FEDERAL MINISTRY OF HEALTH

DEPARTMENT OF PUBLIC HEALTH

National Tuberculosis and Leprosy Control Programme

FAST...

A Tuberculosis Infection Control Strategy

Acknowledgements

ART   - Anti Retroviral Therapy
DOTS   - Directly Observed Treatment Short-course
DR-TB   - Drug-resistant Tuberculosis
FAST   - Finding, Actively, Separating, Treating
HIV   - Human Immunodeficiency Virus
KNCV   - KNCV Tuberculosis Foundation
LGA   - Local Government Area
MDR-TB   - Multi-drug resistant Tuberculosis
MTB   - Mycobacterium tuberculosis
NTBLCP   - National Tuberculosis and Leprosy Control Programme
PITC   - Provider Initiated HIV Testing and Counseling
PLHIV   - People living with HIV
RIF   - Rifampicin
SOP   - Standard Operating Procedure
STBLCP   - State Tuberculosis and Leprosy Control Programme
TB   - Tuberculosis
TB-IC   - Tuberculosis Infection Control
USAID   - United States Agency for International Development

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Introduction

This guide is meant to be used for the implementation of the *FAST* strategy at healthcare facilities.

The purpose of this guide is intended to provide a comprehensive introduction to the *FAST* strategy: a focused approach to stopping TB spread in healthcare facilities. *FAST* stands for **F**inding, **A**ctively, **S**eparating, and **T**reating.

FAST focuses health care workers on the most important administrative TB transmission control intervention: effective treatment.

The strategy is built on a renewed appreciation of evidence showing that effective TB treatment reduces TB spread rapidly, even before sputum smear and culture turn negative.

The *FAST* strategy can be used to reduce TB or DR-TB transmission in outpatient and inpatient healthcare settings. Also, the strategy will contribute to increased case detection.

This guide explains how *FAST* may be implemented in two types of healthcare settings:

a) General medical settings, where the focus is finding patients with unsuspected infectious TB; and
b) TB settings, where patients are already diagnosed with TB and the focus is finding patients with drug resistant TB in order to provide effective therapy and rapidly stop spread.

Crowded waiting area

FAST for General Medical Settings

The most important setting where *FAST* can be implemented is the outpatient and inpatient general medical setting, particularly HIV and ART clinics. Actively looking for otherwise unsuspected TB patients through organized cough surveillance in general medical settings will reveal many with presumptive TB, some of which will have the disease. New molecular tests allow rapid diagnosis of TB and drug resistance – both essential for the effective treatment that will rapidly stop its spread.

Finding TB Patients:

The most infectious TB patients are the ones that we don't know about because they are not being treated. Undiagnosed TB patients can be in clinics, waiting areas, casualty departments, and wards that care for surgical or other medical problems. Asking patients about TB symptoms, such as cough, fever, night sweat and weight loss can lead to unsuspected TB cases, as can observing patients for cough in waiting rooms, registration areas, and admission holding areas.

Actively:

TB is usually diagnosed passively, such that it occurs when patients' symptoms lead them to seek help. However, symptoms, such as cough, fever, night sweat and weight loss can be present for a long time, be attributed to other conditions, or be overshadowed by other pressing issues. The *FAST* strategy incorporates daily assigned nursing and auxiliary staff whose responsibility is to identify patients with current cough, fast track them to be screened for other symptoms suggestive of TB, promptly collect sputum of those with presumptive TB for lab investigations, including rapid molecular testing, as per national guidelines.

Separating safely:

While waiting for a laboratory diagnosis, patients identified through cough surveillance should be educated on respiratory hygiene (cough etiquette and separation) and moved to a designated, well-ventilated area away from other patients to prevent further spread of TB.

Treatment:

Effective treatment is the most important step in preventing TB spread to others. Patients become non-infectious soon after starting effective TB treatment. Patients with unsuspected drug resistant TB, may not be on treatment that is effective and may still spread the disease, which creates even greater risks for other patients and health care workers.

Pediatric settings deserve special consideration. In pediatric settings, the *FAST* strategy must include cough surveillance targeting the accompanying adult family members.

SOP 1: Instructions for General Medical Settings

1. Daily, conduct cough surveillance at selected entrance and service areas of the healthcare facility.

2. Fast track the patient identified with cough to be screened for other symptoms suggestive of TB according national guidelines.

