusive Health Systems

Moderator: Dr Gafar Alawode (Managing Partner, DGI Consult)

Opening video

- **Dr Charles Doherty,** General Manager, Ekiti State Health Insurance Scheme (video submission): argued sustainable health financing is about strategic deployment of resources, not just volume, citing Ekiti's health insurance scheme funding free antenatal, delivery, and postnatal care, free under-5 care, routine immunization, family planning, and free malaria diagnosis and treatment for state residents, covering an estimated 75% of the disease burden. Cited the 2024 Nigeria Demographic and Health Survey showing 50%+ improvement across maternal and child health indicators since the scheme's introduction.

Panel

Dr Francis Ohanyido (Chair, African Future of Health Commission / African Healthcare Federation)

- Argued genuine partnership requires two conditions: mutual respect (avoiding donor/government power imbalance) and "collaborative action" over MOU-signing without follow-through implementation.
- Traced Nigeria's Basic Healthcare Provision Fund to the National Health Act's provision of not less than 2% of the Federation's consolidated revenue, framing pooled financing (the sector-wide approach) as the right "downstream accelerator" for scaled, sustained financing, a model he said he'd once opposed. Cautioned against "copy-paste" financing models that ignore local context.

Dr Yusuf Yusufari (Gates Foundation)

- Reiterated that sustainability means government program ownership plus domestic resource mobilization, freeing partners to focus on high-impact interventions and execution excellence.

> **"Commodities on a shelf don't save lives, last-mile delivery does."**
>
> — Dr Yusuf Yusufari

Abiola Oshunniyi (Head/Coordinator, Project Implementation Unit & Grants Portfolio Management, NCDC)

- Noted health-security financing is typically siloed (government, donor, and private funding rarely co-invest), with roughly 70% of national health expenditure currently out-of-pocket.
- Proposed a tripartite model: government sets regulatory rules, donors catalyze, and the private sector sustains reinvestment through genuine commercial incentive. Referenced the National Action Plan for Health Security (NAPHS 2.0) as an existing, underused framework, and raised One Health framing, e.g. cholera as fundamentally a WASH/infrastructure issue, not purely a health-sector one, as a case for cross-sectoral co-investment.

Maryam Mohammed (Head, Business Enablement, The Alternative Bank (non-interest/Islamic finance))

- Cited two products: a multi-partner revolving drug fund (with OEMs, state governments, and logistics providers) ensuring authenticated medication supply; and solar-powered financial kiosks converted into health kiosks with an embedded insurance component, developed with state governments.
- Flagged a specific regulatory constraint: profit-sharing (non-interest) health-sector financing currently carries a capital requirement roughly 400% higher than a standard short-term facility, framed as a fixable policy lever to unlock more patient capital into health.

> **"Financing follows policy."**
>
> — Abiola Oshunniyi

Dr Mories Atoki (CEO, ABC Health / African Business Coalition for Health)

- Argued CSR alone cannot close the sector's financing gap, health financing should be approached as investable business, not philanthropy, with attention to the full value chain (production capacity, market access, policy) rather than one link in isolation. Called for deliberate mentorship of young innovators, distinct from funding alone.

Moderator's closing synthesis

- Adopt a problem-driven, not solution-first, approach to financing design.
- Government should own both the problem definition and its own spend before asking others to co-invest.
- Be intentional about financing collaboration itself, not just financing activity.
- Consider the whole value chain: a break anywhere breaks the system.
- Use data and scorecards to hold every party, including government, accountable.

eHA × AHTS Breakout:

Advancing Intelligent Health Systems Through Partnerships

Run jointly by eHealth Africa and the Africa HealthTech Summit under the banner "From Dialogue to Delivery,"

Moderator: Lola Aderemi (Co-founder, PharmaRun (health-tech medication fulfilment infrastructure); Board Member, Africa Digital Health Network, leading conversations on youth and innovation).

Panellists: Dr Ifunanya Ilodibe (CEO, EHA Clinics) • Jean Philbert Nsengimana (Chairman, AHTS; Chief Digital Advisor, Africa CDC) • Dr Ahmed Ogwell (CEO, VillageReach).

What does an intelligent health system look like?

- **Dr Ahmed Ogwell:** intelligence itself is universal; what differs by context is application and delivery. Defined an intelligent system as one that addresses the actual priorities of the community it serves, however imperfect, and produces results that visibly change circumstances, not just results "nice to have in an annual report."
- **Jean Philbert Nsengimana:** framed intelligence across three tiers: community and frontline health workers using technology to get help faster and act proactively; the clinic/lab/hospital mid-tier, where AI helps a nurse read an X-ray or interpret a portable ultrasound at a level that previously required a specialist; and the policy-making level, via National Health Intelligence Centers.

National Health Intelligence Centers

- Rwanda launched the first such centre in the region in April 2025; roughly 20 countries are now developing similar centres. Nigeria has completed "phase 1" and is moving into phase 2 of its own centre, plausibly the same initiative as

the National Health Technology and Data Analytics Office announced earlier by Dr Adigwe, though the two were not explicitly linked on stage.

- The centre's function is to pull siloed national data into one place, use AI to make sense of it for decision-making, and, critically, publish the standards required to "plug in," giving startups an actual pathway from pilot to national-scale adoption, something Nsengimana said is currently missing across the continent.

Why do innovations struggle to move beyond pilot?

- **Dr Ifunanya Ilodibe:** innovations are often built without enough attention to the actual context and patient/practitioner journey they're entering into, citing a surgical-checklist tool once abandoned because the operating theatre had unreliable internet, a constraint never designed for. Argued for humility ("every creation is an assumption"), iteration, and genuine change management, not a one-time build-and-walk-away.
- **Jean Philbert Nsengimana** named financing as "the elephant in the room": compared the US government's roughly $40 billion HIPAA-compliance investment (helping providers adapt to new data-exchange standards) to the roughly $0 African governments have put toward compliance with their own, similar data-protection laws, while African per-capita health spend remains under $100/year versus roughly $10,000/year in the US. Cited Kenya's National Digital Health Superhighway as a rare example of a government successfully attracting private capital (roughly $700M) into digital health infrastructure.
- **Dr Ahmed Ogwell** added a second, often-ignored enabler: no innovation enters a blank system; every context has existing (sometimes dysfunctional) norms and vested interests. Innovations succeed by working with that system, not trying to overturn it outright. Described African health systems as "patchworks" shaped more by partner and donor interests than domestic ones, and argued whoever benefits most from a change should be first to invest in it, naming this as the root of "pilotitis": people without a real stake in success are often the ones funding pilots.

> **The system will enable you to succeed, or the system will enable you to fail."**
>
> — Dr Ahmed Ogwell

Parallel Evening Track:

Pathfinder International x PharmAccess x EHA Clinics

Pathfinder International: Beyond the Pilot Institutionalizing Scalable, Government Embedded Digital Health Ecosystems in Africa

Presentation + facilitated panel discussion: Northern Nigeria focus; with pilot work spanning Kaduna and Kano states.

Presentation (Track 1): Moving from Fragmented Interventions to Government-Aligned Health Networks

Dr. Olufemi Ibitoye (Technical Advisor, Maternal, Newborn and Child Health (MNCH), Pathfinder International)

- Framed Pathfinder's mission as serving women and girls in underserved communities across reproductive, maternal, newborn, child, and adolescent health, and positioned the presentation as examining how a digital ecosystem must work across three domains, digital, technical, and operational, embedded within existing government health frameworks..
- Named the core problem: Nigeria's primary healthcare facilities plan quarterly through a largely paper-based "microplan" process. In northern Nigeria specifically, population movement driven by insecurity means quarterly settlement counts miss people who have relocated, those arriving in a new settlement go unplanned for, while those who've left are still counted at their prior location, leaving frontline health workers under-resourced for the population actually in front of them.
- Described Pathfinder's response, the GeoST4R initiative (Geospatial Data, Tools and Technology for RMNCH Microplanning and Decision Support), a pilot in Kaduna and Kano States that opened with a digital-literacy and government-readiness assessment, which surfaced governance, not technology, as the missing piece. This led to a two-tier governance structure: a strategic tier expanded beyond the state primary healthcare agency to include the directors of planning and disease control and the MNCH department, and a technical tier

translating those decisions into state- and LGA-level implementation..

- Outlined what sustaining the work required beyond the pilot: a shared connectivity platform; integrated governance with named institutional ownership, rather than repeat advocacy visits; privacy-respecting data infrastructure aligned to existing systems such as DHIS2; and health-service data that is actually usable for decision-making.
- Presented the resulting tools as living frameworks rather than static deliverables: a Master Settlement Registry supporting crowdsourced updates so settlement data stays current; a validation protocol letting different organizations validate settlement data independently and still arrive at consistent outcomes; and a chatbot and dashboard giving frontline workers and decision-makers visibility into which settlements and populations have actually been reached.
- Demonstrated live: the registry showing a settlement's history tied to specific communities, and how many people are accessing services there.

Panel — Beyond the Pilot: Institutionalizing Scalable, Government Embedded Digital Health Ecosystems in Africa

Moderator: Dr Hameed Adediran (Country Director, Doctors Medical Aid Foundation)

Panellists: Prof Salisu Ahmed (Director-General, Kano State Primary Healthcare Management Board; represented by Alhaji Aliyu Jinjiri Kiru, Director of Planning, Monitoring, and Evaluation (M&E), Kano State Primary Healthcare Management Board) · Mr Nuradeen Maidoki (Executive Director, Natview Foundation) · Dr Olufemi Ibitoye (Technical Advisor, Maternal, Newborn and Child Health (MNCH), Pathfinder International) · Carlos Yerena (Director of Partnerships and Growth, Reach Digital) · Masduk Abdulkarim (Senior Officer, Data, Analytics & MLE, Gates Foundation)

- Panel framed around three guiding questions: What is the essence of a pilot? What needs to be prepared before piloting? How should a pilot be implemented so the initiative outlives the pilot phase or the funding cycle itself?
- Alhaji Aliyu Jinjiri Kiru, representing the Kano State Primary Healthcare Management Board, spoke about how the initiative's governance should hold beyond the current administration, insulated from political transitions. His institution sits at the center of that governance structure described above, with the Board's Director-General chairing the Technical Governance Committee responsible for day-to-day system oversight.
- Mr Nuradeen Maidoki (Natview Foundation) described the geospatial dashboard as making previously invisible settlements visible to planners: it shows which settlements are covered by a facility versus missed entirely, and tracks outreach frequency and coverage gaps per facility. Argued this evidence base supports proper budget, vaccine, and supply-chain planning across wards, not just settlement-level visibility.
- Carlos Yerena (REACH Digital Health) argued the sector's challenge isn't knowing what good digital-health design looks like, frameworks already exist, but actually implementing it, and

praised the presentation's focus on governance structures over technology choice. Cited a recurring failure pattern: a digital tool introduced without removing the paper backup it was meant to replace, so health workers end up recording data twice. Argued sustainability starts with a government-led governance structure and clear ownership from the outset, since long-term financing depends on it.

- Dr Olufemi Ibitoye (Pathfinder International), on transitioning ownership to government: argued capacity building must target systems, not individuals, since training two people who later relocate wastes the investment. Described a two-phase approach, an engagement phase with clearly defined institutional responsibilities, and a deployment phase built on user feedback and iterative simplification for frontline workers, alongside sustained digital-literacy support for long-time paper-based users. On data quality specifically: described a governance process built around quarterly settlement-harmonization reviews with tiered access controls, structured around a verification step (checking settlement data against a shared validation protocol) and a consolidation step (layering in additional data sources under that same protocol), while acknowledging the settlement data set is not yet fully complete and remains a work in progress with the Kano State Government.
- Masduk Abdulkarim (Gates Foundation) framed sustainable governance as starting with three questions: whether demand for a solution genuinely originates from government, who the institutional owner of that solution is, and whether government has put a policy instrument in place mandating its use. Argued that without institutional mandate, a solution remains "a project housed in a government office," dependent on funding rather than owned by the system it's meant to serve, and said funders are increasingly building these questions directly into their own measurement frameworks alongside a clear transition plan.
- Dr Aliyu Jinjiri Kiru, representing the Kano State Primary Healthcare Management Board, was invited to speak to how government will sustain the initiative's technical capacity and infrastructure needs beyond the current phase of support. His institution sits at the center of the governance structure described above, with the Board's Director-General chairing the Technical Governance Committee responsible for day-to-day system oversight.
- Referexon for it.

PharmAccess Foundation: Fireside Chat

Moderator: Chisom Amadi (Program Director, Digital Innovations, Foundation).

Guest (virtual): Dr Ebere Okereke (Independent global health strategist and advisor with 30+ years' experience; former Global Health Advisor to the DG, Mohammed bin Zayed Foundation for Humanity; former Chief Program Officer, Reaching the Last Mile; former CEO, Africa Public Health Foundation; senior advisory roles at Africa CDC, WHO AFRO, and

the Tony Blair Institute for Global Change; Board of Trustees, Healthcare Federation of Nigeria; Advisory Board,).

- Framed explicitly as a prelude to the /HFN/ NCDC roundtable held on Day 2, on getting the private sector to report infectious-disease data in a timely, responsive way, and grounded in NCDC's National Action Plan for Health Security (NAPHS 2), which already names the private sector as key to achieving the agenda. The identified gap is not strategy but execution; most care in Nigeria is privately delivered, yet private-sector data reporting remains opaque..
- Chisom Amadi's opening framing: the current global health architecture was built to be reactive to crisis, entrenching donor dependency, parallel systems, and externally set targets. Argued that health security independent of the next emergency requires a resilient, sovereign health system, one where the private sector actively implements government priorities rather than government acting alone.
- Dr Ebere Okereke opened with the 2014–16 West Africa Ebola outbreak, when a private-sector practitioner in Lagos intercepted an imported case and notified authorities in time to prevent a wider outbreak, and with the private sector's COVID-19-era collaboration with NCDC, as evidence that public-private health-security collaboration already works. Cited that roughly four in five Nigerians access healthcare through a private-sector provider, and that 60–70% of primary care is privately delivered, as reasons there is no health security in Nigeria without systematic collaboration between the two sectors; framed the private sector as an entire ecosystem built on entrepreneurship that must own surveillance as a public good in return for the space government gives it to operate
- On the gap between policy and practice: argued Nigeria's National Action Plan for Health Security is a genuinely strong plan, but that plans fail without being broken down into tiered, differentiated responsibilities matched to each provider's capability (a hospital group can carry more than a single pharmacist), backed by resourcing and accountability, complicated further by health being a concurrent federal and state responsibility. Argued that partnership must then run in both directions: providers need to receive feedback on what their reported data achieved, not just submit it upward, since that feedback loop is what sustains participation over time.
- On the role of professional bodies and the private sector in translating government standards: raised patient-confidentiality concerns, how notification duties square with duty of care, as the kind of practical detail that only providers and professional bodies, not government alone, can resolve. Called for that dialogue to happen continuously between state epidemiologists and private providers, in peacetime, not only once an emergency forces it.
- On development financing: referenced Ghana's "health sovereignty agenda" (the Accra Reset) as a model, arguing it is countries, not donors, who should define their own priorities. Warned that donor-built surveillance systems are often non-interoperable, and called for NCDC and the Ministry of Health to define a single, digital, tiered minimum dataset that funders can then invest behind, with data insights returned to the frontline so providers see the value of what they report..

