Near Point-of-Care TB Diagnostics Market Outlook (2026-2030)

Projected Adoption and Demand Forecast

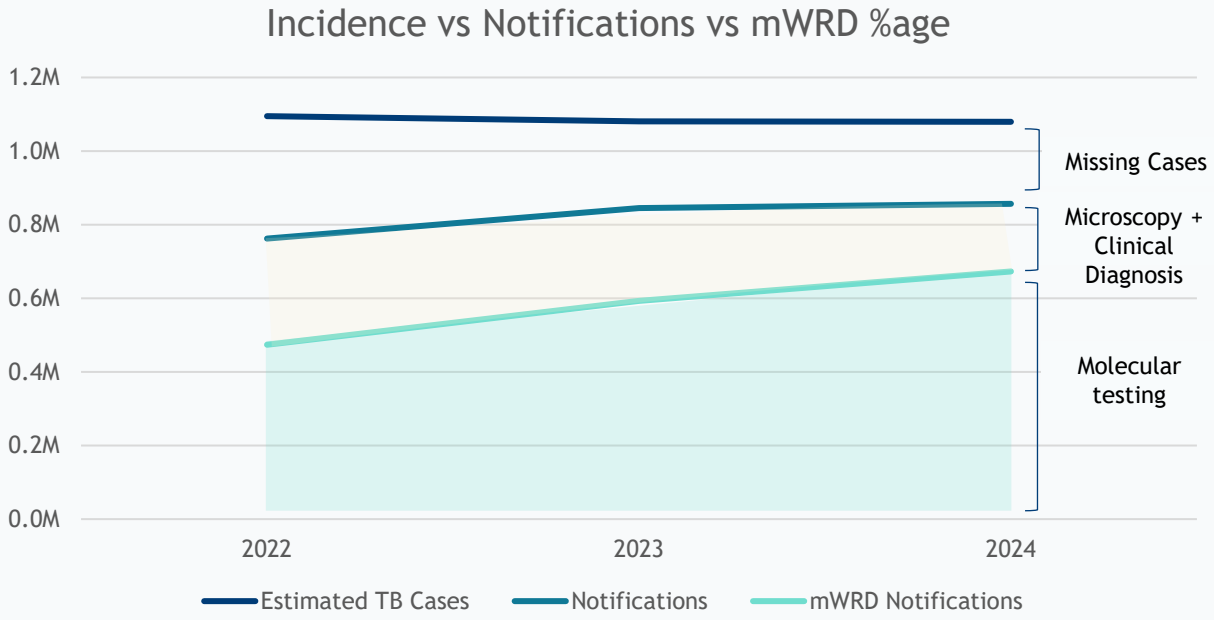
Diagnostic gaps create opportunity, but do not alone determine adoption

Assessment conducted in 7 high TB burden countries

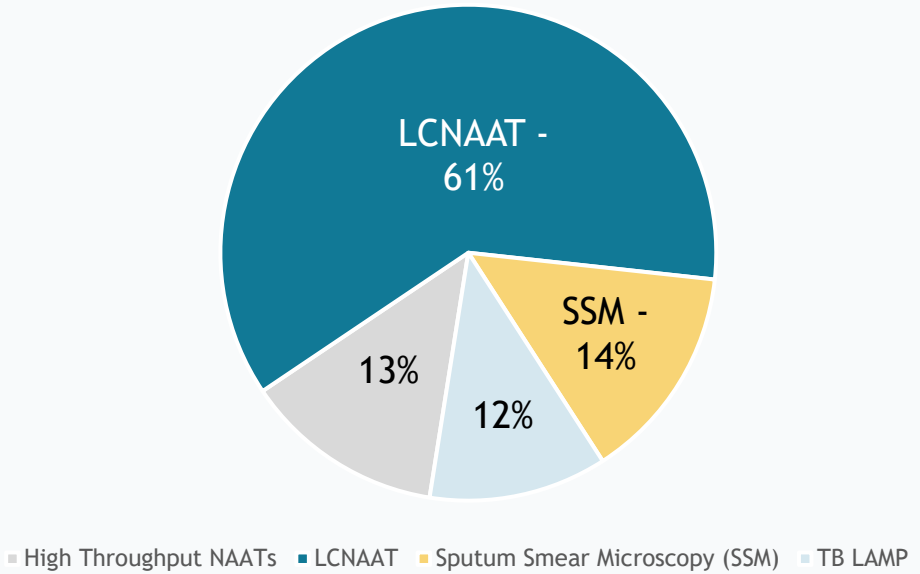
Cameroon | Ivory Coast | Kenya | Nigeria | Uganda | Zimbabwe | South Africa