3. If TB is presumed,
   a) Instruct the patient to produce and submit sputum according the TB Worker's Manual
   b) Educate the patient on respiratory hygiene: cough etiquette and temporary separation
   c) Direct the patient to a designated, well-ventilated waiting area to wait for the results OR give appointment for the next day to collect the results
   d) Provide HIV testing and counseling

4. The same day, test the sputum sample for TB by a rapid testing method.
   - Smear microscopy for presumptive TB
   - Xpert MTB/RIF® for presumptive DR-TB and symptomatic PLHIV
   - For smear-negative patients and children, chest x-ray is another rapid but non-specific test for TB

5. As soon as possible after receiving results, start any patient that has a positive sputum test on effective TB treatment.
   - If Xpert MTB/RIF® is MTB positive/RIF negative, standard treatment for drug-susceptible TB is likely to be effective
   - If Xpert MTB/RIF® is RIF positive, the DR-TB regimen should be chosen according the national DR-TB guidelines

6. Collect the following time intervals for effective *FAST* implementation monthly:

   a) Time to Diagnosis: The number of days from the date of patient presentation on which sputum was collected (column: *Date of collection*) to the date the lab result was received (column: *Date result released*) as recorded in the clinic TB suspect register.

   For DR-TB, the date the lab result was received shall be recorded in the *Comments* column of the DR-TB suspect register.

   b) Time to Treatment: The number of days from the date on which the lab result was received (column: *Date registered*) to the date treatment was initiated (column: *Date treatment started*) as recorded in the clinic TB suspect register.

   For DR-TB, the date the lab result was received shall be recorded in the *Comments* column and the date of treatment start shall be recorded in the *Treatment facility referred to* column.

FAST can also be applied to a TB setting, such as a DOTS clinic or TB ward. In these settings, patients have already been diagnosed with TB. Most patients are assumed to have drug-susceptible TB, and the challenge is to find those patients who have DR-TB.

Finding DR-TB patients:

Undiagnosed and inadequately treated DR-TB patients can infect or re-infect other patients or health care workers. Most TB patients are not tested for drug resistance until they fail first-line treatment. Therefore, there are often patients with undiagnosed DR-TB being inadequately treated for drug-susceptible TB. Such patients remain infectious. The purpose of detecting DR-TB is to treat it effectively and stop transmission.

Actively:

It is essential that TB patients are tested for DR-TB if they belong to a target group or if a risk factor is present according to the national DR-TB guidelines. The fastest way to diagnose a DR-TB patient from a patient with drug-susceptible TB is drug susceptibility testing. Xpert MTB/RIF® can identify DR-TB patients within two hours

Separating safely:

After diagnosis, for the short time that it takes for effective treatment to begin and take effect, hospitalized and non-hospitalized DR-TB patients should be educated on respiratory hygiene (cough etiquette and separation) and moved to a well-ventilated MDR-TB ward to prevent the transmission of DR-TB to health care workers and other patients.

Treatment:

Treatment is the most important way to interrupt TB transmission. DR-TB patients should be started immediately on second-line TB drugs according to the national DR-TB guidelines. DR-TB patients rapidly become non-infectious after being started on effective treatment. The effect of effective treatment on transmission occurs much faster than the conversion of sputum smear or culture to negative.

SOP 2: Instructions for TB Settings

1. Test a patient with presumptive DR-TB straight with Xpert MTB/RIF® as per national PMDT guidelines.

2. Using Xpert MTB/RIF®, collect results for rifampicin resistance on the same day the sputum is submitted.

3. Immediately, separate hospitalized RIF-positive patients by moving them to a designated, well-ventilated DR-TB ward. They can be discharged as soon as possible to be treated on ambulatory basis as per national Community DR-TB guideline.

4. Provide HIV testing and counseling.

5. Once a patient is diagnosed with rifampicin resistance, put the patient on a standard MDR-TB treatment regimen according to the national DR-TB guidelines.
   - Patients who are negative for rifampicin resistance by Xpert MTB/RIF® should continue standard TB treatment according to the national guidelines.

6. Collect the following time intervals for effective **FAST** implementation monthly:

   a) Time to Diagnosis: The number of days from the date of patient presentation on which sputum was collected (column: *Date of collection*) to the date the lab result was received (column: *Date result released*) as recorded in the clinic TB suspect register.

      For DR-TB, the date the lab result was received shall be recorded in the *Comments* column of the DR-TB suspect register.

   b) Time to Treatment: The number of days from the date on which the lab result was received (column: *Date registered*) to the date treatment was initiated (column: *Date treatment started*) as recorded in the TB register.