EHA Clinics: When the Clinic Works

Moderator: Dr Ifunanya Ilodibe — Chief Executive Officer, EHA Clinics

Panellists: Feyintoluwa Ogungbenro Chief Nursing Officer, EverCare Hospital · Dr Ayodele Cole Benson (Chairman, Echolab Radiology and Laboratory Services; also Vice President, Healthcare Federation of Nigeria) · Dr Kelechi Okoro (Founder/CEO, Heal for Africa Initiative; Founder/Lead Consultant, Healthertainer Consults)

- Opening framing: drew a sharp line between access and quality. A facility that sends a patient away undiagnosed for lack of a basic reagent counts as access, not care. Quality primary care is a development outcome as much as a health outcome, since trusted, continuous care changes patient behaviour upstream and downstream, while its absence pushes people straight to tertiary facilities as a first stop rather than a last resort.
- Named the core structural problem as health systems having built "verticals when we needed ecosystems": facilities underfunded, understaffed, and isolated from community structures and from the diagnostic and

"It isn't for the development partners to look. It is for us to tell the development partners what we need."

— Dr Ebere Okereke

specialist services that should sit alongside them.

- Dr Cole Benson (Echolab) framed diagnostics as the point where a clinical suspicion either becomes an actionable diagnosis or disappears, the practical "missing link" in primary care. Argued point-of-care diagnosis is routinely left out of primary healthcare planning in favour of basics like power and staffing; without it, care defaults to guesswork treatment, pushing patients to self-refer to diagnostic labs before ever reaching a doctor.
- Dr Cole Benson argued prevention is systemically underfunded because HMO reimbursement is structured around treating acute illness, not preventing it, citing Israel's policy of tying HMO registration to mandatory biannual health checks as a working, policy-driven example. Argued that Nigeria's roughly 70% health-budget spend on salaries in teaching hospitals and research centres, versus procurement and construction, could instead fund private operators under public contract to deliver preventive and diagnostic care, citing bank financing that follows a government service contract as evidence the capital would follow.
- Dr Kelechi Okoro (Heal for Africa) argued the barrier to primary healthcare is not access to health information but access to health information people can actually understand, delivered in the language and format they already use (Pidgin, local languages, short-form content), rather than the policy documents and articles the formal sector defaults to.
- Cited her own "Know Your PHC" campaign as evidence: many people did not know nearby primary health centres had been revitalised or could deliver more than basic care, because communicators are typically brought into government interventions late, if at all, rather than from the design stage.
- Feyintoluwa Ogungbenro (EverCare) argued the system over-invests in tertiary infrastructure relative to Nigeria's population, leaving primary care under-resourced. Most patients pay out of pocket, and many arrive at tertiary facilities only after exhausting money and time moving between diagnostic centres, by which point conditions have often become complicated and expensive to treat, despite roughly 85% of patient needs being appropriately met at the primary level.
- On what patients' journeys reveal about the primary layer beneath them: Ogungbenro cited a recurring pattern of default malaria and typhoid diagnoses without testing, and complications traced directly to basic lapses, hand hygiene, correct PPE use, antibiotic stewardship, rather than resourcing alone. Argued accountability at the primary level, including named KPIs such as maternal mortality ratios, matters as much as investment.
- Closing synthesis: quality primary care is defined by whether it works for the people it serves, not by whether a facility exists. Closing the access-outcomes gap requires honest partnership across government, private providers, facilities, communities, and communicators, and the sector has enough evidence; what it now needs is the willingness to name what isn't working and commit to specific action over more frameworks.

> **"A clinic that is open is not necessarily a clinic that is working."**
>
> — Dr Ifunanya Ilodibe

ILF Flagship Dialogue II:

From Intelligence to Action: Strengthening Data Governance, Public Health Intelligence, Digital Public Infrastructure, and Interoperability at Scale

Closing panel session of Day 1.

Moderator: Dr David Akpan (Deputy Director, Partnerships and Programs, eHealth Africa)

Panellists: Dr Fatima Saleh (Director, Surveillance and Epidemiology, Nigeria Centre for Disease Control and Prevention (NCDC)) · Dr Salihu Daniel (Regional Digital Health Lead, UNICEF East & Southern Africa) · Ogochukwu Maduabum (Senior Manager, Products and Services, eHealth Africa) · Dr Nneka Sederstrom (Managing Partner, Healthcare Strategy and Innovation, AMA Consultants; joined virtually) Closing remarks: Lexie van Waes (Senior Program Officer, Gates Foundation)

Dr Leke Ezekiel Ojewale, Advisor on Digital Health to the Honourable Minister of Health, was expected but unable to attend.

- **Dr Fatima Saleh** (NCDC) distinguished data collection from public health intelligence: data describes what happened; intelligence explains what is happening, what is likely to happen next, and what action it demands. Named four requirements for building it: timely, quality data; a One Health approach linking human, animal, and environmental data; connected rather than siloed data platforms; and a direct link to action, illustrated by a recent suspected Ebola case in Lagos caught and resolved through NCDC's event-based surveillance platform rather than routine reporting
- **Dr Salihu Daniel** (UNICEF) argued for a firm separation between policymaker (government) and tool-builder (partner), against any single partner becoming indispensable ("lock-in"), and for partners to hold patient-level data on a zero-trust basis, encrypted and inaccessible even to the partner itself, visible only in aggregate unless government explicitly authorises otherwise..
- **Ogochukwu Maduabum** (eHealth Africa) distinguished interoperability from integration: integration means custom-building an understanding of each partner's data and APIs one by one, while interoperability, building to shared standards, removes that layer entirely, making it possible to move data between systems (for example, into NCDC's SORMAS platform for outbreak reporting) without repeating the work each time.
- Dr Nneka Sederstrom (AMA Consultants, virtual) returned to Ota Akhigbe's earlier framing that communities experience system gaps as personal care gaps, not abstract system failures, arguing that digital transformation itself is not the goal; closing that personal-level gap is. Argued integration and innovation should happen concurrently rather than sequentially, since fragmentation is both the root of distrust and the most expensive path available, paying for the same capability twice at a time when external aid is falling.
- Dr Nneka Sederstrom illustrated the stakes with a contrast: a widely deployed sepsis-prediction model rolled out in a US hospital without local validation, named ownership, or a monitoring plan can generate false alarms and erode trust, while the same technology deployed with real local ownership and accountability can close

> **"Data for action; collected information that isn't acted on in a timely way has limited value."**
>
> — Dr Fatima Saleh

care gaps. Argued real reform means trusting local institutions over imported senses of urgency, and named three concrete requirements: a data steward institution with real federal authority, not a side committee; procurement standards that make interoperability, auditability, and data protection contractual conditions; and funding governance itself as infrastructure, not an afterthought.

- **Dr Salihu Daniel** argued government's role is to require partners to integrate horizontally onto a shared digital public infrastructure, built on common interoperability standards (HL7 FHIR, OpenHIE, SNOMED CT, ICD-10/11, LOINC), rather than compete vertically in isolation, so that data collected for one disease area can still inform decisions made using another.
- **Ogochukwu Maduabum** said she worries about AI misuse in health systems given the stakes involved, and cautioned against assuming models trained on US or other external data sets transfer directly to the Nigerian context. Cited eHealth Africa's work with the Gates Foundation validating AI-assisted models for community patient management as the kind of local validation, alongside continued human oversight, that should precede any wider AI deployment.

Closing remarks — Gates Foundation

Lexie van Waes (Senior Program Officer, Gates Foundation)

- Closed the session with four practical takeaways for moving from public health intelligence to action: design tools and data collection around the specific decisions they need to enable; architect systems with future interoperability in mind, since Nigeria's data already sits in many disparate places; get specific on data governance, naming who owns and is responsible for each dataset; and build trust from the start by involving end users in design so they understand what is being measured and why. Closed by framing success as getting from data to decisions faster, not simply deploying new tools.

Day 1 Close

Video message

Brian O'Connor (Chair, Global Health Connector)

- Congratulated eHealth Africa for convening ILF, describing it as more than a conference, a space where policymakers, implementers, innovators, funders, and development partners exchange practical insight and move toward action rather than simply talking.
- Referenced a recent eHA Executive Roundtable at an AHTS event in Toronto ("AHTS X") on scaling health tech from pilot to system-level impact, echoing the "pilotitis" language used earlier in the day.
- Described the Global Health Connector's model: a network of 90+ permanent, multi-stakeholder "ecosystems" worldwide, intended as neutral ground for accelerating learning, partnership, and adoption.
- Offered a candid outside perspective: encouraged the room to "lift your eyes... outside of Africa" to learn from and be learned from globally, while cautioning that the world under-hears "the true African story."

Closing synthesis and transition to evening

- The day's synthesis carried forward four themes: build connected, interconnected systems and actively avoid fragmentation; pursue partnership that aligns with government priorities both bottom-up (local/state) and top-down (national); pursue vertical partnership between different technology partners; and keep investment focused on inclusion, interoperability, and collaboration.
- Closing remarks thanked delegates for their engagement and reiterated the Forum's theme (Insights, Partnerships, Inclusion, Interoperability, Investment) as ideas made real through connection, not just language. The room was then reconfigured for the ILF Welcome Cocktail Party and networking dinner.

"Without interoperability, even excellent technologies remain isolated."

— Brian O'Connor

Insights Learning Forum 2026

Day 2 ran as two simultaneous breakout tracks through the morning (Breakout Room 1 and Breakout Room 2), converging into Main Hall for the afternoon proceedings, the Commitment Session, and the Forum's close.

DAY 02

Wednesday, 29 July 2026

Breakout Room 1 (Morning Session)

Accelerating African Innovation Through Structured Pathways for Invention-Based Enterprises

Official launch of the Invention-Based Enterprises (IBE) Playbook.

Winnie Wangari (Mechanical Engineer & MedTech Lead, Villgro Africa).

- Villgro Africa (Nairobi) has supported healthcare innovators for 11 years: 250+ companies supported, $4M+ in capital deployed, and in-person technical support across 33 countries.
- Framed the core gap the Playbook addresses: hardware medical-device innovators consistently under-plan for infrastructure, quality management systems (QMS), and regulatory pathway, treating QMS as a late-stage concern rather than a day-one requirement.
- Walked through the five-phase medical device lifecycle the Playbook structures around (Design Input, Design & Development, Verification, Validation, Design Transfer (market/regulatory submission)), each phase mapped to a requirement traceability matrix tying every engineering requirement to a testable, standards-referenced (ISO 13485 quality management; ISO 14971 risk management) verification step.
- Core audiences for the Playbook: innovators, incubators and portfolio managers, universities, manufacturers, and clinical partners supporting early-stage readiness.

Case Study: Kidney Wallet

Dr Shuaib Sani Shuaib (Executive Director, FutureMap Foundation)

- Kidney Wallet is a point-of-care kidney-health screening device: a sensor and AI interface that determines heavy-metal blood levels, blood glucose, and blood pressure in under 20 seconds, and flags kidney-disease risk.
- Origin: a cross-sectional study with the Nigerian Medical Association (Jigawa State chapter), WHO, and the Jigawa State Government found near-universal, late-stage kidney disease presentation around the Hadejia–Jama'are river basin, roughly 200 new cases identified, with about 85% presenting only at end-stage. Root cause traced to heavy metals in groundwater from agrarian and fishing practices and pesticide use.
- Future Map Foundation built a dedicated specialist dialysis clinic in Hadejia (free for the underserved, subsidized for others), now drawing patients from up to 200km away.
- Positioned explicitly as a screening tool, not a replacement for clinical diagnostic markers; built under the same partnership umbrella as the Peaceoma Clinic and Academy, launched by Nigeria's First Lady with NPHCDA, NITDA, and eHealth Africa support.

> **"Innovation does not stop at the prototype stage, it improves the product lifespan that is validated, manufactured, and financed to be sustainable in the long term."**
>
> — Winnie Wangari

Fireside Chat

From Pilots to Public Good: What Does It Really Take to Scale Health Innovation Across Africa

Presented by the African Medical Center of Excellence (AMCE).

Moderator: Dr Rosemary Otalor (Head of Corporate Communications, AMCE)

Dr Anshul Govila (Chief Operating Officer, African Medical Center of Excellence)

- Background: surgeon by training, with roughly 18 months at AMCE. AMCE was commissioned in June 2025 and is approaching one year of clinical operations, with 80% of the medical work performed described as never previously done in Abuja.
- Framework for what healthcare innovation requires: empowered political and social will ("will without money is a dream"); demand, framed as the constant, universal burden of disease; and provision that goes beyond doctors to supply chain, digital outreach, and longitudinal follow-up, since chronic conditions keep patients in the system for decades, not single encounters.
- On infrastructure versus technology: argued technology's real value is "scavenging the market" for disease at the public-health level, since everyone now carries a device that can relay clinical information and receive prescriptive advice. AMCE, meanwhile, represents the tertiary/hospital end of that same continuum.
- On reaching the base of the pyramid: argued the more fundamental gap is often sanitation and clean water, and that tertiary centres add value less by treating the base directly and more by training secondary and primary providers to a standard that prevents avoidable complications.
- On the single highest-leverage partnership for Africa's healthcare future: rejected the idea that one partnership suffices (citing the UAE's 20-year, multi-nation healthcare build-out for 12 million people as an example of a market too large for any single partner), but named the mother/caregiver–frontline health worker relationship as the most consequential "partnership," given its longitudinal reach into the household.
- Closed with a direct callback to the Kidney Wallet case study, encouraging the team to pursue scale as an illustration of how tertiary/private-sector actors can help local innovations reach exit-scale.

> **"Everybody in his pocket is essentially carrying a beacon where he can relay his clinical information."**
>
> — Dr Anshul Govila

NCDC × HFN × Roundtable

Advancing Nigeria's Health Security Agenda: The Role of Public-Private Partnerships

Side event on IDSR (Integrated Disease Surveillance and Response) reporting, co-hosted by NCDC, the Healthcare Federation of Nigeria (HFN), and Nigeria.

- Welcome delivered on behalf of NCDC Director-General Dr Jide Idris, framing private-sector engagement as essential given 70%+ of Nigerian out-of-pocket health spending flows through the private sector, intelligence currently sitting outside NCDC's visibility.
- **Goodwill remarks:** Dr Mohammed Saleh, Co-Chair, Health Security Technical Working Group (US CDC), argued the sector must move beyond forums to catalyzed action, citing COVID-19-era partnerships as proof of concept.
- **Goodwill remarks:** Nigeria / HFN leadership described a forthcoming MOU between , HFN, and NCDC, and flagged that informal-sector health data (community pharmacies, patent medicine vendors) is currently invisible to government despite often being the first point of contact for outbreak signals. This was illustrated with a Kenya COVID-era example where community-pharmacy fever-clustering data provided an early warning signal.

NCDC technical presentation, the IDSR reporting architecture

Dr Fatima Saleh (Director of Surveillance and Epidemiology, NCDC)

- NCDC's national reporting backbone is SORMAS, an electronic IDSR platform introduced from 2014, now live across the FCT plus 6+1 states, tracking 25 of 45+ nationally priority notifiable diseases in real time, with mobile capture, contact tracing, geo-mapping, lab integration, and dashboarding.
- Explicit acknowledgment of a private-sector blind spot: NCDC does not yet have a holistic picture of disease burden, since the majority of private-facility data is not captured, with concrete named costs: delayed outbreak detection, inaccurate disease-burden estimates, weaker health-system scores, missed early-response windows, and reduced partner/donor confidence.
- SORMAS is technically interoperable (API links to DHIS2, EIOS for event-based/rumour surveillance, SITAware, and NCDC's Connect Center for verification), but private-facility EMR-to-SORMAS linkage remains largely unbuilt.
- Explicit call to action: NCDC stated willingness to onboard private facilities onto SORMAS, negotiate data-governance terms (minimum necessary variables, not case-identifying data), and invest in capacity building, framed as collaboration rather than the NCDC Act's existing enforcement powers.

