Report of virtual rGLC mission to Indonesia

Mission dates – 29 June to 15 July 2021 (with 3 online meetings)

Mission participants:
rGLC members – Dr Asif Mohammad, Dr Fraser Wares, Dr Padmapriya Chandrasekharan, Ms Paran Sarimita Winarni, Prof Wipa Reechaipichitkul, and
rGLC secretariat – Dr Vineet Bhatia (referred to as mission team)

Report compiled by rGLC secretariat with inputs from the participating rGLC members and review by NTP Indonesia

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Abbreviations and acronyms

aDSM	Active TB drug safety monitoring and management
BPaL	Bedaquiline, Pretomanid and Linezolid containing regimen
BPOM	*Badan Pengawas Obat dan Makanan* (National Agency of Drug and Food Control)
DHO	District Health Office
DR TB	Drug-resistant tuberculosis
DST	Drug susceptibility testing
FKTP	*Fasilitas Kesehatan Tingkat Pertama* (first level/primary referral health center in National Health Insurance system)
GFATM (GF)	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
LPA	Line Probe Assay
LJ	Lowenstein Jensen
MDR-TB	Multidrug-resistant tuberculosis
MICA	Monthly interim cohort analysis
MOH	Ministry of Health
NGO	Non-governmental organization
NTP	National Tuberculosis Programme
NTRL	National TB Reference Laboratory
PHO	Provincial Health Office
Puskesmas	*Pusat Kesehatan Masyarakat* (Primary Health Center)
rGLC	regional Green Light Committee
SITB	*Sistem Informasi Tuberculosis* (TB Information System)
SITRUST	*Sistem Informasi Tracking Untuk Specimen Transport* (Information System for Tracking Specimen Transport)
SLD	Second-line anti-tuberculosis drug
SOP	Standard operating procedures
STPI	STOP TB Partnership Indonesia
TB	Tuberculosis
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis
YKI	Yayasan KNCV Indonesia

Objectives

Objectives of the virtual rGLC mission:

- Assess progress since the previous rGLC mission and against the recommendations made by the previous rGLC mission
- Provide information of the updated WHO guidelines on MDR-TB diagnosis and treatment
- Identify challenges in the implementation of current WHO recommendations
- Update information on:
    - Whole genome sequencing preliminary result
    - Active TB drug safety monitoring and management (aDSM) preliminary result
- Discuss the ongoing preparations for implementation of the BPaL treatment regimen

Methodology of the rGLC mission

The mission was held virtually starting with on-line meetings on the 29 and 30 June 2021. The detailed agenda of these meetings is placed at the end of this report (Annex 1). This meeting was followed by email exchanges on further information needs and clarifications sought by the rGLC mission team. A follow-up on-line meeting was held on 15 July to discuss responses from the NTP and present draft recommendations from the mission team.

Observations

Progress against the priority recommendations of the 2020 rGLC mission

Recommendation	Responsible persons/agency	Timeline	Progress
1. Reducing the gap between detection and enrollment of MDR/RR-TB ➢ Engage clinicians to elaborate on prompt initiation of MDR/RR-TB treatment YUSIE, TIM LAB, SITB	NTP, Provincial health office	June 2020	NTP has conducted several workshops inviting DR-TB clinicians and nurses from all treatment centers to disseminate the DR-TB treatment guidelines which allow clinicians to initiate treatment within 7 days after RR-TB diagnosis is confirmed. It is also stated in the guidelines that clinicians do not need to wait for all laboratory/baseline exams result to be available to start the treatment.
➢ Strengthening pre-treatment counseling, through training and supportive supervision, focusing on positive aspect of treatment in order to encourage treatment uptake			• Engagement of Penabulu-STPI consortium as Community PR 2021 – 2023 to strengthen the community support for TB and DR-TB in 30 (out of 34) provinces and 190 (out of 514) Districts • Capacity building for DR-TB survivor groups by YKI (Mandiri TB) in collaboration with Provincial Health Offices • Updating, printing and dissemination of communication material for community team and cadres.
➢ Strengthening the linkage between Xpert sites and DOTS/DR-TB units at hospital and Puskesmas, including implementation of Xpert connectivity application, to ensure that health workers and patients are informed of Xpert results timely			• Regular Monthly interim Cohort Analysis (MICA) in districts to monitor enrollment of confirmed R resistant patients and minimize LTFU. MICA is monitored regularly by the provincial technical officers. • Up to June 2021, there were 268 (out of 1168) GeneXpert sites that had

