

The Structural Evolution of Point-of-Care Diagnostic Adoption in Lagos Private Hospitals:

A Professional Observational Perspective

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ABSTRACT

The adoption of Point-of-Care Testing (POCT) in Lagos private hospitals reflects a structural shift from centralized to decentralized diagnostics. Drawing on professional observation in the Lagos private healthcare ecosystem (2022–2024), this paper examines how economic instability, infrastructural fragility, and organizational behavior have shaped the trajectory of POCT deployment. The analysis highlights that while POCT devices can improve clinical decision-making and patient outcomes, their sustainable integration hinges on Health Technology Management (HTM), institutional leadership, and policy-driven financing models. The paper concludes with recommendations for stabilizing the diagnostic ecosystem through currency-anchored procurement, frugal device design, and strengthened public–private collaboration.

TABLE OF CONTENTS

1. Introduction.....	4
2. The Diagnostic Landscape in Sub-Saharan Africa and Nigeria.....	5
3. The Evolution from ASSURED to REASSURED Criteria.....	6
4. The Role of the Private Sector in Lagos.....	8
5. Systemic Barriers to POCT Adoption in Lagos Private Hospitals.....	9
5.1 Economic Constraints and the Currency Crisis.....	9
5.2 Infrastructural Deficiencies and Connectivity Gaps.....	11
5.3 Workflow Disruptions and Human Factors.....	12
5.4 Trust and Quality Assurance.....	13
6. Enablers of Point-of-Care Diagnostic Adoption.....	14
6.1 The Role of Clinical Champions and Institutional Leadership.....	14
6.2 Training, Digital Literacy, and Capacity Building.....	16
6.3 State-Level Policies and Universal Health Coverage.....	17
7. MedTech Deployment Strategies in the Nigerian Context.....	18
8. Professional Insights on Clinical Pathways and Patient Outcomes.....	20
9. Future Outlook: Lagos as a MedTech Hub.....	22
10. Conclusions and Recommendations.....	23
References.....	25

1. Introduction

The landscape of clinical diagnostics in sub-Saharan Africa (sSA) is undergoing a paradigm shift, transitioning from a reliance on centralized, often inaccessible laboratory facilities to decentralized, patient-centric models. In Nigeria, and specifically within the dense metropolitan environment of Lagos, the private healthcare sector has emerged as the primary vehicle for this transformation. Point-of-care testing (POCT), defined as diagnostic procedures conducted near or at the site of patient care, represents a vital technological intervention for a region where infectious diseases remain the leading cause of mortality. The deployment of these tools in Lagos is not merely an incremental upgrade but a structural necessity driven by the dual burden of communicable diseases like malaria and HIV, and the rising prevalence of non-communicable diseases (NCDs) such as diabetes and cardiovascular conditions.

The utility of POCT in resource-limited settings is framed by the ability to provide rapid, affordable, and accurate results that facilitate immediate clinical action, thereby reducing the traditional delays associated with sample transportation and laboratory turnaround times. However, the professional observer notes that the adoption of these technologies within the Lagos private hospital ecosystem is influenced by a complex interplay of macroeconomic volatility, infrastructural fragility, and organizational behavior. While the clinical benefits of POCT are well-documented, the sustainable integration of such systems requires navigating a landscape where the cost of consumables is tied to a fluctuating exchange rate, and the reliability of digital tools is challenged by persistent power and connectivity gaps.

2. The Diagnostic Landscape in Sub-Saharan Africa and Nigeria

The diagnostic gap in sub-Saharan Africa remains one of the most significant barriers to achieving universal health coverage. Historically, healthcare systems in the region have been characterized by a centralized laboratory model, which, while capable of high-complexity testing, is often localized in urban tertiary centers. This leaves rural and peri-urban populations underserved, as the logistical challenges of sample transport and result retrieval often render the diagnostic process ineffective. In Nigeria, the decentralization of healthcare governance has created a fragmented system where primary healthcare (PHC) is largely the responsibility of the public sector, while the private sector accounts for approximately 70% of the population's first point of call for medical services.

