

Forus Health

Technology delivering care

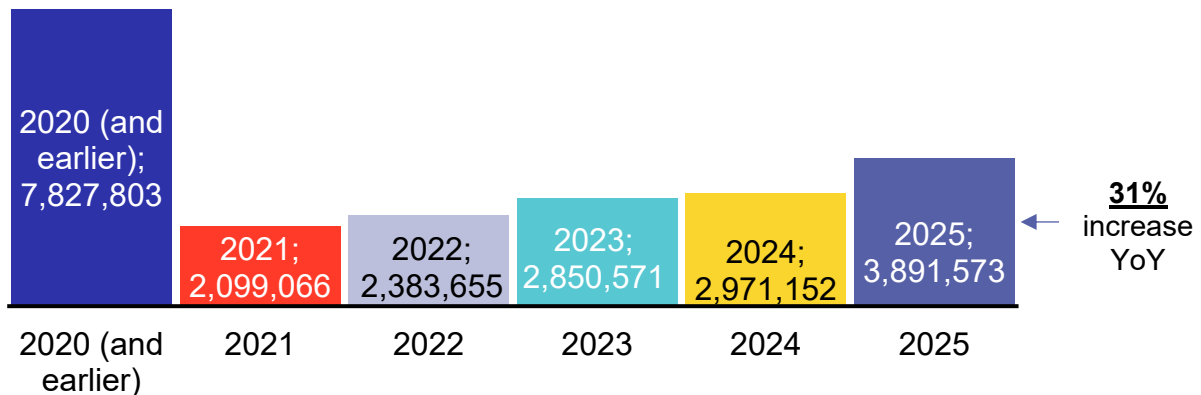
Creator of a proprietary, fully integrated, AI-assisted digital health platform of solutions for eye care and ocular disease management. Forus Health is developing the future of eye care on its mission to eradicate preventable blindness. [Visit Forus Health's website.](#)

I. FY 2025 IMPACT GRAPHICS

A. Patients/Populations Touched

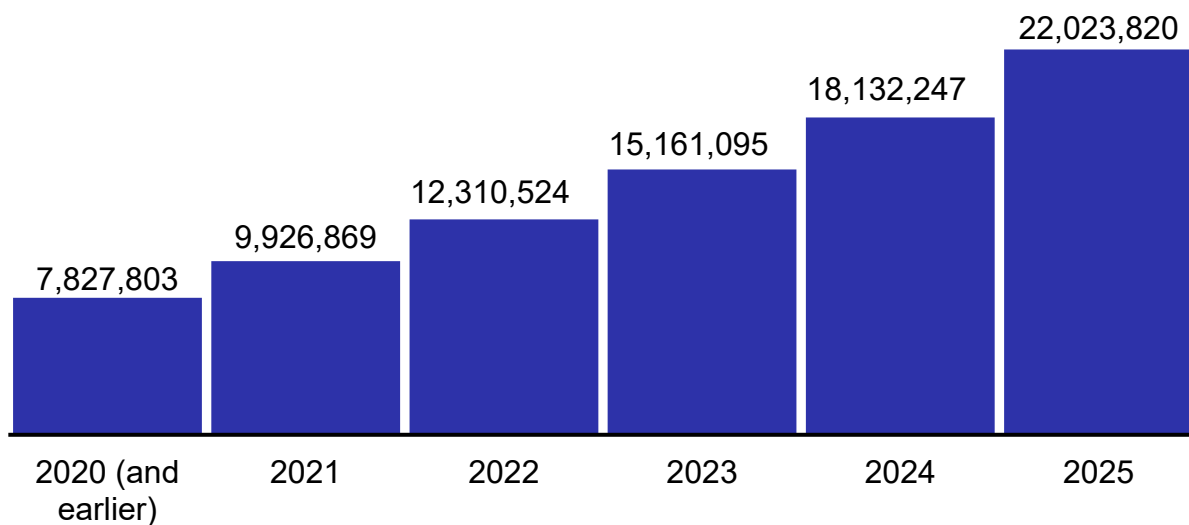
1. Total Unique Patients Served by Year (through March 2026)

N = 3,891,573 (2025); 22,023,820 (cumulative)



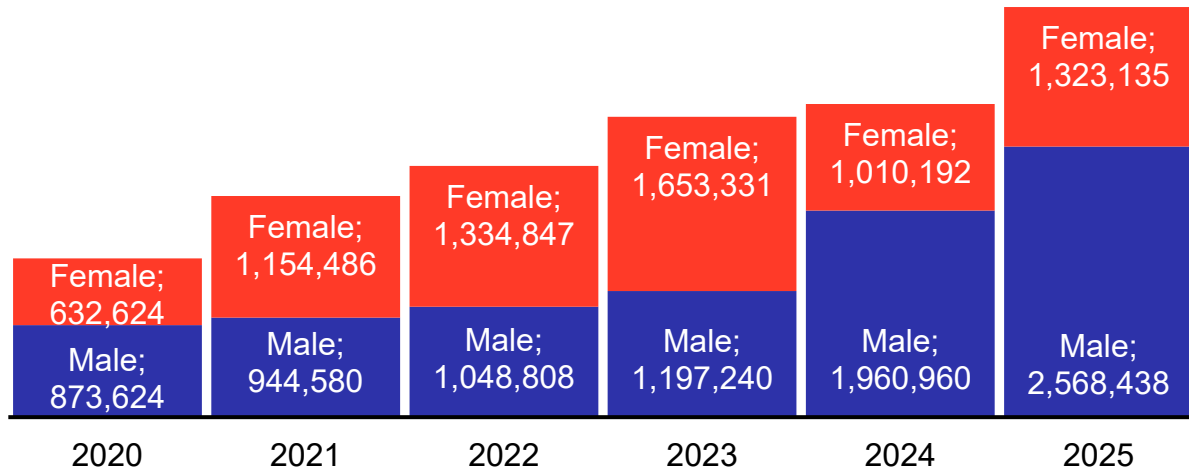
2. Cumulative Unique Patients Served by Year (through March 2026)

N = 3,891,573 (2025); 22,023,820 (cumulative)

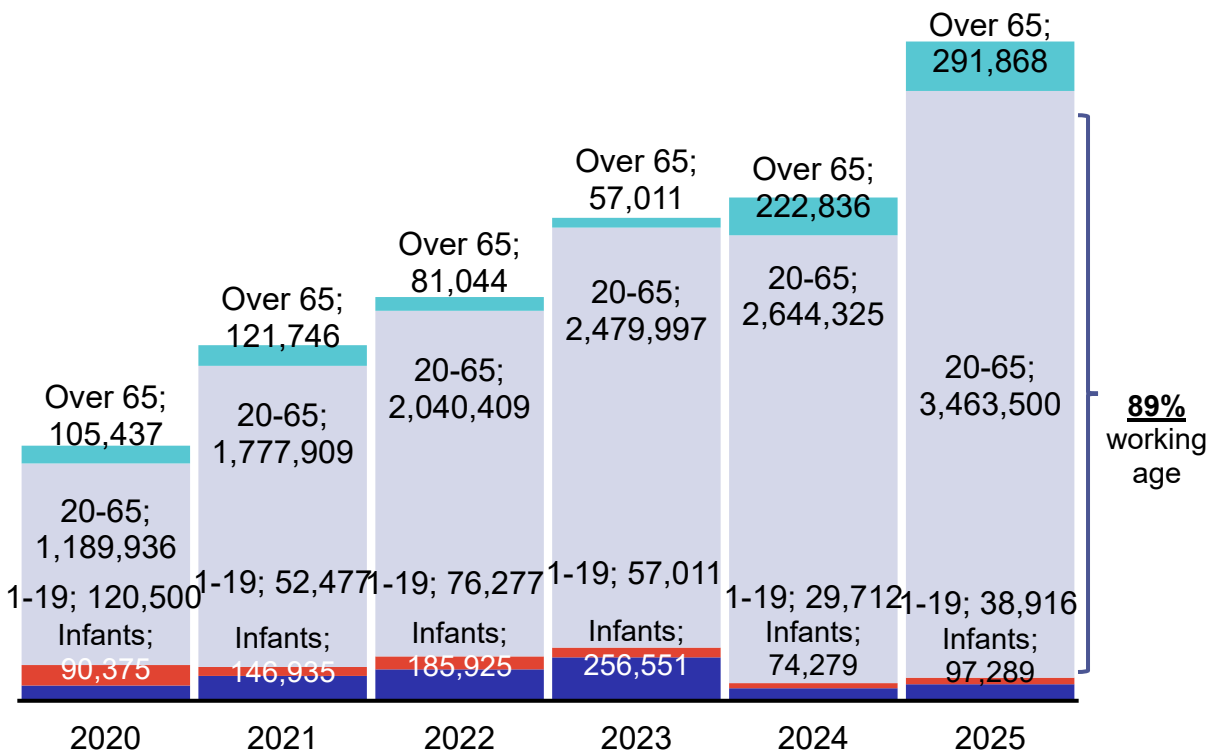


3. Population Profiles

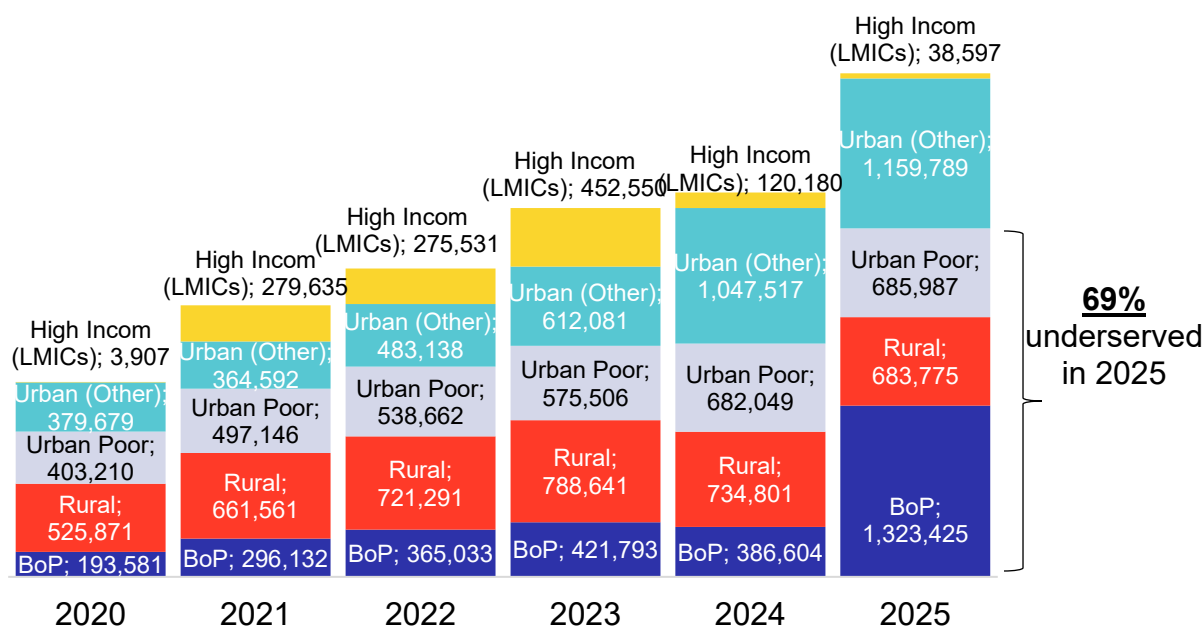
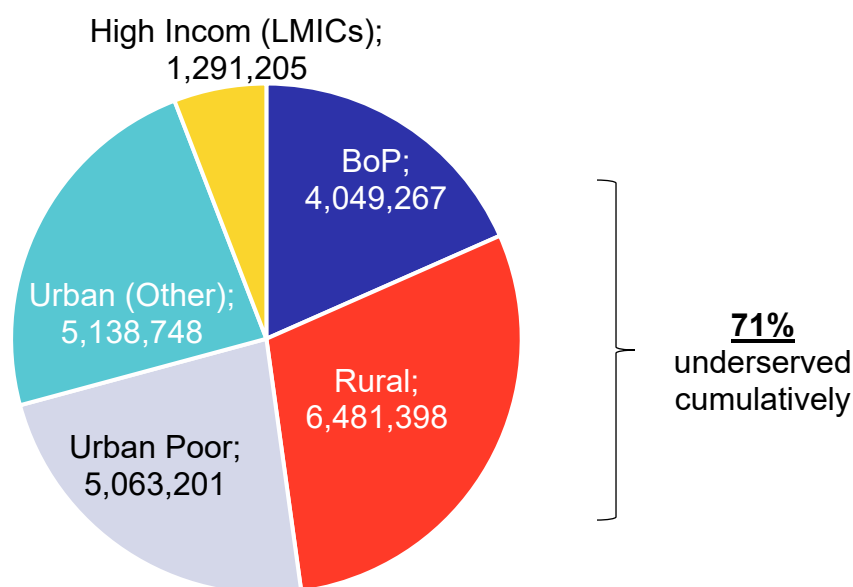
a. Estimated Unique Patients by Gender and Year (Annual 2020 – 2025)¹
N = 3,891,573 (2025); 22,023,820 (cumulative)



b. Estimated Unique Patients by Age and Year (Annual 2020 – 2025)
N = 3,891,573 (2025); 22,023,820 (cumulative)



¹ The increase in male share of patients was primarily driven by the launch of Forus' worksite employee screen service in 2023.

