

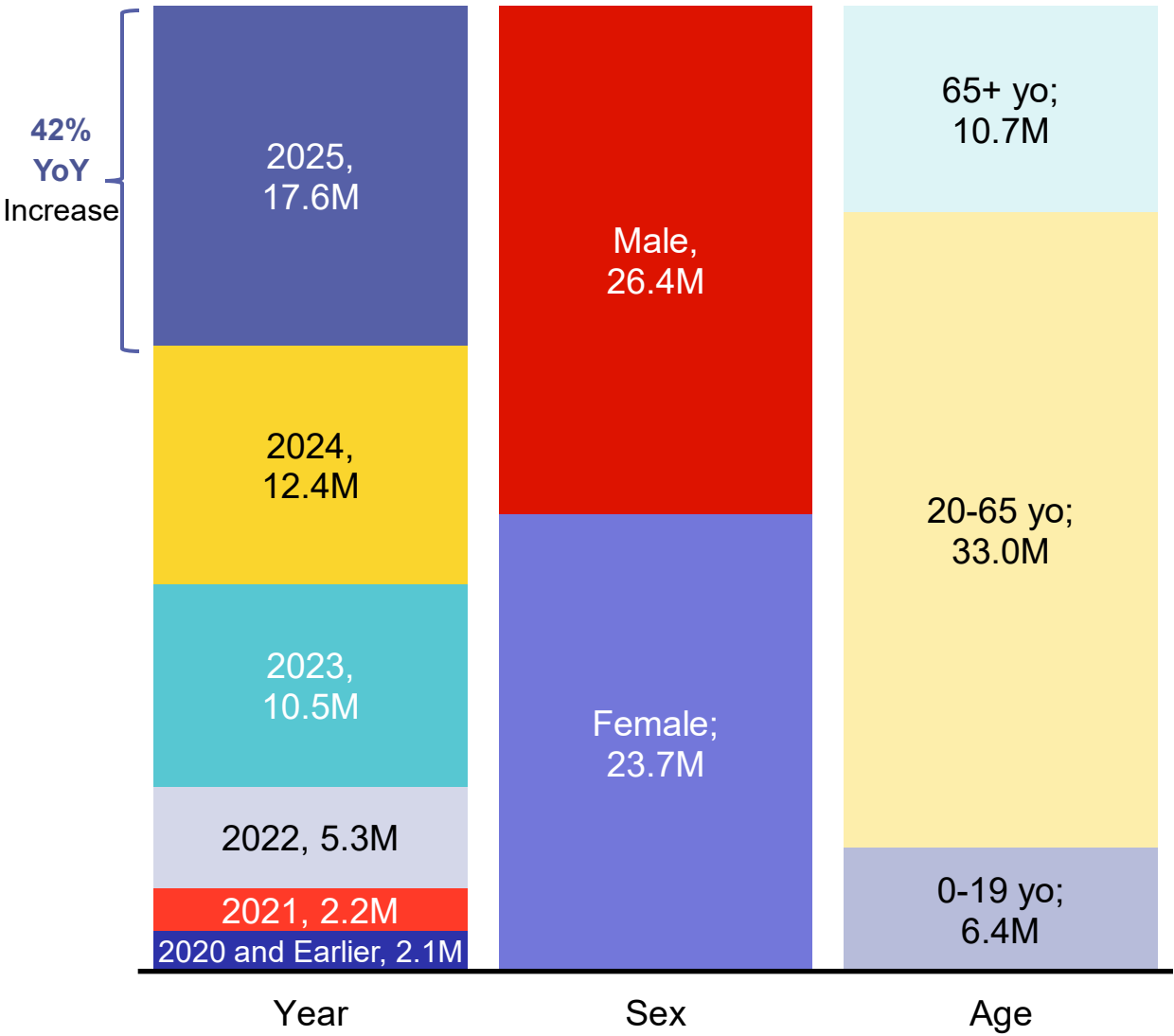


Creator of deep learning technology automating the interpretation of radiology exams like X-rays, CT scans, and ultrasounds, offering a chance to detect early signs of lung cancer and other diseases. Visit the [qure.ai website](https://qure.ai).