      For DR-TB, the date the lab result was received shall be recorded in the *Comments* column and the date of treatment start shall be recorded in the *Treatment facility referred to* column.

Advocacy

Render a planned visit to the facility management to advocate for the implementation of the *FAST* strategy.

Baseline assessment

Conduct a baseline assessment consisting of an evaluation of the existing processes and procedures and collecting the data set used to monitor the selected indicators for the implementation of the **FAST** strategy in the targeted healthcare facilities.

Selection of areas

Select entrance and service areas (departments/units) where the **FAST** strategy will be implemented to increase case detection and case notification resulting in reduced transmission.

Appointment of focal persons at all levels

Identify and appoint staff at National, State, Local Government Area (LGA) and Healthcare Facility level responsible for the implementation of (parts of) the **FAST** strategy.

Sensitization

Render a planned visit to the healthcare facility to sensitize all involved staff using the appended **FAST** sensitization tool.

Monitoring

A subset of already available data is used to monitor the selected indicators for the implementation of the **FAST** strategy in the targeted healthcare facilities. Data is collected monthly by the Facility/LGA focal person and included in the formatted monthly e-report.

Reporting

The monthly e-report is submitted within two weeks of the following month to the STBLCP and NTBLCP / KNCV where the data is compiled and analyzed. Feedback is given to the STBLCP and facility level focal persons within two weeks after receipt of ALL monthly reports.

Evaluation

Weekly evaluation for the first three months by a facility focal person using the facility level evaluation tool; monthly follow-up evaluation for six months by state level staff, meeting with facility staff and using the follow-up evaluation tool; and quarterly follow-up evaluation during the six months of implementation by the NTBLCP and implementing project partners using the follow-up evaluation tool.

State and National follow-up evaluation

Using the follow-up evaluation tool, monthly supportive supervision is provided by the State and quarterly supervision by the NTBLCP and implementing project partners (WHO, KNCV).

FAST Implementation Indicators

The presence of a TB-IC Facility plan and committee is the core indicator for TB-IC in the 2010-2015 National TB and Leprosy Control Strategic Plan (Objective 4.4). But this indicator is not being captured at national and state level. Better monitoring needs to be instituted[1]

The following *FAST* implementation indicators are selected:

1. Average number of days to diagnosis calculated by the LGA/Facility TB focal persons
2. Average number of days to treatment calculated by the LGA/Facility focal persons
3. Total number of presumptive TB cases drawn from the quarterly summary form for suspects and tuberculosis case-finding by the LGA/Facility TB focal persons
4. Total number of presumptive DR-TB cases drawn from the quarterly DR-TB summary form by the LGA/Facility TB focal persons
5. Total number of TB patients started on treatment drawn from the quarterly summary form for suspects and tuberculosis case-finding by LGA/Facility TB focal persons
6. Total number of rifampicin resistant TB patients enrolled for treatment drawn from the quarterly DR-TB summary form by the LGA/Facility TB focal persons

In view of the low case detection in Nigeria, the *FAST* active case finding strategy at healthcare facilities should result in an increase of presumptive TB and notified TB cases if access to TB diagnostic services (smear microscopy and rapid molecular testing) is at the same time increased.

> The Baseline data is collected and calculated by the state programme manager and facility staff *during* the facility sensitization visit. Data of the preceeding quarters are totaled and then divided by the number of quarters reviewed. If the Baseline data is obtained by the state programme manager from the facility reports *before* the facility sensitization visit, then the data is validated *during* the facility sensitization visit.

> The average numbers of days to diagnosis and to treatment shall be reported. To calculate the AVERAGE numbers of days to diagnosis and to treatment the numbers of days are totaled and divided by the number of cases registered in the reporting month. Presumptive TB cases whose results are received the following month are cohorted in the month that the results were received, not in the cohort of the previous month when their sputum was collected.