Open floor: blockers and private-sector perspectives

- EMR and health-tech providers named the core technical blockers: lack of a single reporting standard (FHIR versus other formats), fragmented facility-by-facility reporting templates, unresolved data-protection questions under the NDPR/NDPA, unclear cost-bearing for middleware and interoperability layers, and a commercial chicken-and-egg

> **"Data is the lifeblood of surveillance, and partnerships are the arteries that allow that lifeblood to flow."**
>
> — Delivered on behalf of NCDC DG Dr Jide Idris

problem in building custom integrations for one or two customers at SaaS scale.

- **Dr Simpa Dania,** CEO, HealthStack, noted the private sector has long been technically capable (citing a 2021 Facebook/CcHub-sponsored competition that produced a WhatsApp-based IDSR reporting prototype), while institutional connection to NCDC lagged.
- **Samir Abubakar,** Head, ProductHelium Health, stated that 95% of Nigerian EMRs are not connected to DHIS2, and pressed for DHIS2 API access to be opened to all EMR vendors as the highest-leverage first step, ahead of broader interoperability and NDHA work.
- **Celestine Ogbudeke,** Elephant Healthcare Nigeria, welcomed NCDC's engagement as a first for the sector, and proposed that willingness to co-submit joint funding proposals with private vendors would be a concrete test of NCDC's collaborative posture, given that aggregated public-health data ultimately belongs to government regardless of who collects it.
- **Dr Jenom Danjuma,** Resolve to Save Lives, cautioned the room isn't starting from zero: a similar private-facility IDSR onboarding pilot ran in 2015–17, and even after that intervention 60–70% of relevant data still wasn't reaching the national platform, urging the room to mine the lessons from that shortfall. Separately noted the Federal Ministry of Health, via a memo passed at last year's National Council on Health, has already secured commissioner-level agreement that all states should adopt EMRs.

> **"A fever spike would not meet the case definition, but if we're able to get some of these predictive, symptom-level signals in earlier, the surveillance system would be even more powerful."**
>
> — Dr Omokhudu Idogho, SFH

- **Dr Omokhudu Idogho,** Group CEO, Society for Family Health (SFH), joined online and raised a structural point: 60–70% of first healthcare contact in Nigeria happens outside facilities that meet IDSR's formal case-definition threshold (community pharmacists, patent medicine vendors). Cited SFH's own "test-before-treat" malaria program (7,000+ community-pharmacy touchpoints) tracking real-time fever spikes as a pre-case-definition, predictive layer current IDSR architecture doesn't yet capture.
- **Dr Ugabe,** UNICEF Abuja, reframed the room's financing question ("what are the DFIs willing to fund"), arguing the prior question is data quality: donors and DFIs pool resources around proposals, and weak underlying data undermines funding requests regardless of amount sought.
- Session closed with confirmation that HFN and NCDC are proceeding to sign a formal Memorandum of Collaboration.

"The private sector is talking, and the government is acting. NCDC is open for business."

— NCDC co-anchor, closing the session

Breakout Room 2 (Morning Session)

eHealth Africa CHAT Tool Demo + Building Climate-Resilient Health Systems Panel

Demo: Climate Health Vulnerability Assessment Tool ("CHAT")

- CHAT supports integrating climate adaptation directly into routine health-facility planning and policy; built with offline functionality for low-connectivity areas, and DHIS2-aligned to enable cross-country adoption.
- Positioned as a research asset as much as an operational one: generates standardized, multi-state facility-level climate vulnerability data usable for subnational climate-health research, comparative rural/urban and conflict-affected analysis, and geospatial modelling of climate-related service disruption and hotspot clustering.

Panel: Building Climate-Resilient Health Systems.

Moderator: Safiya Shaibu-Isa (Director of Advocacy and Partnership, Nigeria Health Watch). Panellists: Toju Chibuzor Ogele (Development Specialist, eHealth Africa) · Tolu-tope Dada (Schneider Electric) · Dr Edwin-Isotu Edeh (WHO, Climate & Health) · Dr Bello Salman (Technical Advisor, Office of the MD/CEO, Rural Electrification Agency).

- **Ogele (eHA):** named short-termism as the core barrier, health systems treat resilience like a one-time installation rather than an ongoing property, and haven't yet built the planning discipline for shocks 3–10 years out. Referenced 238 facilities under his own solarization portfolio, alongside cold-chain infrastructure work.
- **Dada (Schneider Electric):** argued environmental framing alone doesn't move Nigerian adoption; decision-makers respond to the economics, and messaging must be localized to what a community actually experiences.
- **Dr Edeh (WHO):** agreed communication and economics compound a deeper development-stage issue: communities still contending with basic energy access experience climate/solar messaging as "an advanced problem," and called for African-designed climate-action framing rather than a template built for other contexts. Noted Nigeria's Health National Adaptation Plan is explicitly domesticated by state.
- **Dr Salman (REA)** laid out the agency's approach: geospatial mapping to identify off-grid-eligible communities, standardized technical specifications now enforced through SON, 20+ signed state MOUs, and 500+ completed healthcare electrification projects, delivered through DARES, a performance-based grant model requiring developers to remain on-site post-installation. Flagged the flagship eHeart initiative: a joint Ministry of Health / Ministry of Power program to electrify all 774 local government areas at 100kW each, with a dedicated envelope of roughly $100M.
- **Dr Edeh** closed with a 5-year continental prioritization: climate-smart health workers who integrate climate action into routine service delivery; sustainable, blended financing (70% of African countries report a financing gap in their national adaptation plans); climate-resilient physical infrastructure, not just solarization; climate health intelligence, predictive modelling linking climate data to disease-outbreak forecasting, citing the eHA/NiMet WISER project; and climate-informed disease programs, mainstreaming climate variables into existing malaria, NTD, and NCD programs.
- Positioned Nigeria as a continental leader on this intersection: the first African country to mainstream health into its Nationally Determined Contribution (NDC), and credited eHealth Africa's CHAT tool as the first government-partnered digital tool linking climate and health data, now DHIS2-mainstreamed and being examined by other African countries.

> **"Don't tell him about the environment, tell him he'll be saving money from diesel. Then global warming, the earth dying, can come in."**
>
> — Tolu-tope Dada, Schneider Electric

Main Hall (Afternoon Session)

Ministerial Keynote

Dr Iziaq Kunle Salako
(Honourable Minister of State for Health and Social Welfare)

Delivered via live video feed from an adjoining hall due to space constraints.

- Opened by explaining a scheduling choice: attended the FCMB healthcare financing summit in Lagos on Day 1 rather than ILF, framing it explicitly ("without money, we cannot do much with this digital session") before joining ILF for Day 2.
- Thanked eHealth Africa specifically for the handover of 238 solarized public health facilities across 12 states under the National Power for Health Initiative, and for EOC (public health emergency operations centre) deployment support in several states.
- Framed the Forum's five-word theme as the direct operational framework of the Nigerian Health Sector Renewal Investment Initiative (NHSRII), launched by President Bola Ahmed Tinubu in December 2023.
- Cited the administration's Eight-Point Renew Hope Agenda for health, and a cluster of headline investment-case figures: an estimated ₦4.8 trillion in annual economic return recoverable through the reform blueprint; potential to domestically retain roughly ₦850 billion currently spent abroad on medical tourism; a targeted 50% reduction in preventable maternal and child deaths; and closing an almost 19-year life-expectancy gap between states.
- Named delivery progress to date: over 3,000 primary healthcare facilities revitalized; an emergency medical ambulance system that has moved tens of thousands of pregnant women and newborns from remote areas; and an already-recorded double-digit percentage reduction in maternal and newborn deaths in covered areas.
- Was candid about the gap still open: public health infrastructure still requires "massive revitalization," out-of-pocket expenditure remains high, and government has not yet hit its own target of allocating at least 5% of the annual health budget to digital interventions.
- Announced the Sector-Wide Approach's $500M Compact financing incentive to states that move fastest on domesticating the national digital health framework, framed explicitly as a race states can choose to lead.
- Direct asks by audience segment: development partners to align investment to the Sector-Wide Approach rather than parallel systems; private sector to commit to the national digital health architecture as the agreed framework, working through regulatory sandboxes; and youth innovators framed explicitly as "architects," not merely beneficiaries, of the system.
- Closing response and thanks delivered on eHealth Africa's behalf by **Ota Akhigbe,** who highlighted the Minister's "breaking silos" message as consistent with ILF's own throughline, and separately thanked the Dala Africa / AHTS partnership represented by Jean Philbert Nsengimana.

> **"We cannot use 19th century tools to build a 21st century nation. Innovation is not an accessory. It is our lifeline."**
>
> — Dr Iziaq Kunle Salako

ILF Flagship Dialogue IV

The Future of Care Investment: Community, Primary Care, and Digital Health Integration

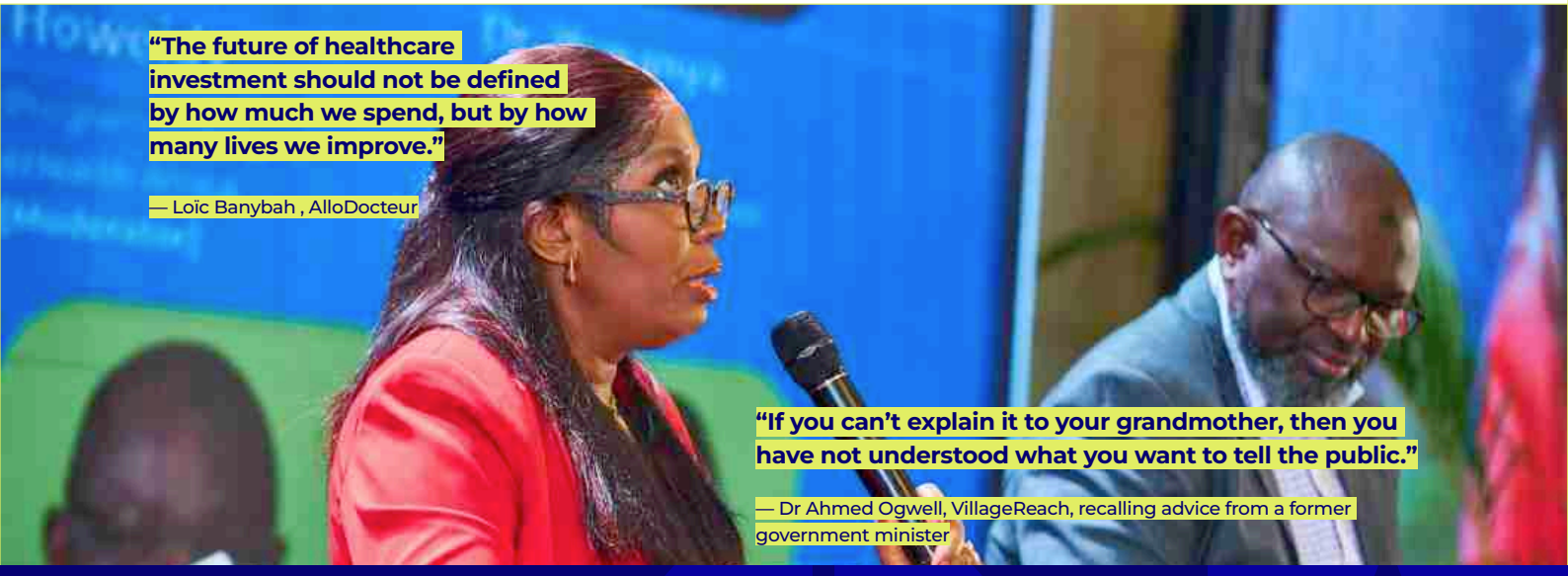
Moderator: Fatimah Howeidy (Program Manager, eHealth Africa).

Panellists: Dr Ahmed Ogwell (CEO & President, VillageReach) • Dr Nkemdilim Femi-James (CEO, Persons Associates for International Development) • Loïc Banybah (COO, AlloDocteur) • Dr Ifunanya Ilodibe (CEO, EHA Clinics).

- **VillageReach:** an international non-profit operating in roughly 20 African countries plus the US and Pakistan, working at the primary-healthcare level across data visibility, capacity building, supply chain, and policy.
- **Persons Associates for International Development:** a Nigerian, women-led monitoring, evaluation, and learning (MEL) firm operating since 2013, working with both government and international NGOs on impact assessment and policy learning nationwide.
- **AlloDocteur:** a platform connecting patients with vetted healthcare professionals, aiming to bring affordable care closer to where patients already are rather than requiring travel to it.
- **EHA Clinics:** a connected-care ecosystem, not a clinic network alone, combining primary care delivery, an HMO/membership arm to reduce out-of-pocket cost, a community REACH outreach arm, EHA Care (data/outcomes infrastructure), and EHA Pharma (WHO-compliant pharmaceutical distribution).

What should define the future of care investment

- **Banybah** proposed a continuum-of-care investment framework: strong primary healthcare as the system's entry point; digital infrastructure that connects rather than creates new silos; and further principles extending the same logic across specialist and long-term care.
- **Dr Ogwell,** on how governments should align investment across community, primary care, and digital transformation, named three sequenced priorities: invest in people first, so communities can articulate and feed back on what's actually working; invest in accessible data collection at the point closest to decision-making before aggregating nationally; and invest specifically in the usage of digital tools, not just their deployment.
- **On what holds government decision-makers back from acting on data:** named two recurring weaknesses, decision-makers frequently lack the specific range of information



"As you design, remember: it is not an encounter, it is a journey."

— Dr Ifunanya Ilodibe, EHA Clinics

needed to decide, and the sector routinely over-technicalizes its own messaging. Separately named self-interest in decision-making positions as a harder, more structural barrier that varies by administration and individual.

- **Dr Femi-James,** on what distinguishes scalable investments from successful pilots: pilots optimize for proving "what" is possible and are typically externally funded, well-resourced, and time-boxed; scale requires government ownership of the "how," built into existing frontline infrastructure rather than parallel project structures. Cited the Nigerian Health Sector Renewal Investment Initiative's ministerial-level backing as an example of the political capital scale requires, versus pilots that lose institutional memory within a few years of donor exit.
- **On whether digital innovation can strengthen health systems without adding fragmentation:** Dr Ilodibe argued the discipline is designing for the patient journey, not bolting a solution onto an existing pathway, citing change management, trust ("the currency of healthcare… also the easiest thing to lose"), and outcome-based design (an appointment system is worthless if there's no clinician to staff the appointment, or medicine to prescribe once diagnosed) as the recurring failure points behind fragmentation.
- **On what COVID-19 taught the sector:** Dr Ilodibe reflected candidly that the sector "hasn't learned enough"; EHA Clinics itself launched only months before the pandemic and had to rapidly rebuild its strategy (including standing up an isolation centre), and argued systems must be designed for resilience and proactive preparedness rather than reactive response to the next shock.
- **Closing framing across the panel:** investment should follow outcomes (lives reached, maternal mortality improved, under-5 mortality, preventable-death ratios), not outputs (facilities built, systems deployed), and that measurement discipline needs to be designed in from the start of any project, not retrofitted once investors ask for results.