I. FY2025 Impact Metrics

1. Number of unique patients served (cumulative)¹

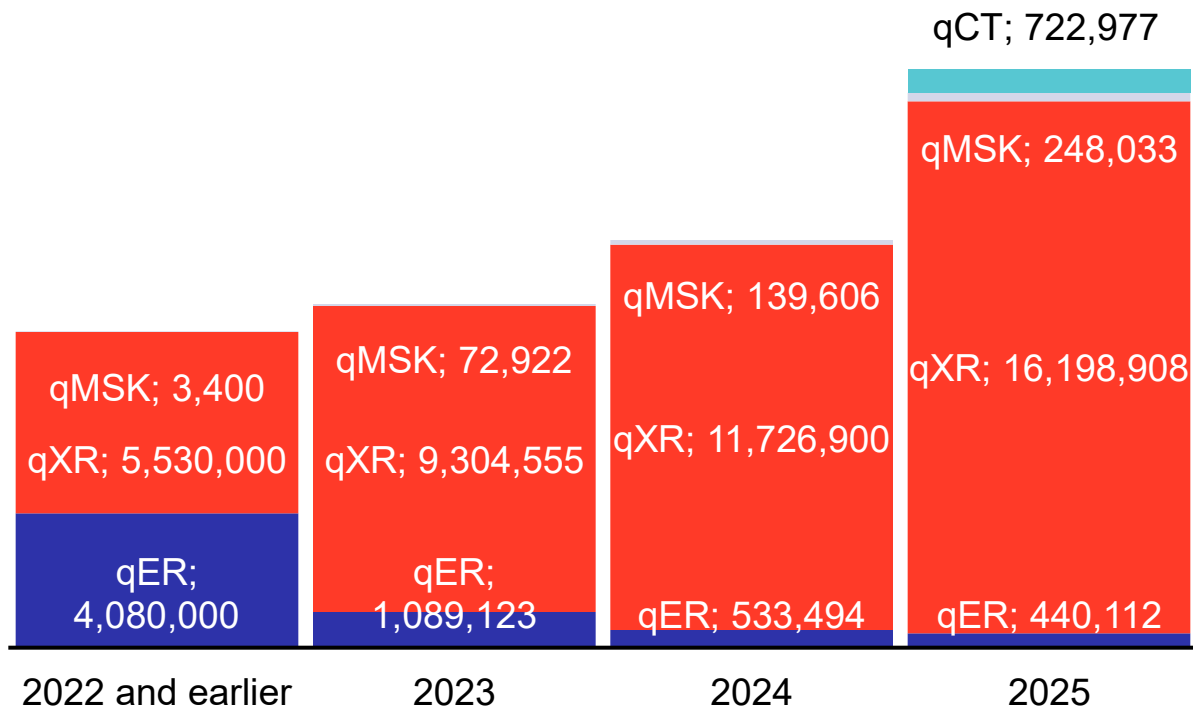
N = 17,610,030 (2025); 50,090,030 (cumulative)



¹ Patient distribution by sex is 53% male:47% female.

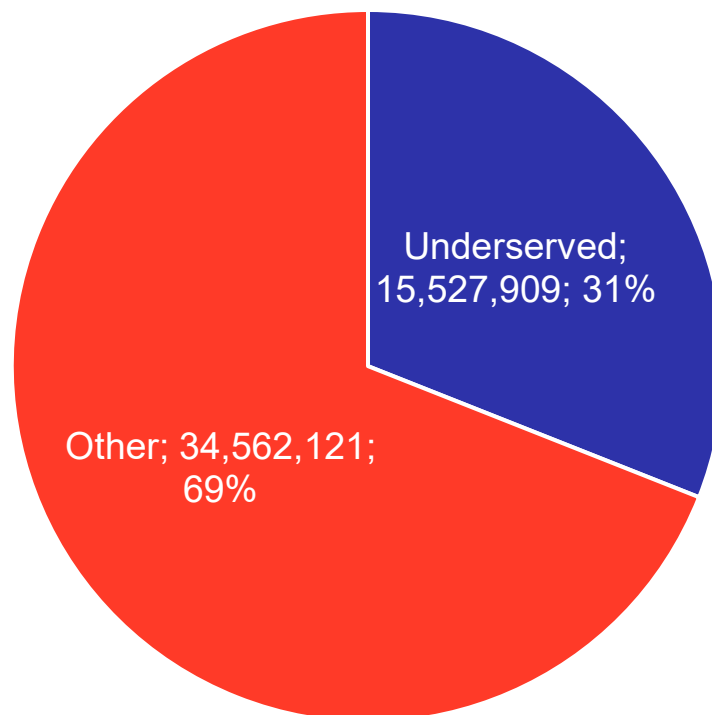
2. Patients Served by Product (Annual)

N = 17,610,030 (2025); 50,090,030 (cumulative)



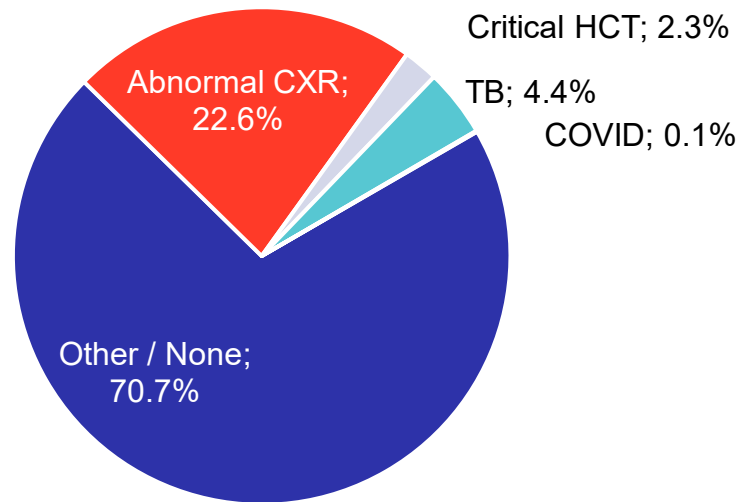
3. Total Patient Population by Underserved Status (Cumulative Estimate)

N = 5,159,909 (2025 underserved); 15,527,909 (2025 cumulative underserved)