43%
Regional Disease Burden

Estimated TB Cases vs. Notified Cases across the 7 countries: Aggregate (Historic)



Current Testing Mix (2024)



21% TB cases undiagnosed annually across these 7 countries

Most countries plan to deploy nPOC platforms at PHCs, where readiness will need to be strengthened to support uptake

Target sites for nPOC placement across countries

Primary Health Centers	Facilities with TB microscopy services	District/regional hospitals	Community/mobile outreach	ART Clinics

% Countries that highlight site as target for nPOC for their priority use cases

What does minimum viable site look like

Countries highlight ***device placement alone isn't sufficient – site readiness planning is needed*** that includes infrastructure, staff and reliable supply chain

Infrastructure	• Reliable facility power or UPS needed • Adequate workspace and biosafety requirements for sputum collection
Human Resource	• Trained staff capacity needed at lower level sites where staff are already overburdened or there are massive shortages
Device Management	• Devices need to be functional and active for successful uptake • Logistics model needed that replaces non working devices quickly to prevent service interruption
Supply chain	• Robust quantification, ordering processes and distribution needed to ensure on-site availability of tests at large number of decentralised facilities

Cross-cutting implementation challenges emerging across countries

These challenges are not unique to any single country but represent systemic patterns observed across countries in this analysis

Regulatory delays and policy revisions

Long approval, licensing and guideline revision processes

Infrastructure gaps limit deployment reach

Power reliability, physical space constraints at PHC level.

Workforce readiness requires more than training

Task-shifting, staff retention, resistance to change, and regulatory restrictions on who can operate equipment surface consistently.

Financing sustainability beyond the initial uptake

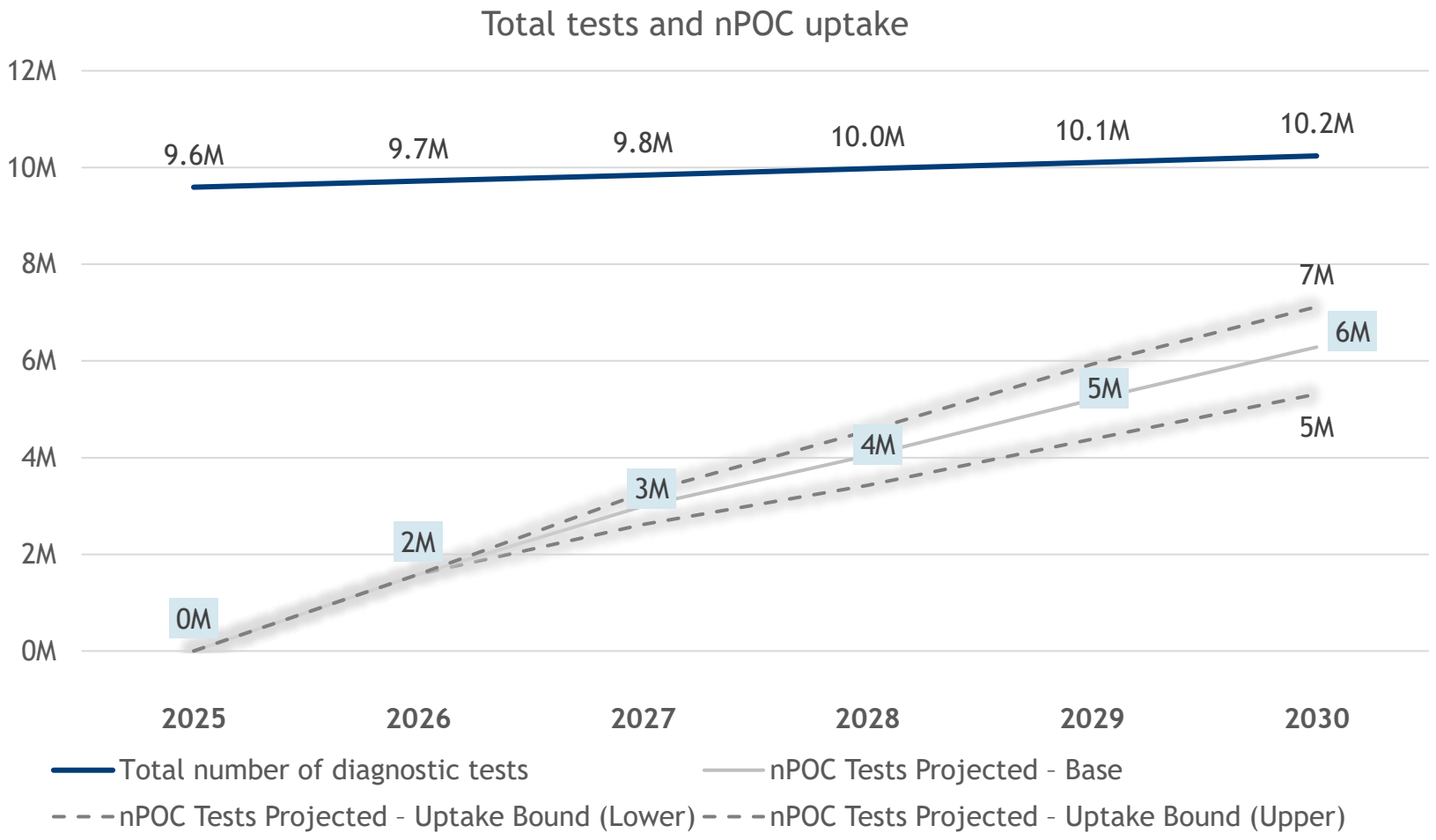
Sustained scale-up depends on sustained funding

