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# Two Pandemics, One Challenge—Leveraging Molecular Test Capacity of Tuberculosis Laboratories for Rapid COVID-19 Case-Finding

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In many settings, the ongoing coronavirus disease (COVID-19) pandemic coincides with other major public health threats, in particular tuberculosis. Using tuberculosis (TB) molecular diagnostic infrastructure, which has substantially expanded worldwide in recent years, for COVID-19 case-finding might be warranted. We analyze the potential of using TB diagnostic and research infrastructures for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing. We focused on quality control by adapting the 12 Quality System Essentials framework to the COVID-19 and TB context. We conclude that diagnostic infrastructures for TB can in principle be leveraged to scale-up SARS-CoV-2 testing, in particular in resource-poor settings. TB research infrastructures also can support sequencing of SARS-CoV-2 to study virus evolution and diversity globally. However, fundamental principles of quality management must be followed for both TB and SARS-CoV-2 testing to ensure valid results and to minimize biosafety hazards, and the continuity of TB diagnostic services must be guaranteed at all times.

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The ongoing coronavirus disease (COVID-19) pandemic presents a massive challenge for healthcare systems globally (1,2). Rapid case-finding and patient isolation are crucial to limit transmission and avoid exceeding capacity limits of critical healthcare infrastructures. Therefore, the World Health Organization (WHO) (3) strongly advocates a large and rapid increase of global testing capacities to detect severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) RNA (2,4). This task is enormous, in particular in resource-poor settings without widespread availability of microbiological laboratories and, even more so, specialized virologic laboratories. For example, although other outbreaks such as the 2014–2016 Ebola epidemic in West Africa triggered substantial investments into surveillance and preparedness, many hospitals, clinics, and laboratories in sub-Saharan Africa were already operating at maximum capacity before the COVID-19 pandemic (5). Consequently, the WHO Joint External Evaluation reports suggest that the ability to respond to an international health hazard, such as the importation of an infectious disease like COVID-19, requires almost universal laboratory improvement across sub-Saharan Africa (6).

With one quarter of the world's population infected with bacteria belonging to the *Mycobacterium tuberculosis* complex (MTBC), tuberculosis (TB) still represents a major global health threat (7). Substantial efforts have been made to scale-up highly sensitive and specific molecular diagnostic systems in high- and low-resource settings, which greatly improved TB care globally (8). Strategies included programmatic implementation of (near) point-of-care, easy-to-handle testing systems, such as the cartridge-based

GeneXpert (Cepheid, <https://www.cephid.com>) platform (8,9). In addition, high-throughput PCR instruments are in use mostly at large central laboratories, in particular those also offering HIV and hepatitis viral load testing (10). Because TB diagnostic infrastructures offer high spatial coverage, preexisting supply chains and clinical networks, staff trained to work with airborne pathogens, and the availability of analytical and biosafety equipment, leveraging the potential of these systems for SARS-CoV-2 testing is tempting. In fact, guidance has recently been issued by WHO (11) and the Stop TB Partnership (7). However, although rapid action is needed, we believe that quality must not be sacrificed for speed. We examined what efforts are needed to allocate molecular testing capacity to SARS-CoV-2 case-finding and research in laboratories usually dealing with TB and how the essentials of quality control apply in this context.

### **Establishing SARS-CoV-2 Testing Capacity for Routine Patient Care**

We studied the availability of SARS-CoV-2 assays on analytical platforms commonly used in TB laboratories of different service levels, that is, at the point of care, at peripheral testing sites, at intermediate laboratories, and at central laboratories (Appendix Table 1, <https://wwwnc.cdc.gov/EID/article/26/11/20-2602-App1.pdf>) (12). It is evident that these approaches differ considerably with respect to setting, sample throughput, and hands-on time. For designing a SARS-CoV-2 testing strategy for a TB laboratory, we suggest considering 5 aspects: availability of hardware and consumables, expected throughput, distance between sampling sites and the laboratory, available personnel and their qualification levels, and pricing. For example, clearly a rapid testing response would ideally rely on existing instruments. In this regard, using GeneXpert instruments, which are available at many TB laboratories, is an obvious consideration. In addition, the Xpert Xpress SARS-CoV-2 testing cartridge, which has received US Food and Drug Administration (FDA) emergency use approval, is available through the Global Drug Facility of the Stop TB Partnership, albeit with a lead time of several months and at a price of \$19.80 USD, which might still be too high to allow high-throughput testing (13,14). Also, in many district laboratories, single 4-slot GeneXpert instruments are used for TB diagnostics, which will easily be overwhelmed by a community screening program for SARS-CoV-2, putting at risk both COVID-19 and TB response. Moreover, although prior experience with GeneXpert is beneficial, additional training on interpretation