3. The Evolution from ASSURED to REASSURED Criteria

The benchmarks for ideal diagnostic tests in resource-limited settings have evolved to keep pace with technological advancements, particularly in the digital sphere. The original WHO/TDR ASSURED criteria (Affordable, Sensitive, Specific, User-friendly, Rapid, Equipment-free, and Delivered) provided a foundational framework for developing tests that could function without sophisticated laboratory infrastructure. However, as the global health community recognized the need for better data surveillance and real-time clinical monitoring, these criteria were expanded to the REASSURED framework.

Criterion	Technical Requirement	Strategic Value in Lagos Hospitals
Real-time Connectivity	Integration with mHealth and cloud systems.	Facilitates state-level disease surveillance and EHR synchronization.
Ease of Sample Collection	Minimally invasive (e.g., finger prick or saliva).	Reduces the requirement for specialized phlebotomy staff in overburdened clinics.
Affordable	Minimal out-of-pocket cost for the patient.	Essential given that 73% of Nigerians live on less than \$2.00 per day.
Sensitive	High probability of detecting the target pathogen.	Minimizes the risk of missed diagnoses in high-burden environments.
Specific	High probability of a true negative result.	Prevents unnecessary treatment and antibiotic resistance development.
User-friendly	Operation by non-laboratory personnel.	Allows nurses and midwives to conduct tests during routine consultations.
Rapid and Robust	Results within minutes; stable at ambient temperatures.	Vital for emergency triage and high-volume outpatient management.
Equipment-free	Minimal hardware and no dependency on stable electricity.	Bypasses the 30–50% equipment failure rate observed in sSA.
Delivered	Availability at the primary care level.	Bridges the gap between screening and immediate treatment linkage.

The professional observer must acknowledge that while many modern POCT devices aspire to meet these criteria, the reality in Lagos private hospitals is often a compromise. For instance, real-time connectivity is frequently hampered by the fact that internet penetration in Nigeria is only approximately 40%, and power supply remains unreliable, with only about 60% of the population having grid access. This necessitates the adoption of hybrid strategies, such as offline-capable devices that can synchronize data when a connection is restored.

4. The Role of the Private Sector in Lagos

Lagos represents a unique microcosm of the Nigerian healthcare market. With a rapidly urbanizing population and a burgeoning middle class, the state has seen a proliferation of private hospitals, clinics, and pharmacies. These facilities are regulated by the Health Facilities Monitoring and Accreditation Agency (HEFAMAA), which mandates that all health facilities register annually to ensure quality and compliance. In a megacity where public facilities are often overburdened and perceived to have poor service quality, the private sector caters to over 60% of the residents.

The private sector's contribution is not limited to high-end hospitals. Private Proprietary and Patent Medicine Vendors (PPMVVs) and community pharmacies play a critical role, especially for the rural and urban poor. These outlets often serve as the first point of healthcare contact, although they frequently lack the skills and tools for formal diagnosis. The introduction of POCT into these environments, such as the deployment of malaria rapid diagnostic tests (mRDTs) and blood glucose monitors, has the potential to standardize care at the community level. Studies in Enugu State have shown high practice scores for blood pressure and glucose screening in pharmacies, although the adoption of HIV and malaria testing remains lower, highlighting a gap in the range of services provided at the point of sale.

5. Systemic Barriers to POCT Adoption in Lagos Private Hospitals

The adoption of POCT in Lagos is not a linear process of procurement and deployment; it is a negotiation between clinical necessity and structural constraints. Professional observation identifies several core categories of barriers that impede the sustainable use of these technologies.

5.1 Economic Constraints and the Currency Crisis

The most significant barrier identified in the 2022–2024 period is the volatility of the Nigerian economy. Nigeria's reliance on imported medical devices means that the cost of POCT is inextricably linked to the exchange rate of the Naira. Between mid-2023 and early 2024, the Naira underwent a dramatic devaluation, dropping from ₦450 to over ₦1,600 per US Dollar. This triggered a cost-push inflation within the healthcare sector, where the price of diagnostic cartridges, reagents, and even basic consumables skyrocketed.

Economic Variable (2023–2024)	Statistic / Value	Clinical / Operational Implication
Naira Depreciation	40.9% in 2024 (Official Rate)	Direct increase in the landing cost of POCT consumables.
Annual Inflation Rate	34.8% (December 2024)	Erosion of patient purchasing power for elective diagnostics.
Health Sector OpEx Rise	67% increase (H1 2023 vs H1 2024)	Hospitals forced to increase fees or ration diagnostic services.
Finance Costs Surge	1,345% increase for major firms	Severely limited capital for investing in new technology infrastructure.