➢ Conducting cohort review of Xpert *M tuberculosis* rifampicin resistance detected to monitor loss of patients at each step from diagnosis to treatment			GeneXpert connectivity using *Sistem Informasi Tracking Untuk Specimen Transport* (SITRUST) – still in early implementation phase Under the acceleration plan, MICA was introduced and actively monitored in 119 priority districts (out of a total of 514 districts) resulting in 58% enrollment rate in 2020, compared to 48% in 2019. In 2021, MICA will be expanded into more districts and monitored by the PMDT technical officer of the TB programmer at the provincial level.
2. Improve outcome of MDR/RR-TB ➢ Strengthening the capacity of treatment sites for early decentralization of treatment ➢ Strengthening education of health workers and incentivize willingness of health care workers in taking care of MDR/RR-TB ➢ Establish provincial consilia for mentoring clinical management of MDR/RR-TB at treatment cites and, in the community, under the guidance and support of national consilium.	NTP, Provincial health office	June 2020	Most of the DR-TB satellites are Puskesmas which is at the first level of the health services for referral (FKTP). DR-TB training material is included in the FKTP training material. The FKTP training budget is available and has already been distributed to all provinces. Additional on-the-job training is decentralized to Puskesmas, organized by the Hospital and DHO, and is given to DR-TB patients when needed. In the piloting phase of providing ± USD 14 incentives for DR-TB Health Centre and satellite's staff for each completed and cured 2021 patients. • Finalization of the SOP for the Provincial Consilia, will be disseminated on July 2021. • Budget available in each province • Supervision will be conducted with the provincial team consisting of DR TB clinical expert team and Provincial/District Health Office team • Most provinces have a WhatsApp group to discuss management of DR-

➢ Enhance the capacity of health workers in clinical management of MDR-TB treatment by regular on-site supervisory visit and off site consultation by provincial consilium			TB cases among clinicians and programme staff • Some provinces have already established the team above informally. • On site supervisory visit activities will follow the Consilium guideline. Budget available at the provincial level • Clinical mentoring activity available in 119 (of 514) districts

3. Addressing social and financial barriers (including income loss) of patients to access treatment service by mobilizing additional funding from provincial and city/district government	NTP, Provincial health office		• Some provinces have already provided social support for DR-TB patients:
			  • Food/nutritional support, enabler from local government budgets, ambulance for patients transportation from district level to provincial level or beyond,
			  • Monthly support from Ministry of Social Welfare (PKH) 2020
			• Presidential Decree for TB programme almost finalized

4. Engaging civil society organization and establishing patients support group to establish community-based patient centered care	NTP, Provincial health office		• National guideline for TB Community Support finalized and disseminated
			• PR community work in 190 (/514) districts – 30 (/34) provinces
			  ○ POP-TB network
			  ○ Establishment / expansion of the availability of patient organizations into more districts
			  ○ Some patient organizations receive support from the local government budgets (for example DKI in South Sulawesi)
			  ○ Yayasan KNCV Indonesia (YKI) through Mandiri TB project in 3 provinces for strengthening CSO
			• Development of mobile application for treatment monitoring by satellite staff and Cadre
			• Provision of mask and hand sanitizer for community and cadres to ensure

			continuity of treatment support during COVID-19 pandemic

5. Strengthening TB infection control and active TB drug safety monitoring and management (aDSM) at treatment centres, treatment sites and also in the community, through training, on site supportive visit, and on-line consultation	NTP, Provincial health office		• PV National Committee established and has develop workplan - not yet implemented due to COVID-19 pandemic situation
			• Strengthening Implementation of aDSM in Indonesia via technical assistance (TA)
			• On track in the development of a "Concept Note for Strengthening aDSM in Indonesia" via TA (Dr Geraldine Hill)
			• On track regarding identification of training needs for aDSM and workshop planning via TA
			• Centralized Causality Assessment by Badan Pengawas Obat dan Makanan (BPOM)
			• Survey results looking at the implementation of aDSM in the DR-TB sites :
			  • Awareness of aDSM remains low despite the trainings that have taken place.
			  • The distance between patients' homes and the hospital is a barrier to accessing the hospital-level DR-TB treatment services.
			  • Limited availability of laboratory tests and diagnostic equipment at the Puskesmas level.
			  • On-line training on Sistem Informasi Tuberkulosis(SITB)was conducted in 2020, but many healthcare workers are not yet familiar with how to report severe adverse events (SAE).

Achieved	
Some progress/ ongoing	
No change	

Programme performance - (based on the presentation by NTP during the meetings and subsequent information provided over e-mail).