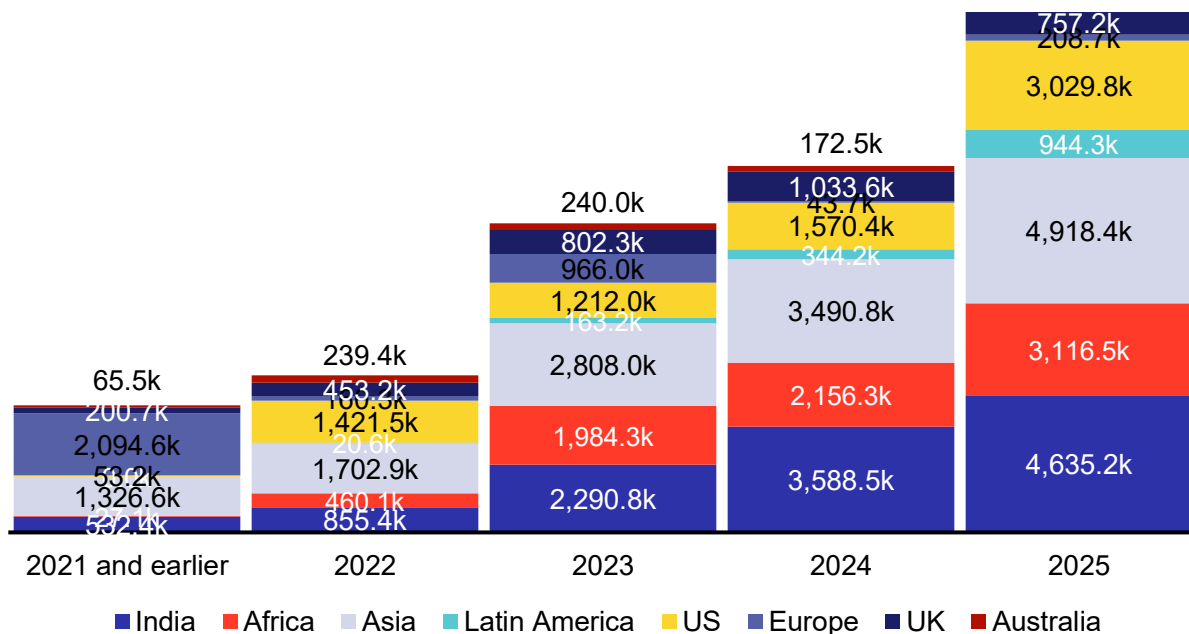
4. Total Patient Population Flagged by Disease Status (Cumulative)²

N = 50,010,030 (2025 cumulative)



5. Total Patients Served by Geography (Annual)

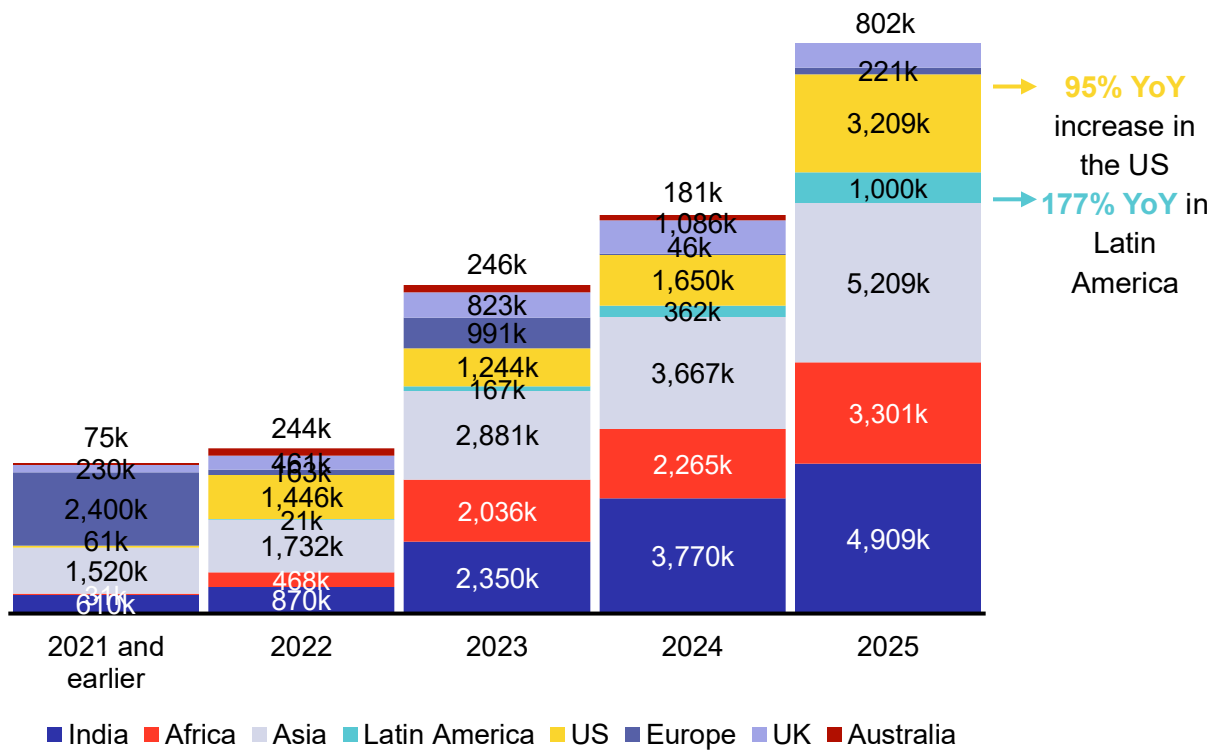
N = 17,610,030 (2025); 50,010,030 (cumulative)



² The Qure.ai platform flags abnormalities which are then reviewed by a clinician as part of the diagnosis process. Since a scan reviewed by Qure.ai may not show any abnormality (and would not be flagged) or return no abnormality or one outside the diseases Qure.ai focuses on, those not attributable to conditions broken out above are categorized as 'Other /None' for our report's purposes).