This economic climate creates a "cycle of avoidance." As private hospitals are profit-oriented, they must pass these increased costs to patients. For the 73% of Nigerians living on less than \$2.00 a day, the cost of a diagnostic test—ranging from \$2.30 to \$8.00 even in the public sector—becomes a financial deterrent. Consequently, patients often delay seeking diagnosis until their condition is advanced, leading to higher morbidity and mortality.

The theoretical cost-benefit analysis of POCT often fails to account for a behavioural phenomenon encountered repeatedly across deployment sites: the chilling effect of visible per-test costs on clinical ordering patterns. Following the Naira devaluation of 2023–2024, the landing cost of i-STAT cartridges — particularly the CG4+ panel used for blood gas and critical care parameters — escalated to between ₦8,000 and ₦15,000 per cartridge at parallel market rates. The initial demonstration phase of deployments invariably proceeded smoothly; procurement teams approved the devices, clinical staff attended training, and there

was genuine institutional enthusiasm. The inflection point came when finance departments calculated the consumable burden at scale. The institutional response was not outright rejection but something more corrosive: rationing. Devices were restricted to the ICU or emergency unit, removing them from general ward use where early diagnostic decision-making carries its own clinical value. Frontline staff, aware of the financial scrutiny attached to each cartridge request, began self-censoring their clinical orders — avoiding the device not because they doubted its accuracy, but because they did not want to be the person who had to justify the expense. This progressive avoidance, compounded over weeks, produced the outcome indistinguishable from non-adoption: a functional device, consistently unused, collecting dust in a clinical environment that nominally possessed point-of-care capability.

5.2 Infrastructural Deficiencies and Connectivity Gaps

Even when a facility can afford the initial investment in POCT technology, maintaining its functionality is a constant challenge. The primary infrastructural barrier is the unreliable supply of electricity. In Nigeria, grid access is inconsistent, particularly in suburban and rural areas where the grid access rate is only about 41.1%. This is particularly problematic for POCT models that require constant power for device charging or refrigeration for temperature-sensitive reagents.

The reliance on diesel-powered generators significantly increases overhead costs for private hospitals. When fuel prices rise—following the removal of government subsidies—hospitals are forced to ration power, leading to periods where diagnostic equipment is non-operational. Furthermore, the lack of stable internet connectivity hampers the "Real-time Connectivity" requirement of the REASSURED framework. Stakeholders have identified "load shedding" and "limited connectivity" as high-priority barriers that prioritize the need for devices with robust offline functionality and long-lasting battery life.

5.3 Workflow Disruptions and Human Factors

The introduction of POCT into a hospital setting often disrupts established clinical workflows. In many Lagos private hospitals, there is a chronic shortage of medical professionals—the "brain drain" or "Japa" phenomenon—which leads to extreme work overload for the remaining staff. When a nurse or physician is tasked with performing a bedside test, it adds to their already burdensome checklist, potentially increasing waiting times for other patients if not integrated efficiently.

Professional resistance is also a significant human factor. There is often a disconnect between the clinical bioscientists responsible for quality assurance and the frontline clinicians operating the POCT devices. Research indicates that "Effort Expectancy" (the perceived ease of use) and "Performance Expectancy" (the perceived benefit) are the strongest determinants of whether a clinician will adopt a new diagnostic tool.

Across the facilities observed during this deployment period, the most consistent and institutionally entrenched resistance did not originate from frontline clinical staff but from laboratory scientists — and this distinction carries significant implications for HTM strategy. When the Abbott i-STAT and Afinion AS100 arrived at facilities with functioning central laboratories, the response from laboratory personnel was frequently one of professional challenge rather than clinical curiosity. The recurring question — "has this been validated against our existing analyser?" — was not unreasonable in isolation, but in practice it functioned as a procedural barrier. Laboratory staff would insist that POCT results be confirmed by central laboratory analysis before any clinical action could be taken, a requirement that structurally negated the primary value proposition of point-of-care testing: immediacy. What the professional observer noted was that this resistance was rarely malicious. Rather, it reflected a genuine professional identity threat — the perception that POCT represented a bypass of the quality assurance infrastructure that laboratory scientists are trained to protect. In facilities where this dynamic was not proactively managed through early stakeholder engagement and clearly defined scope-of-use protocols, the POCT device was operationally marginalized within weeks of deployment, regardless of its clinical merit.