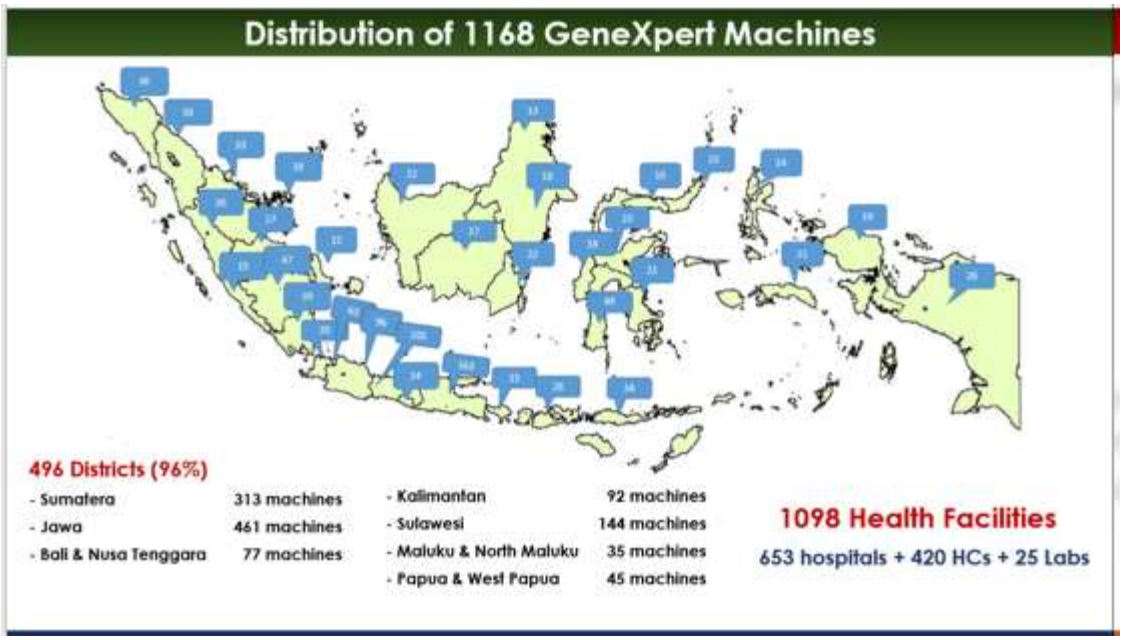
Overall Achievements

- Improving DR-TB case finding activities until 2019. A peak of more than 11,000 patients diagnosed in 2019.
- SITRUST being used for laboratory networking. This software helps in booking services and tracking sample referral. The software is bridged with SITB, the current reporting software being used by national programme.
- Slight improvement in treatment outcomes of patients on second-line treatment, though at 46% it is still far from the ideal.
- Introduction and roll-out of an all-oral regimen. There are also increasing targets/proportions for patients to be initiated on the shorter all-oral regimen.
- The country is planning operational research (OR) for the BPaL treatment regimen. A draft OR protocol has been developed and was in last stage of finalization during the mission.
- Availability of a "PMDT acceleration plan" focusing on key areas and challenges that need to be addressed for improving the diagnosis and treatment of RR-/MDR-TB patients, which has subsequently been incorporated in the National Strategic Plan 2020 – 2024.
- Strong engagement of community networks. A capacity building workshop of survivor groups was organized in 2020 with rGLC support and local NGOs.

Laboratory capacity

The country has done well in expanding access to the WHO recommended molecular diagnostic services. The mission team were informed that there are now total of 1 168 GeneXpert machines distributed in 1 098 health facilities covering 496 (of 514) districts. However, the distribution of the machines does not appear to be uniform across all provinces. Kalimantan and Papua seem to have a lower number of machines, considering the geographical expanse, the situation may be resulting in limiting access in these areas.

Figure 1. Availablity and distribution of GeneXpert machines in Indonesia



The country has also established an increased drug susceptibility testing (DST) capacity, with currently 14 DST laboratories. There is in-country capacity to undertake DST to key second line drugs (SLD) including the new and repurposed drugs such as bedaquiline (Bdq), linezolid (Lzd) and clofazimine (Cfz) (see Table 1). There is one DST lab in Papua and one in Kalimantan Provinces, they do not have the capacity to perform second-line (SL) line probe assay (LPA) testing, but in 2021 NTP is under process for final installation of 500 GeneXpert 10 colour modules as part of preparation of expanding the access to SL DST, including to Kalimantan and Papua. Training workshop is ongoing.

Table 1. DST capacity in the country

Drug	DST (MGIT)	SL-LPA	Number of laboratories
INH- High Dose	✓		14
Moxifloxacin- High Dose	✓	✓	15
Moxifloxacin- Low Dose		✓	-
Levofloxacin	✓	✓	15
Amikacin	✓	✓	15
Kanamycin		✓	7
Capreomycin		✓	
Pyrazinamide	✓		14
Linezolid	✓		14
Clofazimine	✓		14
Bedaquiline	✓		14

A system for linking various diagnostic centres using SITRUST software has been established. The system allows for linking specimen collection to a courier agency which can then transport the specimen to appropriate laboratory. The collection centre does not need to pay for the transport when the transport is within the province. However, in certain cases where the laboratory is located outside the province

such as for DST to new drugs, payments need to be made upfront and charge the payment to the PHO later.

Treatment regimen

The country is now moving to treatment regimens in alignment with the latest WHO recommendations. All-oral shorter and longer regimens are being rolled out. As described in Table 2. below the regimen composition is in accordance with the latest guidance issued by WHO.

Table 2. Second-line regimens being used

Treatment Option (2020)	Drugs Composition	Total treatment duration	Previous composition
All-oral shorter regimen	Bdq (6M) – Lfx- CFz- H^{HD}- Z-E- Eto/ Lfx-Cfx-Z-E	9-11 Months	Am- Mfx-Cfz- H^{HD} - Z-E—ETO/Mfx-Cfz- Z-E
All oral longer regimen	Starting with 5 drugs from Groups A/B/C, continue with 3-4 drugs after Bdq is stopped	18-24 Months	5 effective drugs form group A/B/C/D (WHO 2016), including second-line injectable (SLI) agents

The National TB Programme (NTP) has ambitious targets for enrolment of patients on all-oral shorter regimen, reaching nearly 4,000 patients in 2021. There is also a plan to phase out the second-line injection-containing regimens (shorter and longer) in the coming years. However, it is reported that certain patients were put on a shorter injection-containing regimen in the year 2021. This is apparently because of limited access to SL DST, exacerbated by the ongoing COVID-19 pandemic. The longer injection-containing regimens are being used as a backup for patients who cannot be administered the all-oral regimen for various reasons.