of the Xpert SARS-CoV-2 assay results will be required. For example, unlike Xpert MTB/RIF, the Xpert SARS-CoV-2 assay might yield a presumptive positive result calling for a reflex testing algorithm made available for such cases. Furthermore, in some low-resource settings, PCR-based tests are still only available at central laboratories far away from primary or secondary healthcare facilities. These potential complications would increase turnaround time even with a relatively quick and easy test. Laboratories intending to offer SARS-CoV-2 testing must therefore thoroughly evaluate whether the available instruments will meet current and expected demands. This task is challenging because sample numbers might quickly increase, for example, because of the dynamics of the epidemic or through changes in testing policies, or decrease, for example, because of additional laboratory capacity becoming available elsewhere.

Similar considerations apply to staffing resources. Although in-house PCRs are comparably cheap and flexible because PCR chemistry of different manufacturers can be used, they are technically more demanding to perform than cartridge-based tests. Rigorous process control and higher operator skill levels are required to minimize cross-contamination, sample mixups, and PCR failures. In contrast, cartridge-based systems offer ease of use and rapid results at the cost of being dependent on a single manufacturer for reagent resupplies and instrument maintenance. Because countries have been bidding against each other for limited test reagents, low-resource countries with limited local funding might have concerns about their ability to procure enough tests. WHO, together with the United Nations and other international organizations, have recently set up a Global Supply Chain Task Force to secure SARS-CoV-2 tests produced by several manufacturers at negotiated prices for low- and middle-income countries (3).

Consideration of changing testing demands for TB during the ongoing SARS-CoV-2 pandemic also is important. For instance, at a national reference laboratory level, we experienced a decrease in samples sent for culture-based TB testing during the 12-week period of mid-March through mid-June, whereas requests for molecular TB testing increased. This pattern is likely because peripheral laboratories focused their own capacities on SARS-CoV-2 PCRs. Laboratory managers tasked to allocate workforce to SARS-CoV-2 testing need to consider potentially changing TB testing demands to guarantee the uninterrupted availability of TB diagnostic services at all times.

### Biosafety and the 12 Quality System Essentials

Achieving, maintaining, and improving accuracy, timeliness and reliability of test results are key deliverables of diagnostic laboratories. As is the case for TB, late or false-negative SARS-CoV-2 test results will lead to delays in or even preclude correct diagnosis, jeopardizing timely isolation and prevention of transmission. In turn, false-positive tests will waste public health resources, will lead to incorrect epidemiologic data, and might even lead to patient stigmatization. Quality control is a cornerstone of safe, consistent, reliable diagnostics, and many studies and frameworks outline the structure of quality-management systems suitable for diagnostic laboratories (15–18).

We used the laboratory quality-management system guidance issued jointly by WHO, the US Centers for Disease Control and Prevention, and the Clinical and Laboratory Standards Institute to deduce critical interventions and management tasks required to expand the diagnostic workflow of TB laboratories to SARS-CoV-2 testing in a quality-controlled manner (18). Based on International Organization for Standardization document 15189 and Clinical and Laboratory Standards Institute document GP26-A3, the 12 Quality System Essentials approach is centered on 12 interlinked topics: organization, personnel, equipment, purchasing and inventory, process control, information management, documents and records, occurrence management, assessment, process improvement, stakeholder service, and facilities and safety. All 12 topics have practical implications relevant to the context of successfully implementing SARS-CoV-2 testing in TB laboratories (Appendix Table 2). When considering the 12 Quality System Essentials, we found that making the necessary changes to the analytical workflow is just one piece in the puzzle. In fact, several additional steps are needed, ranging from staff training (e.g., on sample collection for COVID-19 testing, which differs from coaching patients to produce sputum, and the definition and review of meaningful quality indicators) to participation in SARS-CoV-2 proficiency testing and anticipation of strategies for management of nonconformities. Furthermore, biosafety procedures will need to be carefully scrutinized, and staff instructions will need to be adapted in a concise, practical, and easy-to-understand manner. Procedures such as performing virus propagation, virus isolation, or neutralization assays should be performed only by competent personnel under Biosafety Level 3 conditions, ruling out such work at peripheral laboratories and in many resource-poor settings. WHO has summarized its biosafety recommendations for working with SARS-CoV-2 (19).