5.4 Trust and Quality Assurance

Trust remains a pervasive issue in the adoption of POCT in Nigeria. Concerns over the accuracy of bedside tests—especially compared to conventional laboratory methods—are frequently cited by both patients and providers. This lack of trust is compounded by the high prevalence of broken or poorly maintained medical equipment. The WHO estimates that between 30% and 50% of medical devices in sub-Saharan Africa are non-functional. Without a robust Health Technology Management (HTM) system that includes regular calibration and quality control, POCT results can be unreliable, leading to misdiagnosis and compromised patient safety.

6. Enablers of Point-of-Care Diagnostic Adoption

Despite the formidable barriers, professional observation also reveals a set of powerful enablers that, when leveraged effectively, can facilitate the integration of POCT in Lagos private hospitals. These enablers range from individual leadership and training to state-level policy interventions and innovative financing.

6.1 The Role of Clinical Champions and Institutional Leadership

The successful adoption of new technology in a healthcare setting is rarely a purely technical endeavor; it is a leadership challenge. "Clinical champions" or "super users"—clinicians who are technically savvy and advocate for the technology—are essential for driving peer acceptance and troubleshooting implementation issues. In the Lagos context, private hospitals that have successfully integrated EHRs and POCT often have leadership that actively champions the transition, allocates resources for training, and fosters a culture of innovation.

Two contrasting deployment outcomes observed across this period illustrate with particular clarity that the determinant of POCT sustainability is rarely technological — it is human. In one facility, two i-STAT devices were deployed as part of a broader diagnostic upgrade. No individual was designated as the primary operator or device custodian; responsibility was assumed to be collective and therefore, in practice, belonged to no one. The cartridges, requiring refrigeration between 2°C and 8°C, were stored in a shared ward refrigerator alongside medications and staff provisions — an arrangement that produced inconsistent temperature control and, over time, compromised cartridge integrity. Within three months, one device was displaying persistent error codes traced to handling failures during cartridge insertion; the other had not been charged and held no battery capacity. Both were logged in the facility's maintenance register as "awaiting OEM technical support" — a designation that, in the absence of a local service infrastructure, functioned as permanent deferral. The devices were never clinically decommissioned; they simply ceased to be used. The institution retained the appearance of POCT capability while possessing none of its function.

The contrasting outcome was observed at a facility where a senior nursing officer took unsanctioned but decisive personal ownership of the Afinion AS100. She controlled the cartridge stock, maintained the usage log, and anchored HbA1c testing to the facility's weekly diabetic clinic as a non-negotiable procedural step. When results appeared discordant, she repeated the test herself rather than attributing error to the device. Physicians at that facility trusted the Afinion's output

because they trusted her process. Adoption did not hold because the institution had built a robust HTM system — it held because one individual had effectively become that system. Both outcomes confirm what the literature suggests but rarely states with sufficient directness: in resource-constrained environments, the personal accountability of a single motivated operator is often a more reliable predictor of POCT sustainability than any institutional protocol.

6.2 Training, Digital Literacy, and Capacity Building

The effective utilization of POCT tools relies on the expertise of clinicians, technicians, and even patients. Education and training programs are essential to equip healthcare professionals with the requisite skills to operate, maintain, and interpret results from POCT diagnostic instruments. In sSA, laboratory technicians often have backgrounds in medical laboratory science (MLS) and require a deep understanding of biochemical principles to prevent misdiagnosis.

There is a noted deficit in general digital literacy among healthcare workers in Nigeria. In some regions, only about 26.7% of healthcare workers possess sufficient proficiency with computer tools for advanced tasks. This gap emphasizes the need for integrating EHR and POCT training into medical and nursing school curricula, continuous professional development (CPD) through workshops and mobile-based microlearning, and in-service training courses focused on the practical hands-on operation of specific devices. Training must also extend to Health Technology Management (HTM). Without technicians trained to maintain and repair equipment, POCT systems quickly become "white elephants."

6.3 State-Level Policies and Universal Health Coverage

Lagos State has taken proactive steps to create an enabling environment for MedTech adoption. The Lagos State Health Management Agency (LASHMA) is the central player in this effort, overseeing the Lagos State Health Scheme (LSHS) and its social health insurance plan, "Ilera Eko."