Table 3. Enrollment on regimen

Regimen	Criteria for using the regimen	Number of patients			
		2019	**2020**	**2021 (Target)**	**2021 (on 7 May)**
Oral shorter regimen	MDR/RR-TB (*introduced in Aug 2020*)	0	571	3853	515
Oral longer regimen	MDR/RR-TB previously treated> 1 month, pre-XDR/XDR-TB, STR intolerant (*introduced in October 2019*)	1393	2111	2012	770
Shorter regimen with SLI agent	MDR/RR-TB (*Introduced in Aug 2017*)	3085	1159	0	37

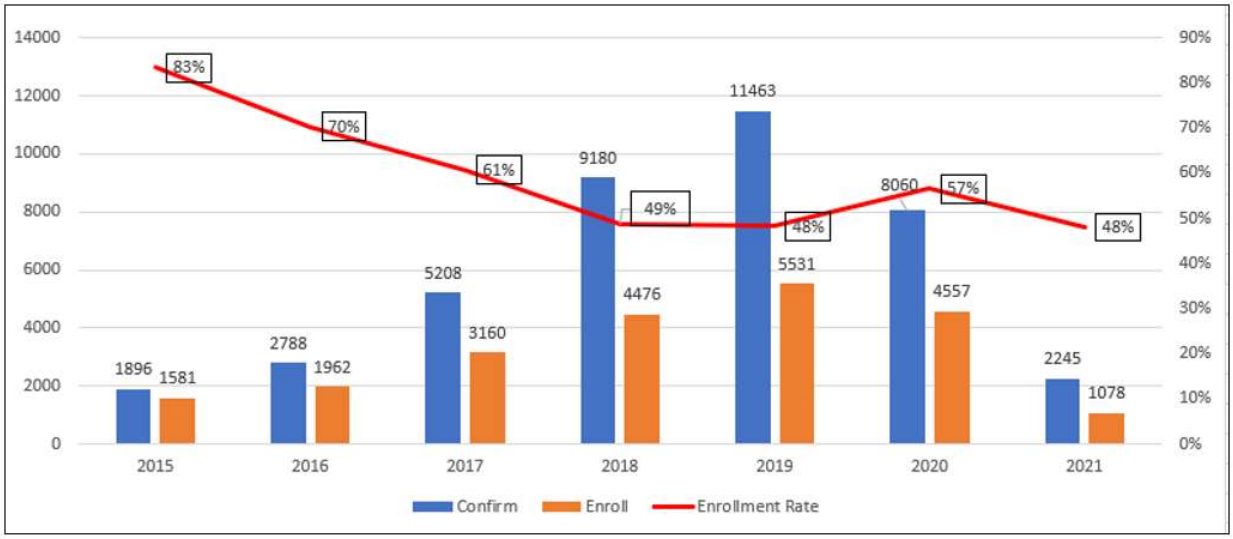
longer regimen with SLI agent	MDR/RR-TB previously treated> 1 month, pre-XDR/XDR-TB, STR intolerant	1172	544	150	37
Total		**5650**	**4385**	**6015**	**1359**

Trends in notification and enrolment of MDR/RR-TB patients

As can be seen from the graph below there has been a steady increase in case finding of MDR/RR-TB since 2015. The number of MDR/RR-TB cases diagnosed has increased by more than eight-fold since 2015. However, a decline of about 20% is seen between 2019 and 2020. Also, it is to be noted that WHO estimate that 24,000 MDR/RR-TB cases emerging each year (c.f. only 4,557 enrolled on treatment in 2020).

Amongst the diagnosed cases those who are enrolled on for treatment had in 2020 improving, but still not at the same pace as the increase in numbers being diagnosed. The proportion of numbers diagnosed versus enrolled on treatment dropped to a low of 48% in 2019. Although this slightly improved to 57% in 2020, it is still far from the expected enrolment proportion of at least 90% among those diagnosed with MDR/RR-TB.