### Using TB Infrastructure for Research on SARS-CoV-2

Although research requiring propagative work with SARS-CoV-2 will likely be beyond the scope of most dedicated TB laboratories, even when equipped with fully operational Biosafety Level 3 facilities, the TB community is strongly influenced by progress in next-generation sequencing (NGS), a technology that is also in heavy demand for research on SARS-CoV-2. Prime examples for the application of NGS in the TB field are the prediction of drug resistance from genome sequencing of clinical isolates (which can potentially also be performed directly from clinical samples), evolutionary studies looking into the adaptation of MTBC strains in response to antibiotic treatment, and the use of genome sequencing to trace local, regional, and national transmission or for cross-border molecular surveillance (8,20–23). Over the past few years, the potential of NGS technologies to replace time-consuming and complex-to-perform phenotypic techniques for resistance testing of MTBC isolates became more evident (21,24). Accordingly, WHO has released a technical guide on the use of NGS for the detection of resistance-associated mutations in MTBC strains (25), and some countries, such as the United Kingdom, have already shifted their TB diagnostic and surveillance approach to NGS, including substantial investments in hardware and bioinformatics infrastructure (26). In addition, NGS facilities are increasingly established in settings with high TB prevalence, including implementation of laboratory workflows with data analysis pipelines and quality-control procedures, in line with the 12 Quality System Essentials (18). In parallel to workflow and infrastructure set up, intensive training of technical and academic personnel is ongoing, for example, through a network dedicated to the application of sequencing technologies for the fight against resistant TB in high-incidence settings (SeqMDR TB\_NET), which supports the implementation of NGS technologies in Kyrgyzstan, Moldova, Namibia, Mozambique, and Eswatini (<https://ghpp.de/en/projects/seqmdrtb-net>). These sequencing capacities, which are embedded in local and international clinical and epidemiologic research networks, are in principle suited to address urgent research questions related to the COVID-19 epidemic, such as establishing key epidemiologic, clinical, and virologic characteristics of the pathogen and, in particular, defining its ability to spread in humans. Several sequencing protocols, such as the ARTICnetwork nCoV-2019 protocol (<https://artic.network/ncov-2019>), have been developed for NGS of SARS-CoV-2 (27). Virus sequencing

has been used early in the epidemic to understand the origin, spread, and evolution of SARS-CoV-2 in different regions of the world as well as for outbreak investigations (28–31). SARS-CoV-2 sequences are also collected by online tools that enable a prospective monitoring of the virus spread and evolution on the global level. For example, 4,397 genomes sampled during December 2019–August 2020 are archived in the GISAID online hCoV-19 database (<https://www.gisaid.org/epiflu-applications/next-hcov-19-app>). Virus sequencing will be crucial in the next phase of the COVID-19 pandemic for population-based surveillance and control of viral transmission (e.g., by allowing a precise understanding of the regional spread of the virus in relation to time, place, human migration, and other determinants) (32).

Another important aspect is the influence of coinfection with TB (and also with HIV) on the epidemiologic, clinical, virologic and immunological trajectory of COVID-19, and vice versa, in high-incidence settings as we observe the collision of 3 global pandemics with unpredicted outcomes. Moreover, with a renewed global focus on active case-finding in TB programs, resources dedicated for COVID-19 community-based research, such as household contact tracing or seroprevalence surveys, could easily be linked to programs to test for TB as well, providing a gateway for training, capacity building, and future TB research. However, as is the case for the capacity of TB diagnostic services, careful planning and close collaboration between the TB, HIV, and COVID-19 research communities will be crucial not to overburden these infrastructures, especially in resource-poor settings. In addition, strong political will and support for research communities are essential, especially in low- and middle-income settings, to advocate for and allocate resources needed to investigate these coinciding pandemics.