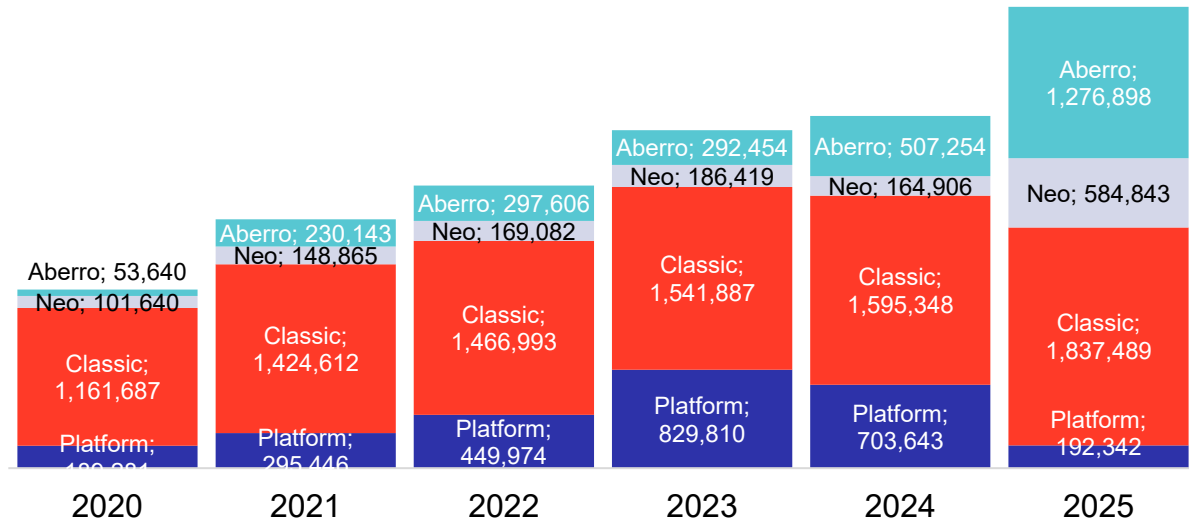
c. Unique Patients by Underserved Status and Year (2020 – 2025)^{2,3,4}***N = 3,891,573 (2025); 22,023,820 (cumulative)*****d. Unique Patients by Underserved Status (cumulative)*****N = 22,023,820 (cumulative)***

² BoP is an abbreviation for 'Base of Pyramid'. TEAMFund collectively categorizes the Base of Pyramid, Rural and Urban Poor as 'Underserved Populations'. These patients are served by public health facilities.

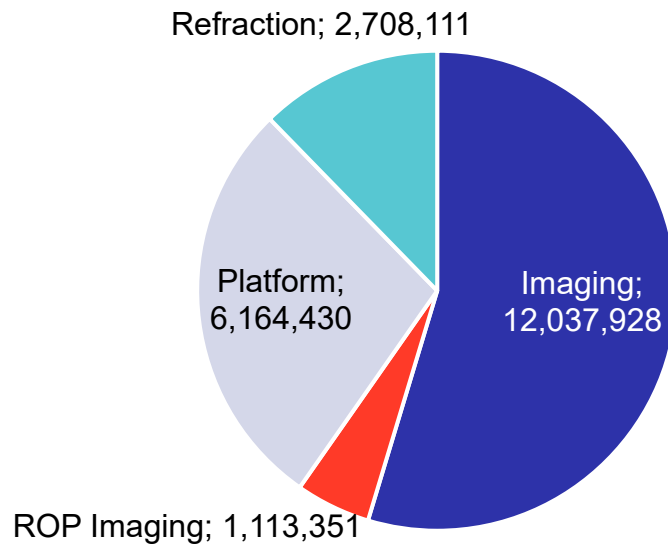
³ Socioeconomic data until 2018 was provided on a cumulative basis (and as such is omitted for readability). The breakdown for the 2018 cumulative period was - BoP (16%), Urban Poor (27%), Rural (37%), and Urban/High Income (19%).

⁴ Patients in the Urban (Other) category are generally served by private hospitals or Forus' B2B solutions business. Customers in that business are enterprises that tend to have an urban/white collar employee base.

e. Unique Patients by Product (Annual 2020 – 2025)^{5,6}
N = 3,891,573 (2025); 22,023,820 (cumulative)



f. Cumulative Unique Patients by Product Category (2025)⁵
N = 22,023,820 (cumulative)

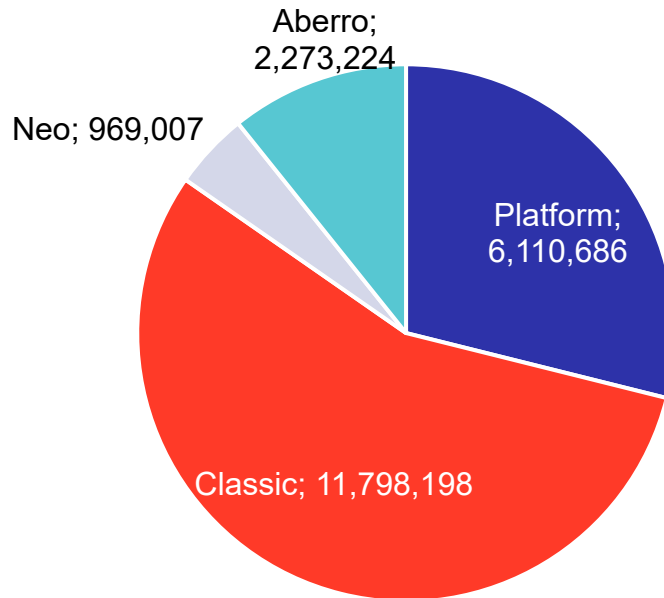


⁵ Imaging (i.e. retinal imaging) and ROP imaging are used to diagnose retinal issues.

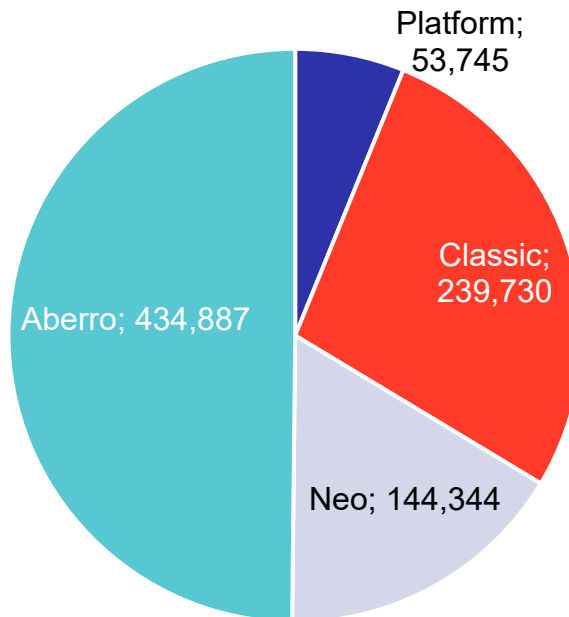
⁶ Greater share of Classic and Aberro driven by increase in public system utilization.

g. Population by Product Category and Geography (India vs. International 2025)
N = 22,023,820 (cumulative)

Cumulative Unique Indian Patients by Product

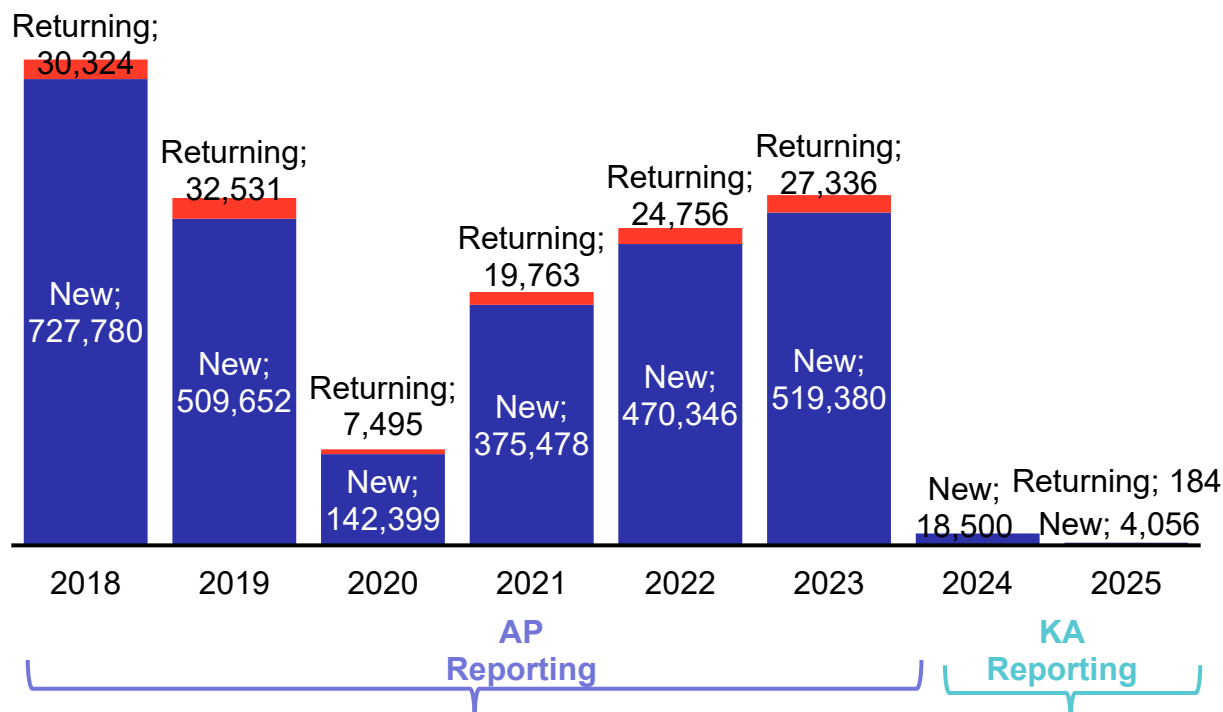


Cumulative Unique International Patients by Product



4. Patient Interventions/Compliance Cohorts (where available)

a. General (from AP and KA^{7,8} cohort; 2018 – 2025)



b. Refractions (from AP and KA cohort; 2018 – 2025)^{5,6,9,10}

Refractions						
Year	Program	Total	New (%)	Returning (%)	Needing Spectacles	Receiving Spectacles
2018	AP	758,104	96%	4%	629,235	612,815
2019	AP	542,183	94%	6%	442,405	464,525
2020	AP	149,894	95%	5%	126,870	121,155
2021	AP	395,241	95%	5%	328,347	324,887

⁷ In prior reports, we have provided annual patient intervention data collected as part of a screening program in the State of Andhra Pradesh ("AP"). In 2024, the Company shifted to using it in a new program in Karnataka ("KA"). As such, readers should take care in directly comparing the 2018-2023 period to the data reported starting in 2024. The Company has also recently a program in Punjab, which has screened 49,076 patients, with 20,121 spectacles prescribed.