Figure 2. Trend in MDR/RR-TB case diagnosis and enrolment on treatment, 2015 - 2021



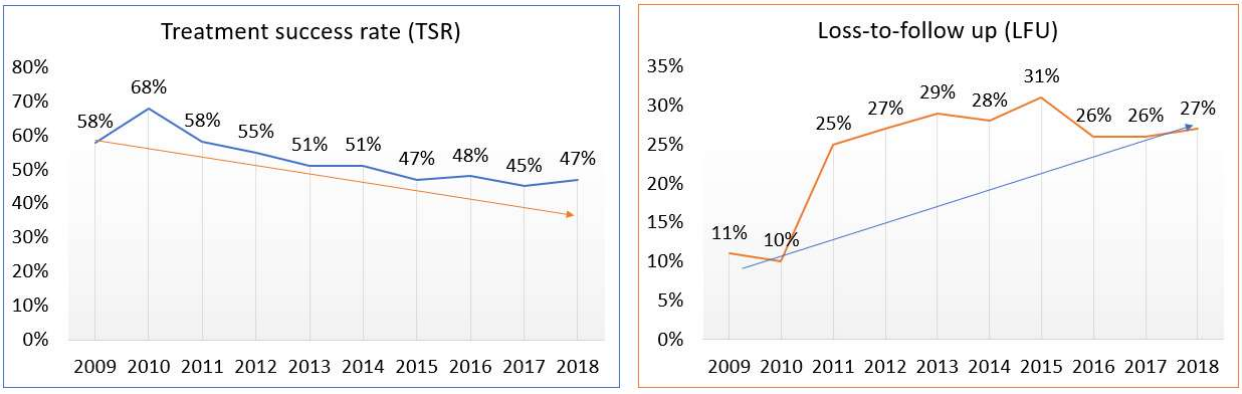
Challenges with treatment outcomes

Overall, the country has witnessed a low and declining treatment success rate amongst MDR/RR-TB cases since the 2010 cohort. The success rate has been less than 50% among those initiated on treatment since 2015, reaching its lowest for 2017 cohort at 45% (see Figure 3). In addition to the initial loss from diagnosis to being initiated on treatment described above, there is also a very high loss to follow-up amongst those put-on treatment - remaining above 25% for past seven years (see Figure 3).

Of interest was the (anecdotal) comment by Indonesian colleagues that a significant number of patients who were enrolled on the all-oral shorter treatment regimen (STR), were in fact not eligible. Also, it was

reported (again anecdotally) that many patients treated with the all-oral STR suffered adverse events, although less than when the regimen contained a SLI.

Figure 3. Trends in treatment success rate and loss-to-follow-up among those initiated on second-line treatment, 2009 - 2018



COVID-19 situation at the time of rGLC mission

Indonesia has been severely impacted by the COVID-19 pandemic in 2021. At the time of the mission, the country was reporting nearly 50,000 cases daily. The outbreak has both directly and indirectly impacted TB services, including those for the DR-TB patients. There has been diversion of TB programme resources to the COVID-19 response activities, including human, financial and infrastructure. Namely:

1. About 80 % of the TB program staff have been diverted to manage COVID-19 pandemic & vaccination program;
2. GeneXpert utilization for TB has dropped to 30-35%;
3. Many TB and MDR-TB wards are now COVID-19 wards (about 300 hospitals and 100 MDR- TB wards are now being used for COVID-19 patients).

Figure 4. Snapshot of COVID-19 status on 13 July 2021 (in Bahasa)

Impact of COVID-19 on TB detection in Indonesia in 2020

As per the preliminary, unpublished data available for TB case notification, there is a decline of about 40% against that observed in 2019 (Figure 5). Looking at the monthly data, the decline has been maximum in the later part of 2020 (Figure 6). This data may be seen in the background of the facts that the maximum impact of COVID-19 is being seen only now in 2021. Therefore, the decline is likely to be even more severe in the current year.