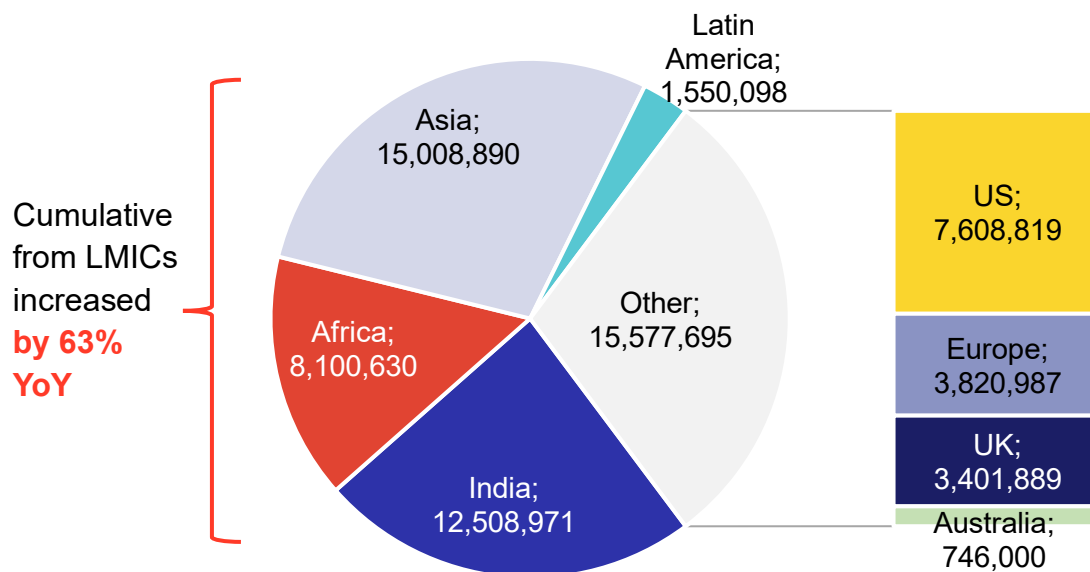
6. Total Scan Units by Geography (Annual)

N = 18,650,284 (2025); 52,746,284 (cumulative)



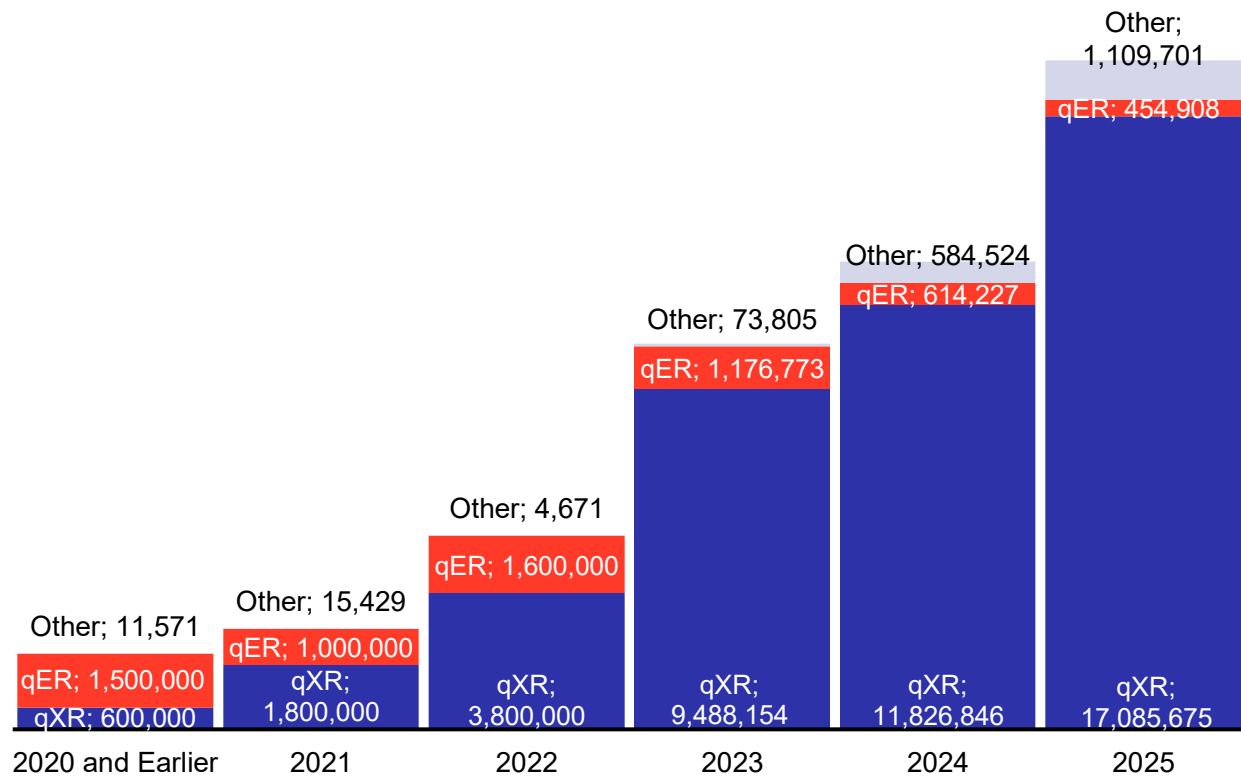
6. Total Scan Units by Geography (Cumulative)