⁸ We also note that the KA program has two distinct programs – one that is refraction focused (using the Forus Aberro device) and a telemedicine program (using the Forus Classic device) – unlike the AP program. As such, we report both totals under the 'general' segment, but only the Aberro-focused program under the 'refraction' segment.

⁹ Many 2020 patients were seen again in 2021 due to the impact of COVID-19, resulting in the sum of the annual patients exceeding the cumulative total number of unique patients.

¹⁰ The decrease in the percentage receiving spectacles as a % of total screened reflects greater awareness program penetration broadly, and thus fewer patients presenting with an unmet need for spectacles.

2022	AP	495,102	95%	5%	420,121	404,919
2023	AP	546,715	95%	5%	510,440	502,276
2024	KA	18,500	100%	0%	2,200	2,200
2025	KA	32,600	95%	12%	3,912	3,912

c. Imaging (from Welcare; 2018 – 2025)¹¹

Year	Referred to Specialists	Other	Total
2018	84,700	36,300	121,000
2019	69,120	26,880	96,000
2020	21,000	9,000	30,000
2021	21,000	9,000	30,000
2022	21,000	9,000	30,000
2023	21,000	9,000	30,000
2024	22,825	N/A	22,825
2025	2,200	46,700	48,900
Total	262,845	145,880	408,725

d. ROP Population (2018 – 2025)

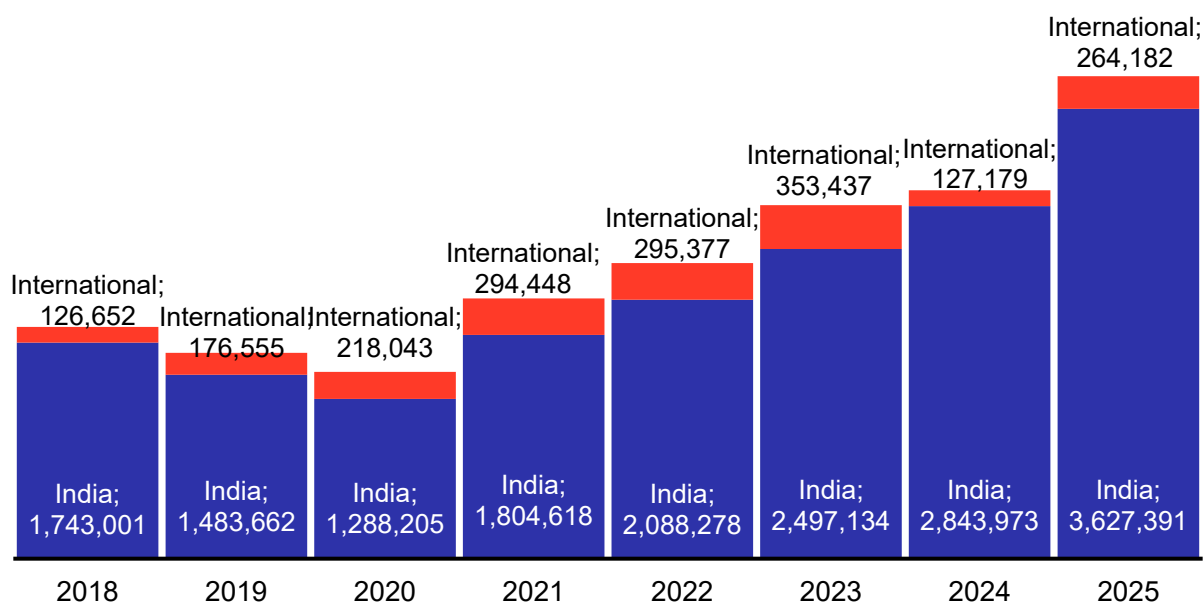
Welcare and Imaging Subscription Patients		
Year	% Referred to Specialists	% Treated Once Referred
2018	100%	100%
2019	100%	100%
2020	100%	100%
2021	100%	100%
2022	100%	100%
2023	100%	100%
2024	100%	100%
2025	100%	100%

¹¹ See note 10.

5. Total Unique Patients by Geography (India vs. International)¹²

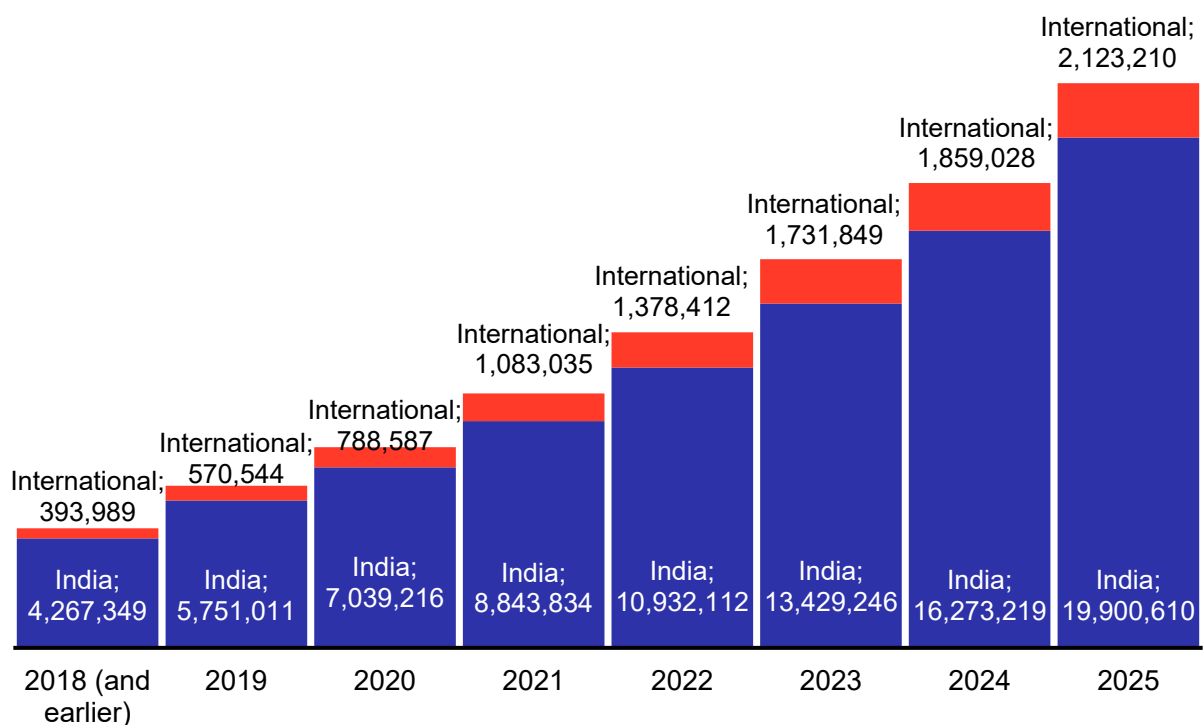
a. Annual Unique Patients by Geography (2018 – 2025)

N = 3,891,573 (2025); 22,023,820 (cumulative)

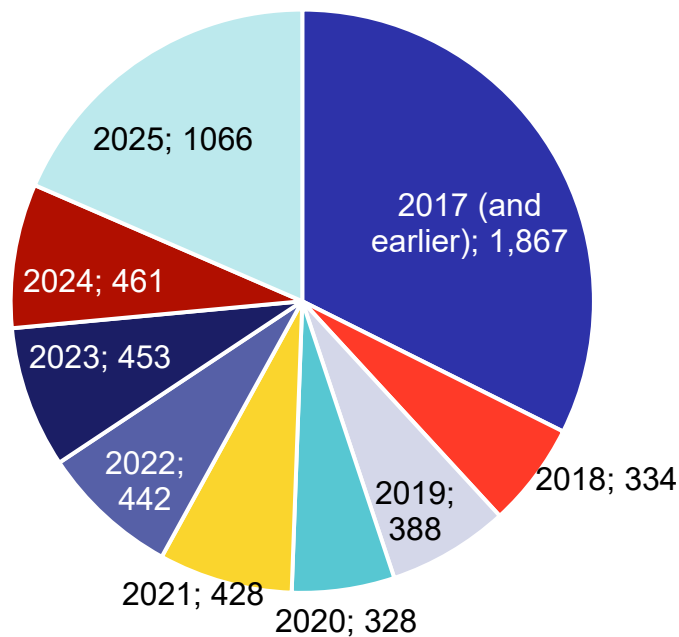
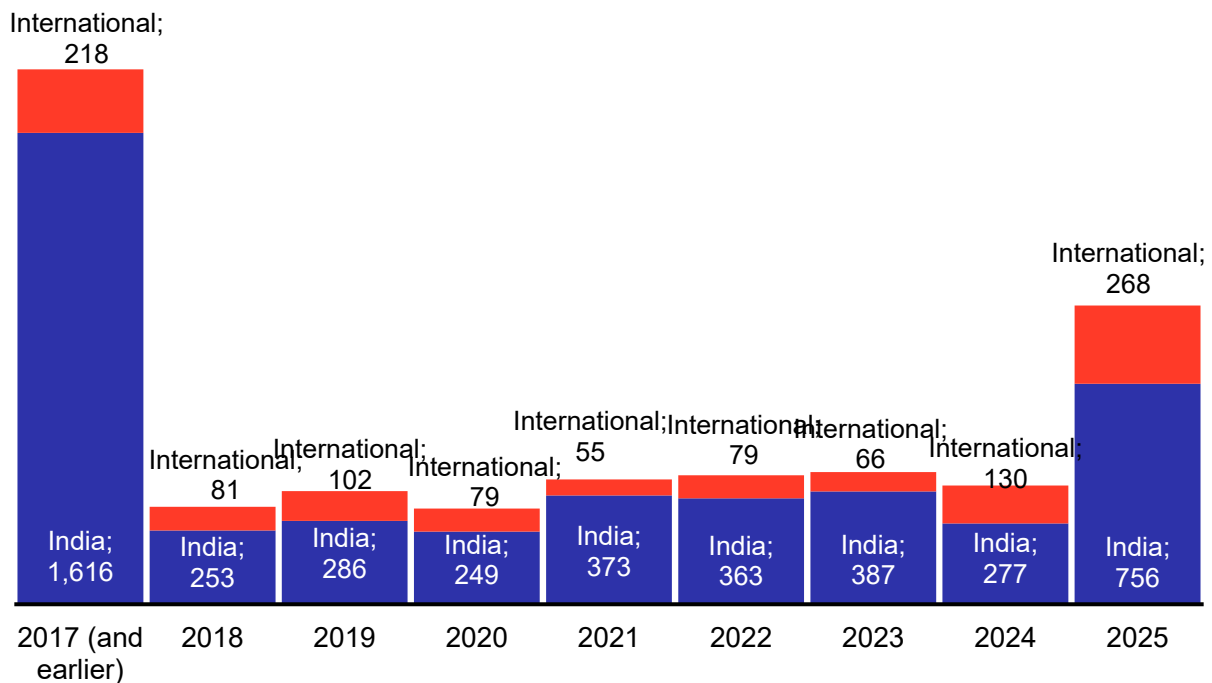


b. Cumulative Population by Geography (2018 – 2025)

N = 22,023,820 (cumulative)



¹² The bulk of 'international' patients are from Nepal & Nigeria (Tele-refraction).