Figure 5. Annual trend of TB case finding since 2016

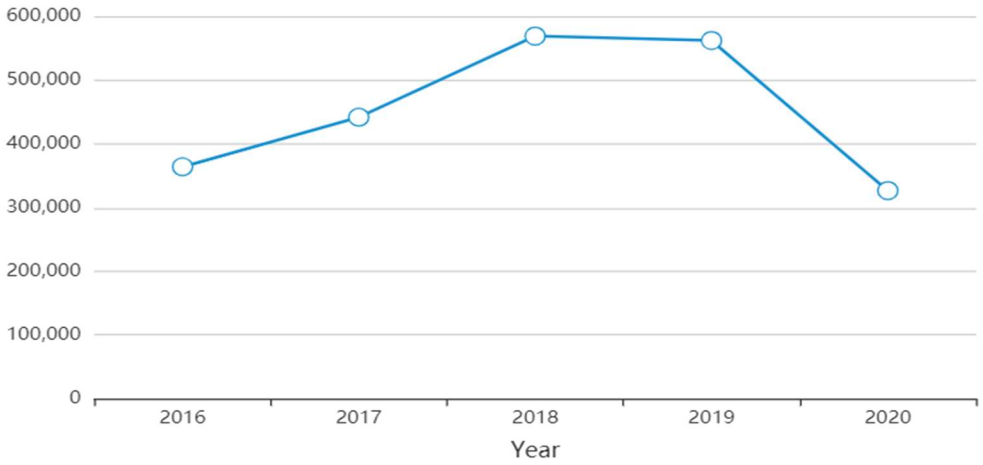
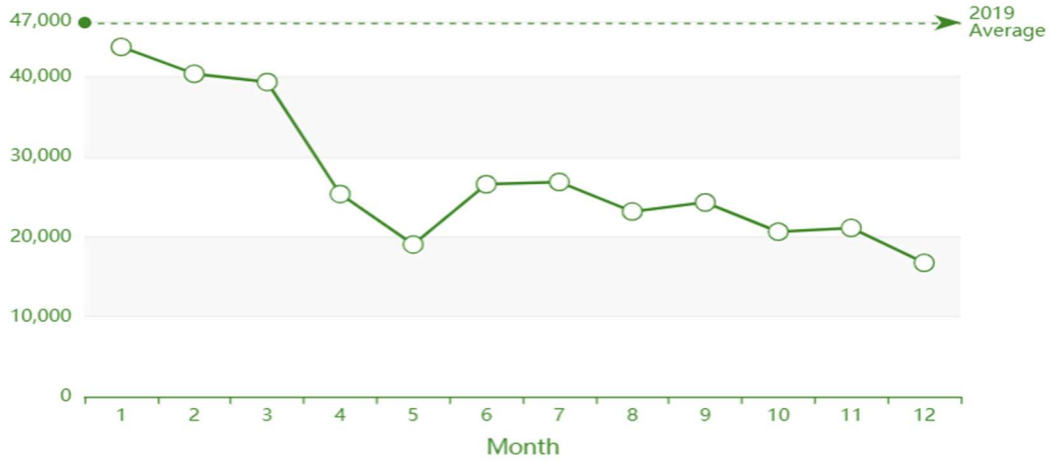
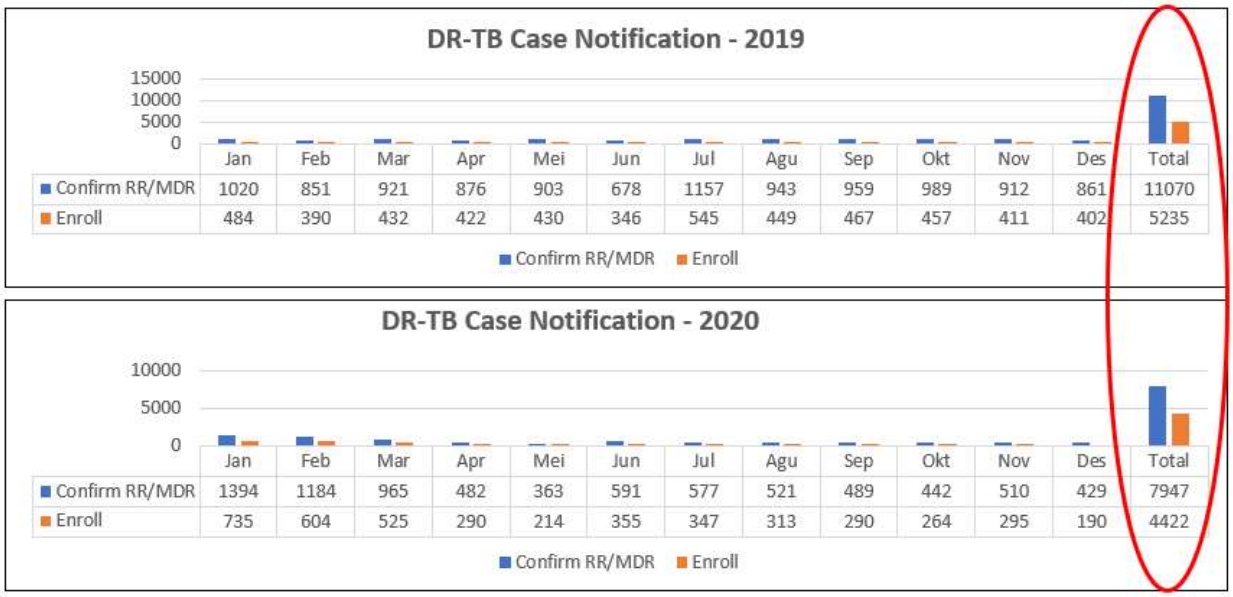


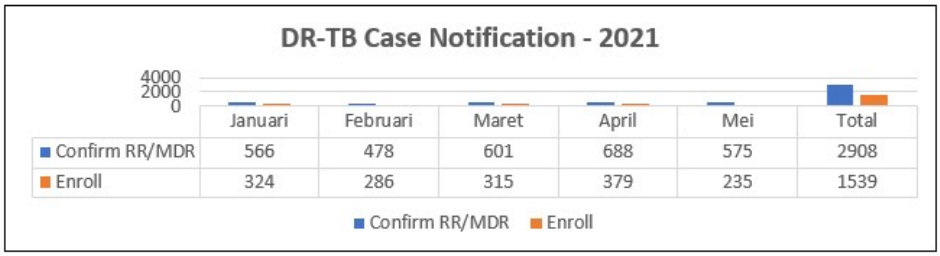
Figure 6. Monthly trend of TB case finding in 2020



Extrapolating from the data presented to the mission team for the first half of 2021, it appears that around 6,000 MDR/RR-TB cases may be diagnosed in this year, which would be far below the peak of more than 11,000 cases diagnosed in 2019 (Figure 7). The current enrolment of MDR/RR-TB patients is just above 50%, which is another major concern, given that the country is also embarking on rolling-out of the all-oral regimens.