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[1] Mid-Term Evaluation of the Nigeria National Tuberculosis and Leprosy Control Strategic Plan

ANNEX A: *FAST* Implementation Activity Schedule

Activity	M0	M1	M2	M3	M4	M5	M6	M7	Implementation Budget
Advocacy	●								●
Baseline assessment	●								●
Selection of areas	●								
Focal person/team	●								
Sensitization	●								●
Distribution of tools	●								
Facility level evaluation		●	●	●	●	●	●		
STBLCP follow-up evaluation		●	●	●	●	●	●		●
NTBLCP follow-up evaluation				●		●			●
Data collection			●	●	●	●	●	●	
Reporting to STBLCP			●	●	●	●	●	●	
Reporting to NTBLCP			●	●	●	●	●	●	
Feedback on reports			●	●	●	●	●	●	
Sputum transportation		●	●	●	●	●	●		●[2]
Telephone communication		●	●	●	●	●	●		●
Post project end-evaluation								●	●

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[2] If applicable and not already funded by other projects

Use this *FAST* Guide for sensitization of health care workers. Print out page 7, 9, 22 and copies of the guide for the sensitization session.

- Explain that *FAST* is an acronym which stands for: **F**inding, **A**ctively, **S**eparating and **T**reating.
- Explain that the initial implementation of the *FAST* strategy will be supported (technical and financial support) during the first six months
- Explain that the *FAST* strategy is a refocused approach to stopping TB spread in healthcare facilities refocusing on a subset of administrative controls for TB-IC. It means nothing new, if already implementing TB-IC.
- Explain that the most infectious TB patients are the ones that we don't know about.
- Explain that the effect of standard treatment regimens on transmission of susceptible and drug resistant TB occurs much faster than the conversion of sputum smear or culture to negative.
- Explain that *FAST* can be used in general medical outpatient and inpatient settings, especially HIV clinics, as well as in TB outpatient and inpatient settings.
- Take the health care workers through the *FAST* algorithm; if necessary, adapt it to reflect the local setting.
- Take the health care workers through the *FAST* SOPs for general medical settings and for TB settings, if applicable.
- Agree on the entrance and service areas where the *FAST* strategy will be implemented, in order to increase case detection and decrease average time to diagnosis and time to treatment.
- Explain to the health care workers which indicators are monitored, how to calculate the average time to diagnosis and time to treatment, from which sources the data is collected, and the modus operandi of data collection, reporting and feedback.
- Establish at all entrance and service areas, which staff member is responsible for implementation, data collection and data reporting.
- Take the health care workers through the Facility level Evaluation Tool and adapt the tool to the facility-specific situation, if necessary.
- Inform health care workers that supervision will be conducted (six times) on a monthly schedule from the state level and (two times) on a quarterly schedule from national level during the first six months of implementation.
- Ask actively for questions, comments and observations to open an informal discussion, before visiting the selected entrance and service areas.
- Visit the selected entrance and service areas to gain a better understanding of the opportunities and challenges to implement *FAST*.
- Debrief your findings and recommendations and agree on the *FAST* implementation plan, either a revision / prioritization of the existing facility TB IC plan or a focused *FAST* implementation plan.

ANNEX C: Reporting Format

Name of the Health Facility:

State: LGA:

Month and Year of reporting:

INDICATOR-TB	VALUES
Average time to diagnosis (days)[3]	
Average time to treatment (days) [3]	
Total number of presumptive TB cases	
Total number of TB patients started on treatment	

INDICATOR-DRTB	VALUES
Average time to diagnosis (days) [3]	
Average time to treatment (days) [3]	
Total number of presumptive DR-TB cases	
Total number of Rifampicin resistant TB enrolled for treatment	

Short narrative report with relevant information extracted from the monthly follow-up evaluation form:

Name of reporting officer: _____

Date of submission: _____/_____/2014

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[3] Formula: to calculate the AVERAGE numbers of days to diagnosis and to treatment, the numbers of days are totaled and divided by the number of cases registered in the reporting month.

Presumptive TB cases whose results are received the following month are counted in the month that the results were received, not in the cohort of the previous month when their sputum was collected.

ANNEX D: Facility level Evaluation Tool

Instructions: *This form should be completed each week for the first three months post implementation of the FAST strategy. Maintain for record keeping. You may use the back of the form for comments.*

Date:	#Presumptive TB cases:
Department:	#Presumptive DR-TB cases:
Name of Evaluator:	#TB cases:
Who is being evaluated? Doctor Nurse Laboratory staff Auxiliary staff (*Circle all that apply*)	#DR-TB cases:

	Health Care Workers:	Y	N
1	Are the health workers correctly and completely filling out the sputum request form?		
2	Are the health workers collecting sputum on the day or the morning after a hospitalized patient is found with presumptive TB?		
3	Are sputum samples of inpatients sent to the laboratory the day samples are collected?		
4	Are the health workers filling out the TB registers correctly and completely?		
	Doctors:		
5	Are doctors initiating treatment the same day a confirmed diagnosis is produced:	■	■
a	The same day they are received?		
b	The next day they are received?		
c	Thereafter?		
	Laboratory staff:	■	■
6	Are laboratory staff processing specimens:		
a	The same day they are received?		
b	The next day they are received?		
c	Thereafter?		
7	Are laboratory staff filling in the lab register correctly and completely		
8	Are laboratory staff providing results back to the departments:	■	■
a	On the day specimens are processed?		
b	On the next day specimens are processed?		
c	Thereafter?		
9	What is the percentage of not collected AFB / Xpert results?		
10	Are auxiliary staff taking specimens to the lab and collecting results from the lab the same day they are collected?		

Signatures of Evaluator and Evaluatees:

_____

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ANNEX E: *FAST* Follow-up Evaluation Tool

Instructions: This evaluation should be completed by a supervisor or coordinator overseeing the implementation of the ***FAST*** strategy at state and at national level. This evaluation should be conducted monthly by the STBLCP and quarterly by the NTBLCP and implementing partners to address any challenges and needed modifications to the overall strategy.

General Information:

Date:	#Presumptive TB cases:
Name of Healthcare Facility:	#Presumptive DR-TB cases:
	#TB cases:
Name/ID of Evaluator:	#DR-TB cases:

Healthcare setting Information:

Questions in this section of the evaluation should be asked of health care workers directly providing care to patients. For example, doctors, nurses, and auxiliary staff involved in the implementation of the ***FAST*** strategy should be asked about the most relevant aspects of it. Record responses in the space provided.

1. Assess if the health care workers are completing all ***FAST*** related registers, request forms, etc. correctly:

    _____
    _____

2. Assess how health care workers are collecting, labeling, and sending specimens for processing:

    _____
    _____

3. Ask health care workers what they do with laboratory results once they receive them:

    _____
    _____

4. Ask about "separating" patients once a presumptive TB case is established:

    _____
    _____

5. Ask about any challenges (causing avoidable delays) associated with putting patients on treatment after a confirmed diagnosis is obtained:

    _____
    _____

6. Ask health care workers approximately how much time the *FAST* strategy takes as it pertains to their work load:

_____

_____

Laboratory Information:

Questions within this section need to be asked of laboratory staff involved in the direct processing and reporting of laboratory tests. Record all responses in the sections provided.

1. Ask the laboratory staff approximately how long it takes them to process a patient's sputum sample from the time they receive it until when results are available since the implementation of the *FAST* strategy:
   Xpert MTB/RIF® _____
   Smear_____

2. Ask the laboratory staff how they send results back to the health care workers responsible for putting patients on treatment:

_____

_____

3. Ask laboratory staff about any challenges (causing avoidable delays) associated with *FAST* implementation:

_____

_____

4. Assess if the laboratory staff is filling out registers and reporting data correctly and completely:

_____

_____

5. Check and calculate the average turn-around time in days of (10 randomly selected) specimens:

Please tick	AFB	Xpert		AFB	Xpert
Same day	☐	☐	Next day	☐	☐
Later than next day	☐	☐	More than one week	☐	☐

A representative of the administration should sign this evaluation after it is completed:

Signature of Evaluator: *Signature of Evaluatee:*

_____   _____

ANNEX F: Simplified TB-IC Facility Plan prioritizing *FAST*

The **FAST** strategy gives priority to rapid accurate diagnosis and prompt effective treatment.

Organized cough surveillance and temporary separation are complementary administrative TB-IC measures. Every healthcare facility should at least plan for these at the selected general and TB entrance and service points of the healthcare facility.

Those healthcare facilities that already have a TB-IC Facility plan only need to revise their existing plan ensuring that the activities listed below are incorporated in it and prioritized. Those that have no Facility TB-IC plan yet should adopt the simplified TB-IC Facility plan below and implement it, with technical support of the State and LGA focal persons.

Compliance with the **FAST** SOPs and Algorithm that are available in this guide are accompanying tools to successfully implement the outlined TB-IC Facility Plan below.