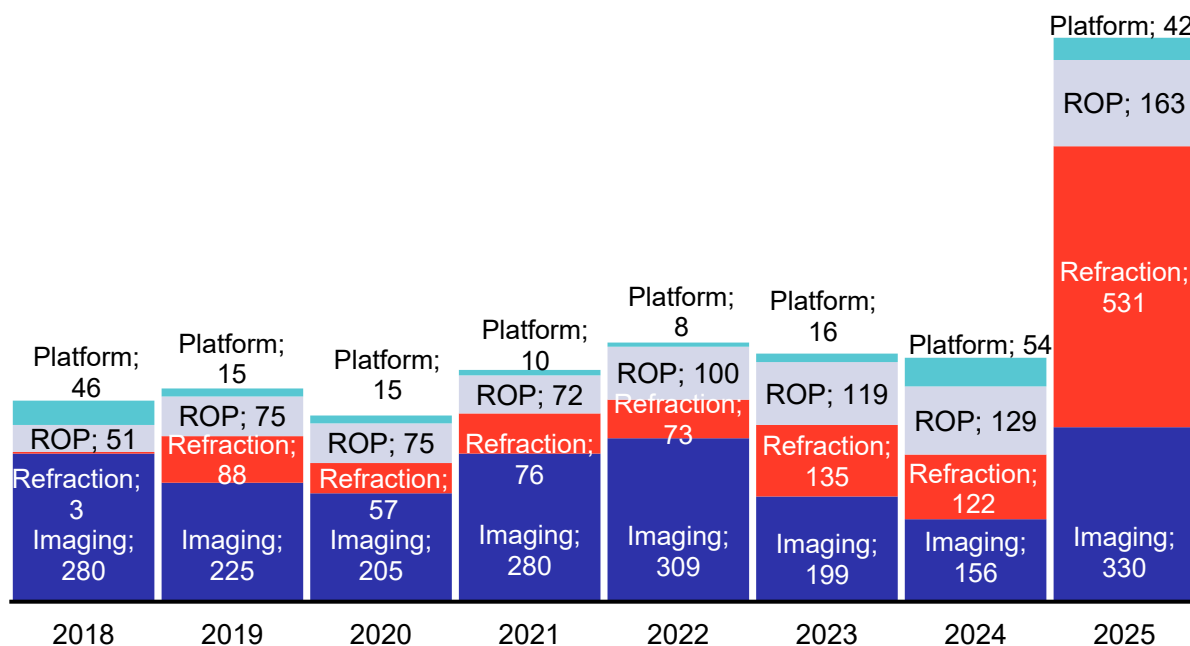
B. Units**1. Total New "Units" (2017 and earlier, 2018 – 2025)¹³*****N = 1,066 (2025, including platform); 5,767 (cumulative)*****2. Units by India vs. International (through 2025)¹⁴*****N = 1,024, (2025, excluding platform); 5,638 (cumulative)***

¹³ The large increase in units was primarily driven by large public tenders including the deployment of classic + in Bihar (200) and also in Punjab for Aberro (260).

¹⁴ Platform is often bundled with other products and thus we exclude the platform from this summary total.

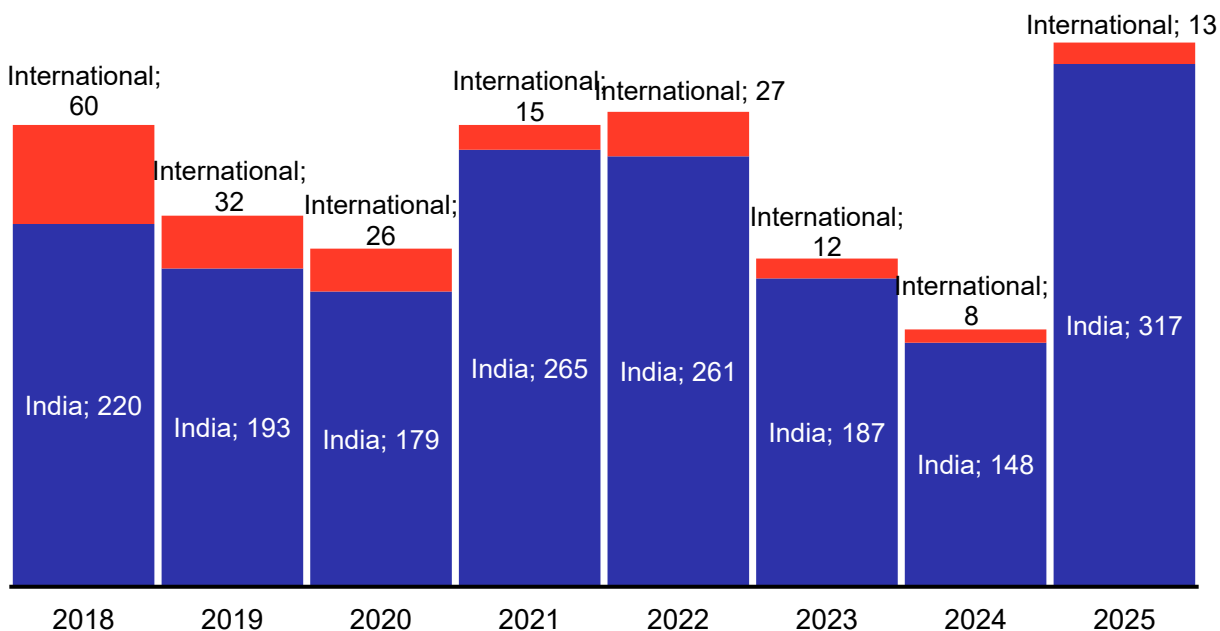
3. Units by Product Category (2018 – 2025)^{5,15}

N = 1,066 (2025, including platform); 5,767 (cumulative)



a. Imaging Units by India vs. International (2018 – 2025)

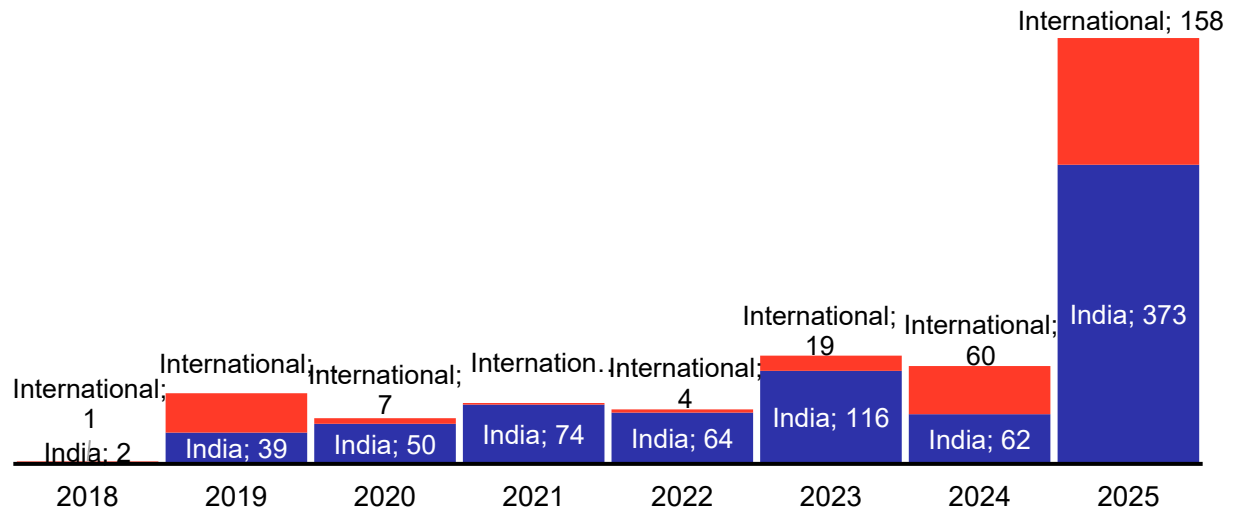
N = 280 (2018), 225 (2019), 205 (2020), 280 (2021), 288 (2022), 199 (2023), 156 (2024), 330 (2025)



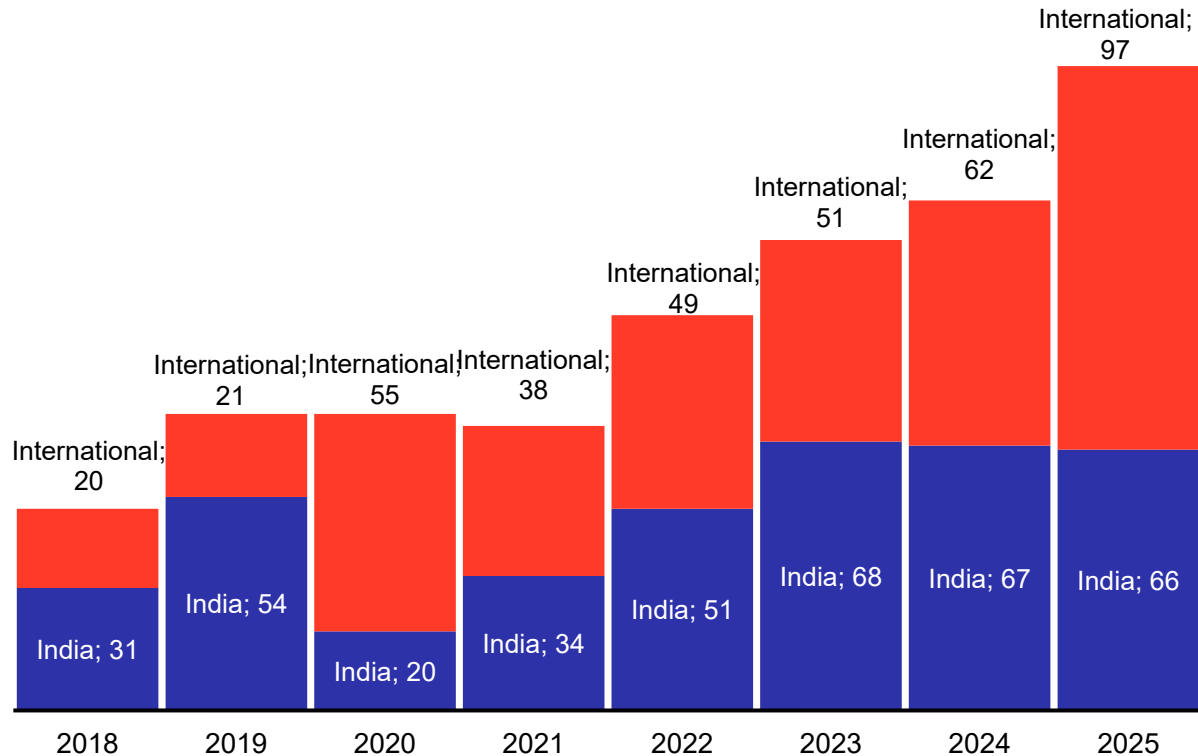
¹⁵ FY'25 included 521 Indian public health installations, 235 Indian private system installations, and 20 installations in the UK.

b. Refraction Units by India vs. International (2018 – 2025)¹⁶

N = 3 (2018), 88 (2019), 57 (2020), 76 (2021), 68 (2022), 135 (2023), 122 (2024), 531 (2025)

**c. ROP Units by India vs. International (2018 – 2025)**

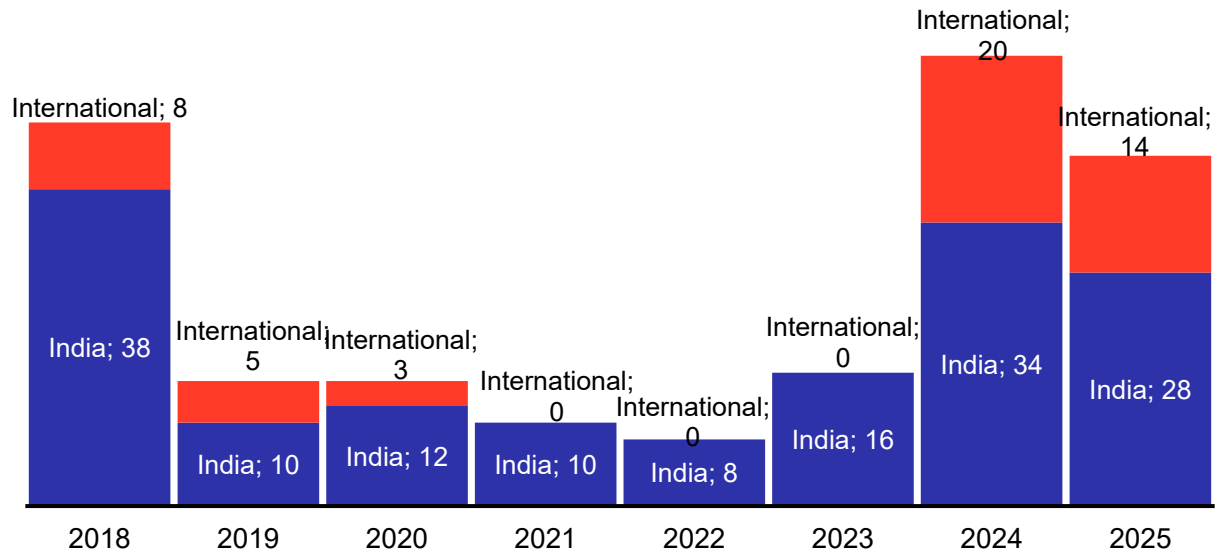
N = 51 (2018), 75 (2019), 75 (2020), 72 (2021), 100 (2022), 119 (2023); 129 (2024), 163 (2025)