Figure 7. Comparison of DR-TB case finding and enrolment 2019-2021 (at the time of the mission)





Source : e-TB dan SITB per 26 Juni 2021

Active TB drug safety monitoring and management (aDSM)

At the time of conducting this mission, an external review of aDSM had just been completed. The aDSM review has been facilitated by the SEA rGLC secretariat and funding made available through the TDR unit of WHO. Preliminary findings of aDSM review were presented during the mission. While the discussions on aDSM were held with the consultant and NTP team during the rGLC mission, there was no separate review of this important aspect. The rGLC mission team found it concerning that the system of recording and reporting, specifically of serious adverse events is still weak in the country. There is incomplete data in SITB, the national reporting system for TB programme. There is also little analysis of information generated from SITB on adverse events. An emphasis on strengthening aDSM in totality with stronger linkages between the national programme and the pharmacovigilance department is being laid by the rGLC mission. This report should be read in conjunction with the aDSM report.

Implementation of the BPaL regimen under operational research conditions

Four presentations were made on 30 June 2021 to the rGLC mission team in relation to the BPaL regimen. The first was from the SEA rGLC Chair on the current WHO guidance and recommendations on the use of BPaL. Two presentations were given by representatives of the TB Alliance in relation to clinical updates and drug availability for BPaL, and current status of BPaL OR activities around the world. This was followed by a presentation of the implementation plan of BPaL in Indonesia and the draft BPaL OR protocol by the NTP in collaboration with YKI. The plan and protocol were subsequently discussed, with the rGLC mission team providing suggestions to the Indonesian colleagues on the plan and draft protocol.

Summary challenges

- Low detection of MDR/RR-TB cases against an estimated incidence of 24 000. Possible causes:
    - low accessibility to diagnostics and especially insufficient capacity for SL DST;
    - laboratory network not adequately functional due to:. remote location, wide distribution, lack of specimen transport mechanism, etc. ; and
    - Underutilization of GeneXpert capacity and subsequent diversion of laboratory capacity to COVID-19 response from 2020.
- High initial loss to from diagnosis to enrolment on treatment, and low treatment success rates (with very high LTFU rates) possibly due to:
    - inadequate decentralization;
    - inadequate or inappropriate pre-treatment counselling; and
    - lack of sufficient socio-economic support.
- COVID-19 pandemic expected to aggravate these problems because of diversion of TB service resources to the COVID-19 response.
- Weak aDSM system – incomplete information in SITB, little analysis, some missing SOPs.
- Weak supervision and monitoring to hospital and further to satellite level.

Priority recommendations from the 2021 rGLC mission

Recommendation	**Responsible persons/agency**	**Timeline**
1. Case finding: ○ Update the 2020 PMDT acceleration plan, to include plans for additional catch-up activities. ○ Expand GeneXpert network, usage and use as initial diagnostic test. Wider use of updated diagnostic algorithm accordingly. ○ Expand DST laboratories and SL LPA capacity. Consider introduction of Xpert/XDR tests to further expand access to SL DST ○ Plan for the introduction of diagnosis and treatment of isoniazid-resistant TB patients – expand isoniazid susceptibility/resistance testing capacity, preferably using first-line LPA.	NTP, PHO, DHO, community groups and patients, along with all partners	Q4, 2021
2. For reducing initial loss from diagnosis to enrolment on treatment: ○ Analyze challenges for implementing the proposed activities for reducing this initial loss. Strengthen MICA and expand to all districts. Community generated patient information can be used for review of field situation. ○ Strengthen social protection for TB and MDR/RR-TB patients, including pre-treatment counselling with wider engagement of communities. ○ Use social media for contacting patients once they are referred for diagnosis of drug-resistance or immediately after diagnosis. ○ Expand treatment centres and decentralize treatment initiation as much as possible. However continued diversion of isolation wards from MDR-TB to COVID-19 services could remain a challenge. Decreased dependence on hospital admission may help. ○ Expand geographical coverage of MICA and document impact of pilot sites (if not done already). ○ Additionally, consider the use of report from Penabulu-STPI available from the patient supporter for information on adverse events and reports of home visit. This will provide insight into reasons for loss to follow-up	TWG, NTP, PHO, DHO MDR-TB treatment sites, community groups and patients.	Qtr 4 2021