Policy / Initiative	Mechanism	Impact on POCT
Ilera Eko Mandatory Insurance	2024 Executive Order mandating registration.	Creates a stable, pool-funded revenue stream for diagnostics.
Provider Reimbursement	Paperless settlement of claims for accredited facilities.	Incentivizes private hospitals to provide standardized care.
Public-Private Partnerships	Collaboration with Maisha Meds for malaria diagnostics.	Standardizes care for 75,000+ fever patients via digital software.

Policy / Initiative	Mechanism	Impact on POCT
HEFAMAA Monitoring	83% coverage of facilities in 2023.	Ensures that POCT is conducted within a quality-assured framework.

The "Ilera Eko" scheme is particularly innovative because it includes telemedicine services and access to a community pharmacy network, expanding the "point" of care beyond the traditional hospital walls. The introduction of rapid diagnostic testing in public facilities has reportedly reduced malaria positivity rates from 60% to 5%, demonstrating that accurate diagnosis—rather than presumptive treatment—is key to improving health indices.

7. MedTech Deployment Strategies in the Nigerian Context

For technology developers and hospital administrators, deploying POCT in Nigeria requires a strategy that acknowledges the constraints while leveraging the unique opportunities of the market. Professional observation suggests several strategic pillars for successful deployment.

Design Philosophy: Frugality and Robustness

Deployment strategies must start with the design of the technology itself. There is a stark contrast between the research philosophy in high-income countries (HIC), which often focuses on high-efficiency, high-complexity devices, and the needs of low- and middle-income countries (LMICs). In Lagos, a "frugal innovation" approach is often more effective. Low-complexity tests (LCTs), such as lateral flow tests for malaria or pregnancy, are highly affordable and low-maintenance, making them more suitable for the decentralized PPMV and pharmacy networks. Handheld microfluidic and "Lab-on-a-chip" devices offer a promising middle ground, capable of detecting infectious diseases and cardiovascular biomarkers at low cost. Infrastructure-first design principles—favoring finger-prick over venipuncture—further enhance real-world deployability.

Health Technology Management (HTM) as a Service

A common failure in MedTech deployment is the "drop and depart" model, where equipment is delivered without a long-term maintenance plan. Successful deployment strategies in Nigeria increasingly emphasize HTM as a core component of the offering. This involves establishing an asset register to track the location and functionality of all devices, and the use of Computerized Maintenance Management Systems (CMMS) to schedule preventive maintenance and track repair histories. Private hospitals that partner with world-class mentors or independent service organizations (ISOs) to build in-house repair capacity often see better long-term outcomes than those relying solely on original equipment manufacturers (OEMs) who may have limited local presence.

8. Professional Insights on Clinical Pathways and Patient Outcomes

The ultimate goal of POCT adoption is the improvement of patient outcomes. Professional observation in Lagos indicates that when POCT is formally integrated into clinical pathways, the benefits extend beyond just "fast results."

Impact on Acute and Chronic Care — The HbA1c Divide

In critical care situations, the reduction of turnaround time can be life-saving. In Nigerian ICUs, where mortality rates for conditions like severe head injury or obstetric complications are high, the ability to conduct rapid blood gas and electrolyte testing allows for immediate adjustments in patient management. The use of portable devices like the Abbott i-STAT has been identified as a key factor in improving turnaround times in these high-stakes environments.

The deployment of the Afinion AS100 for HbA1c monitoring revealed a significant heterogeneity in baseline diagnostic practice across Lagos private facilities that is absent from aggregate data. In a substantial proportion of facilities — particularly mid-tier private hospitals and specialist clinics operating without in-house biochemistry departments — HbA1c testing had not been part of routine diabetes management prior to deployment. These facilities relied on fasting plasma glucose and random blood glucose as the primary glycaemic monitoring tools, with HbA1c available only through referral to external reference laboratories such as Clina-Lancet, with turnaround times of 24 to 72 hours. In these contexts, the Afinion's 3-minute result was genuinely transformative, enabling same-consultation treatment adjustments that had previously been logistically impossible. However, in facilities with established central laboratory HbA1c capacity, the professional observer encountered a different dynamic. Here, the device did not fill a gap — it proposed to replace an existing workflow, and the laboratory infrastructure resisted that displacement. The result was a pattern of parallel testing: the Afinion used at the bedside, the central lab result ordered simultaneously as a confirmatory measure, with clinical decisions deferred until both results were available. This parallel workflow preserved laboratory authority while eliminating the efficiency gains that justified the POCT investment — a structural irony that speaks directly to the need for facility-level workflow mapping prior to device deployment.