Supply chain and maintenance capacity

Stockouts, device downtime, and limited local service capacity are flagged across settings, particularly at lower-level facilities.

nPOC Test Volumes expected to reach 6M (5-7M) annually by 2030 forming ~60% of the total diagnostic testing volumes

The forecasted nPOC pathway reflects substitution of smear microscopy and LCNAAT based on country feedback on priority use cases.



OBSERVATIONS

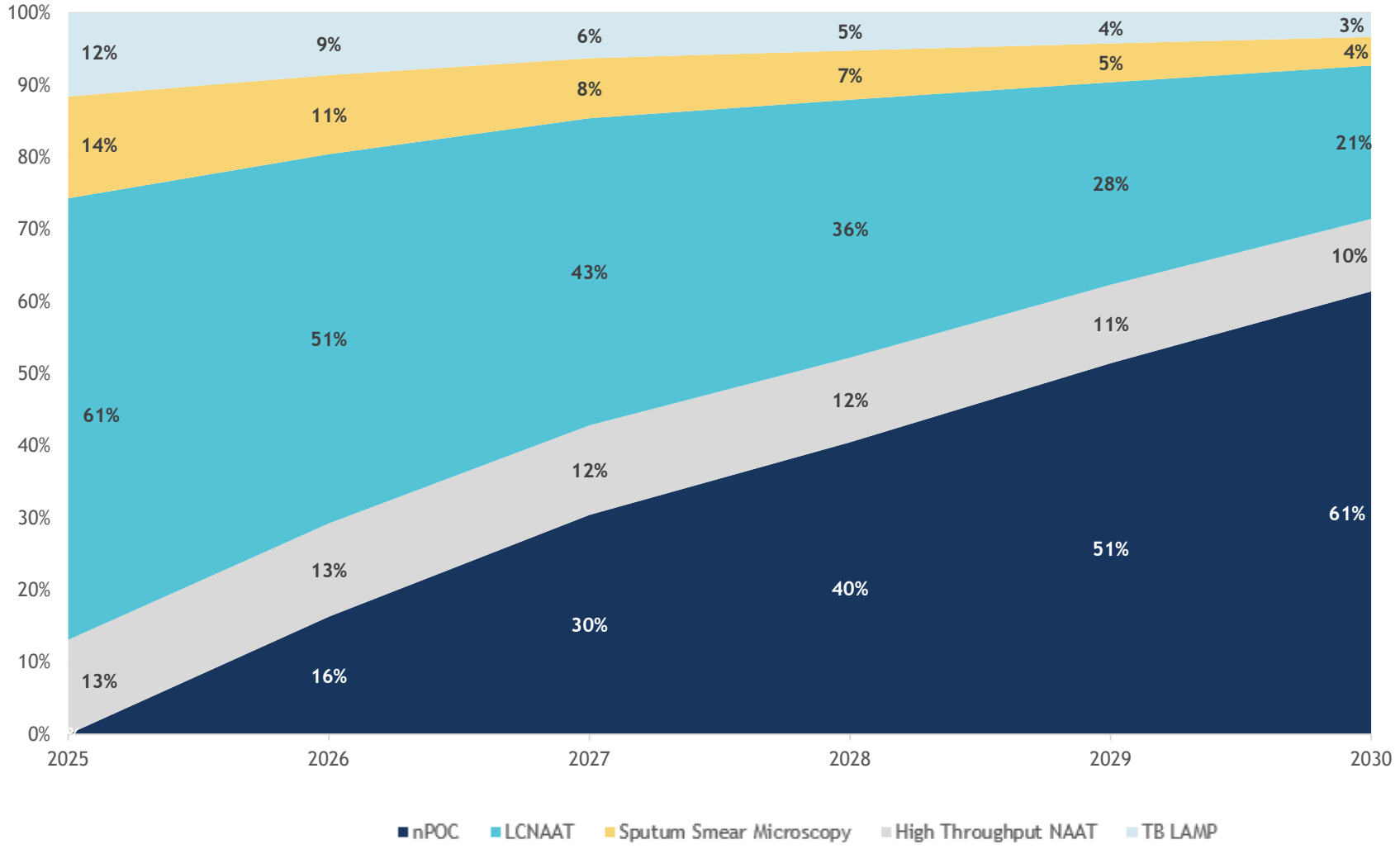
In the current budget environment, forecasted market share is gained not through market expansion but through technology substitution