## Conclusion

TB laboratories can be an important resource to increase the global capacity for SARS-CoV-2 diagnostic testing and research. However, expanding their scope to the detection of a viral pathogen warrants careful planning. Challenges will be different for peripheral, intermediate, and central-level laboratories and can relate to any of the 12 Quality System Essentials we have outlined. Despite the availability of SARS-CoV-2 assays on all major molecular TB testing systems, careful capacity planning is crucial to match the local demand, operator skills, and funding available. Mitigating the risk for supply chain interruptions is another key management task, and

establishing >1 SARS-CoV-2 test is advisable to guarantee service continuity. The diagnostic industry is challenged to manufacture SARS-CoV-2 tests without deprioritizing production of reagents needed to test for TB, HIV, and malaria. In addition, concerns exist about TB case-finding and culture-based diagnostics being impaired by the ongoing SARS-CoV-2 pandemic, as has been shown in a rapid assessment by the Stop TB Partnership (33). Likewise, a recent modeling analysis showed a 70% drop in the probability of TB diagnosis per visit to a health-care provider because of reduced laboratory capacity and availability of healthcare staff secondary to the COVID-19 pandemic in countries such as India, Kenya, and Ukraine (34). Consequently, although leveraging the globally available TB diagnostic and research infrastructures is a powerful strategy to increase SARS-CoV-2 testing capacity and to elucidate some of the open research questions that have arisen during the ongoing SARS-CoV-2 pandemic, care must be taken that TB services are not disrupted at any time during the COVID-19 response.

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discussion on tuberculosis and COVID-19 research. F.P.M., a clinical microbiologist and head of the Supranational Reference Laboratory, was responsible for the overall project design. S.H., L.P., S.N., and F.P.M. wrote the manuscript. All authors approved the final version of the manuscript.

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## EID Podcast: Two Ways of Tracking *C. difficile* in Switzerland

Science wields many different tools in the pursuit of public health. These tools can work together to capture a detailed picture of disease. However, many tools accomplish similar tasks, often leaving policy-makers wondering, when it comes to disease surveillance, what is the best tool for the job?

Different tests are currently used to diagnose *Clostridioides difficile*, a dangerous bacterium found in hospitals around the world. As rates of this infection surge globally, researchers need to be able to compare statistics from different hospitals, regions, and countries.

In this EID podcast, Sarah Tschudin-Sutter, a professor of infectious disease epidemiology at the University Hospital - Basel in Switzerland, discusses using 2 tests for *C. difficile* infection in Europe.

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# Two Pandemics, One Challenge—Leveraging Molecular Test Capacity of Tuberculosis Laboratories for Rapid COVID-19 Case-Finding

## Appendix

**Appendix Table 1.** Platforms commonly available at TB testing sites suitable for detection of SARS-CoV-2 RNA\*

| System  | Manufacturer  | Laboratory level (1) | SARS-CoV-2 assay available | Throughput (samples/time) (depending on instrument) | Recommended specimen type | Approval status of SARS-CoV-2 assay | Comment  |
|---|---|----------------------|----------------------------|---|---------------------------|-------------------------------------|--|
| GeneXpert   | Cepheid   | PL, IML, CL          | Yes                        | 1 to 80/45 min (depending on instrument)            | NP swabs                  | FDA-EUA                             | Approximately 23,000 systems deployed worldwide†; SARS-CoV-2 cartridges available through the Stop TB Partnership Global Drug Facility |
| Truenat Beta CoV  | Molbio Diagnostics  | PL, IML, CL          | Yes                        | 4/1 h   |                           | CE-IVD                              | Confirmatory SARS-CoV-2 test recommended   |
| BD MAX  | Becton Dickinson  | PL, IML, CL          | Yes                        | 24/3 h  | NP and OP swabs           | FDA-EUA, CE-IVD                     |  |
| Manual or semiautomatic NA extraction combined with programmable realtime PCR thermocyclers | Various, e.g., Applied Biosystems 7500; Bio-Rad CFX Connect™; Roche LightCycler 480 II; Qiagen Rotor-Gene Q | IML, CL              | Yes                        | up to 96/3 h‡                                       | NP and OP swabs, sputum   | Depending on reagents used§         | Both commercial reagent kits and in-house methods available  |
| Cobas 6800/8800   | Roche   | CL                   | Yes                        | 384/8 h; 1056/8 h                                   | NP swabs                  | FDA-EUA, CE-IVD, WHO-EUL            |  |
| m2000   | Abbott  | CL                   | Yes                        | 470/24 h  | NP and OP swabs           | FDA-EUA, CE-IVD, WHO EUL            |  |

\*PL, peripheral laboratory; IML, intermediate laboratory; CL, central laboratory; NP, nasopharyngeal; OP, oropharyngeal; FDA, United States Food and Drug Administration; EUA, Emergency Use Authorization; WHO, World Health Organization; EUL, Emergency Use Listing; NA, nucleic acid; CE-IVD, *Conformité Européenne-in vitro* diagnostic.