Audience question

- Asked how the sector ensures digital transformation doesn't widen inequalities for communities with limited technology access or digital literacy, the panel's response centred on intentional, inclusive design: user-friendliness (including voice-prompt interfaces reducing the need for literacy or coding skill) can and should be built in by design, levelling access regardless of a user's formal education.

"Investment is successful because we are changing and improving people's lives, not because we spent a lot of money."

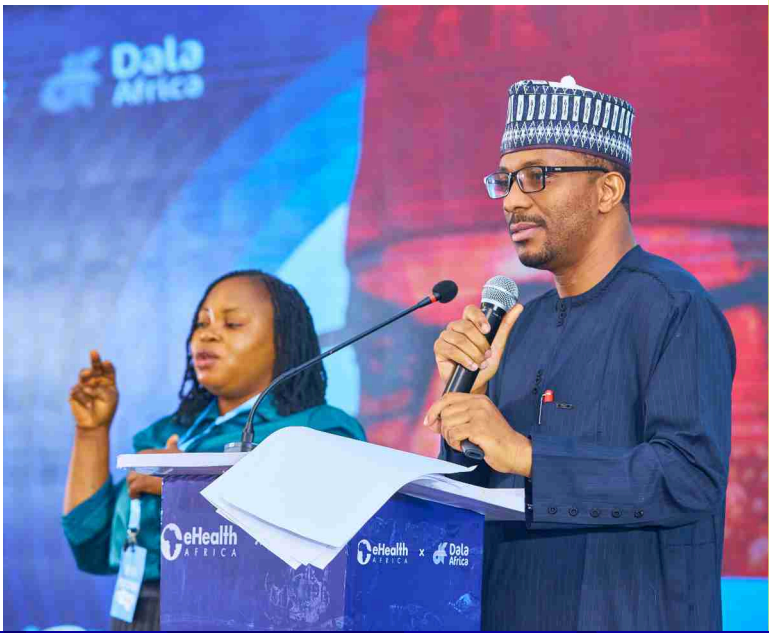
— Panel synthesis, Future of Care Investment dialogue

Special Address. Strengthening Community Systems:

The Role of Rural Development in Delivering Equitable Primary Healthcare in Africa

Hon. Abdulkadir Abdulsalam, Honourable Commissioner for Rural and Community Development (Kano State Government).

- **Framing:** roughly 57–60% of Africa's population lives in rural areas. Argued equitable primary healthcare requires closing the access gap between, for example, a rural woman in Kano State and a woman in a major city: access should not depend on geography.
- **Nigeria-specific figures cited:** per the National Bureau of Statistics (2023), over 60% of the rural population lacks functional primary healthcare centres with electricity or clean water; per a 2024 UN projection, Nigeria is set to become the world's third most populous country by 2050 (400M+ people), with 45–50% still rural at that point.
- **Core argument:** healthcare access cannot be solved in isolation from basic infrastructure. This used Maslow's hierarchy of needs (food, water, hygienic environment, healthcare) as the frame, illustrated with a direct example: a rural clinic is meaningless to a woman in labour if there is no road to reach it..
- **Presented Kano State's own response:** a "Data for Sustainable Rural Community Development" needs-assessment exercise, built on town-hall engagement with local governments and traditional and district leadership, feeding into a 5-year Integrated Rural Development Plan (2026–31) aligned to 9 of the 17 UN Sustainable Development Goals plus national and state development plans.
- **The plan has five pillars** (health, education, agriculture, infrastructure (including ICT and roads), social protection, peace/security/ governance, and climate resilience), explicitly designed as interdependent (solar power keeps clinic vaccines cold; roads connect farms to markets; school feeding uses local produce) rather than pursued one at a time.
- **Budget:** approximately $500M (roughly ₦650–700 billion), structured as a diversified funding model requiring private-sector and development-partner co-investment, explicitly framed as beyond what state or federal government can fund alone given Nigeria's population trajectory.
- **Named 2030 KPI targets:** 60% primary healthcare centre functionality (crediting eHealth Africa's existing solarization of roughly 20 Kano PHCs as a contributor, alongside an ongoing World Bank-funded impact project) and 70% primary-school completion, named explicitly as a precondition tied to poverty and hunger reduction, ahead of further digital or AI-focused investment.
- Closed by echoing the day's electrification thread from the morning climate panel, positioning power access as foundational to any rural primary-care delivery model.



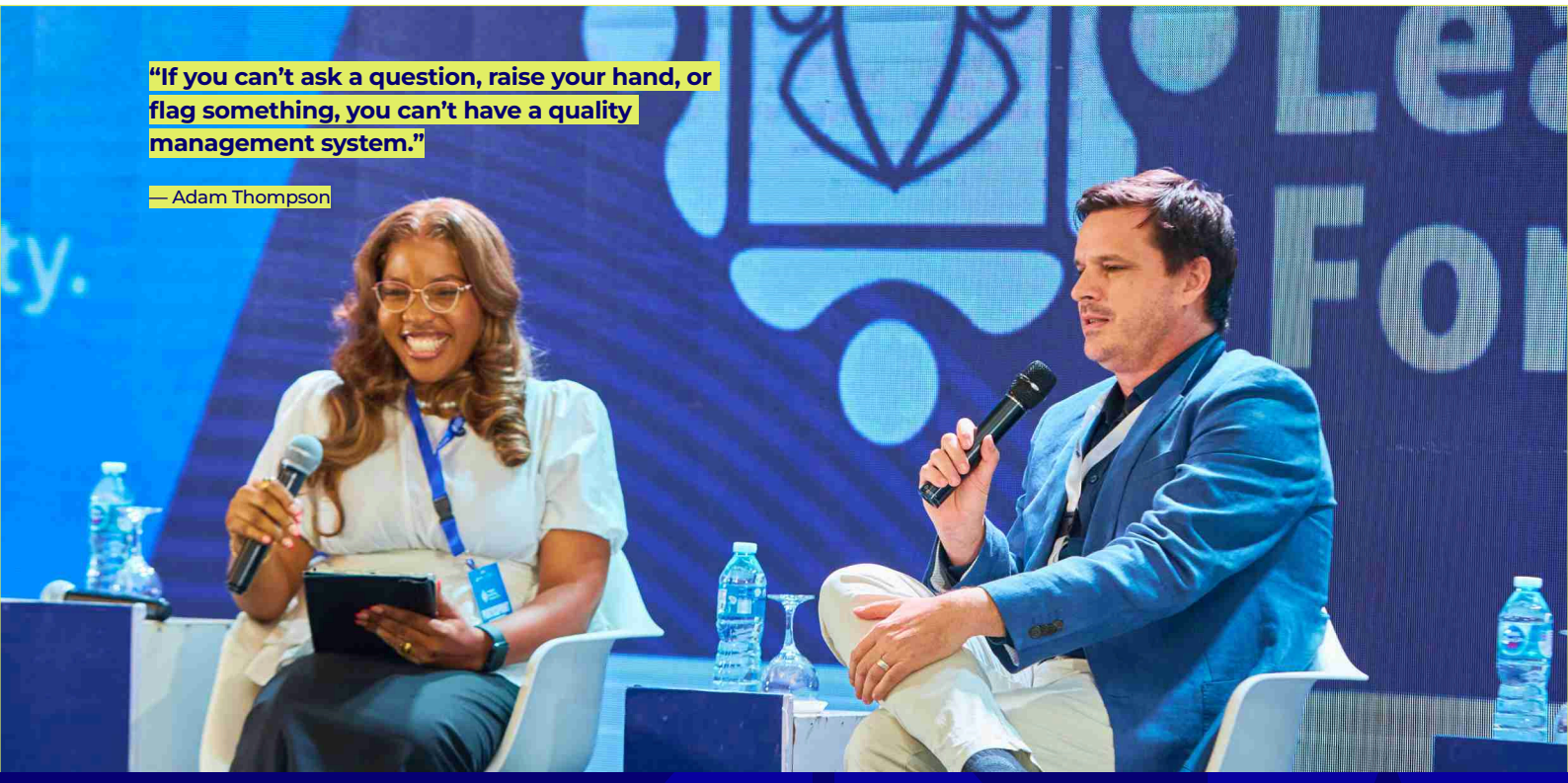
Fireside Chat

No One Builds a Health System Alone

Host: Daniella Ukwa (Group Communications Lead, EHA Group).

Guest: Adam Thompson (Co-founder & Chief Executive Officer, EHA Group).

- Framed around "ecosystem thinking" and EHA Group's deliver–build–invest operating thesis (eHealth Africa, EHA Clinics, EHA Impact Ventures); a single-focus "we do data/digital and plug into other systems" model doesn't hold up in public health, because standalone technical solutions have nothing keeping them running once deployed.
- Illustrated with two examples from the organization's own history: during Sierra Leone Ebola response data work (2014–15), no existing vendor could staff the call centre needed to manage incoming data, so the team built the capability with a local partner and then handed full ownership over, rather than retaining it; separately, EHA once built its own petrol station in Kano purely to manage field-vehicle logistics and fuel costs.
- Connected this directly to the Women Vendor Directory story: an internal review found EHA Group procurement was concentrated among a small, largely male-owned vendor pool, not through active exclusion but because most female-owned businesses lacked the paperwork and compliance documentation the organization's government-contract obligations require. Rather than wait for vendors to arrive fully compliant, the team went out and trained them directly, adding roughly 300 female-owned vendor companies to the procurement base within about six months.
- On quality management systems: argued the two most commonly overlooked prerequisites are open, critical communication and psychological safety to flag problems, illustrated



"If you can't ask a question, raise your hand, or flag something, you can't have a quality management system."

— Adam Thompson

> **"There's not going to be one person left standing serving Nigeria's public healthcare sector, if there's someone else you can help build up to solve part of the problem, that's how you build the ecosystem."**
>
> — Adam Thompson

via Atul Gawande's surgical-checklist research (where the single strongest predictor of surgical survival wasn't surgeon seniority but whether the surgeon knew the operating-room nurses' names) and the observation that the safest US hospitals are typically the ones that report the most incidents, not the fewest, because a low reported-incident count usually signals under-reporting, not safety.

- Named EHA Group's internal quality slogan, "see it, say it, solve it", applied irrespective of seniority or role.
- Directly rebutted the idea that ecosystem/partnership-first thinking is slower or more expensive: argued it's the difference between delivering a project once versus redoing it after missing foundational steps, and contrasted the development sector (characterized as more territorial and competitor-averse) with the private sector, where he said direct competitors routinely collaborate without friction.
- Audience Q&A: on the single hardest leadership challenge over 16 years running EHA Group, named the transition from managing projects directly to managing managers as consistently underestimated, attributing most organizational collapse to leadership failure rather than economics or external shocks. On balancing business and impact, rejected a hard separation between the two: argued any employer treating staff and community well is having impact, regardless of nonprofit/for-profit structure, and that some NGOs with "impact" missions do less genuine good than well-run private businesses because of how they treat their own people.

Beyond Access:

Leveraging Digital Solutions to Advance the Health and Rights of Women and Girls

Moderator: Audrey Odogu (Senior Manager, Business Development, eHealth Africa).

Panellists: Dr Chizoba Wonodi (Epidemiologist, Johns Hopkins IVAC) • Dr Charles Usie (Country Director, Plan International Nigeria) • Dr Kemi Dasilva-Ibru (Founder, WARIF) • Mary Edoro (Head of Strategy, BellaNaija).

- **Framing:** digital solutions for women's and girls' health, examined through three lenses: how digital tools affect intervention design, the accountability organizations carry for the safety, rights, and protection of women and girls online and offline, and digital gender-based violence specifically.
- **Dr Usie (Plan International)** identified three population segments digital solutions serve differently: those with no healthcare access at all, those with partial or under-resourced access, and those with facility access but overwhelmed capacity. Pointed to INEC's claimed 98% internet coverage (cited in the context of the BVAS election-verification system) as evidence that connectivity is often available even where health-sector actors assume it isn't, and challenged the sector to interrogate why the same infrastructure argument isn't applied consistently.
- **Edoro (BellaNaija)** described digital media's opportunity as visibility into the full lifecycle of a health message, not just campaign-end metrics, citing the "Stop HPV for Her" campaign, where a real-time comment from a woman who reversed an earlier vaccine-hesitancy decision surfaced information the campaign's formal endline metrics would have missed. Named the corresponding risk directly: platforms, including her own, over-index on reach metrics at the expense of measuring actual behavioural change, because reach metrics are what continued funding responds to.
- **Dr Dasilva-Ibru (WARIF),** speaking from a dual vantage point as a practising obstetrician/gynaecologist and safeguarding-focused non-profit founder, named AI-assisted diagnostic tools (for example, AI-assisted ultrasound interpretable via smartphone by a minimally trained community health worker) as a concrete near-term opportunity to extend specialist-level decision support into rural primary care without requiring new specialist training pipelines.
- **Closing round** on sector priorities: consensus emphasis across panellists on co-creating solutions directly with the communities they're meant to serve, integrating innovations into existing government systems as the only credible scale path, and measuring innovation by impact on women's and girls' lives rather than by app count.

"We use this argument when it suits us. When it comes to elections, there's internet connectivity in 98%. When it comes to healthcare digital enablement, more than 60% are cut off. There's a conversation we're not having."

— Dr Charles Usie, Plan International Nigeria

EHA Impact Ventures:

Investment Moment & Certificate Presentation

Ramatu Abdullah (EHA Impact Ventures).

With: Dr Ifunanya Ilodibe (CEO, EHA Clinics).

- **Dr Ilodibe** opened with the underlying case for reinvestment: 85% of what patients actually need should be served by primary care, yet primary care remains structurally underfunded relative to that need; 75% of patients still pay out of pocket; Nigeria trails the African average on maternal mortality.
- **EHA Clinics** restated its five-part connected-care model: quality primary healthcare in urban communities; HMO/membership plans to reduce out-of-pocket exposure; the REACH community outreach program explicitly targeting underserved, not just paying, populations; EHA Care for data and outcomes infrastructure; and EHA Pharma for WHO-compliant medicines distribution.
- Evidence cited for the reinvestment case, since EIV's last investment in 2024: an additional 20,000 people served annually; three new facilities built; a 100% growth rate in antenatal-care attendance; 250+ jobs supported. Since EHA Clinics' 2018 founding: roughly 9 locations across Nigeria, 57% female employee count, 47% female manager count, and roughly $6.2M deployed by EIV to date.
- An investment/reinvestment moment for EHA Clinics was marked on stage with a certificate presentation, delivered by Adam Thompson (CEO, EHA Group), Ota Akhigbe (Director, Partnerships and Programs), and the VP of Business Development, EHA Clinics.
- The Certificate of Investment was presented on stage by Adam Thompson (CEO, EHA Group), Ota Akhigbe (Director, Partnerships and Programs), and the VP of Business Development, EHA Clinics.

Announced reinvestment:

$1,250,000

(EIV's third investment round into EHA Clinics)

The Certificate of Investment was presented on stage by Adam Thompson (CEO, EHA Group), Ota Akhigbe (Director, Partnerships and Programs), and the VP of Business Development, EHA Clinics.

Youth at the Centre:

Creating Digital Solutions That Leave No One Behind

Moderator: Dr. Muhammadu Mamman (Medical doctor; Founder, Sahel MedTech).

Panellists: Dr Zainab Olamide Sadik (African Health Innovation Fellow; maternal/primary-health digital solutions) • Dr Victory Ekpin (Digital Health Researcher, LSHTM graduate) • Jaafar Muhammad Isa (Chair, domestication and implementation of the Africa CDC Youth Health Strategy; immediate past President, Federation of African Medical Students' Associations; co-founder, Sahel MedTech).