- Growth in total testing is limited to modest increases in bacteriological testing in the short to medium term.
- nPOC base case is expected to grow to 6M tests annually (5-7 M). This reflects uncertainties around regulatory lag, site readiness, HR constraints and funding challenges.
- nPOC takes upto 60% of the market in the 7 countries by 2030

Extrapolated to 25 high burden countries globally which form 88% of molecular testing volumes nPOC volumes are expected to reach 22 M (17-26 M) per year under conservative estimates

Diagnostic Mix Evolution Under Forecasted Conditions

The forecasted trajectory implies a gradual structural shift in testing mix: declining smear share, rising molecular share. The nPOC share reflected is based on median uptake

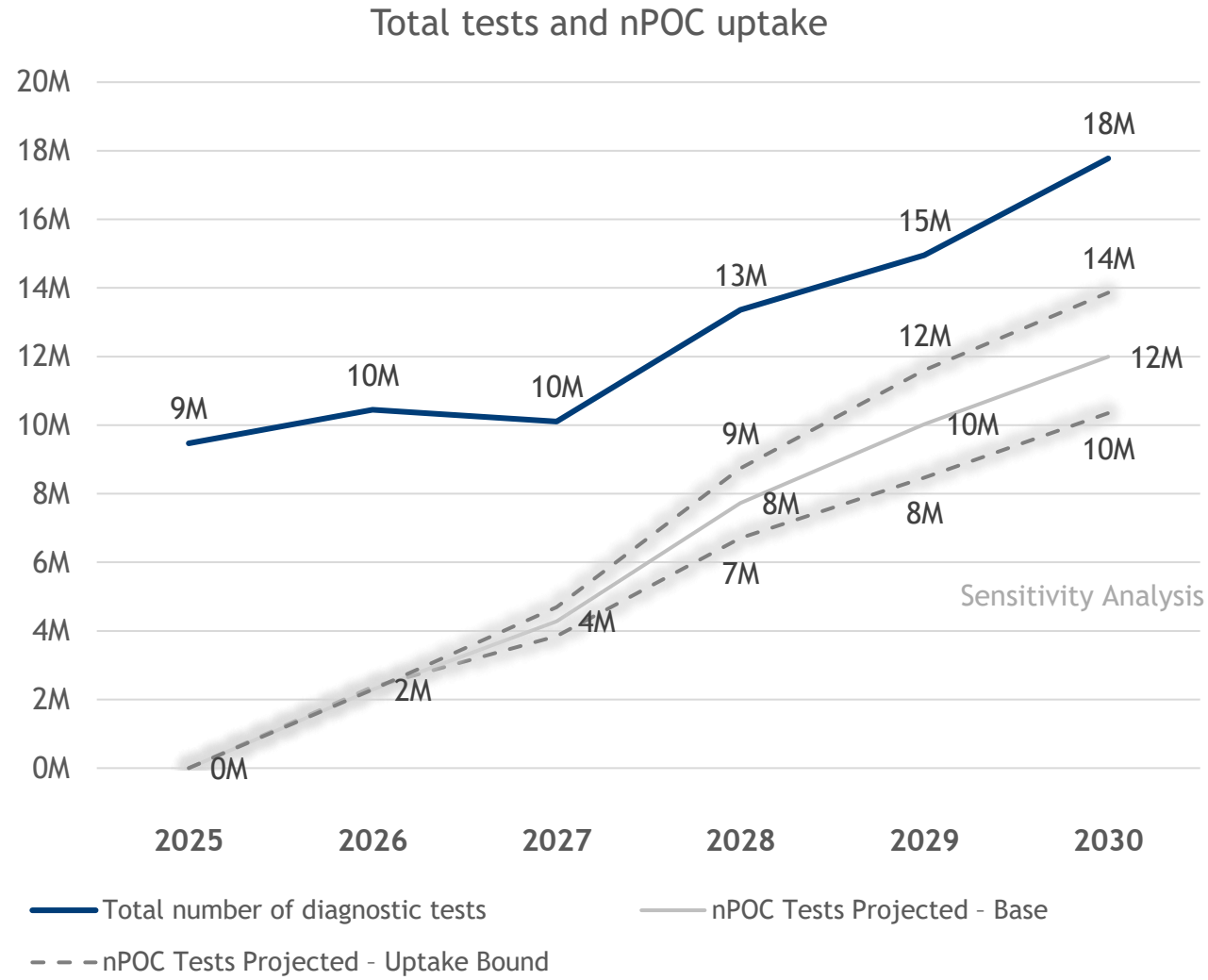


OBSERVATIONS

- The replacement is guided by a mix of use cases across countries which include both decreasing cost of molecular diagnostics and increasing molecular testing as well as decentralization of TB testing.
- LCNAAT retains some volumes for DR testing.
- Smear microscopy drops from 14% to 4% of all tests over five years.
- Additional reflex testing need appears lower as for countries where nPOC volumes are driven by SSM replacement since historical LCNAAT volumes already incorporate reflex testing, so no additional reflex testing need is estimated against those volumes.

Reinvesting diagnostic cost savings into nPOC could nearly double total testing volumes by 2030