†According to manufacturer (2).

‡Depending on RNA extraction protocol and thermocycler used.

§Various CE-marked kits available; some PCR assays are included in WHO emergency use listing for in vitro diagnostics detecting SARS-CoV-2 nucleic acid (3).

**Appendix Table 2.** Key determinants for achieving, maintaining and improving accuracy, timeliness and reliability of laboratory test results and their implication for SARS-CoV-2 testing in TB laboratories\*

| Determinant              | Description  | Implementation strategies for the SARS-CoV-2 / MTBC context   |
|--------------------------|--|---|
| Organisation             | <ul style="list-style-type: none"> <li>• Existence of a formal QMS that supports consistent procedures</li> <li>• The management team and quality unit play an integral role in a quality-driven culture, along with structures for monitoring ongoing quality</li> </ul>  | <ul style="list-style-type: none"> <li>• Expand the scope of the laboratory quality management system to SARS-CoV-2 testing</li> <li>• Define scope and assign clear responsibilities for both implementation of SARS-CoV-2 testing and maintenance of TB diagnostic service</li> <li>• Set up a regular SARS-CoV-2 briefing</li> <li>• Laboratory leadership needs to implement an internal communication strategy to assure adequate information of staff on SARS-CoV-2 pathobiology, biosafety in relation to MTBC, changes in laboratory organization, prioritisation of MTBC versus SARS-CoV-2 testing</li> <li>• It is critical that TB services are not disrupted during the COVID19 response</li> </ul> |
| Facilities and safety    | <ul style="list-style-type: none"> <li>• Laboratories need a comprehensive set of procedures and standards to ensure a safe, secure, and clean environment</li> </ul>  | <ul style="list-style-type: none"> <li>• Define SARS-CoV-2 workspaces and usage times for shared equipment to minimize interference with TB diagnostics</li> <li>• Limit SARS-CoV-2 laboratory access to authorized staff</li> <li>• Place orders for additional PPE with &gt;1 distributor to mitigate risk of shortages</li> <li>• Check whether available disinfectants have proven activity against enveloped viruses</li> <li>• Implement a staff screening mechanism for COVID-19 symptoms (some TB laboratories in high-burden settings routinely screen staff with a TB symptom questionnaire)</li> </ul>   |
| Equipment                | <ul style="list-style-type: none"> <li>• Every piece of equipment used in the laboratory must be maintained to assure correct operation</li> </ul>   | <ul style="list-style-type: none"> <li>• Assess if additional equipment is needed for SARS-CoV-2 testing</li> <li>• Develop contingency plans for equipment failures, if possible set-up &gt;1 SARS-CoV-2 assay to mitigate risk of reagent shortages</li> <li>• Check maintenance protocols for pipets, UV clean spots, safety cabinets, thermocyclers, and freezers</li> </ul>  |
| Purchasing and inventory | <ul style="list-style-type: none"> <li>• Proper supply chain management is critical to ensure that raw inputs and other supplies are consistently available and of high quality</li> <li>• Inventory activities should verify that materials and supplies are stored in a way that protects integrity</li> </ul> | <ul style="list-style-type: none"> <li>• Establish clear processes and responsibilities for selection, purchasing, order tracking and storage of SARS-CoV-2 supplies</li> <li>• Documentation and daily review of order status and inventory for SARS-CoV-2 reagents, MTBC reagents and PPE</li> <li>• Develop contingency plans and allocate resources for supply chain disruptions for all critical consumables, e.g., quality-controlled in-house preparation of transport medium, running alternative assays, reducing testing frequency, diverting samples to other laboratories</li> </ul>  |
| Process control          | <ul style="list-style-type: none"> <li>• Process control encompasses QC processes for testing</li> </ul>   | <ul style="list-style-type: none"> <li>• Perform in-house assay verification / validation for all newly introduced methods and reagents</li> <li>• Ensure that extraction and amplification controls, positive and negative control samples as well as QC ranges are valid for each test run before release of patient results</li> <li>• Set up lot control documentation for all SARS-CoV-2 test reagents</li> <li>• Implement four-eyes principle for interpretation and release of SARS-CoV-2 test results</li> <li>• Verify that the in-house testing algorithm is consistent with national and international standards and technical guidelines</li> </ul>  |
| Assessment               | <ul style="list-style-type: none"> <li>• Systematic examination of the quality management system to demonstrate that testing meets regulatory, accreditation and customer requirements</li> </ul>  | <ul style="list-style-type: none"> <li>• Cross-check random samples in regional, national or international SARS-CoV-2 reference laboratories</li> <li>• Set up internal and external SARS-CoV-2 audits</li> </ul>   |