- **Context set early:** youth constitute roughly 70% of Africa's population and 60% of Nigeria's, framed as both the demographic reality driving demand for youth involvement and the reason it hasn't historically translated into decision-making seats.
- **Dr Israel,** on what genuine youth co-creation looks like in practice, distinguished it from two failure modes: token participation, where a youth presence "ticks a box" after solutions are already designed; and total abandonment, where youth are left to figure it out alone. Argued real co-creation means involvement from the ideation stage, in working groups, panels, and design processes from day one.
- **Dr Sadik,** on systemic research barriers, gave a first-person example: a paper-based ethics submission at a primary care centre that stalled for weeks with no tracking, escalated to a secretariat with no clearer process, and was ultimately found never to have progressed past its initial stage. This was used to illustrate how opaque approval systems discourage exactly the innovators the sector says it wants.
- **Jaafar,** on the Africa CDC Youth Health Strategy, confirmed Nigeria is the first African country to formally adopt the strategy, crediting the Minister of Youth Development for raising a domestication and implementation committee, which Jaafar chairs. Noted Africa CDC maintains a dedicated Youth Division with a public application channel for young people seeking capacity-building support.
- **On what an enabling ecosystem for youth-led innovation requires:** consensus across the panel that the binding constraint isn't ideas but access, specifically, a navigable "architecture" for where and how to plug into existing systems, and access to finance for the much larger system surrounding any given idea.
- **On partnerships needed to sustain youth engagement into 2026:** named two distinct needs: deliberate engagement of young people so they actually understand how the health system works (explicitly flagged as something not taught in school, including by a panellist who is a practising medical student), and more youth-to-youth partnership specifically, to reduce duplicated, fragmented single-founder efforts.

ILF 2026 Commitment Session

Organizations and individuals were invited on stage to state a public, on-record commitment ahead of ILF 2027.

- **Dr Mories Atoki (ABC Health):** committed to continued engagement and knowledge-sharing, “keep looking, learn more, but more importantly, share, so that other people can learn.”
- **Ramatu Abdullah (EHA Impact Ventures):** committed to increasing support for African female founders, extending EIV’s founder-support platform, and deepening partnership and collaboration channels.
- **Dr Amina Aminu Dorayi (Pathfinder International Nigeria):** committed to deepening state- and LGA-level engagement, continuing co-created, locally led solutions with eHealth Africa and partners, and continued knowledge-sharing, noting Pathfinder’s roughly 60-year, 16-country operating history.
- **EHA Clinics (via Dr Ifunanya Ilodibe):** committed to continued partnership as the only credible path to scaling primary care at Nigeria’s population size, “we cannot do it as private sector only.”
- **Dr. Muhammadu Mamman (youth founder, Sahel MedTech, the Youth panel's moderator):** made two commitments: consolidating currently fragmented youth mentorship and fellowship programs in digital health under a single collaborative umbrella, and building a public directory of every active digital-health pilot in Nigeria, aimed at reducing duplicated effort and improving investor visibility into the pipeline.
- **Dr Ahmed Ogwell (VillageReach):** made three commitments: to return to ILF 2027 “in a much bigger way,” to serve as an ambassador for the Insights concept itself, not only the event, and to bring a concrete, action-attached partnership to report back on by ILF 2027.
- **Dr Hameed Adediran (Country Director, Doctors Medical Aid Foundation,** a grant initiative of the Nigerian Medical Association): committed the network’s 50,000+ practising member doctors to continued partnership aligned with any mandate that improves Nigerians’ access to quality healthcare.
- **Lola Aderemi (Co-founder & Chief Products Officer, PharmaRun; Youth & Innovation Lead, Africa Digital Health Network board):** committed to sharing PharmaRun’s aggregated medication/medical data (100,000+ Nigerians represented) for responsible, ethical use in advancing digital-health interoperability.
- **Solomon Okonkwo (Head, Corporate Social Investment, The Alternative Bank,** the non-interest arm of Sterling Financial Holding Company) committed The Alternative Bank as a financial partner to the Kano State Government, via the Office of the Commissioner for Rural and Community Development (Hon. Abdulkadir Abdulsalam), across five pathways: health, education, agriculture & food security, infrastructure, and climate resilience. Two further, distinct elements of the same commitment: to finance scalable, fundable innovations surfaced at ILF, and to deepen partnership with eHealth Africa directly. No amount or date was stated on stage for this commitment. (Separately referenced in the same remarks, not part of this new commitment: the Alternative Bank has previously empowered 2,000+ women with electric tricycles in Kano State.)
- **Jean Philbert Nsengimana (“JP”; Chairperson, Africa Digital Health Network; representing Dala Africa/AHTS):** committed to converting ILF’s insights into quantified, trackable action, framed around interoperability, integration, and intelligence. Publicly credited eHealth Africa’s seed investment into ADHN, confirmed as already deployed and funding ADHN’s first Executive Director and a now-operating Nairobi office.

“When I hear eHealth Africa saying something, I know you mean business.”

— Jean Philbert Nsengimana

Women Vendor Directory Launch

- Part of eHealth Africa's Women Vendor Acceleration Program, established in response to the Board's vision for strengthening women's participation in eHA's own procurement ecosystem.
- Reported results to date: 262 women-owned businesses trained across 15 states over two cohorts; 176 contract awards secured across 58 of those businesses; combined procurement value exceeding $1M; women-owned businesses now account for over 22.5% of eHA's total procurement engagements.
- Officially launched the Women Vendor Directory (a platform connecting qualified women-owned businesses with procurement opportunities), with an explicit ask to other organizations in the room to prioritize female vendors in their own procurement.

Vote of Thanks & Close

Vote of Thanks: Audrey Odogu (Senior Manager, Business Development, eHealth Africa).

Delivered on behalf of the EHA Group (EHA Clinics, EHA Impact Ventures, eHealth Africa Foundation) and the ILF planning committee.

- **Named partners thanked from the stage:** Dala Africa / African Health Tech Summit ("strategic continental partner," credited specifically with expanding ILF from a one-day national event into a two-day continental one); Africa Hub for Innovation and Development (theme partnership); AMCE (knowledge partner); Pathfinder International Nigeria (strategic partner); ; Schneider Electric; Villgro Africa; Nigeria Health Watch; The Alternative Bank; BellaNaija (media partner); EverCare; Healthcare Federation of Nigeria; and its wider network of health guardian partners.
- **ILF 2027 announced from the stage with specific dates: 27–28 July 2027.**
- **Closing remarks noted ILF 2026 was the Forum's fourth edition,** with the 2027 edition explicitly framed internally as "ILF at 5." The Forum's fixed calendar slot (last Tuesday/ Wednesday of July) was reconfirmed from the stage.
- **Event closed with a full-group photograph,** dignitaries, delegates, ILF committee, eHA staff, and volunteers.

Insights Learning Forum 2026

Voices, Involvement & Partnership

The people, the organization behind the Forum, and the continental story

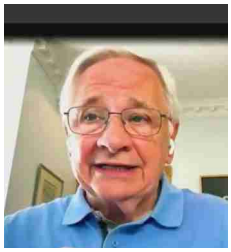
Voices from ILF 2026

"Interoperability is no longer a technical ambition—it is the foundation of Africa's health future."

— Jean Philbert Nsengimana, Chairman, Africa HealthTech Summit & Africa Digital Health Network

"The strongest partnerships are built around shared outcomes, shared accountability and long-term commitment."

— Dr Yusuf Yusufari, Gates Foundation



"Without interoperability, even excellent technologies remain isolated."

— Brian O'Connor, Chair, Global Health Connector

"We don't need more revitalized primary healthcare centres without actual lives being reached."

— Dr Ifunanya Ilodibe

"It's not a federal drive, it's not a state drive. Primary healthcare is where digital transformation must deliver its greatest value; closest to the people, it's all of us moving in one direction in an integrated way."

— Dr Muyi Aina, ED/CEO, NPHCDA

"The best investment is the one that is co-created with communities, because communities understand what works for them."

— Dr Ahmed Ogwell, CEO, VillageReach

"Investments have traditionally followed outputs. What needs to change is that investments must follow outcomes."

— Dr Ifunanya Ilodibe, CEO, EHA Clinics

"Financing is what turns promising ideas into solutions that improve lives at scale."

— Dr Yusuf Yusufari, Gates Foundation

"If the mountain doesn't have to come to Mohammed, Muhammad has to go to the mountain."

— Dr Anshul Govila, COO, African Medical Center of Excellence

"Data is the lifeblood of surveillance, and partnerships are the arteries that allow that lifeblood to flow."

— Dr. Kemi Ladeinde
(Delivered on behalf of NCDC DG Dr Jide Idris)

"Pilots are about proving what works. Scale is about building the process that makes it work everywhere.."

— Dr. Nkemdilim Femi-James - CEO, Preston Associates International Development (PAID)

"The tools we use are often built on clinical models that do not represent African women. That bias becomes a healthcare challenge"

—Dr. Kemi Da-Silva -Founder, Women At Risk International Foundation (WARIF)

"The private sector is talking, and the government is acting. NCDC is open for business."

— Dr. Kemi Ladeinde

"We cannot use 19th century tools to build a 21st century nation. Innovation is not an accessory. It is our lifeline."

— Dr Iziaq Kunle Salako, Honourable Minister of State for Health

"The future of healthcare investment should not be defined by how much we spend, but by how many lives we improve."

— Loïc Banybah, COO, AlloDocteur

"If you can't explain it to your grandmother, then you have not understood what you want to tell the public."

— Dr Ahmed Ogwell

"The biggest opportunity is the population we've left behind. Digital solutions can help us bridge that gap faster than ever before." ."

— Dr Charles Usie, Plan International Nigeria

"The future belongs to organizations willing to collaborate across sectors, disciplines and borders."

— Adam Thompson, CEO, EHA Group

"Africa's greatest health innovations will emerge when we strengthen the digital last mile."

— Adam Thompson

"Youth engagement is not about having one or two young people in the room. It's about empowering them to shape solutions from the very beginning."."

— Dr Victory Ekpin, Youth at the Centre panel

"The continent's greatest opportunity lies in connecting our systems, our institutions and our collective intelligence."

— Jean Philbert Nsengimana, Commitment Session

"When intelligence informs investment, innovation becomes a driver of economic and social transformation."

— Nazir Haliru - Director General/Chief Executive Officer · Kano State Investment Promotion Agency (Office of the Executive Governor

"Digital health becomes transformational only when partnerships are intentional, locally owned and designed to scale."

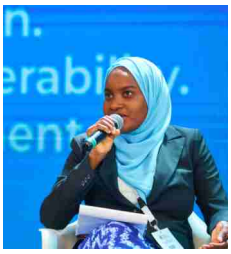
— Ota Akhigbe (Director, Partnerships & Programs, eHealth Africa)

"The future of health systems will be built where governments, innovators and communities work as one ecosystem."

— Atef Fawaz (Executive Director, eHealth Africa)

"ILF exists because sustainable transformation happens when insights become commitments, and commitments become action."

— Atef Fawaz (Executive Director, eHealth Africa)



"When established organisations lend their credibility to young innovators, they become trusted partners rather than risky bets.

— Dr. Olamide Sadik -Medical Officer, Ministry of Interior,

We need more youth-to-youth partnerships alongside partnerships between young innovators and experienced leaders."

— Muhammad Isa Jaafar - Chairman, Africa CDC Youth Engagement Strategy (YES)

This is the turning point where reflection becomes resolve, insights become intention, and conversations begin their journey into action.

— Dr. Muhammadu Mamman Musa

eHealth Africa / EHA Group Involvement

eHealth Africa and EHA Group played the central organizing and thought-leadership role throughout ILF 2026, extending, for the first time, into a formal continental co-hosting structure alongside AHTS and Dala Africa.

Leadership Roles

- Event Host & Convener: eHealth Africa and EHA Group convened ILF 2026, setting the agenda and, for the first time, sharing the co-hosting role formally with AHTS and Dala Africa.
- Opening Remarks: delivered by Atef Fawaz, Executive Director, eHealth Africa, framing ILF's first continental edition.
- Context-Setting Address: Ota Akhigbe, Director, Partnerships and Programs, delivered the Forum's clearest articulation of its purpose, the "missing middle" between insight and institutional ownership.
- Origin & Organizational Story: Adam Thompson, Co-founder & Group CEO, gave the most extensive public account to date of how eHealth Africa, EHA Clinics, and EHA Impact Ventures fit together as EHA Group, delivered twice, once as part of the Day 1 opening and again as a dedicated Day 2 fireside chat.
- Session Moderation: eHA senior staff moderated or co-anchored a substantial share of the Forum's sessions, including Flagship Dialogue II (Dr David Akpan), the eHA × AHTS breakout (via panellist Dr Ifunanya Ilodibe), the NCDC roundtable (co-anchored by an eHA team member), the Future of Care Investment dialogue (Fatimah Howeidy), the Beyond Access panel (Audrey Odogu), and the Vote of Thanks (Audrey Odogu).

EHA Group, Structure Spotlight

Adam Thompson's two addresses gave ILF's clearest public picture yet of how EHA Group's three arms relate, genuinely new material not previously captured in the Forum's reporting history:

- eHealth Africa (2009): the founding organization, originally focused on digital systems for public health programs, which expanded into building the surrounding infrastructure, logistics, and human capital needed to make those systems actually work, lessons drawn directly from Ebola response and polio eradication work.
- EHA Clinics (2018): eHA's own investment in primary care delivery, originally built for eHA's own staff following a personal access-to-care experience recounted by Thompson, deliberately kept small and non-scalable at first to learn what worked. Now led by Dr Ifunanya Ilodibe, with roughly 9 locations, 57% female employee count, and 47% female manager count.
- EHA Impact Ventures: launched with a dedicated endowment specifically because EHA Clinics' own fundraising experience as a health-sector startup proved so difficult; EIV exists to be the investor that says yes to African health entrepreneurs in under-funded areas like mental health and nutrition.
- EHA Group: the newest layer, formed to integrate what had become three standalone organizations after recognizing a lack of cross-learning between them. Now building shared finance, HR, and procurement services, plus a roughly six-month-old cross-organization research team that has already hit its fundraising goal with six publications in progress. Described explicitly by Thompson as a "proving ground," not a finished model.

Presentations & Announcements by eHA / EHA Group Team

- Planfeld, Dayo Akinleye and Abubakar Shehu, showcasing eHA's digital microplanning tool for immunization campaigns and its measured impact across 500,000+ settlements.
- Climate Health Vulnerability Assessment Tool (CHAT), demonstrated live and discussed on the Climate-Resilient Health Systems panel, now a nationally adopted, DHIS2-mainstreamed instrument.
- EHA Impact Ventures investment moment: Ramatu Abdullah, announcing a $1.25M reinvestment in EHA Clinics.
- Women Vendor Directory launch: eHealth Africa's own procurement-inclusion program, presented with full results (262 businesses trained, 176 contracts secured, 22.5%+ of procurement).
- Vote of Thanks and Forum close: Audrey Odogu, delivered on behalf of the full EHA Group and the ILF planning committee.