If savings from adopting lower-cost nPOC are reinvested into testing rather than absorbed as budget reductions, the same diagnostic budget could deliver 12M tests annually by 2030 compared to 6M today



OBSERVATIONS

- The scenario assumes cost savings are fully reinvested; partial reinvestment would produce volumes between the base case and these projections
- Structuring financing to recycle savings rather than reduce budgets is the critical enabler, the volume upside is only realized if programs and funders actively reinvest transition savings
- Countries with higher LCNAAT shares stand to gain the most from reinvestment, the cost differential between LCNAAT and generating proportionally greater savings to recycle into expanded testing.
- Countries with transition from SSM to nPOC will take budgetary pressure which would be absorbed by some volumes moving from LCNAAT to nPOC parallelly.

Conclusion - Key Decisions on nPOC will determine the uptake

Placement

Where nPOC would be placed ?

In smear-heavy systems: nPOC primarily expands access to molecular testing

In molecular-heavy systems: nPOC substitutes existing LC-NAAT capacity and reduces costs

Define clear use cases

Activation

What does it take to make a site functional?

Assessing current site readiness based on infrastructural and HR requirements of running these tests.

Network Design

What does diagnostic network look like in future?

Mapping Patient journey from diagnosis till reflex testing

How will existing LC-NAAT capacity and reflex testing fit into the future network?

How can savings generated be reinvested into diagnostic algorithms?