N = 18,650,284 (2025); 52,746,284 (cumulative)



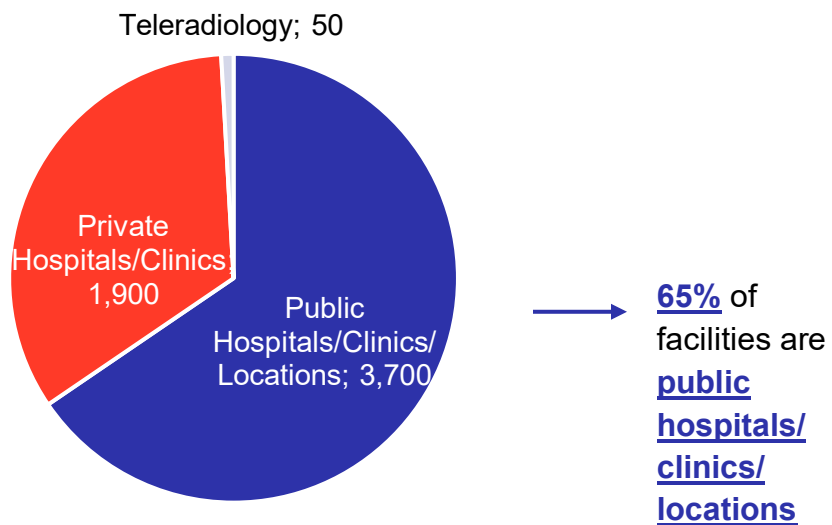
7. Total scan units by product

N = 18,650,284 (2025); 52,746,284 (cumulative)



8. Facility profiles by type³

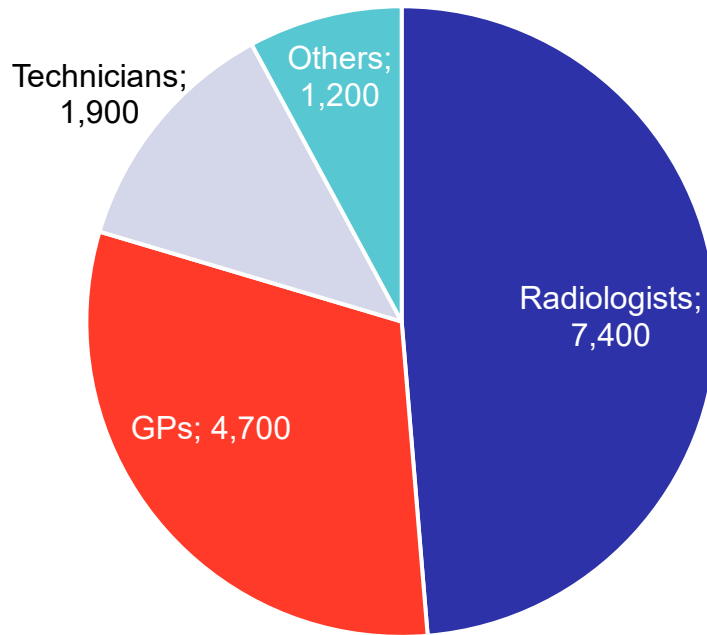
N = 5,650 (2025 cumulative)



³ A large percentage of the use cases for hospital / clinic providers (especially those in the public sector) involve scans conducted at the point of care or outside of hospitals.

9. Provider profiles by type^{4,5}

N = 15,200 (2025 cumulative)



⁴ 'Other' providers most frequently were 1) healthcare workers working under National TB Programs, 2) state and district-level program managers, and 3) Program managers and field staff from other organizations running TB Projects for on-ground implementation.

⁵ TEAMFund estimates providers trained each year based in the growth of the total provider users of Qure's platform. In FY'25, we estimated that 4,700 providers were trained using this method.

IMPACT SPOTLIGHT

Bridging the Frontline Gap in Underserved Markets: AI-Driven Early Detection and Management of Tuberculosis and Pneumonia in Children and Adults