The "Cost of Care" Paradox

While POCT is often perceived as having a higher "cost per test" than centralized laboratory testing, the downstream savings can be substantial. By enabling rapid diagnosis and immediate treatment, POCT can reduce the number of follow-up visits required, prevent the spread

of infectious diseases through earlier detection, reduce antibiotic misuse by accurately identifying patients without bacterial infections, and decrease hospital stay durations by facilitating faster clinical decision-making in emergency departments. However, these economic benefits are often difficult to gauge using traditional cost-effectiveness analyses, as they accrue across the entire patient pathway rather than just within the laboratory budget. For the Lagos private hospital administrator, this necessitates a shift in perspective—viewing POCT as an investment in service quality and patient satisfaction rather than just a line-item expense.

9. Future Outlook: Lagos as a MedTech Hub

The professional perspective on POCT in Lagos is cautiously optimistic. While the economic challenges are severe, the state is positioning itself as a hub for medical innovation. The ongoing investments in specialist hospitals, modern primary healthcare centers, and research institutions—such as the Massey Children's Hospital and the new 1,000-bed mental health institute—provide a physical infrastructure for advanced diagnostics.

The projected growth of the portable and point-of-care diagnostic device market in the region—expected to reach USD 279 million by 2029—suggests that demand remains strong despite the headwinds. The "One Health" approach, recognizing the interconnection between human, animal, and environmental health, is also gaining traction in Lagos, providing a framework for more robust data surveillance and coordinated policy advocacy. To capitalize on this potential, Nigeria must address the "brain drain" and the "digital divide," and prioritize local production of essential diagnostic tools to reduce vulnerability to global exchange rate fluctuations.

10. Conclusions and Recommendations

The journey toward widespread and sustainable Point-of-Care diagnostic adoption in Lagos private hospitals is a reflection of the broader challenges and opportunities within the Nigerian healthcare system. Professional observation suggests that while the REASSURED criteria provide a compelling target, the path to adoption is blocked by the hard realities of Naira devaluation, infrastructural decay, and a strained health workforce. To overcome these barriers, a multi-pronged strategy is required:

- **Economic Stabilization and Policy Support:** The federal and state governments must work to stabilize the currency and provide targeted financial support to the health sector, including tax incentives or customs waivers for essential diagnostic equipment.
- **Infrastructure-Resilient Design:** MedTech developers must prioritize the development of "frugal" technologies that are battery-operated, offline-capable, and stable at high ambient temperatures.
- **Strengthening HTM Systems:** Hospitals must transition from a procurement-centric model to a Health Technology Management model that prioritizes maintenance, training, and asset lifecycle management.
- **Leveraging Private-Public Synergies:** The LASHMA/Ilera Eko insurance model should be used to standardize diagnostic protocols across the private sector, ensuring that facilities are reimbursed for quality-assured POCT.
- **Investing in the Human Element:** Capacity building must go beyond technical training to include digital literacy, leadership development for clinical champions, and a culture of quality assurance that bridges the gap between the laboratory and the bedside.

Ultimately, the goal is to ensure that every resident of Lagos—regardless of their socioeconomic status—has access to rapid, accurate, and affordable diagnostics. By addressing the structural barriers and leveraging the powerful enablers of the private sector, Lagos can build a resilient healthcare ecosystem that serves as a model for the rest of sub-Saharan Africa. The shift toward POCT is not just a technological change; it is a commitment to a more equitable and efficient future for healthcare in Nigeria.

The professional observer remains cognizant that while technology is the "easy part," the true success of POCT lies in the "hard part"—improving regulatory issues, training the workforce, and creating a sustainable ecosystem where clinical evidence and economic value are aligned. As Lagos continues to push the boundaries of science-driven policy, the integration of Point-of-Care diagnostics will undoubtedly remain at the center of the state's quest for health security and universal health coverage.

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