¹⁶ FY'25 included 260 Aberro devices were billed for a public eye screening in Punjab.

d. Platform Units by India vs. International (2018 – 2025)

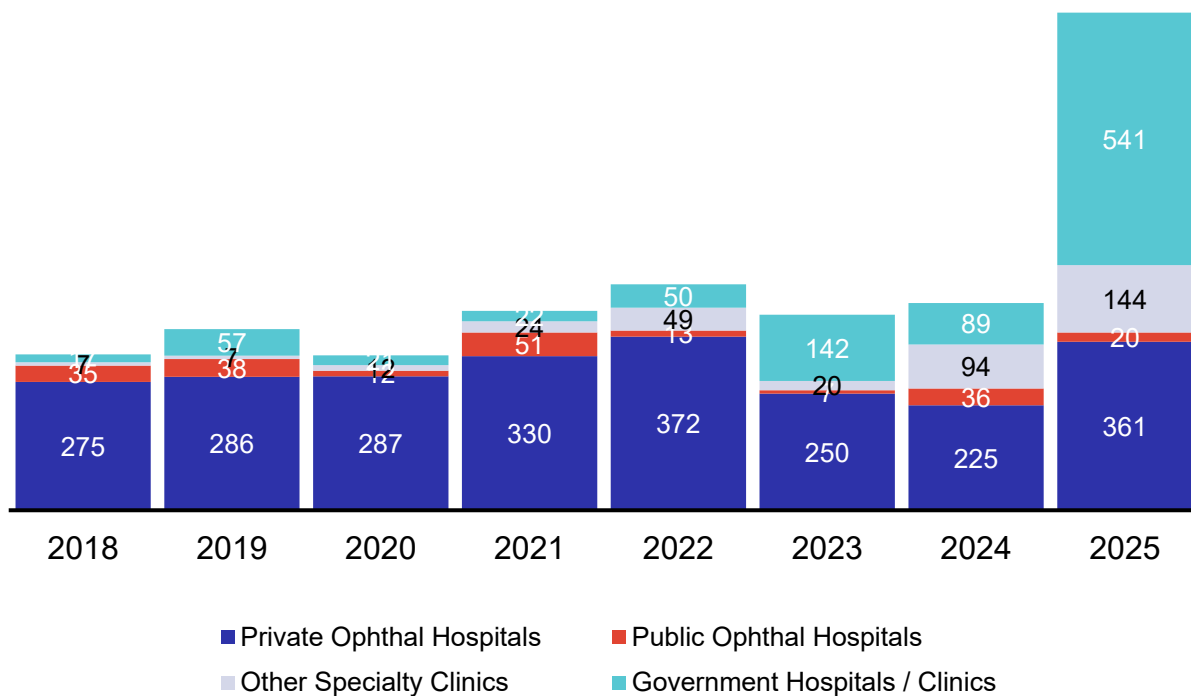
N = 46 (2018), 15 (2019), 15 (2020), 10 (2021), 8 (2022), 16 (2023), 54 (2024), 42 (2025)



C. Facility Profiles

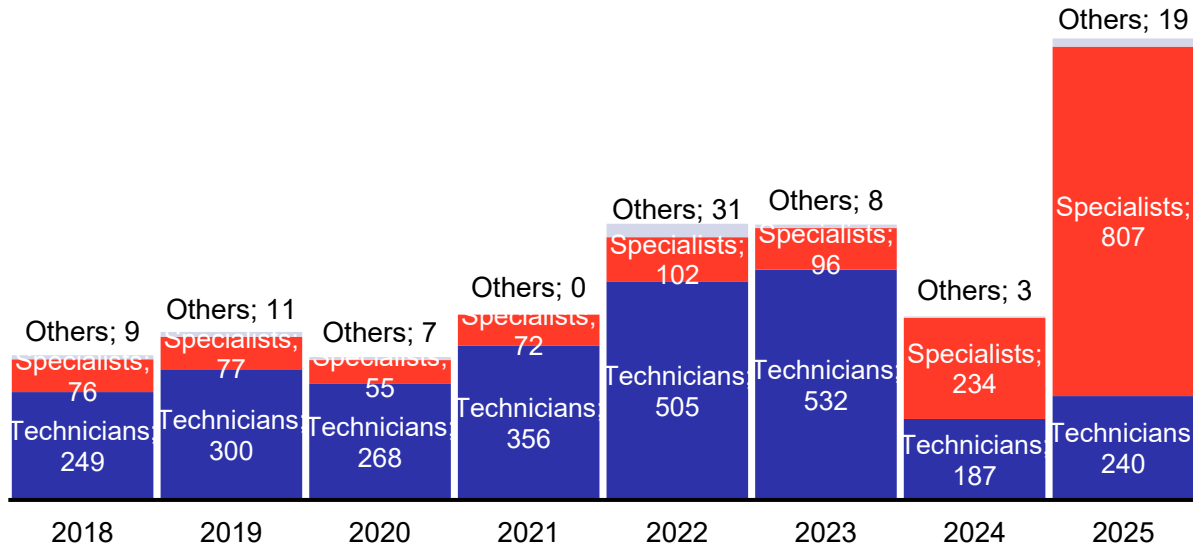
1. Facilities by Type (2018 – 2025)¹³

N = 334 (2018), 388 (2019), 332 (2020), 427 (2021), 484 (2022), 419 (2023), 444 (2024), 1,066 (2025)

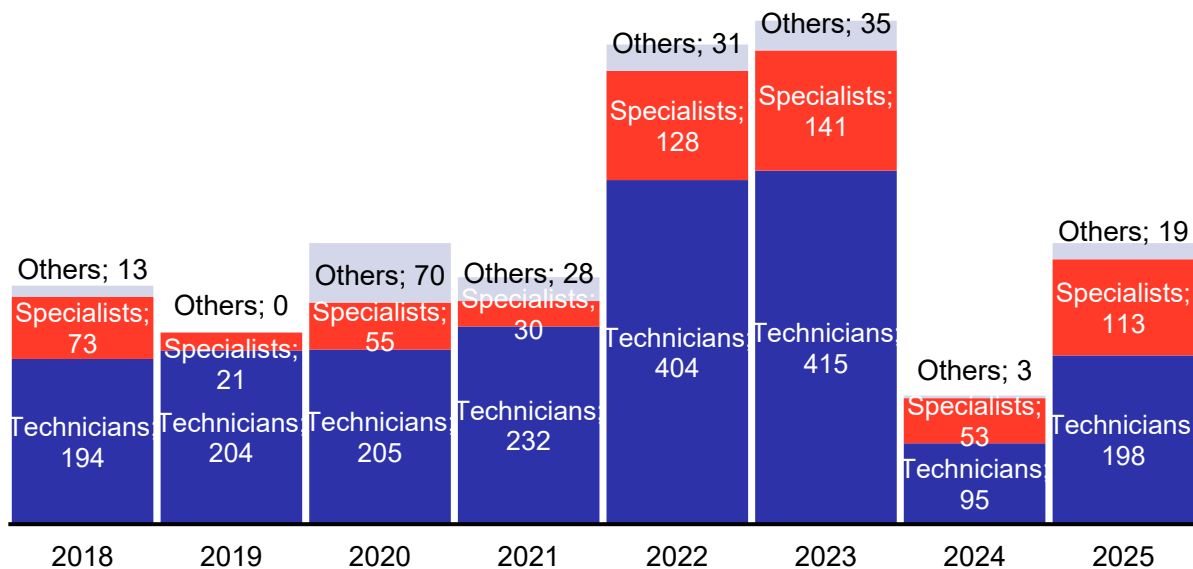


D. Provider Profiles¹⁷**1. Providers / 'Users' by Type (2018 – 2025)**

N = 334 (2018), 388 (2019), 330 (2020), 428 (2021), 638 (2022), 636 (2023), 424 (2024), 1066 (2025)

**a. Imaging Providers / 'Users' by Type (2018 – 2025)**

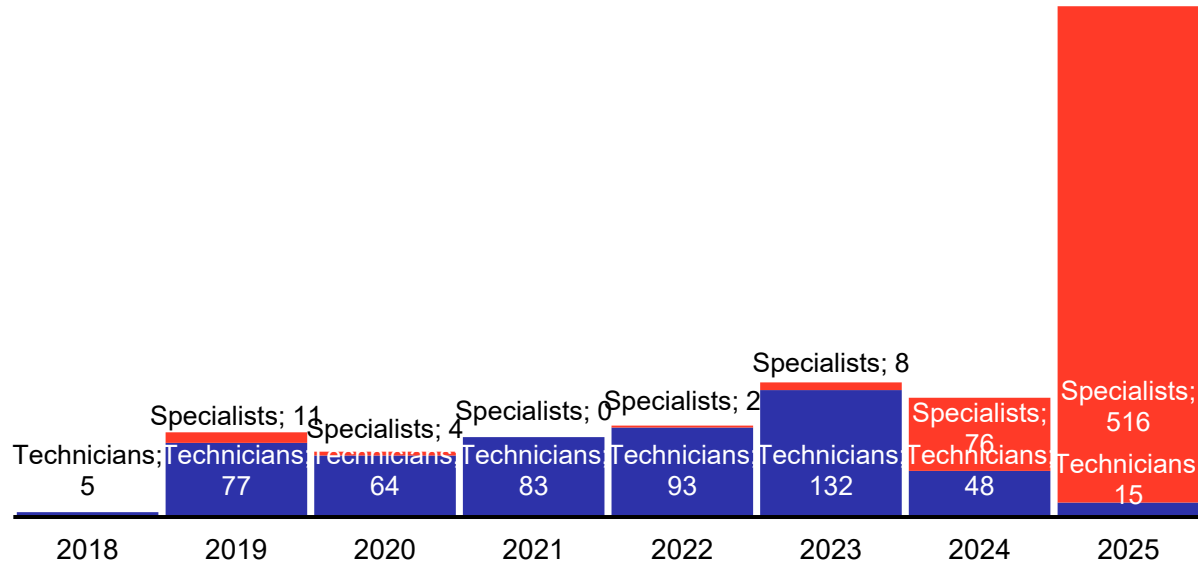
N = 280 (2018), 225 (2019), 330 (2020), 290 (2021), 563 (2022), 591 (2023), 151 (2024), 330 (2025)



¹⁷ The significant uptick in specialist providers in FY'25 was because all the government installations have a policy where if there are multiple handlers (who are primarily optometrists) per location (usually 2/3 users per device), specialists are required.