A. Challenges/Background

1. The burden of tuberculosis and pneumonia in low- and middle-income countries (“LMICs”)

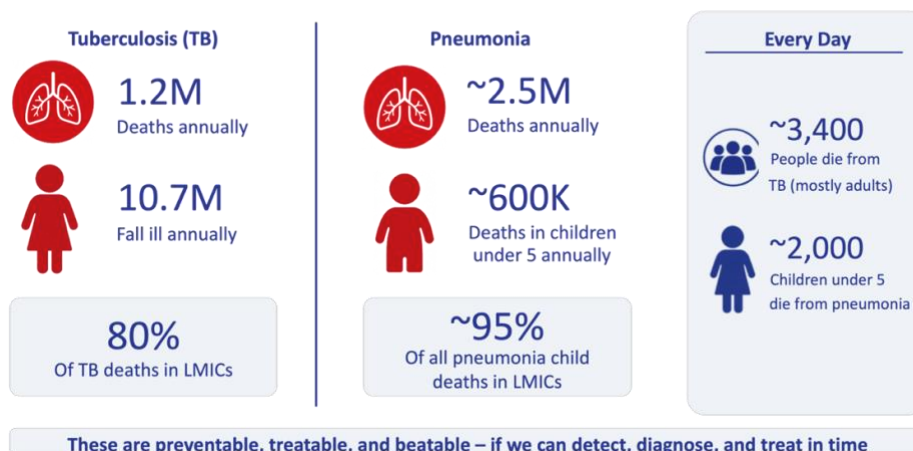
Globally, tuberculosis affects **10.7M** individuals annually, with approximately **1.2M** deaths each year¹. **India** alone accounts for **roughly a quarter** of this burden, making it the single largest contributor worldwide. In Sub-Saharan Africa (“SSA”), **TB** remains closely intertwined with **HIV**, compounding both diagnosis and treatment challenges. While some progress has been made -- particularly in Africa where TB deaths have declined -- the pace of improvement remains insufficient relative to global targets. **Every day** there are **approximately 3,400 people** who die from this disease. Children carry a substantial and under-reported share of this burden. Children aged 0–14 account for roughly 7–8% of notified TB cases globally, but only 58% of estimated cases in this age group are diagnosed and reported, falling to 50% among children under five.

Pneumonia, particularly in **children under five**, is another major contributor to preventable mortality. Each year, around **600,000** children under 5 years die from pneumonia globally², with some estimates placing the toll higher, at nearly **2,000** children dying every day³. The overwhelming majority of these deaths occur in LMICs, especially in South Asia and SSA. Most of these deaths are preventable with early diagnosis and appropriate treatment, including antibiotics and supportive care.

Despite being **largely preventable** and **treatable** when diagnosed early, both diseases continue to cause substantial mortality and morbidity in underserved settings where diagnostic infrastructure is limited. In children, the consequences also extend beyond the acute episode, with early respiratory illness linked to impaired lung health into adulthood. These are not only **clinical challenges, but also infrastructural ones**, deeply tied to access, health system design, and timely diagnosis.

The Burden of TB and Pneumonia in LMICs

Two leading infectious killers. Disproportionately affecting the poorest



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¹ World Health Organization. Global Tuberculosis Report 2025. Geneva: World Health Organization; 2025. <https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2025>.

² Institute for Health Metrics and Evaluation (2025). Global Burden of Disease Study 2023. <https://ghdx.healthdata.org/gbd-2023>.

³ UNICEF (2023). Pneumonia and Diarrhoea Progress Report. <https://data.unicef.org/resources/pneumonia-and-diarrhoea-progress-report/>.

⁴ Institute for Health Metrics and Evaluation (2025). Global Burden of Disease Study 2023. <https://ghdx.healthdata.org/gbd-2023>.

Emerging approaches, especially **AI-enabled imaging** using **point-of-care ultrasound (“POCUS”)** and **X-ray**, offer the potential to transform this paradigm. By enabling earlier, more accurate detection at the frontline -- without creating additional demand for specialist interpretation -- these technologies may compress time to diagnosis from weeks to days, improve diagnostic precision, and ultimately reduce preventable mortality by bringing specialist-grade diagnoses closer to the patient and within reach of the most underserved populations.

2. The central gap: delayed and missed diagnosis

The burden of TB and pneumonia in LMICs is as much about delayed and missed diagnosis as it is about disease prevalence. Two distinct failures occur. Under-diagnosis arises upstream, where patients never enter a diagnostic pathway at all. Misclassification arises downstream, at the clinical encounter, where overlapping non-specific symptoms such as cough, fever, weight loss, and respiratory distress, combined with absence of imaging, lead to incorrect attribution, which can delay appropriate treatment and worsen clinical outcomes.

In **SSA**, access along with infrastructure are the main structural barriers. Health systems face workforce shortages, particularly a scarcity of trained radiologists and radiographers; rural populations travel long distances to reach care; and many facilities lack basic imaging capability.⁵ A mother arriving at a rural clinic with a sick four-year-old after several days of fever and labored breathing will see the child treated empirically for pneumonia, or in some settings for malaria, a decision consistent with WHO and national pediatric guidelines. The gap is not the clinical judgment exercised but the absence of tools to identify children who require further TB examination. Onward referral is constrained by transport costs, distance, and poor roads, and because pneumonia and TB in young children can deteriorate more rapidly, much of the risk lies in delayed arrival at any facility able to manage the child.

In **India**, infrastructure is more developed, but the system is highly fragmented across public and private providers, with unclear referral pathways and variable diagnostic quality. An individual with a persistent cough and weight loss may be treated symptomatically by one private practitioner, then by another when that patient’s condition persists, with delays extending for weeks or months in the case of TB.⁶ These delays accumulate at the community level, across multiple informal or private providers rather than a single public facility, which is why cost-effective frontline alternatives, closer to the community, matter.

Both diseases depend on early diagnosis, for different reasons. For TB, early detection halts chronic progression and interrupts transmission. For pneumonia, it prevents acute mortality that can occur within days.⁷ These gaps fall hardest on populations living at the intersection of geographic isolation, poverty, and fragile health systems: rural and tribal communities, migrant laborers, urban slum dwellers, remote and conflict-affected regions, children under five affected by malnutrition, and people living with HIV. Women and girls, the elderly, and those with disabilities face additional barriers arising from social norms, caregiving responsibilities, and limited autonomy in seeking care. For the poorest, TB often progresses undetected until advanced stages, reinforcing intergenerational cycles of morbidity, transmission, and poverty. Equity-focused diagnostic strategies are therefore essential.