Name of Facility	
Focal team/person (at each selected entrance and service point)	Name Responsible staff
1. GOPD	
2. HIV clinic	
3. DOTS clinic	
4. General Medical ward	
5. TB ward	
Date this plan was endorsed	
Number of presumptive TB cases in the previous year	
Number of presumptive DR-TB cases in the previous year	
Number of notified TB patients in the previous calendar year	
Number of notified DR-TB patients in the previous calendar year	
1	Conduct organized cough surveillance at selected entrance and service points
2	Fast track presumptive TB and active TB cases or place them in a separate well-ventilated area
3	Use rapid molecular testing methods for symptomatic PLHIV and presumptive DR-TB cases
4	Start effective anti-TB treatment as prompt as possible after receiving test results
5	Monitor the number of presumptive (DR-) TB cases and notified TB patients
6	Monitor the average numbers of days to diagnosis and treatment start
7	Educate identified coughing patients on cough etiquette[4] and reason for separation
8	Keep all openable windows open at all times[4]

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[4] Not part of **FAST**, but important

ANNEX G: Frequently Asked *FAST* Questions

Who should participate in *FAST*?
- Doctors providing direct patient care
- Laboratory staff responsible for diagnosing TB and MDR-TB
- Auxiliary staff who look for and triage outpatients
- Nurses who look for and triage inpatients
- Facility administrators and decision makers who support infection control policies and endorse the implementation of **FAST**

Why should health care workers support the *FAST* strategy?
Health care workers should support the **FAST** strategy to help protect themselves and their patients from infection with TB, possibly drug resistant TB.

What are the benefits of *FAST*?
The most important benefit is that presumptive TB and DR-TB cases get tested quickly, and if they are diagnosed with TB or MDR-TB, they are treated effectively. Effective treatment stops TB transmission.

Are other TB infection control practices no longer needed with *FAST*?
Other infection control practices should be conducted as usual. For example, wearing N95 respirators while attending to presumptive DR-TB cases is still important. However, in the **FAST** strategy, rapid diagnosis and effective treatment is given priority. Studies have shown that when a confirmed TB or DR-TB patient is put on effective treatment, he or she becomes non-infectious very soon. This should therefore become the priority of TB administrative infection control practices.

What is meant by good respiratory hygiene?
Respiratory hygiene is achieved by the application of cough etiquette and temporary separation in a designated, well-ventilated area, near to an open window and away from other patients, if such an area is available.

Will *FAST* create more work for health care workers?
There is some additional work that is required as part of **FAST**. However, everyone benefits by more rapidly identifying and treating TB cases. The benefits of **FAST** are worth the extra work of actively looking for coughing patients, collecting sputum, promptly getting it tested, and getting those results to the requesting doctor or nurse so that treatment can begin.

Can a healthcare facility still implement the *FAST* strategy if it does not have rapid diagnostic options, such as Xpert MTB/RIF®?

Yes, for **FAST** to be most successful, a rapid molecular method is better than sputum smear, but smears can also be rapid. Xpert MTB/RIF® is more sensitive than smear microscopy especially in people living with HIV, and can also diagnose rifampicin resistant TB at the same time. However, in low DR-TB prevalence settings, traditional diagnostic methods such as smear microscopy can be used until rapid molecular tests are available.

Where the patient should be separated while waiting for a diagnosis or to see a clinician or nurse?

The patient should be located to an area of the healthcare facility that is well-ventilated to reduce the risk of transmission to other patients. This may be another ward, room in a clinic, or outside waiting area.

Won't implementing *FAST* cause some patients to be stigmatized?