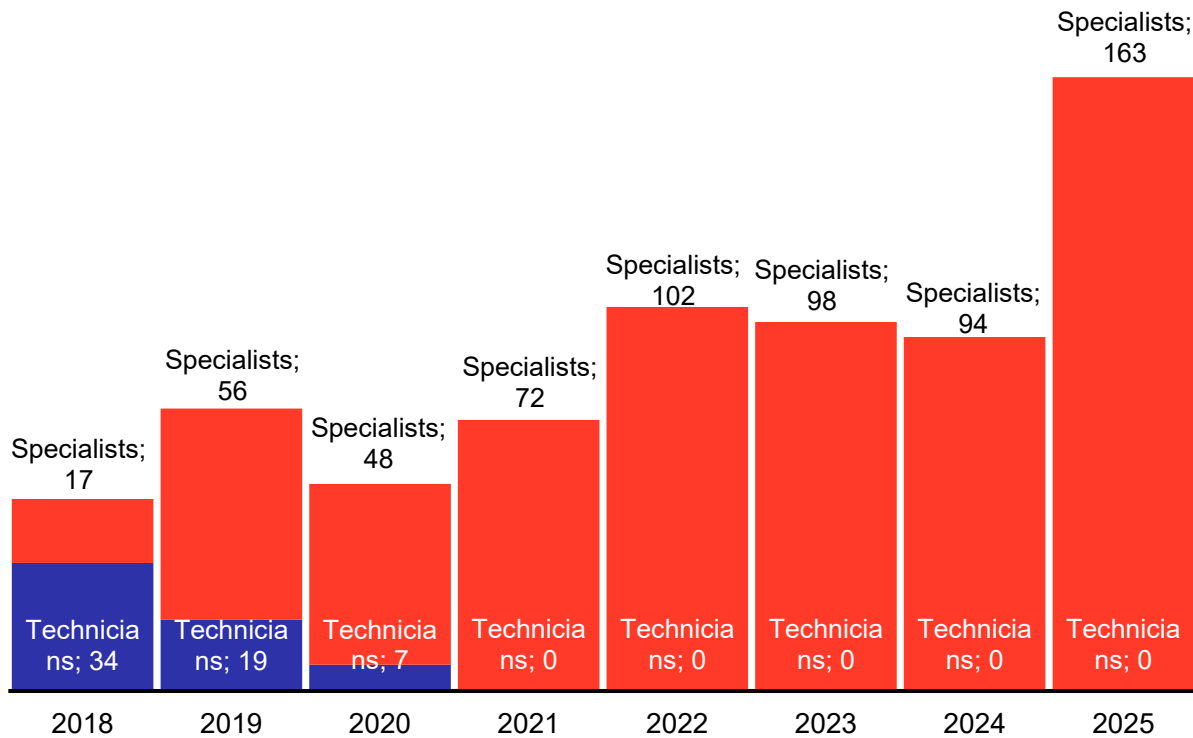
b. Refraction Providers / 'Users' by Type (2018 – 2025)

N = 5 (2018), 88 (2019), 68 (2020), 83 (2021), 95 (2022), 140 (2023), 124 (2024), 531 (2025)



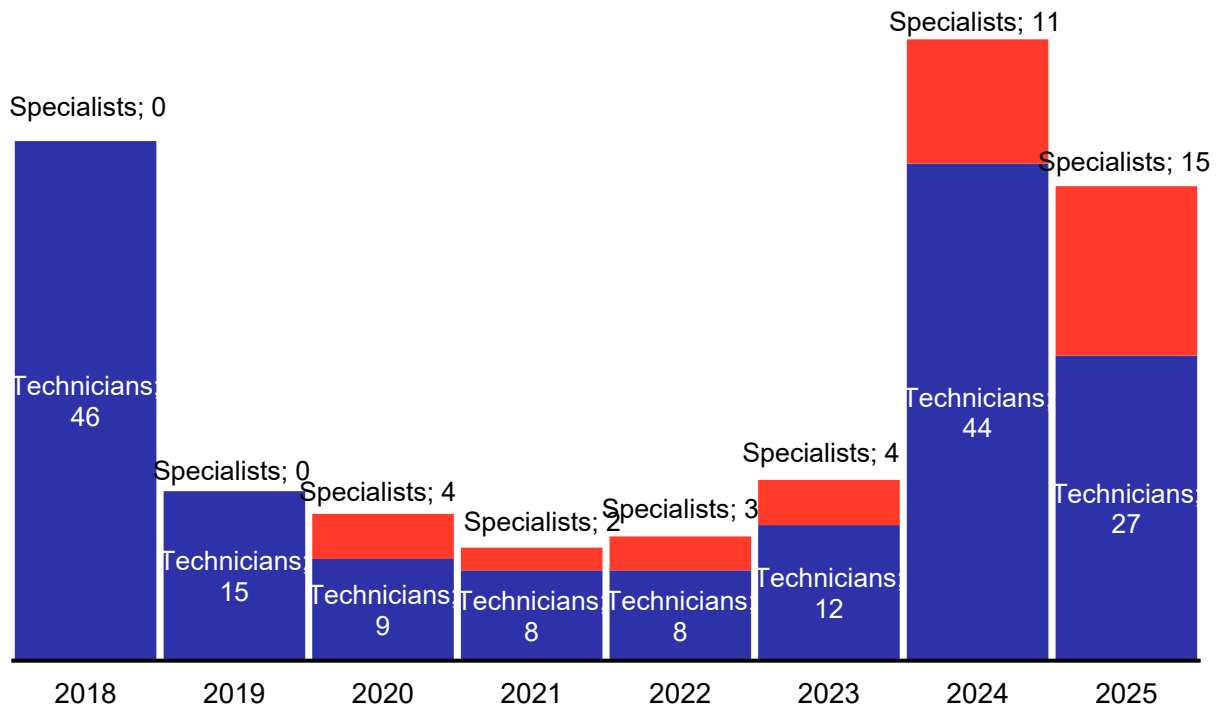
c. ROP Providers / 'Users' by Type (2018 – 2025)

N = 51 (2018), 75 (2019), 55 (2020), 72 (2021), 102 (2022), 98 (2023), 94 (2024), 163 (2025)



d. Platform Providers / 'Users' by Type (2018 – 2025)^{18, 19}

N = 46 (2018), 15 (2019), 15 (2020), 10 (2021), 11 (2022), 16 (2023), 55 (2024), 42 (2025)

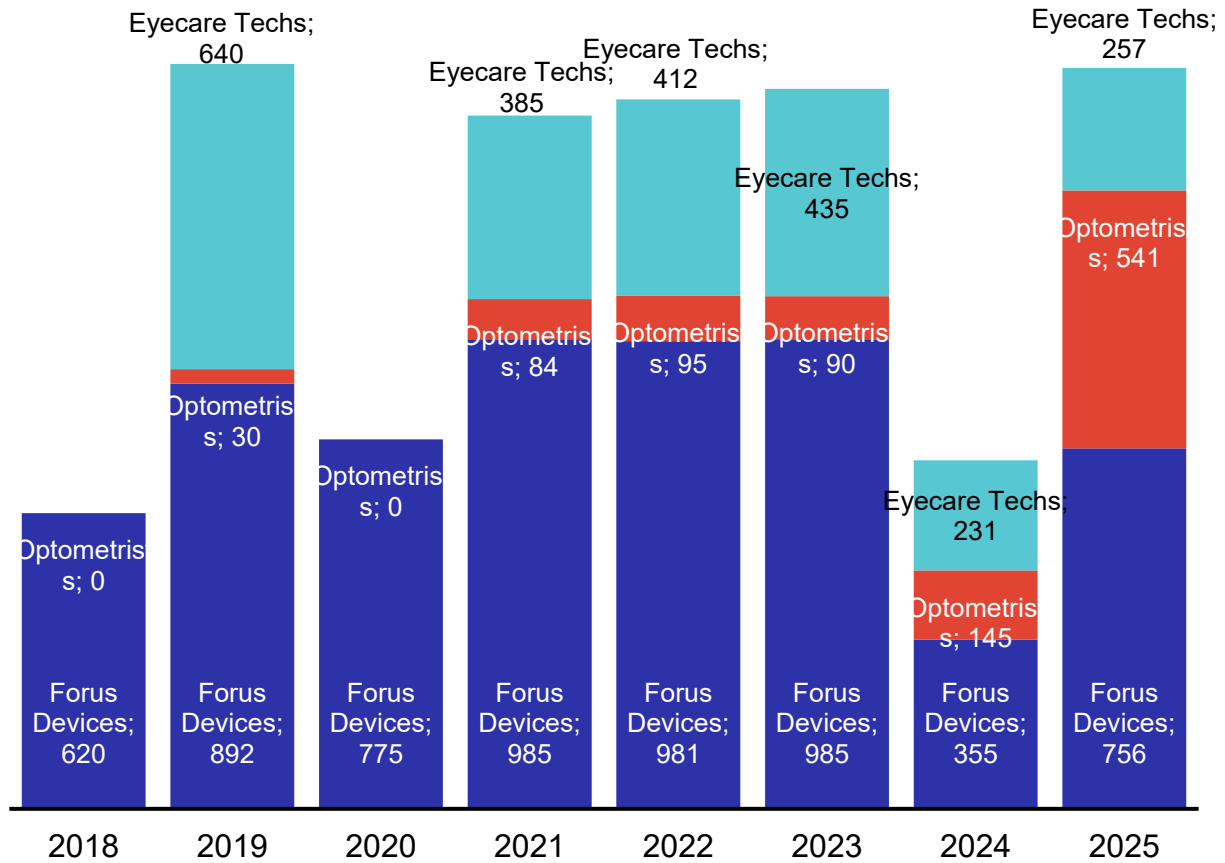


¹⁸ There is not a precise correlation between users and facilities across categories.

¹⁹ The increased ratio of specialists to non-specialists trained was the result of more customers requesting that the Company train its specialists, with the intent that those specialists would train the technicians and other staff.

2. Training by Type of Provider (2018 – 2025)²⁰

N = 620 (2018), 1,562 (2019), 775 (2020), 1,454 (2021), 1,488 (2022), 1,510 (2023), 731 (2024), 1,554 (2025)



²⁰ See note 19.

II. Vision Impairment and the Limits of India's Public Eye Care System

A. BACKGROUND

1. The Scale of Vision Impairment in India — Beyond Blindness

Vision loss is among the most studied, most preventable, and most persistently neglected public health challenges in the world. Globally, an estimated 2.2 billion people live with some form of vision impairment, of which roughly half involve conditions that are either preventable or yet to be addressed by surgery or spectacles.¹ Today, India carries the world's highest burden of uncorrected vision impairment, with an estimated 275 million affected individuals as of 2020. Despite meaningful reductions in blindness over the past two decades, the country continues to report rates of moderate-to-severe visual impairment nearly four times higher than those found in high-income countries. Concerted and expansive governmental efforts led to impressive reductions in blindness prevalence from 5.3% in 2001 to 1.99% in 2019 among adults over fifty, but a quieter, larger crisis is now affecting the country. A large subset of the Indian population experiences substantial vision impairment, with routine eye care structurally out of reach.

Once established, blindness demands intervention of a different order, including surgery, rehabilitation, and specialist care. Poor vision, by contrast, is largely correctable: a pair of glasses addresses most refractive error cases, and timely screening catches diabetic retinopathy and glaucoma before they become irreversible. As with many chronic illnesses,

¹ In the interest of more informal readability, literature references are provided at the end of this Report without sentence-by-sentence attribution. Should readers want specific references pertinent to information provided, they are encouraged to contact TEAMFund.

the problem is not clinical but rather one of access, geography, and a health system that has not yet focused on more routine vision challenges.

2. Who Bears the Burden

India's public health system serves the population least able to bear the costs of untreated vision loss. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the government's flagship health financing scheme, covers approximately 500 million of the country's lowest-income beneficiaries. This healthcare scheme is, by any measure, extraordinary. Yet the benefit package is structured primarily around inpatient and surgical care for acute conditions, rather than outpatient eye care services, which include routine refraction testing, diabetic retinopathy screening, and glaucoma monitoring, services not typically covered in primary clinical settings. For the AB-PMJAY patient managing early-stage diabetic retinopathy, the policy that nominally includes them in India's health system offers little support for the regular, low-cost monitoring that would prevent their condition from progressing to something far more serious and far more expensive for the government to treat.

Unlike the “missing middle” (those who want to receive care outside public hospitals but are too poor to afford high-quality private insurance) challenge highlighted in several spotlights this year, poor access to vision care is often driven by limited geographic distribution of eye care services. More than 70% of India's ophthalmologists and optometrists are concentrated in urban areas, leaving rural patients facing average travel distances of 30 to 50 kilometers to reach a qualified eye care provider. For a daily wage worker or an elderly patient in a rural district, that distance is a functional barrier to care.

Furthermore, India's healthcare funding model, which transfers funds from the federal government to state health departments, creates substantial state-to-state variability in the quality of vision care offered to patients, determined by each state's healthcare funding priorities. While some states (e.g., Telangana, Andhra Pradesh, Tamil Nadu) leverage their funds to conduct government-led eye screening programs, cataract surgeries,

and subsidized spectacles, most states view routine vision care as a low priority, creating access barriers that remain difficult to overcome.