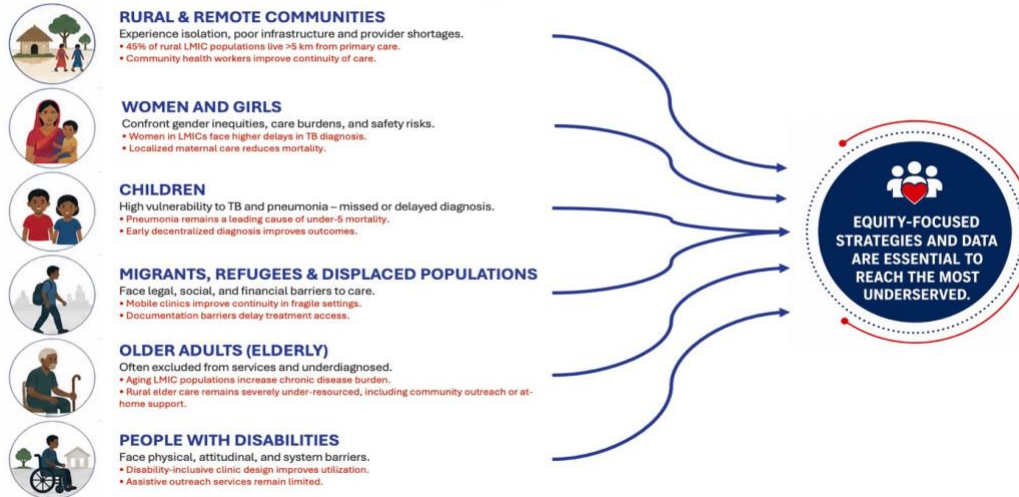
⁵ Oleribe OO, Momoh J, Uzochukwu BS, et al. (2019). Identifying key challenges facing healthcare systems in Africa and potential solutions. PubMed Central, 12, 395–403.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC6844097/>.

⁶ Das J, Hammer J. (2014). Quality of primary care in low-income countries: facts and economics. Annual Review of Economics, 6, 525–553. <https://doi.org/10.1146/annurev-economics-080213-041350>.

⁷ Zar HJ, Ferkol TW. The global burden of respiratory disease-impact on child health. *Pediatr Pulmonol*. 2014 May;49(5):430-4. doi: 10.1002/ppul.23030. Epub 2014 Mar 9. PMID: 24610581.

Reaching Underserved Populations in LMICs



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LMIC health authorities, in increasing numbers, have begun to assert that the next generation of AI-enabled global health tools be designed for **local ownership**, not passive adoption, with the capacity to **adapt, refine, and continuously improve AI systems using their own data** -- ensuring that AI tools reflect local epidemiology, languages, and workflow needs. What has been missing is an **LMIC-centric, open-access dataset**, sufficient to build and train **AI-enabled TB and pneumonia diagnostic innovations for local needs**. AI innovations built from this data source would allow for local adaptability and control built into the AI architecture.

B. Tackling the Problem: Building AI Tools for Early Detection of TB and Pneumonia, with Broader Data Support for Equitable AI

1. Introduction

TB and pneumonia continue to claim millions of lives across LMICs, not because these diseases are untreatable, but because diagnosis often comes too late. Specialist radiologists are scarce, advanced imaging is centralized in urban hospitals, and overburdened community healthcare workers are frequently forced to make decisions with limited tools and information. Qure.ai has been taking AI-enabled imaging from urban centers to remote corners of SSA, Southeast Asia, and beyond, helping reduce diagnostic delays that can often run into weeks.¹⁰

More recently, Qure.ai has received a grant from **the Gates Foundation** and other on-the-ground partners, to advance access and help close longstanding health equity gaps.¹¹ Through the **BREATHE initiative** -- “Building Respiratory Evidence for AI Tools and Health Equity” -- Qure.ai is helping to create the global data infrastructure and AI tools necessary to move TB and pneumonia diagnoses closer to the

⁸ Kruk ME, Gage AD, Arsenault C, et al. (2018). High-quality health systems in the Sustainable Development Goals era. *The Lancet Global Health*, 6(11), e1196–e1252. [https://doi.org/10.1016/S2214-109X\(18\)30386-3](https://doi.org/10.1016/S2214-109X(18)30386-3)

⁹ UNICEF (2023). Pneumonia and Diarrhoea Progress Report. <https://data.unicef.org/resources/pneumonia-and-diarrhoea-progress-report/>.

¹⁰ Qin ZZ, et al. (2021). Using artificial intelligence to read chest radiographs for tuberculosis detection: A multi-site evaluation. *Lancet Digital Health*. [https://doi.org/10.1016/S2589-7500\(20\)30277-8](https://doi.org/10.1016/S2589-7500(20)30277-8)

¹¹ Qure.ai. Qure.ai Secures Major Global Health Grant to Build AI-powered Point-of-Care Ultrasound Solutions. <https://www.quire.ai/news-press-coverages/quireai-secures-major-global-health-grant-to-build-ai-powered-point-of-care-ultrasound>.

community, earlier in the care pathway, and into the hands of frontline health workers in primary health care facilities.