| Determinant            | Description  | Implementation strategies for the SARS-CoV-2 / MTBC context   |
|------------------------|--|---|
| Personnel              | <ul style="list-style-type: none"> <li>• Training, motivation, and engagement of staff members as key parts of quality-controlled diagnostics</li> </ul>   | <ul style="list-style-type: none"> <li>• Participate in SARS-CoV-2 proficiency testing</li> <li>• Assure competency of personnel involved in SARS-CoV-2 testing by defining a practical training schedule with documented assessment including, as needed, safe sample collection, handling, transport, disposal of swabs, nucleic acid preparation, instrument operation, handling of results, biosafety</li> <li>• Develop contingency plans for staff shortages</li> <li>• Participation of key personnel in COVID-19 webinars can support rapid knowledge transfer to a local group of experts</li> <li>• Perform regular staff briefings on the local, national and international development of the COVID-19 situation to maintain motivation and engagement</li> </ul> |
| Stakeholder service    | <ul style="list-style-type: none"> <li>• The laboratory needs to understand the stakeholders and their needs and use feedback for improvement</li> </ul>   | <ul style="list-style-type: none"> <li>• Identify the needs of clinicians with regard to specimen transport, turnaround times for inpatients and outpatients, and reporting preferences</li> <li>• Identify the needs of public health authorities with respect to case notification requirements</li> </ul>  |
| Occurrence management  | <ul style="list-style-type: none"> <li>• Correct handling of nonconformities / accidents</li> </ul>  | <ul style="list-style-type: none"> <li>• Document and review all occurrences followed by feedback and discussion with technical staff</li> <li>• Facilitate investigations to identify the root cause of any occurrence to prevent reoccurrence</li> </ul>  |
| Process improvement    | <ul style="list-style-type: none"> <li>• Process improvement establishes a program to ensure continuous quality improvement over time</li> </ul>   | <ul style="list-style-type: none"> <li>• Define meaningful (measurable, achievable, interpretable, actionable, balanced, timed) quality indicators for SARS-CoV-2 testing, e.g., for turnaround time, competency of personnel, quality control, proficiency testing and customer satisfaction</li> <li>• Provide regular feedback to personnel about test and QC results</li> <li>• Foster team discussion of unclear results</li> </ul>  |
| Documents and records  | <ul style="list-style-type: none"> <li>• Documents need to be available at the point of work, maintained, accurate, and secure</li> </ul>  | <ul style="list-style-type: none"> <li>• Establish an SOP for SARS-CoV-2 testing covering reagent and sample management (collection, transport, processing, storage, retention, disposal), testing procedure and information management (reporting, notification to health authorities, archiving)</li> <li>• Set up a SARS-CoV-2 laboratory report sheet</li> <li>• Implement supporting documentation, e.g., training checklists, briefing protocols, inventory spreadsheets</li> <li>• Implement SARS-CoV-2 document control and storage</li> </ul>  |
| Information management | <ul style="list-style-type: none"> <li>• Laboratory data needs to be managed in a way that ensures all information is accurate, secure, confidential, and accessible to individuals with the right privileges</li> </ul> | <ul style="list-style-type: none"> <li>• Expand the current TB laboratory information workflow to handle SARS-CoV-2 data</li> <li>• Implement a process for timely notification of public health authorities</li> </ul>   |

\*QMS, quality management system; MTBC, *Mycobacterium tuberculosis* complex; PPE, personal protective equipment; SOP, standard operating procedure; UV, ultraviolet. Adapted from WHO guidelines (4).

## References

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