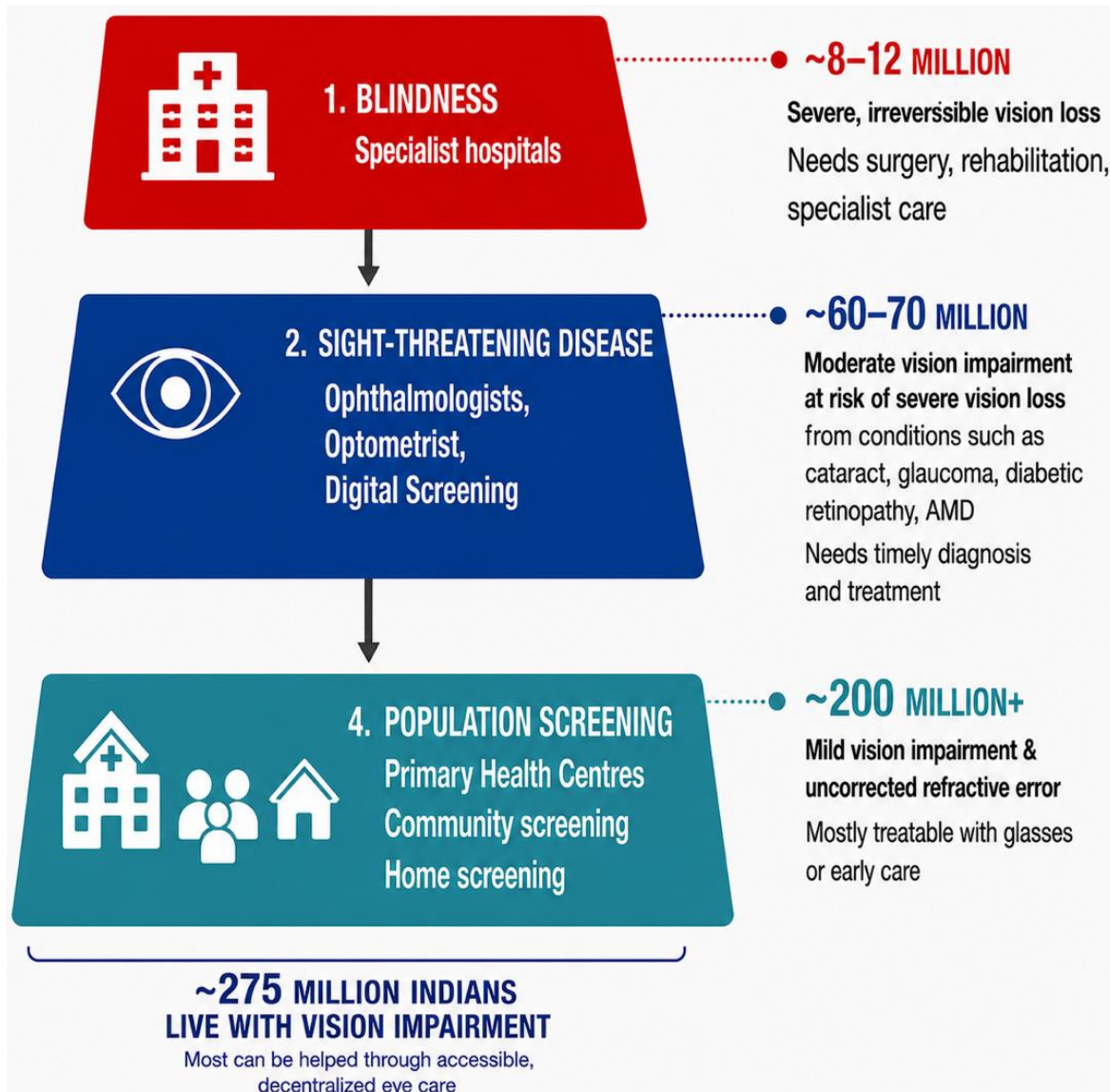


Figure 1 – India's vision care burden

Delayed vision screening means conditions that were correctable become complicated, driving not just patient burden but also substantial economic burden to the country. Recent estimates put the cost of uncorrected vision loss for India alone at approximately US\$38.4 billion in lost gross national income annually.

3. The Structural Gap in Public Eye Care Delivery

The absence of routine vision care in India's public health system reflects a set of structural realities that have made justifying the expansion of government eye care programs genuinely difficult. Poor access creates an incomplete picture of the epidemiological burden: government decision-makers may be asked to fund programs for conditions whose local prevalence is poorly understood, using devices whose operational viability in primary care has not been demonstrated at scale, for populations whose health-seeking behavior around vision care remains low. Without proof on the ground, procurement tenders stall; without procurement, proof cannot be generated. This is compounded by the near-total absence of eye care from India's primary health centers, which serve as the first point of contact into the health system for most of the population but rarely offer vision screening as a standard service. Instead, vision care is concentrated at district hospitals, which are more distant, more congested, and less accessible to rural patients who would benefit from opportunistic screening.

The result is a vision care network defined by geographically concentrated private-sector eye clinics alongside poorly funded, unintegrated public vision care programs. This combination has left India with the highest concentration of uncorrected vision impairment in the world.

B. TACKLING THE PROBLEM

India's vision care gap is not, at its core, a technology problem. AI-enabled digital technology capable of screening for refractive error, diabetic retinopathy, glaucoma, and retinopathy of prematurity exists, is affordable by global medtech standards, and has been validated in clinical settings across the country and beyond. The missing pieces are:

- **national policy support** for comprehensive, coordinated eye care systems powered by cost-effective, AI-enabled digital innovation.
- **state-level pilots** of these digital care systems that allow for the on-the-ground evidence needed to scale programs to statewide implementation.

Forus Health, through its complete range of vision care diagnostic and monitoring technology, telehealth platforms, AI functionality, and related services, is uniquely positioned to help India address the vision care challenges discussed in this report. As India's market leader in these areas of care, the company has spent the last decade engaging with Indian governments at both the national and state levels to help them build more comprehensive and coordinated vision care systems.

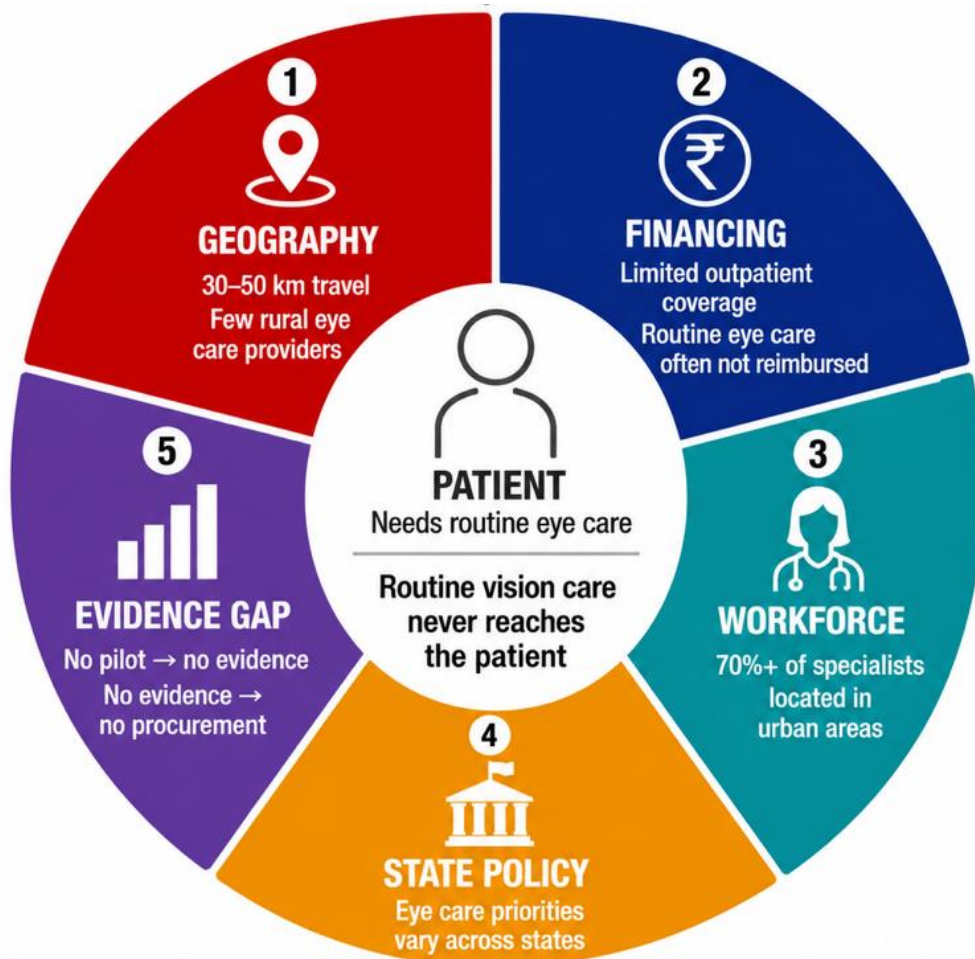


Figure 2 – Structural barriers that prevent routine vision care

1. A Deliberate Pivot Toward Government

Several years ago, Forus Health redeployed its experienced head of sales to lead a dedicated government business unit, built from the ground up. Government health tenders, though requiring patience, have the potential to be large in volume and durable in tenure. They tend to favor

performance leaders with the capacity to scale, including to the hardest-to-reach populations in India with little or no access to routine care.

Today, government tenders account for a considerable proportion of Forus Health's India revenue, a remarkable shift for the company. The “impact multiplier” benefits of this growing business are profound, representing meaningful strengthening of India's primary care capacity at the patient's first point of medical contact, as well as at referral hospitals when specialty care is needed.

Some insights from this business to date:

- **For harder-to-reach populations, proximity drives detection.** For these populations, vision concerns are more effectively identified through devices that are portable and brought close to the patient than when patients are required to travel to centralized, fixed-location instruments.
- **Technology specifications and performance matter in government settings.** Forus Health's wide range of refractive power coverage and handheld portability, and superior performance, make it a natural choice for government-run primary care settings, where space for a fixed instrument is often limited or unavailable.
- **Relatedly, community screening extends reach.** Patient-centered models of care bring screening devices closer to where they live and work. Forus Health's support at busy points of transportation throughput, school-based screening, and community screening at mass gatherings all present opportunities to engage patients at convenient locations.
- **Programs must prove themselves locally through outcomes.** Government pilots need to be shown to work in their specific settings, operationalized sustainably, and justified by measurable reductions in uncorrected vision impairment (and earlier detection of eye diseases) before states will commit to scale.
- **Scale often requires stakeholder collaboration.** Several years ago, ACT Health, a philanthropic organization with a track record of

funding health technology pilots in Indian states, funded a series of eye care pilots involving Forus Health, including Punjab.

- **Grants work best when they fund state implementation and integration, not just devices.** The collaboration with ACT funded not only the testing devices themselves but also a third party on-the-ground implementation partner, whose role was to support installation, train health workers, collect data, and maintain the operational continuity required to generate the evidence needed to evaluate the program as a system of care. Upon successful completion of the Punjab pilot, the evidence generated, together with Punjab's Ministry of Health, resulted in a statewide scale-up. In 2024, Forus Health won a follow-on statewide tender for 260 units, an expansion of over six times the pilot scale. Those devices were delivered in March 2025.
- **Success in one state opens doors elsewhere.** Forus Health's scaling success in Punjab opens the door to government programs across Maharashtra, Odisha, Rajasthan, Uttar Pradesh, and other states. ACT-collaborative pilots in Uttar Pradesh and Maharashtra are ongoing, with statewide scaling anticipated.

2. The Implementation Gap: Structural Barriers to Government Adoption of Innovative Health Technology

The Punjab story illustrates a replicable model that the broader global health funding community has been slow to adopt systematically. Across much of the world, philanthropic or donor-driven pilots are often conducted either as research or incorporated into a government-run or bilateral initiative, rather than being structured as multi-party (i.e., philanthropic donor-public-private) partnerships. But when deployed at pilot stages to prove technological and operational viability within a government system, philanthropic funding can compress the decision-making timeline for state procurement; reduce the uncertainty around large purchasing decisions; and generate the political and bureaucratic momentum that serves as a catalyst for sustainable health financing that strengthens primary healthcare. To do so, Indian states (and other LMICs) need to overcome

the structural barriers that prevent innovative new products from reaching patients:

- **Small and medium-sized technology companies face a structural disadvantage in government markets.** Emerging companies with strong technology and limited organizational bandwidth may face challenges implementing new government initiatives alone. These challenges may be overcome, however, with effective third-party on-the-ground service partners that can assist states with deployment, data collection, capacity building, demand creation, training, workflow refinement, and other key aspects of pilot or scale-up programs.
- **Patient-centric product design for government NCD screening, detection, and monitoring, must look for opportunities beyond clinical space.** Companies designing for the hospital and adapt downward consistently underperform relative to those that design for patient-centric care from the outset. Forus Health's competitive advantage reflects deliberate R&D investment in portability, durability, and operator task-shifting in primary care and community settings, alongside virtual care by experts.
- **Limited implementation partner engagement/collaborations.** Technology companies collaborating with grant-making organizations and governments to advance pilots must realize that without driving scale they are leaving the most impactful part of their investment unrealized. All aspects of pilot initiatives, including outcomes and metrics, should be undertaken with full scale-up as the ultimate objective.
- **Locally driven network partners** who understand the local bureaucratic landscape, are well suited to support innovative new pilot projects, including AI-enabled health initiatives, focused on strengthening primary healthcare.