There are two essential components to this ambitious effort, funded and supported via an ~\$8M grant from the foundation:

- As the first part of the partnership, Qure.ai, along with its on-the-ground network of partners, is working to create the **largest open access, multi-modal database** of medical images, signals, markers, and clinical metadata, for the ultimate purpose of supporting earlier detection of TB and pneumonia on the frontline of LMIC healthcare. Collected from LMIC real-world experiences, this database is intended for use by **researchers and innovators globally**, interested in creating **equitable, affordable, and scalable AI solutions** for earlier TB and pneumonia diagnosis, especially needed in LMICs.
- Based on that dataset, Qure.ai intends to build out **prototype AI algorithms** for **point-of-care ultrasound (“POCUS”)** to be deployed by **frontline health workers** in LMICs, for screening and triage of TB and pneumonia. AI-enabled POCUS will allow use in low-resource primary care, closer to the patient, where traditional imaging and specialist expertise are unavailable.

2. Creating the world’s largest open-access, multi-modal TB and pneumonia database

As noted, the first component of the initiative is the creation of what will become the world’s largest open-access, multi-modal database focused on detection of TB and pneumonia. The project will **prospectively collect** data across **three countries — Nigeria, South Africa, and India**. This prospective collection effort combines chest X-rays, thoracic ultrasound, CT imaging, lung and cough recordings, a variety of laboratory and biological markers, and clinical metadata, into a **unified, anonymized patient dataset**. Newer forms of data will also be added to the database, including, for example, digital stethoscope recordings of lung auscultation and cough sound recordings.

Importantly, Qure.ai and its collaborators are not developing a proprietary/commercial database. The initiative is structured as an **open-access global resource** intended to support researchers, government health systems, academic institutions, AI innovators, and other global health stakeholders, interested in developing **equitable, accessible and scalable** AI-enabled tools to advance triage and screening of TB and pneumonia, especially in LMICs.

The **prospective data collection protocol** calls for each anonymized patient record to have a unique identifier and to include the patient’s medical information, clinically annotated imaging, diagnostic results, as well as other supportive data that has been collected, including cough sounds and digital auscultation. The collective data will serve as the basis upon which AI tools are trained and validated against real-world TB/pneumonia patterns in high-burden environments.

Additional retrospective data is anticipated from entities that agree to open-access use, consisting of thoracic ultrasound imaging of adult and pediatric patients with pneumonia, TB, and controls. The data gathered will be used to further reinforce the AI algorithm prototypes that are being developed through the BREATHE study and capture **a broader range of real-world POCUS operating conditions**.

The resulting prototype AI algorithms, if developed, will be **independently validated** to confirm that the AI performance in aggregate has sufficient sensitivity and specificity needed to ensure its appropriate use as a screening and triage tool for pneumonia and TB. Once the targeted aggregate data has been

collected, the **unified data repository** will be transferred to a centralized data hosting platform to enable access to the dataset.

3. Ensuring Representative Data Collection Across LMIC Settings

Data collection will be conducted in three countries, each with multiple clinical sites representative of their TB and/or pneumonia populations. By intentionally situating data generation and clinical validation within Nigerian, South African, and Indian institutions and patient populations, the initiative reflects a broader effort to ensure that LMICs most affected by TB and pneumonia are active participants in building, validating, and adapting AI tools that come from this unique open-access dataset.

Data collection is designed to reflect the realities of low-resource healthcare systems including internet bandwidth limitations, imaging variability, inconsistent infrastructure, and differing levels of operator expertise. To address these realities and reduce variability, the program is incorporating real-time image review workflows, standardizing training protocols, and supplementing the prospective dataset with retrospective datasets drawn from multiple ultrasound research studies. The goal of the dataset is to enable development of AI systems that are robust enough to function across diverse devices, operators, and healthcare environments.

C. Conclusion and Looking Forward

The significance of the BREATHE initiative extends beyond the dataset and diagnostic tools it will support. Historically, many global health technologies have been delivered into LMICs as externally controlled products, often leaving countries dependent on outside sources for updates, customization, and long-term capability. An open-access, multi-modal resource built from prospective, field-generated, clinically annotated data creates an **ecosystem-level capability** instead: researchers, governments, innovators, academic institutions, and other global health stakeholders, will be able to develop, validate, and improve AI tools using data derived directly from high-burden populations. The initiative represents an important new chapter in global health -- one that **moves beyond centralized innovation toward “distributed innovation”** -- allowing countries to participate in shaping the future of their own healthcare systems.

The initiative also moves diagnosis closer to the patient, closer to the community, and earlier in the TB and pneumonia pathway, precisely in the settings where delay means worsening disease, preventable mortality, and continued transmission. This is especially meaningful for children under five, for whom pneumonia remains a leading cause of death and TB remains especially challenging to diagnose. The **broader vision** is both **technological** and **structural**: creating **affordable, scalable**, AI-enabled TB/pneumonia health ecosystems that can function in the world’s most underserved environments -- while ensuring that countries can adapt the technology to their own populations and then govern and continue to build upon those systems.

We will continue to watch with great interest and pride as Qure.ai brings these first-of-a-kind initiatives to impact. We also want to thank our own formidable Leith Greenslade, for her role as Advisor to Qure.ai’s efforts. She has served our Board with distinction since TEAMFund’s inception and is one of the most important thought leaders in global health today.