Stakeholder & Partner Engagements

- Deepened the AHTS/ADHN/Dala Africa relationship from a single 2025 summit visit into a formal, funded, two-way co-hosting partnership, including eHA's $50,000 anchor investment into ADHN, now funding ADHN's first Executive Director and Nairobi office.
- Engaged directly with federal government leadership (the Coordinating Minister's office via Dr Obi Adigwe, the Minister of State for Health, NPHCDA, NCDC) on how the newly announced National Health Technology and Data Analytics Office and Nigeria's broader digital health architecture intersect with eHA's own tooling (Planfeld, CHAT).
- Held targeted engagement with state-level government (Kano State, via KanInvest and the Kano State Commissioner's rural development address) on how eHA's existing solarization and health-system work feeds into state investment and development planning.
- Strengthened relationships with international NGOs, development partners, and private-sector actors present across both days, with several (VillageReach, Pathfinder International, , ABC Health) making named commitments to continued collaboration through the Commitment Session.

Continental Partnership Spotlight: AHTS, ADHN & Dala Africa

ILF 2026's defining structural change from prior editions was its shift from a national to a continental convening, worth its own dedicated account, since the relationship behind it is now load-bearing for the Forum's future, not a one-off co-branding exercise.

How the partnership formed

- October 2025: Atef Fawaz and Ota Akhigbe attended the Africa HealthTech Summit (AHTS) in Kigali, chaired by Jean Philbert Nsengimana. eHealth Africa subsequently made a $50,000 anchor/seed investment into the Africa Digital Health Network (ADHN), the structure AHTS built to sustain momentum between annual summits.
- May 2026: Ota Akhigbe and Atef Fawaz returned to Kigali for the Africa CEO Forum, where the invitation for Dala Africa (AHTS's organizing partner in Kigali) to co-host ILF 2026 in Abuja was formally extended.
- At ILF 2026, Jean Philbert Nsengimana attended in a triple capacity: AHTS Chairman, ADHN Chairman/"Chief Curator," and by extension representing Dala Africa's co-hosting role, a genuinely unusual concentration of continental convening authority in one speaker.

What the partnership has already delivered

- ADHN is operational, not aspirational: eHealth Africa's seed investment has already funded ADHN's first Executive Director and a now-running Nairobi office, confirmed directly by Nsengimana on stage during the Commitment Session.
- ILF itself expanded structurally as a direct result: from a one-day, single-track national event to a two-day, two-track continental one, credited explicitly to the AHTS/Dala Africa partnership in the Forum's own closing Vote of Thanks.
- A shared analytical frame now runs across both organizations' events: Nsengimana's continental investment-ranking data (Kenya leading digital health investment at 33% share, followed by South Africa, Egypt, and Nigeria) and his "pilotitis" framing were referenced repeatedly by other Day 1 speakers, including Dr Obi Adigwe's federal address.

What's next

- AHTS's 5th edition is confirmed for Kigali, building on 2025's 2,500 participants (300+ of whom travelled from Nigeria).
- ADHN remains open for registration as the continuing platform for engagement between ILF editions, delegates were encouraged from the stage to join.
- VillageReach's Commitment Session pledge (to return to ILF 2027 "at greater scale" and serve as an ambassador for the Insights concept itself) was framed explicitly in continuity with this continental expansion, suggesting the 2027 edition is expected to grow further, not simply repeat 2026's format.

Insights Learning Forum 2026

Learnings, Commitments & What's Next

Synthesis across both days, organized around the Forum's own theme

Key Learnings, by Pillar

ILF 2026's theme was five words, not one phrase, Insights, Partnerships, Inclusion, Interoperability, Investment. Rather than a generic list of takeaways, the learnings below are organized against that same structure, since nearly every session across both days spoke to at least one of these five words directly.

Insights

- Data has no value sitting still. Dr Fatima Saleh's distinction between data collection and public health intelligence, "data for action", recurred in different forms all Forum: NPHCDA's MAMII initiative targeting the 172 of Nigeria's 774 LGAs that produce 55% of maternal deaths is the same discipline applied at national scale; the Climate Health Vulnerability Assessment Tool (CHAT) translating facility-level risk data directly into solarization and cold-chain interventions is the same discipline applied to climate.
- Structured pathways beat one-off innovation. Villgro Africa's IBE Playbook is itself an insight product, codifying, for the first time regionally, what African hardware innovators actually need at each of five technical-readiness phases, rather than leaving each innovator to rediscover the same lessons independently.
- Understanding the system is itself a missing insight. The Youth at the Centre panel's most concrete point wasn't about technology at all, it was that how Nigeria's health system actually works isn't taught anywhere, including in medical school, and that gap alone discourages otherwise capable young innovators from engaging with it credibly.

Partnerships

- ILF 2026 was itself the year's biggest partnership case study. The Forum's own expansion from a national, single-day event to a continental, two-day one is a direct, visible product of the eHealth Africa–AHTS–Dala Africa relationship formed over the preceding ten months, see the dedicated Continental Partnership Spotlight above.
- The NCDC–HFN– roundtable was described from the stage as the first time NCDC opened this specific conversation to the private sector collaboratively, rather than by invoking its existing enforcement powers under the NCDC Act, a genuinely new posture, not a repeat of a prior engagement.
- Partnership requires clean role separation, not blurred ones. Dr Salihu Daniel's framing, government remains policymaker, partners remain tool-builders, and Adam Thompson's account of EHA's own history (handing full ownership of a call centre it built during Ebola response back to a local partner rather than retaining it) point to the same underlying discipline: sustainable partnership means giving away control, not just giving away resources.
- Partnership has to be designed for, not assumed. Kano State's rural development plan, KanInvest's investment pipeline, and the Nigeria Health Sector Renewal Compact all explicitly build in private-sector and development-partner co-investment as a structural requirement, not a hoped-for bonus, a shift from earlier models where government absorbed cost alone.

Inclusion

- Access and functionality are not the same thing, and the Forum was unusually consistent about naming that gap directly. Dr Ifunanya Ilodibe's "a clinic that is open is not necessarily a clinic that is working," Dr Charles Usie's challenge on the 98%-connectivity-for-elections-versus-60%-

cut-off-for-healthcare contradiction, and the Kano Commissioner's point that a clinic is meaningless without a road to reach it are three versions of the same underlying finding.

- Genuine youth and gender inclusion is a design choice made from day one, not a participation slot added later. The Youth panel's distinction between tokenism (a youth seat added after solutions are designed) and real co-creation (youth present from ideation) mirrors EHA Group's own account of how its Women Vendor Acceleration Program formed, not by excluding women intentionally, but by defaulting to an existing, under-examined vendor pool until someone went looking for the gap.
- Measured inclusion outperforms declared inclusion. eHealth Africa's Women Vendor Directory (262 businesses trained, 22.5%+ of procurement) and Nigeria's confirmed first-country adoption of the Africa CDC Youth Engagement Strategy both landed as credible precisely because they came with numbers and named next steps, not general statements of commitment to equity.

Interoperability

- Nigeria took its clearest interoperability position yet. The National Health Technology and Data Analytics Office's three guiding principles, security, interoperability, sovereignty, and the national digital health architecture's "one patient, one health record" standard, already endorsed by all states and the FCT, together represent the most concrete national interoperability commitment referenced anywhere in the Forum's four-year history.
- The private-sector interoperability gap is large, specific, and quantified, not vague. The NCDC roundtable's single most concrete data point (95% of Nigerian EMRs not connected to DHIS2) turns "we need better interoperability" into a specific, trackable problem with an identified first fix (opening DHIS2 API access to all EMR vendors).
- National Health Intelligence Centers are becoming the continental interoperability pattern. Rwanda's April 2025 launch, roughly 20 countries now developing similar centres, and Nigeria's own "phase 1 to phase 2" progress (plausibly linked to the newly announced National Health Technology and Data Analytics Office, though not explicitly connected on stage) suggest a shared architecture is emerging across the continent, not isolated national experiments.
- Data governance discipline matters as much as data flow. Dr Salihu Daniel's proposed "zero-trust" standard for data partners, no partner-side visibility into patient-level data without explicit government authorization, is a concrete governance model other interoperability conversations across the Forum lacked.

Investment

- Investment increasingly follows evidence, not goodwill. EHA Impact Ventures framed its $1.25M reinvestment in EHA Clinics explicitly around measured results since the prior round (20,000+ additional patients, three new facilities, 100% ANC growth, 250+ jobs), the same evidence-led logic the Future of Care Investment dialogue argued should apply sector-wide: invest against outcomes, not outputs.
- Financing structure, not just financing volume, is the binding constraint. Maryam Mohammed's point that profit-sharing health finance carries a capital requirement roughly 400% higher than standard short-term facilities, and the Future of Care panel's observation that primary care needs patient, multi-year capital rather than fast-turnaround funding, both identify the same structural mismatch: existing financial products are built for speed, and health outcomes are not fast.
- 'Race to the top' financing design is displacing uniform disbursement. Distinct figures from separate programs illustrate the shift: the Nigeria Health Sector Renewal Compact's $500M incentive (rewarding states that move fastest), and Kano State's own diversified, co-investment-dependent $500M rural development plan. Both deliberately reward early movers rather than distributing funds evenly, a shift from earlier, more uniform state-support models
- The financing gap is real and quantified, not rhetorical. Ota Akhigbe's opening citation of WHO data, external health aid down 30–40% year-on-year, 50+ countries reporting health-worker job losses, some regions seeing up to 70% disruption to maternal care, vaccination, and disease surveillance, set the honest baseline every subsequent investment announcement across the two days was implicitly responding to.

Announcements & Commitments

Headline Announcements

Announcement	Detail	Made By
National Health Technology and Data Analytics Office	New federal coordinating platform for health tech/data. Guiding principles: security, interoperability, sovereignty.	Dr Obi Adigwe, on behalf of Prof. Muhammad Ali Pate, special address reporting on the office at ILF
Snakebite Innovation Prize (regional spotlight)	Wellcome-funded, Challenge Works-delivered global prize; Villgro Africa is one of four entry-phase partners supporting Sub-Saharan African innovators. Applications close 16 Sept 2026; strengthening event in Nairobi 10–11 August. £6.25M stated on stage.	Villgro Africa
Invention-Based Enterprises (IBE) Playbook	Structured technical-readiness pathway for hardware medical device innovators, design input through market entry.	Villgro Africa
EHA Impact Ventures, investment moment for EHA Clinics	$1.25M reinvestment, certificate presented on stage.	Ramatu Abdullah, EHA Impact Ventures
Women Vendor Directory	262 women-owned businesses trained across 15 states (2 cohorts); 176 contract awards involving 58 businesses, combined value $1M+; women-owned businesses now 22.5%+ of eHA procurement.	eHealth Africa / EHA Group
Nigeria Health Sector Renewal Compact	$500M USD financial incentive package cited on stage for states that align with the national digital health architecture. Government claim, reported as context, not an eHA/ILF outcome.	Dr Iziaq Kunle Salako, Minister of State for Health
Africa CDC Youth Engagement Strategy, Nigeria adoption	Nigeria confirmed as the first country to formally adopt the strategy; a government committee is forming to domesticate and implement it.	Youth at the Centre panel
Kano State Integrated Rural Development Plan	5-year plan (2026–31), ~$500M diversified funding model, 5 pillars (health, education, agriculture, infrastructure, social protection/peace/climate). Government claim, reported as context, not an eHA/ILF outcome.	Kano State Government
ILF 2027	Formally announced at the close of ILF 2026: 27–28 July 2027.	eHealth Africa / EHA Group

The 30-Day Accountability Record

ILF 2026 Commitment Session: Named Commitments

At the close of ILF 2026, eleven partner institutions made individually named, trackable commitments on stage, alongside eHealth Africa's own institutional pledge. eHealth Africa publicly promised to publish an accountability report against every one of them within 30 days of the Forum's close, with progress reviewed again publicly at ILF 2027. This table is that record.

Nigeria Health Watch independently reviews these commitments against submitted evidence each cycle.

These are twelve-month commitments; the 30-day record checks evidence submitted so far, not progress achieved. Full independent verification happens at the ILF 2027 review.

Institution	Named Representative	Commitment	What Success Looks Like, by ILF 2027	Review Status
eHealth Africa	Atef Fawaz, Executive Director, eHealth Africa (institutional commitment)	Publish a commitment accountability report within 30 days of ILF 2026; report publicly at ILF 2027 on what was achieved, overachieved, or missed.	Accountability report published within 30 days of ILF 2026 close, covering all eleven named commitments.	eHA-reported; evidence to be submitted for independent review in the next cycle.
Dala Africa / Africa HealthTech Summit	Jean Philbert Nsengimana, Chairman, AHTS & ADHN; Chief Digital Health Advisor, Africa CDC	Convert Forum insights into quantified, trackable action around interoperability, integration, and intelligence. Publicly credited eHA's seed investment into ADHN, already funding ADHN's first Executive Director and a new Nairobi office.	Quantified, trackable interoperability/ integration/intelligence actions defined jointly with ADHN and reported at AHTS Kigali and ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
African Digital Health Network (ADHN)	Jean Philbert Nsengimana (Chairperson, ADHN; Chief Digital Health Advisor, Africa CDC)	eHealth Africa as Anchor Partner, with representation on the ADHN Board; convening partners in Nigeria to assess readiness and develop a roadmap towards a Country Chapter.	ADHN Nigeria Country Chapter established, providing a platform to align national priorities with continental initiatives and position Nigeria as a leading contributor to Africa's digital health ecosystem.	eHA-reported; evidence to be submitted for independent review in the next cycle.
The Alternative Bank	Solomon Okonkwo, Head, Corporate Social Investment	Partner with the Kano State Government (via the Office of the Commissioner for Rural and Community Development, Hon. Abdulkadir Abdulsalam) across five pathways: health, education, agriculture & food security, infrastructure, climate resilience. Also: finance scalable innovations surfaced at ILF, and deepen partnership with eHealth Africa directly. No amount or date was stated on stage.	The Alternative Bank has formally pursued and put forward financing terms for the five-pathway Kano State partnership, and at least one ILF-surfaced innovation has been taken into an active financing conversation, both fully within The Alternative Bank's own control to deliver, independent of Kano State's final decision to accept the partnership.	eHA-reported; evidence to be submitted for independent review in the next cycle.

Institution	Named Representative	Commitment	What Success Looks Like, by ILF 2027	Review Status
EHA Impact Ventures	Ramatu Abdullah	Increase support for African female founders; extend EIV's founder-support platform; deepen partnership and collaboration channels.	Measurable increase in African female founders supported through EIV's platform, against a target set by EIV, reported at ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
Pathfinder International Nigeria	Dr Amina Aminu Dorayi, Portfolio Director for Africa	Deepen state- and LGA-level engagement; continue co-created, locally led solutions with eHealth Africa and partners.	At least one co-created, locally led initiative agreed with Pathfinder at a named state/LGA, with scope and roles defined, by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
ABC Health	Dr Mories Atoki, CEO, ABCHealth	Continued engagement and knowledge-sharing across the sector, "keep looking, learn more, but more importantly, share, so that other people can learn.	At least one concrete knowledge-sharing contribution from ABCHealth to the ILF/ ADHN community (session, publication or shared insight), delivered and logged by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
EHA Clinics	Dr Ifunanya Ilodibe, CEO, EHA Clinics	Continue partnership as the only credible path to scaling primary care at Nigeria's population size.	A defined eHA–EHA Clinics primary-care scaling collaboration, with milestones agreed, by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
Doctors Medical Aid Foundation (Nigerian Medical Association)	Dr Hameed Adediran,	Commit the network's 50,000+ practising member doctors to continued partnership aligned with any mandate that improves Nigerians' access to quality healthcare.	A defined mechanism for engaging the doctor network on a specific health-access initiative with eHA, agreed by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
PharmaRun	Lola Aderemi, Co-founder & Chief Products Officer	Pharmarun is committed to engaging the right stakeholders to explore how the insights generated through our platform can responsibly contribute to advancing digital health interoperability and informing evidence-based decision-making in Nigeria	A documented set of findings or recommendations from the eHealth Africa–PharmaRun conversation, addressing at least one of the specific questions PharmaRun raised (e.g., disease burden signals or access-gap analysis derivable from their transaction data), by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.
VillageReach	Dr Ahmed Ogwell,	Return to ILF 2027 "in a much bigger way"; serve as an ambassador for the Insights concept itself (not only the event); bring a concrete, action-attached partnership to report back on by ILF 2027.	A concrete partnership/ action is showcased on stage at ILF 2027, as explicitly promised.	eHA-reported; evidence to be submitted for independent review in the next cycle.
Sahel MedTech	Dr. Muhammadu Mamman,	Unify fragmented youth mentorship/fellowship programs under one umbrella; build a public directory of every active digital-health pilot in Nigeria to reduce duplicated effort and improve investor visibility.	A single unified youth mentorship/fellowship framework, and a live public directory of active Nigerian digital-health pilots, launched by ILF 2027.	eHA-reported; evidence to be submitted for independent review in the next cycle.