If properly supported, the philanthropic-public-private-implementer model offers a strategic framework for accelerating government adoption and reliable, sustainable implementation of more routine vision care programs.

3. Strategic State Selection and Competitive Positioning

Unless and until national policy mandates country-wide government eye care programs, each Indian state will represent a new and different opportunity for government eye care expansion. Beyond disease prevalence, these factors can all help determine which states represent the strongest near-term opportunities:

- **Election timing shapes the runway for program development.** Newly elected governments with three to four years before their next electoral cycle, offer a longer and more stable runway for program development and expansion than a government in its final year, when large discretionary health commitments and pilot studies become less likely to secure funding.
- **The strength of private eye care infrastructure affects the public-sector demand.** In Tamil Nadu, a large, well-resourced private eye hospital network means, for that government, that significant portions of the population already have access to quality ophthalmic care outside the government system (regardless of burdens created by out-of-pocket expenditures). These parallel systems, in the state's view, reduce both the need for and impact of a public primary care model. Where private ophthalmology infrastructure is thin (e.g., Madhya Pradesh, Uttar Pradesh, and Orissa), public-private partnerships like those offered by Forus Health/philanthropic collaborations would expand the only care available to most residents.
- **Workforce training needs.** Technology is only one component of a new program; a state's workforce must also be trained to best leverage use of new technology and optimize limited specialist resources. Public-private-philanthropic partnerships pave the way for rapid program scale-up, as highlighted in Karnataka where 85 government ophthalmic officers were trained on the 3nethra aberro, and 111 received fundus training.
- **Established digital health infrastructure is a prerequisite for success.** New technologies, particularly those that leverage AI- and

telehealth-enabled care, depend on interoperable data systems, connectivity, and device integration. Without this broader underlying infrastructure, innovative digitally driven tools will remain siloed as stand-alone efforts, without capacity to bridge the last-mile gap in low-resource or rural settings.

- **State-level demands for integrated systems, and the advocacy potential that follows.** The WHO's Integrated People Centered Eye Care framework calls for a shift away from siloed, disease-specific device procurement toward integrated eye care embedded in primary health care. Karnataka's Asha Kirana program, which included Forus Health, generated sufficient evidence of impact to earn recognition as a model of this approach, prompting WHO to conduct an independent assessment for potential global replication. In cases like this, the state government becomes a key opinion leader advancing the case for replication across India and beyond, increasing the likelihood of success elsewhere.

Successful programs in Karnataka and Punjab give state governments concrete evidence of improved public health pathways and broader programmatic reach, reframing the narrative from private sector achievement to public system success, benefiting both parties while positioning early-adopter states as ahead of the curve. With continued support from implementing partners and advocates, Forus Health is well positioned to extend this progress, improving access through both fixed-point clinics and community-based settings, and continuing to develop new products that reach the hardest-to-serve populations.

4. Eye Care at the Doorstep of Those Who Need It Most

Most government tenders to date have focused on high-traffic locations, such as primary health centers and community clinics. But even successful facility-based models have structural limits, requiring the patient to move toward the device, a friction sufficient to interrupt the monitoring and care continuity that chronic disease management demands, especially for the elderly, the disabled, and the poorest of rural residents. Reaching the

hardest-to-reach populations will require innovative strategies that go further.

The patients who most need regular eye monitoring — those with diabetic retinopathy or glaucoma, and elderly individuals with presbyopia or early cataracts — are also the patients least likely to navigate a referral chain to a referral hospital. The consequence is the progressive accumulation of avoidable vision loss across millions of households, carried silently until it becomes severe enough to demand acute intervention.



Figure 3 - Strategic framework for improved vision care outcomes

The Forus Health Digital Eye Clinic (“EyePal”) is a proof-of-concept innovation designed to create opportunities for vision screening in the most patient-centric of settings: directly where people live. This innovation includes the following features:

- A portable, modular, suitcase-format unit that can be transported to the patient and tailored to the situation's needs.
- Three configurations: a refraction-only setup that addresses most cases of uncorrected refractive error; a comprehensive setup that adds fundus and anterior segment imaging; and a disease-

management setup which adds optical coherence tomography for retinal layer analysis.

- Connection to Forus Health's telehealth platform, allowing task-shifting to trained operators who can connect in real time with a remotely supervising optometrist or ophthalmologist.

A pilot is currently underway in Bengaluru, developed in collaboration with private eye hospitals seeking to extend their reach into residential communities and support patients who would not otherwise receive routine screening. The pilot is stress-testing the logistics of transport, patient comfort, and operator workflow across varied residential environments.

Beyond clinical sites, outreach opportunities could include:

- **More comprehensive outdoor and high-traffic community testing (e.g., bus terminals, taxi stands).** This approach has been used effectively in the past for visual acuity screening in hard-to-reach populations. With expanded testing capacities for eye disease, these settings represent important access opportunities alongside home- and facility-based deployment.
- **Home-based care.** Much of the necessary infrastructure for at-home testing already exists in India. Home-based diagnostic laboratory services are now routinely offered in Indian cities and increasingly available in peri-urban areas, demonstrating that home-based health service delivery is operationally viable at scale. Currently, no eye care equivalent exists, but the Bangalore pilot is testing that proposition before broader deployment.

As has been seen in the Punjab tender, successful pilots may drive additional government investment in these strategies. For the least mobile patient cohorts, in-home testing offers a distinct opportunity for impact beyond what community or facility-based sites alone can deliver, but will need to be piloted and validated to better understand its true potential for public health use.

C. LOOKING FORWARD

1. The Eye as a Window to Systemic Health: Oculomics and the NCD Opportunity

Thus far, Forus Health's product portfolio operates within the framework of eye care. But the retinal imaging platform at the center of that portfolio carries a capability that extends well beyond ophthalmology, and that may prove to be among the most significant contributions the company makes to India's public health system over the next decade.

The retinal vasculature is the only part of the human circulatory system directly visible without invasive procedures. Changes in vessel caliber, branching patterns, microaneurysm presence, and vascular tortuosity are measurable proxies for the atherosclerotic processes underlying the majority of cardiovascular disease burden globally. Advances in AI-powered image analysis can now identify patterns invisible to the human eye in standard fundus photographs, allowing for early detection of, and hospital referrals for, vascular abnormalities.

In 2024, Forus Health's R&D team published peer-reviewed validation of this capability in collaboration with Ramesh Cardiology Clinic in Bengaluru. The company's FH-POISE platform achieved 85% accuracy in cardiovascular atherosclerotic risk stratification across 519 subjects, with sensitivity of 85.29% and specificity of 86.36%. While the authors appropriately call for further validation across broader patient cohorts, the results provide early and promising evidence that a device, already deployed across thousands of clinical and community settings in India, can generate a cardiovascular risk signal from a fundus image taken during a routine eye examination.

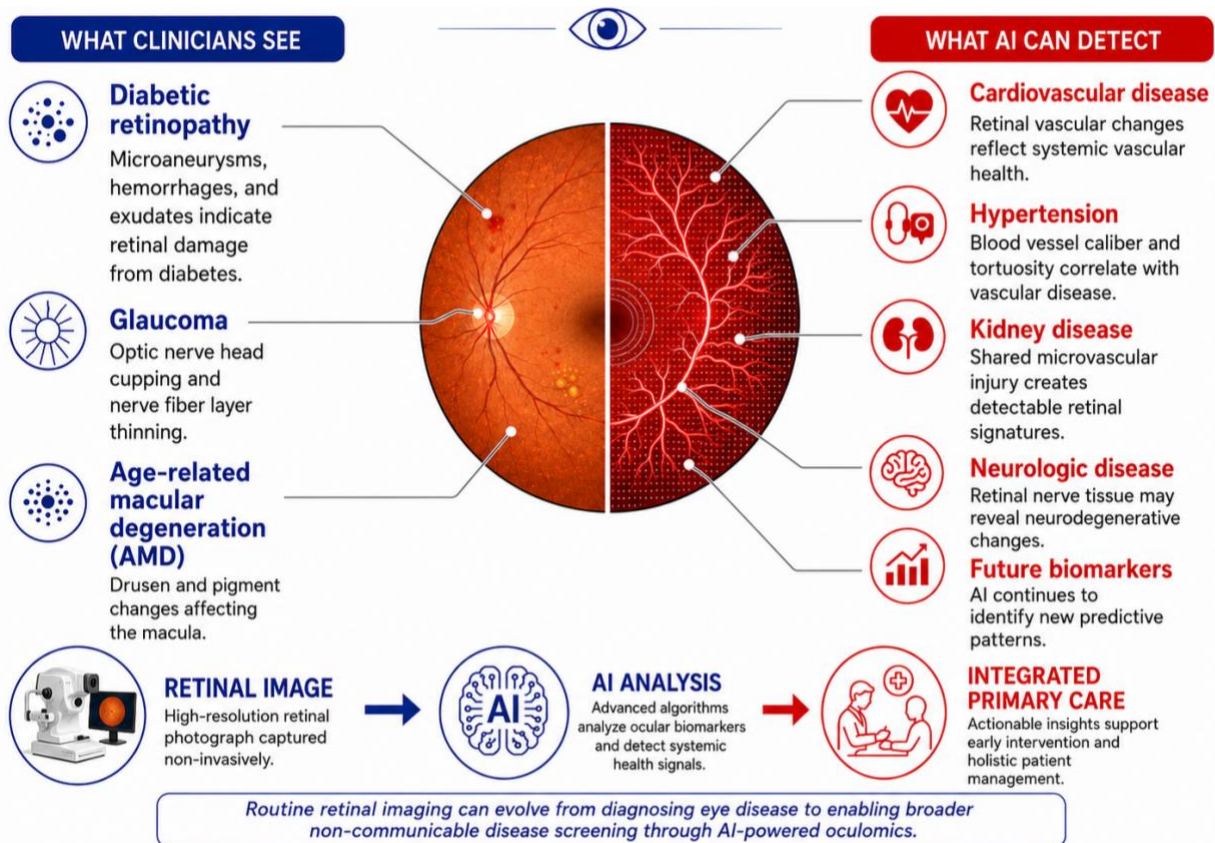


Figure 4 – Oculomics increases opportunities to identify health issues through routine screening

From a practical perspective, this means provider-initiated eye screening at primary care clinics could double as a cardiovascular risk stratification strategy, with a single trained operator screening for both conditions (with access to remote specialists) in a population in which both conditions are substantially underdiagnosed. This convergence also opens the door to a broader set of health financing partners than eye care alone can attract partners and funding sources, including cardiovascular program funding, NCD prevention initiatives, and AI diagnostics investments that would not otherwise intersect with an ophthalmology company's procurement pipeline.

2. Lessons for the Road Ahead

India's primary healthcare system is at an inflection point. The digital infrastructure is in place to address the growing burden of chronic diseases, and the political will to address it exists in many states.

Forus Health's public-sector journey offers lessons that extend beyond the company itself and speak to the broader question of how innovative medtech companies can become effective partners in government health systems across India and LMICs more broadly. Sustained investment in relationships, evidence generation, and implementation partnerships pays off, but only where the underlying system is ready to absorb it. What is needed is a scaled national strategy that leverages:

- private-sector partners;
- on-the-ground implementation models;
- collaborative, multi-party financing structures adapted to the local context to create integrated systems at scale; and
- Delivery of measurable improvements in vision and vision disease outcomes.

Forus Health, with its government sales track record, its grant-to-tender pipeline experience, its Digital Eye Clinic platform, and its published oculomics capability, is well positioned to be India's leading channel partner in vision health, and the opportunity for impact is substantial.

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