Every effort should be made to reduce the stigmatization of TB patients. For example, when the patient is being triaged and separated, this activity should be conducted discreetly and with total respect for the patients and their families. Importantly, patients should be explained the reason why patients can be asked to wear a surgical mask or to be separated in a designated area.
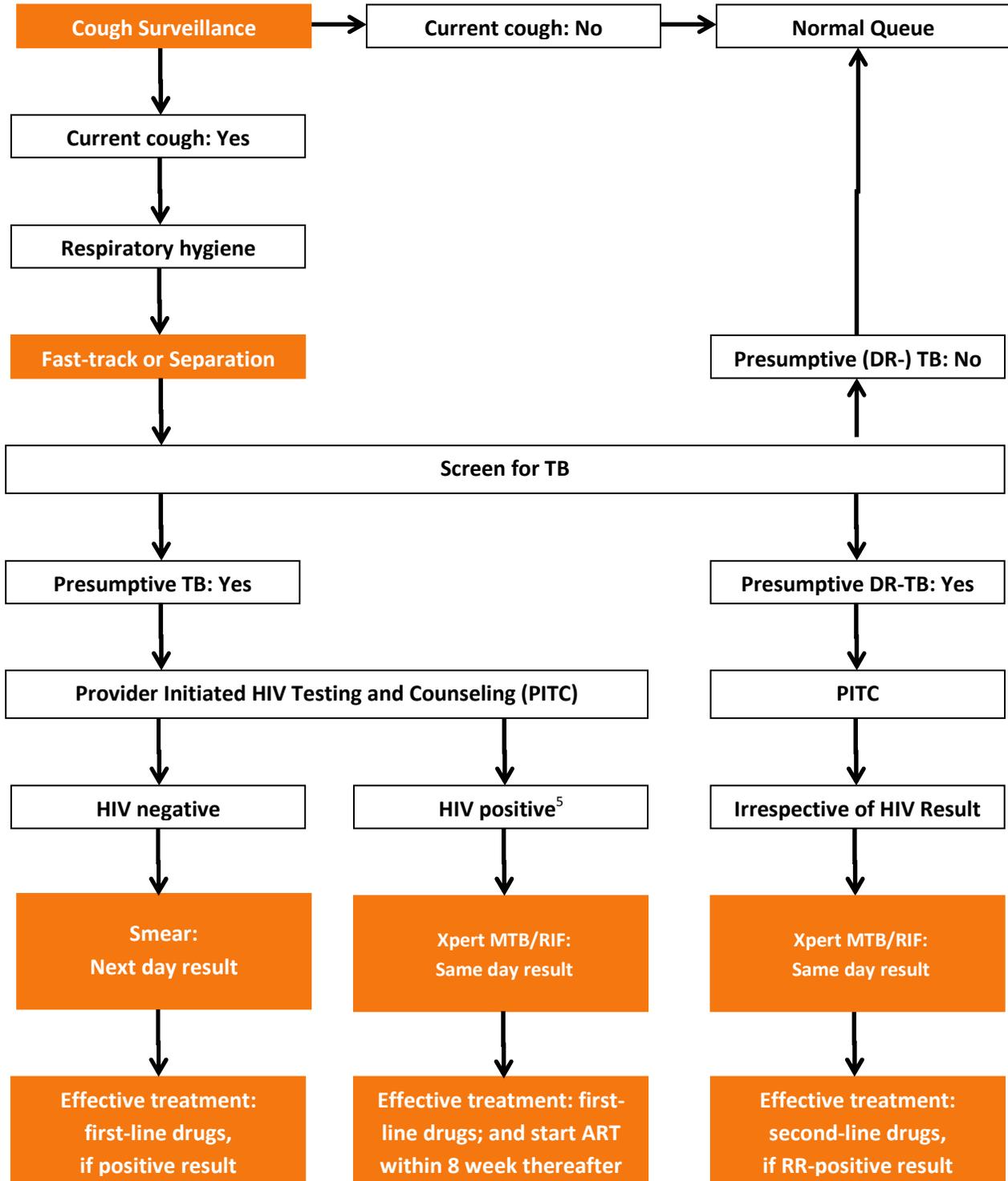
What is effective cough surveillance?

Effective cough surveillance begins as the patient enters the healthcare facility. Current cough is the most common criteria for TB testing. The most important thing is to make sure that all patients entering the facility are assessed for cough.

What are the criteria for staff assigned to cough surveillance?

- Usually a nurse or auxiliary staff.
- Trained on how to screen patients for cough, collect sputum, fill out a sputum request form and register cases in the presumptive TB register (if these functions are not carried out by another health care worker at the facility).
- Someone who can educate patients and their family members about TB.

FAST Algorithm in Healthcare Facilities

Cough Surveillance → **Current cough: No** → **Normal Queue**

Current cough: Yes

Respiratory hygiene

Fast-track or Separation

Presumptive (DR-) TB: No

Screen for TB

Presumptive TB: Yes

Presumptive DR-TB: Yes

Provider Initiated HIV Testing and Counseling (PITC)

PITC

HIV negative

HIV positive[5]

Irrespective of HIV Result

Smear:
Next day result

Xpert MTB/RIF:
Same day result

Xpert MTB/RIF:
Same day result

Effective treatment:
first-line drugs,
if positive result

Effective treatment: first-line drugs; and start ART within 8 week thereafter

Effective treatment:
second-line drugs,
if RR-positive result

_____

[5]Currently, rapid molecular testing of all PLHIV with presumptive TB is limited.