Early Testimonials:

What ILF Set in Motion

Two ILF 2026 attendees have since connected with Villgro Africa for SnakeHack Africa 2026 in Nairobi (10–11 August), securing fully funded travel, a downstream connection the Forum enabled, not an eHealth Africa-led outcome.

Abdulhakeem Abdulsalam, a 5th-year medical student and founder of the Student Career Empowerment Network, credits direct follow-up conversations with eHealth Africa after the Forum for surfacing the opportunity.

Francis Adabenege, founder of HealthBridge Nexus, connected with Villgro Africa directly at ILF by demonstrating his platform, YoliCare.

Looking Ahead

ILF 2027 is confirmed: 27–28 July 2027, at the Forum's fixed calendar slot (last Tuesday/Wednesday of July). Internally framed as "ILF at 5."

- eHealth Africa's commitment accountability report is due within 30 days of ILF 2026's close, covering every named commitment captured in this report, with public review scheduled for ILF 2027.
- The Africa Digital Health Network remains open for registration as the continuing platform for engagement between ILF editions, delegates are encouraged to join.
- Several named commitments carry their own explicit 2027 delivery markers worth tracking specifically: VillageReach's promised concrete partnership showcase, the youth-led national digital-health-pilot directory, and PharmaRun's data-sharing commitment toward interoperability.

Reflections from ILF 2026

Loïc Banybah
COO, AlloDocteur

The key insight I take away from ILF 2026 is that the future of healthcare in Africa will not be built by one sector alone. Community health, primary care, digital innovation, governments, investors and healthcare professionals must work together as part of the same ecosystem.

My experience with AlloDocteur has reinforced this belief: technology can bring care closer to communities, but technology alone cannot transform a health system. We need sustainable investment, strong partnerships, enabling policies and solutions designed around African realities.

What should come next is a stronger focus on turning dialogue into action, connecting ideas, capital, institutions and innovators around measurable health outcomes. I see a significant opportunity for ILF to continue serving as a platform where African leaders don't only exchange perspectives, but build partnerships, test solutions and accelerate practical system transformation across the continent.

Jean Philbert Nsengimana
Chairman, Africa HealthTech Summit & Africa Digital Health Network; Chief Digital Health Advisor, Africa CDC

The strongest takeaway from ILF 2026 is that Africa does not suffer from a shortage of demand, talent or innovation; it suffers from fragmentation, implementation and coordination gaps. Promising solutions remain trapped in silos when governments, innovators, funders and implementers aren't aligned around shared priorities, public digital infrastructure, sustainable financing and clear pathways to scale.

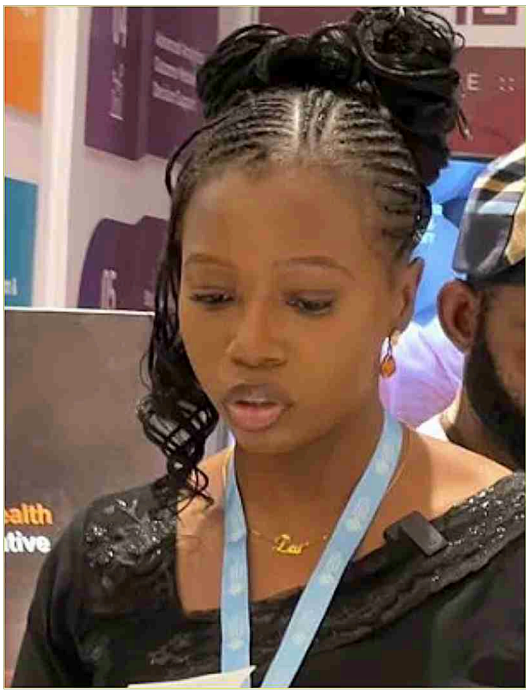
The next step must be "collabor-action": converting the relationships and commitments forged in Abuja into coordinated initiatives with owners, timelines and measurable results. ILF can become more than an annual forum, an accountability and learning platform that tracks progress, shares what works, and connects implementation across countries, accelerating the development of intelligent, inclusive and resilient health systems for every African.

Dayo Akinleye
Technical Project Manager, eHealth Africa

My biggest takeaway from ILF 2026 was how much stronger Africa's development efforts could be if leaders worked together instead of each region tackling problems on its own. So many conversations pointed to the same thing: acting separately limits what we can achieve, but sharing frameworks and learning from each other moves progress much faster.

Going forward, stakeholders need to break down the silos that keep good ideas stuck in one country or sector, and put real investment behind locally led innovation, backed by strong regional partnerships. ILF has a real opportunity here, it sits right at the intersection of policy and the people actually doing the work on the ground. If it keeps building peer-learning networks and encouraging partners to implement jointly rather than in parallel, these conversations won't just stay lessons, they'll shape what happens next across the continent.

Liss Theodora Yori
Africa Hub for Innovation and Development (AHFID)



For AHFID, ILF 2026 reinforced a critical reality: Africa's health challenge is not a lack of innovation, but the implementation gaps that prevent proven solutions from scaling sustainably. What stood out most was the candid focus on bridging the "missing middle" — moving beyond isolated pilots toward interoperable, government-owned systems.

True health equity demands more than new technology, intentional capacity strengthening, gender-responsive policies, and robust digital governance that ensure innovation serves frontline communities, particularly women and vulnerable populations, alongside closing the continent's knowledge-to-action gap.

The greatest opportunity ahead is turning strategic dialogue into collective action. Platforms like ILF break down silos, preserve institutional knowledge, and align stakeholders around shared goals — helping African-led health innovations achieve lasting, systemic impact.

Dr Mories Atoki
CEO, ABCHealth

My key takeaway from ILF 2026 is that Africa's digital health challenge is no longer primarily about innovation — it's about creating the conditions for innovation to scale sustainably. From a private-sector perspective, this means moving beyond fragmented pilots towards commercially viable solutions aligned with public health priorities, supported by predictable regulation, interoperable infrastructure, credible data and sustainable financing.

The conversations reinforced that government, private capital, innovators and development partners must operate as co-creators of health-system transformation, not disconnected actors. Going forward, ILF can convert its experiences into case studies, dialogues into structured partnerships, investment pathways and measurable commitments — building an ecosystem where innovation is not only developed, but adopted, financed and sustained.

Dr Edwin-Isotu Edeh
Climate, Health and Environment Programme Coordinator, WHO

ILF 2026 reinforced a critical message: Africa's health challenges are increasingly interconnected with climate change, digital transformation, environmental sustainability and the resilience of health systems. My key takeaway was the importance of moving beyond isolated innovations towards integrated, scalable solutions that connect data, technology, policy and people.

Going forward, stakeholders should translate the insights from the Forum into actionable partnerships, stronger evidence-to-policy pathways and investments that can deliver measurable impact at scale. ILF has a unique opportunity to become a sustained platform for cross-country learning and systems transformation; not only sharing what works, but helping countries adapt, finance and implement proven solutions.

The next frontier should be deeper collaboration across governments, innovators, development partners, academia and communities, ensuring that Africa's innovations are locally owned, digitally enabled, climate-resilient and capable of transforming health outcomes at scale.

Chisom Amadi

Program Director, Digital Innovations, PharmAccess Foundation

ILF 2026 stood out for how often the same constraint appeared in unrelated sessions. Across conversations on artificial intelligence, supply chains, financing and interoperability, the difficulty was rarely the innovation itself; it was connecting that innovation to the public system it exists to serve.

Our own sessions, the fireside chat on public-private partnerships and the Private Sector IDSR Reporting Roundtable with NCDC, HFN and eHealth Africa, were the same problem in another form: much of Nigerian care is delivered by private providers who sit outside national surveillance.

Integration, rather than invention, is where collective action counts. This is PharmAccess's work between forums: we funded the evidence base, brokered the parties into a shared framework, and are taking it forward with NCDC on interoperability, data standards and governance. Platforms like ILF make that possible, putting the regulator, the technology partner and the provider in one room.

Praise Amavi Agbe

Knowledge Management Advisor / BD Focal Person, Pathfinder International Nigeria

What stood out about ILF 2026 was its refusal to stop at diagnosis. We have sat in many rooms where Africa's health challenges are described with great precision, but too often without SMART, actionable steps to address them. The Commitment Session marked a deliberate shift from conversation to action, creating space for stakeholders to move beyond identifying challenges and publicly commit to what they can do to drive change.

For Pathfinder International Nigeria, the greatest opportunity lies in turning ideas and commitments into solutions that reach people where they are, through stronger health systems, better use of data, innovation, sustainable financing, or deeper partnerships. These efforts matter most when they improve the experience of the woman waiting at a primary health facility, and the communities and health workers around her.

Platforms like ILF matter because trust is often built in person before it is written into a partnership. Serving as a Knowledge Partner reminded us that learning shared openly travels further than learning held closely.

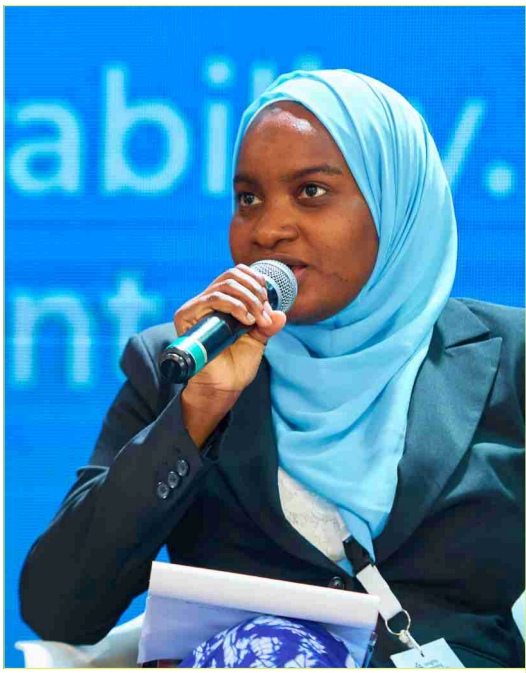
Dr. Muhammadu Mamman
Founder, Sahel MedTech

My primary takeaway from ILF 2026 is this: deliberate design works. While other forums bring stakeholders together and hope collaboration spontaneously happens, ILF 2026 intentionally built the room, set a clear agenda, and forced the right handshakes to occur.

Another key highlight came from Dr Jean Philbert, who noted that Nigeria ranks 4th in healthtech funding across Africa, with exponential growth projected. Capitalizing on this window requires an all-hands-on-deck approach, particularly from young innovators. ILF 2026 set a high standard for meaningful youth engagement; its next evolution must focus on collective accountability. Calling on individuals to commit on stage was an excellent push, but a scorecard, despite the variability of the commitments themselves, would be a remarkable source of motivation.

Setting clear tracking metrics over the next 12 months is the only way to hold ourselves accountable before we gather again in 2027.

Dr Zainab Olamide Sadik
African Health Innovation Fellow



One idea I carried from ILF 2026 is the importance of "knowing when to stop" while delivering digital health solutions. We have defined what is and isn't a problem in Nigeria's digital health ecosystem, but that means little without accountability. This crystallized during the panel on the health and rights of women and girls, when a speaker spoke about recognizing when a solution causes more harm than good; that point reframed how I think about impact.

Stakeholder roles, while distinct, constantly overlap, and fragmentation between innovators, policymakers, and other actors remains a real barrier. The work ahead is less about defining new problems and more about aligning around a shared goal: digital health solutions that are inclusive, equitable, scalable, and effective for everyone.

I hope ILF carries its 2026 commitments forward, especially on data protection and the digital divide, with more practical, action-oriented workshops alongside its presentations and panels.

Conclusion

The Insights Learning Forum 2026 marked a genuine inflection point for the Forum, not simply its fourth annual instalment. What began in 2023 as a national, single-day convening became, over two days in Abuja, a continental platform, co-hosted for the first time with the Africa HealthTech Summit and Dala Africa, and carrying commitments, investment figures, and policy announcements that extend well beyond Nigeria's own borders.

Across both days, the Forum's five-word theme (Insights, Partnerships, Inclusion, Interoperability, Investment) was tested against real decisions rather than treated as a slogan. Nigeria's National Health Technology and Data Analytics Office, approved by the Federal Government weeks earlier, was reported to the Forum in detail. A £6.25M continent-wide innovation prize was spotlighted, with applications already open ahead of the Forum and closing 16 September. And eleven institutions, plus eHealth Africa's own accountability commitment, closed the Forum with individual, trackable commitments, with a public accountability mechanism already in motion to hold the Forum itself, and every named commitment-maker, to what was actually said on stage. The recurring thread across nearly every session, from Ota Akhigbe's opening framing of the "missing middle" to Adam Thompson's account of why EHA Group exists at all, was the same: insight alone does not change outcomes, and neither does investment alone, or partnership alone, or inclusion alone. What ILF 2026 argued, and, in its own Commitment Session, tried to practice, is that durable change requires all five at once, with someone accountable for making sure they actually connect.

Insights, Partnerships, Inclusion, Interoperability, Investment, was tested against real decisions rather than treated as a slogan.

As the Forum closes this chapter and opens the next, with ILF 2027 already dated and ADHN already operating as the connective tissue between editions, the measure of ILF 2026's success will not be this report; it will be whether the accountability report due in 30 days, and the public review at ILF 2027, show that conversation genuinely became commitment.


SCALABLE SOLUTIONS
IVE HEALTH SYSTEMS.


eHealth
Data Africa
Insights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ILF FLAGSHIP DIALOGUE II
FROM INTELLIGENCE
TO ACTION:
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Live Organization Commitments
Insights Learning Forum 0000


Insights Learning Forum 0000


eHealth
Data Africa
Insights Learning Forum 0000
Insights.
Partnerships.
Inclusion.
Interoperability.
Investment.