3. Treatment initiation, monitoring and aDSM: ○ Strengthen supervision, monitoring and mentoring on DR-TB to hospitals and satellite centres. ○ Increased sensitization to the eligibility criteria for enrolment on the STR so that these are adhered to. Consider developing a checklist for this purpose. ○ Develop/update plan for all required capacity building of HCW on the various components of PMDT for 2021-2022. ○ Role of AEs in LTFU needs to be reviewed. (ongoing study) ○ Sensitization of HCW on detection, management and reporting of AEs. Detailed analysis of the AE data in the aDSM system – including segregation of SAEs to be conducted to see patterns of AEs and action taken. Plan interventions according to results of analysis. Critical with the introduction of BPaL in the near future. ○ Discuss support required for BPaL implementation, specifically monitoring of patients on the regimen.	NTP, PHO, DHO along with all partners and patient support groups. For BPaL, PI will be key partner	Q4, 2021
4. PSCM: ○ Urgently conduct a SLD stock inventory and forecasting exercise: and ○ Ensure close stock monitoring to prevent expiry of Xpert cartridges.	NTP	Before end of Q3, 2021
5. Non-laboratory confirmed TB cases: Further analysis of patients diagnosed as TB without laboratory tests needs to be done. The proportion is close to 20% now.	NTP and NRL	Before end of Q3, 2021
6. SITRUST: Explore expansion of the use of SITRUST and also without having the need to make payment when specimen needs to be sent to another province	NTP and NRL	Q4, 2021
7. New case and treatment outcome definitions: NTP to apply the updated pre-XDR-TB and XDR-TB definitions, as well as the updated treatment outcome definitions.	NTP	Q3, 2021
8. Counselling: Counsellors to be re-orientated to provide information in a patient-friendly positive manner that is non-scary to the patient.	NTP, PHO, DHO, counsellors and patient support groups	Q1, 2022
9. Draft BPaL OR protocol: Update draft BPaL OR protocol following inputs of the rGLC mission team, finalize protocol and submit for Institutional Review Board (IRB) approval.	NTP and YKI	Q3, 2021

Annex 1: Agenda of the meeting on 29-30 June 2021

Day	Activity	Participants
Day 1		
	with rGLC	
14.00 – 14.15	Opening	NTP Manager
14.15- 14.45	NTP updates (including Covid Impacts)	NTP Manager
14.45 – 15.00	Discussion	
15.00 – 15.30	NTP presentation of all oral regimen evaluation	Head of DR TB Dept - NTP
15.30 – 15.45	NTP presentation of previous rGLC recommendation	PMDT focal person
15.45 – 16.00	Discussion	
16.00 – 16.15	Updated WHO guidelines on MDR-TB diagnosis and treatment	rGLC secretariat
16.15 – 16.30	Discussion	
Day 2 – Future DR TB drugs – information and implementation preparation		
14.00 – 14.15	aDSM evaluation result	aDSM TA – Dr Geraldine Hill
14.15 – 14.30	Discussion	
14.30 – 14.45	WGS result presentation -	NIHRD DRS/WGS Team
14.45 – 15.00	Discussion	
15.15 – 15.30	BPaL Clinical updates & drug availability	TB Alliance
15.30 – 15.45	BPaL implementation updates	TB Alliance
15.45 – 16.00	Discussion	
16.00 – 16.15	Current recommendations and guidance from WHO on use of BPaL	rGLC chair
16.15 – 16.25	BPaL OR Plan	NTP / YKI
16.25 – 16.30	Discussion	
16.30 – 16.35	Next steps	rGLC secretariat
16.35 – 16.45	Closing	NTP

The above meeting was followed up with a call on **15 July** to discuss information exchanged over e-mails after the meeting and also the draft recommendations.

Annex 2: List of participants

I. Participants from Central Level

1. Ditjen Binfar (2 person
2. DItjen Yankes (2 person)
3. DRS Team/Balitbangkes (3 person)
    a. Dr. Lamria Pangaribuan
    b. Farid
    c. Yuni
4. National reference lab :
   Dra. Ariani
   Dr. Koesprijani Sp.MK
   Dr. Titiek Sp.MK
5. BPOM
    a. Kasubdit
6. PV National Committee
    a. Dr. Nafrialdy Sp.PK, Sp.PD
    b. Dr. Instiaty Sp.PK
    c. Dr Grace Wangge, MPH
    d. Dr. Wawamuli
7. NTP MoH
    a. Kasubdit TB : dr. Imran Pambudi, MPHM
    b. Kasie TB RO : dr. Endang Lukitosari, MPH
    c. Kasie TB SO : dr. Sulistya Widada
    d. Focal Point TB RO : dr. Retno Kusuma Dewi, MPH
    e. Focal Point Logistik : Totok Haryanto, SKM. M.Kes
    f. Triana Yuliarsih, SKM
    g. Hanifah Rizky PS, SKM
    h. Tiara Verdinawati, SKM
    i. Dina Frasasi, SKM
    j. Vini Gokkana, SKM
    k. R Roro
    l. Lydia Mursida
    m. Yudi Permana

8. PR Komunitas & Organisasi Pasien

- POP TB (2 orang)
- PETA (2 orang)

- STPI/Penabulu (2 orang)

9. WHO Indonesia (3 orang)

- Dr. Setiawan Jati Laksono
- Dr. Regina Loprang
- Mikyal Faralina, SKM
- Yoana Anandita, SKM
- Jonathan Marbun

10. TB STAR (3 orang)

- Dr. Yusie Permata, MIH
- Tiar Salman, ST
- Roni Chandra, M.Biomed

11. YKI

- Dr Angelin Yuvensia
- Dr Alva Juan
- Dr Fransisca Sp.PK
- Erman Varella