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THE LONG TABLE


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BUILDING CLIMATE-RESILIENT
HEALTH SYSTEMS: RENEWABLE


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PATHFINDER
Components of PH Surveillance in Nigeria


PATHFINDER
The Cost of Surveillance Blind Spots


Catalysing Country AI-
Framework
for Transformative
Healthcare Systems


businesses thrive when?
$1,250,000
9 Clinics
EHA GHM
Schneider Electric
Dala Africa


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Partners & Acknowledgements

Strategic Continental Partners

- Dala Africa, convener of the Africa HealthTech Summit
- Africa HealthTech Summit (AHTS) / Africa Digital Health Network (ADHN)

Strategic Partners

- African Hub for Innovation and Development, theme partner
- African Medical Center of Excellence (AMCE), knowledge partner
- Pathfinder International Nigeria, strategic partner
- | Schneider Electric | Villgro Africa
- Nigeria Health Watch | The Alternative Bank
- BellaNaija, media partner | EverCare
- Healthcare Federation of Nigeria (HFN) and its network of health guardian partners

Participating Organizations

- Gates Foundation
- World Health Organization (WHO) | UNICEF
- Nigeria Centre for Disease Control and Prevention (NCDC)
- National Primary Health Care Development Agency (NPHCDA)
- Kano State Investment Promotion Agency (KanInvest)
- Kano State Government
- National Institute for Pharmaceutical Research and Development (NIPRD)
- Rural Electrification Agency (REA)
- EHA Clinics, EHA Impact Ventures, EHA Group
- PharmaRun | AlloDocteur
- Sahel MedTech | FutureMap Foundation
- VillageReach | Preston Associates for International Development (PAID)
- Plan International Nigeria | Women At Risk International Foundation (WARIF) | Johns Hopkins IVAC
- Society for Family Health (SFH) | Resolve to Save Lives | HealthStock; Elephant Healthcare Nigeria; Helium Health
- Elephant Healthcare Nigeria | Helium Health
- Doctors Medical Aid Foundation (Nigerian Medical Association)
- US CDC (Health Security Technical Working Group)
- Africa Centres for Disease Control and Prevention (Africa CDC) | Federal Ministry of Health and Social Welfare (FMoHSW) | Federal Capital Territory Administration (FCTA)
- Federal Capital Development Authority (FCDA) | Kano State Primary Health Care Management Board (KSPHCMB) | National Agency for Science and Engineering Infrastructure (NASENI)
- National Space Research and Development Agency (NASRDA)| African University of Science and Technology (AUST)
- Bingham University | Nile University| Georgetown Global Health Nigeria
- Jhpiego| Acasus | Viamo| HACEY Health Initiative| Freedom for Humanity International Foundation
- Today for Tomorrow Initiative
- Connected Advocacy | Development Governance International Consult (DGI)
- Evercare Hospital Lekki| mDoc Healthcare | Seam Health | AllSmartCare
- Navigacare | Venus Medicare HMO | Sevenz Healthcare Services | NNPC Medical Services Limited | West and Central Africa Health
- Standard Chartered Bank | Optiva Capital Partners| Zipline | Sabi| UNICON Group
- ACE Strategy | AHFID | Bloom Public Health| Easy Shot It| Elsophi Global Development| Elevate Africa| FAME Foundation
- Harbor Haven | Innovate Health Africa| LBS Sustainability Centre | NorthStar Global| Reach Digital
- Serena Space | Spolan Consulting Nigeria | TAG Africa | Technical Advice Connect| WCA Health Options Ltd/GTE| YESPictures Imagination.

Annexes

Annex A: Acronym Key

Acronym	Full Meaning
ADHN	Africa Digital Health Network
AHTS	Africa HealthTech Summit
AMCE	African Medical Center of Excellence
ANC	Antenatal Care
API	Application Programming Interface
BHCPF	Basic Healthcare Provision Fund
BVAS	Bimodal Voter Accreditation System
CDC	Centers for Disease Control and Prevention
CHAT	Climate Health Vulnerability Assessment Tool
CSR	Corporate Social Responsibility
DARES	Distributed Access through Renewable Energy Scale-up (REA performance-based grant program)
DFI	Development Finance Institution
DHIS2	District Health Information System 2
EHA / eHA	eHealth Africa
EIOS	Epidemic Intelligence from Open Sources
EIV	EHA Impact Ventures
EMR	Electronic Medical Record
FAMSA	Federation of African Medical Students' Associations
FCT	Federal Capital Territory (Nigeria)
FHIR	Fast Healthcare Interoperability Resources
GDP	Gross Domestic Product
HFN	Healthcare Federation of Nigeria

Acronym	Full Meaning
HIPAA	Health Insurance Portability and Accountability Act (US)
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
IBE	Invention-Based Enterprises
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEV	Identify, Enumerate, Vaccinate (NPHCDA zero-dose approach)
ILF	Insights Learning Forum
IoT	Internet of Things
ISO	International Organization for Standardization
IVAC	International Vaccine Access Center (Johns Hopkins)
KanInvest	Kano State Investment Promotion Agency
LGA	Local Government Area
LSHTM	London School of Hygiene & Tropical Medicine
MAMII	Maternal and Newborn Mortality Reduction Innovation Initiative
MEL	Monitoring, Evaluation, and Learning
MOU / MOC	Memorandum of Understanding / Collaboration
NAPHS	National Action Plan for Health Security
NCDC	Nigeria Centre for Disease Control and Prevention

Acronym	Full Meaning
ICD-10 / ICD-11	International Classification of Diseases (10th/11th Revision)
LOINC	Logical Observation Identifiers Names and Codes
NDC	Nationally Determined Contribution (climate policy)
NDPA / NDPR	Nigeria Data Protection Act / Regulation
NEMSAS	Nigeria Emergency Medical Service and Ambulance System
NGO	Non-Governmental Organization
NHIA	National Health Insurance Authority
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NHTDAO	National Health Technology and Data Analytics Office
NIPRD	National Institute for Pharmaceutical Research and Development
NITDA	National Information Technology Development Agency
NPHCDA	National Primary Health Care Development Agency
NTD	Neglected Tropical Disease
ONC	Office of the National Coordinator for Health IT (US)
OpenHIE	Open Health Information Exchange
PFMO	Performance and Financial Management Officer
PHC	Primary Health Care
PPMV	Patent and Proprietary Medicine Vendor
PPP	Public-Private Partnership
QMS	Quality Management System
REA	Rural Electrification Agency
SDG	Sustainable Development Goal
SFH	Society for Family Health
SITAware	Situation Aware (Public Health Event Management System)
SNOMED CT	Systematized Nomenclature of Medicine, Clinical Terms
SORMAS	Surveillance, Outbreak Response Management and Analysis System
SWAp	Sector-Wide Approach
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WARIF	Women At Risk International Foundation
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Annex B: Key Speakers & Roles

Day 1: Tuesday, 28 July 2026

Speaker	Role/Designation	Session/Contribution
Dayo Akinleye	Technical Project Manager, eHealth Africa	eHA Innovation Spotlight, Planfeld
Abubakar Shehu	Program Manager, eHealth Africa	eHA Innovation Spotlight: Planfeld (Moderator)
Atef Fawaz	Executive Director, eHealth Africa	Opening remarks
Ota Akhigbe	Director, Partnerships and Programs, eHealth Africa	Context-setting address; recurring throughout
Adam Thompson	Co-founder & Group CEO, EHA Group	Origin/organizational story address
Jean Philbert Nsengimana	Chairman, AHTS & ADHN; Chief Digital Health Advisor, Africa CDC	Continental address; eHA × AHTS breakout
Dr Muyi Aina	ED/CEO, NPHCDA	National PHC progress address
Dr Yusuf Yusufari	Deputy Director, Immunization & Disease Control, Gates Foundation	Address; Flagship Dialogue I panellist
Nazir Haliru	DG/CEO, KanInvest	Turning data into investment address
Waringa Kamau	Partnership & Stakeholder Engagement Lead, Villgro Africa	Snakebite Innovation Prize launch
Benjamin Barwa	Project Management Lead, Villgro Africa	Snakebite Innovation Prize launch
Dr Obi Adigwe	DG, NIPRD; pioneer national coordinator, NHTDAO	Special address on behalf of the Coordinating Minister
Dr Gafar Alawode	Managing Partner, DGI Consult	Moderator, Flagship Dialogue I
Dr Charles Doherty	General Manager, Ekiti State Health Insurance Scheme	Video opening, Flagship Dialogue I
Dr Francis Ohanyido	Chair, African Future of Health Commission	Panellist, Flagship Dialogue I
Abiola Oshunniyi	Head, Project Implementation Unit & Grants, NCDC	Panellist, Flagship Dialogue I
Maryam Mohammed	Head, Business Enablement, The Alternative Bank	Panellist, Flagship Dialogue I
Dr Mories Atoki	CEO, ABCHealth	Panellist, Flagship Dialogue I
Lola Aderemi	Co-founder, PharmaRun; Board Member, ADHN	Moderator, eHA × AHTS breakout
Dr Ifunanya Ilodibe	CEO, EHA Clinics	Panellist, eHA × AHTS breakout; EHA Clinics session moderator
Dr Ahmed Ogwell	CEO, VillageReach	Panellist, eHA × AHTS breakout

Speaker	Role/Designation	Session/Contribution
Dr Hameed Adediran	Country Director, Doctors Medical Aid Foundation	Moderator, Pathfinder “Beyond the Pilot”
Dr Olufemi Ibitoye	Technical Advisor, Maternal, Newborn and Child Health (MNCH), Pathfinder International	Panellist, Pathfinder "Beyond the Pilot”
Alhaji Aliyu Jinjiri Kiru	Director of Planning, Monitoring, and Evaluation, Kano State Primary Healthcare Management Board	Panellist (representing Prof Salisu Ahmed), Pathfinder "Beyond the Pilot"
Mr Nuradeen Maidoki	Executive Director, Natview Foundation	Panellist, Pathfinder "Beyond the Pilot"
Carlos Yerena	Director of Partnerships and Growth, Reach Digital	Panellist, Pathfinder "Beyond the Pilot”
Masduk Abdulkarim	Senior Officer, Data, Analytics & MLE, Gates Foundation	Panellist, Pathfinder "Beyond the Pilot"
Chisom Amadi	Program Director, Digital Innovations,	Moderator, fireside chat
Dr Ebere Okereke	Independent global health strategist and advisor	Guest, fireside chat (virtual)
Dr Ayodele Cole Benson	Chairman, Echolab Radiology and Laboratory Services	Panellist, EHA Clinics session
Dr Kelechi Okoro	Founder/CEO, Heal for Africa Initiative	Panellist, EHA Clinics session
Dr David Akpan	Deputy Director, Partnerships and Programs, eHealth Africa	Moderator, Flagship Dialogue II
Dr Fatima Saleh	Director, Surveillance and Epidemiology, NCDC	Panellist, Flagship Dialogue II
Dr Salihu Daniel	Regional Digital Health Lead, UNICEF East & Southern Africa	Panellist, Flagship Dialogue II
Ogochukwu Maduabum	Senior Manager, Products and Services, eHealth Africa	Panellist, Flagship Dialogue II
Dr Nneka Sederstrom	Managing Partner, AMA Consultants	Panellist, Flagship Dialogue II (virtual)
Alexandra (Lexie) van Waes	Senior Program Officer, Gates Foundation	Closing remarks, Flagship Dialogue II
Brian O’Connor	Chair, Global Health Connector	Day 1 close, video message

Annex B, Key Speakers & Roles

Day 2: Wednesday, 29 July 2026

Speaker	Role/Designation	Session/Contribution
Winnie Wangari	Mechanical Engineer & MedTech Lead, Villgro Africa	IBE Playbook launch
Dr Shuaib Sani Shuaib	Executive Director, FutureMap Foundation	Kidney Wallet case study
Dr Rosemary Otalor	Head of Corporate Communications, AMCE	Moderator, AMCE fireside chat
Dr Anshul Govila	Chief Operating Officer, AMCE	AMCE fireside chat
Dr Fatima Saleh	Director, Surveillance and Epidemiology, NCDC	IDSR technical presentation, NCDC roundtable
Dr Mohammed Saleh	Co-Chair, Health Security TWG, US CDC	Goodwill remarks, NCDC roundtable
Dr Simpa Dania	CEO, HealthStack	Open floor, NCDC roundtable
Celestine Ogbudeke	Elephant Healthcare Nigeria Limited	Open floor, NCDC roundtable
Dr Jenom Danjuma	Resolve to Save Lives	Open floor, NCDC roundtable
Dr Omokhudu Idogho	Group CEO, Society for Family Health (SFH)	Open floor, NCDC roundtable (virtual)
Dr Ugabe	UNICEF Abuja	Open floor, NCDC roundtable
Safiya Shaibu Isa	Director of Advocacy and Partnership, Nigeria Health Watch	Moderator, Climate-Resilient Health Systems panel
Tolu Chibuzor Ogele	Development Specialist, eHealth Africa	Climate-Resilient Health Systems panel
Tolu-tope Dada	Regional Head, Access to Energy (West Africa), Schneider Electric	Climate-Resilient Health Systems panel
Dr Edwin-Isotu Edeh	WHO, Climate & Health	Climate-Resilient Health Systems panel
Dr Bello Salman	Technical Advisor, Office of the MD/CEO, Rural Electrification Agency	Climate-Resilient Health Systems panel
Dr Iziaq Kunle Salako	Honourable Minister of State for Health and Social Welfare	Ministerial keynote
Fatimah Howeidy	Program Manager, eHealth Africa	Moderator, Future of Care Investment dialogue
Dr Ahmed Ogwell	CEO & President, VillageReach	Panellist, Future of Care Investment dialogue
Dr Nkemdilim Femi-James	CEO, Persons Associates for International Development	Panellist, Future of Care Investment dialogue

Speaker	Role/Designation	Session/Contribution
Loïc Banybah	COO, AlloDocteur	Panellist, Future of Care Investment dialogue
Dr Ifunanya Ilodibe	CEO, EHA Clinics	Panellist, Future of Care Investment dialogue; EIV reinvestment
Hon. Abdulkadir Abdulsalam	Honourable Commissioner, Kano State Ministry for Rural and Community Development	Special address, rural development & primary healthcare
Daniella Ukwa	Group Communications Lead, EHA Group	Host, Adam Thompson fireside chat
Adam Thompson	Co-founder & CEO, EHA Group	Fireside chat, No One Builds a Health System Alone
Audrey Odogu	Senior Manager, Business Development, eHealth Africa	Moderator, Beyond Access panel; Vote of Thanks
Dr Chizoba Wonodi	Epidemiologist, Johns Hopkins IVAC	Panellist, Beyond Access panel
Dr Charles Usie	Country Director, Plan International Nigeria	Panellist, Beyond Access panel
Dr Kemi Dasilva-Ibru	Founder, WARIF	Panellist, Beyond Access panel
Mary Edoro	Head of Strategy, BellaNaija	Panellist, Beyond Access panel
Ramatu Abdullah	EHA Impact Ventures	EIV investment moment ($1.25M); Commitment Session
Dr. Muhammadu Mamman	Founder, Sahel MedTech	Moderator, Youth at the Centre panel; Commitment Session
Dr Zainab Olamide Sadik	African Health Innovation Fellow	Panellist, Youth at the Centre panel
Dr Victory Ekpin	Digital Health Researcher (LSHTM)	Panellist, Youth at the Centre panel
Jaafar Muhammad Isa	Chair, Africa CDC Youth Health Strategy domestication; co-founder, Sahel MedTech	Panellist, Youth panel
Dr Mories Atoki	ABC Health	Commitment Session
Dr Amina Aminu Dorayi	Pathfinder International Nigeria	Commitment Session
Dr Hameed Adediran	Country Director, Doctors Medical Aid Foundation	Commitment Session
Lola Aderemi	Co-founder & CPO, PharmaRun; Youth & Innovation Lead, ADHN board	Commitment Session
Solomon Okonkwo	Head, Corporate Social Investment, The Alternative Bank	Commitment Session, see full attribution notes in report body
Jean Philbert Nsengimana	Chairperson, ADHN; representing Dala Africa/ AHTS	Commitment Session

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