Ministry of Health
Health Policy Agency
Jalan Percetakan Negara No. 29.
Jakarta 10560
(021) 4261088 (Hunting)
https://www.badankebijakan.kemkes.go.id

Ref. No. : KS.02.03/H.V/4921/2026 **13 November 2026**
Enclosure : One (1) Annex

To: The Chair and Members of the Executive Board of the World Health Organization; the Heads of Delegation of the Member States of the World Health Assembly

Excellencies,

The Government of the Republic of Indonesia has taken note of the letter dated 4 November 2026 from the Coalition for Health Justice Indonesia concerning the nomination of Mr. Budi Gunadi Sadikin as a candidate for the position of Director-General of the World Health Organization for the 2027–2032 term.

The Government of the Republic of Indonesia recognizes the important role of civil society organization in advocating for public accountability and contributing to constructive policy discourse. However, engagement is at its most constructive when it is rooted in verifiable facts, respecting established institutional processes and bearing in mind the difference between legitimate debate on domestic policies and the matters of international institutional appointments.

The Government considers it important in this respect that the process of nominating the Director-General of the World Health Organization not be an extension of domestic political contestation, nor be used for the advancement of agendas unrelated to the evaluation of the qualifications, professional record and capacity of a candidate to lead the Organization. Submissions in relation to the nomination should therefore be assessed in the appropriate institutional context and objectively against the relevant evidence and established criteria.

To ensure that Member States have a full and balanced picture, the Government of the Republic of Indonesia has prepared the accompanying annex to provide factual explanations and relevant institutional context on the issues raised in the Coalition’s letter. The annex deals with seven broad areas. It is founded on relevant legislation, court decisions, official government data, and documented policy developments. It also sets out the Government’s continuing efforts to improve institutional governance, address implementation challenges and ensure accountability across Indonesia’s health system.

The Government trusts that these explanations will assist in an informed and objective consideration of the matters raised. Finally, the evaluation of each candidate should be against the established criteria and requirements of the World Health Organization, including their professional qualifications, leadership experience and ability to promote the mandate of the Organization.

Dokumen ini telah ditandatangani secara elektronik menggunakan sertifikat elektronik
yang diterbitkan oleh Balai Besar Sertifikasi Elektronik (BSrE), Badan Siber dan Sandi Negara (BSSN).

The Government of the Republic of Indonesia reaffirms its commitment to transparency, accountability, constructive engagement and multilateral cooperation. We stand ready to continue the dialog with Member States and relevant stakeholders in our shared endeavour to build a stronger, fairer and more effective World Health Organization.

Please accept, Excellencies, the assurances of our highest consideration.



Harditya Suryawanto
Director of Center for Global Health Strategy and Governance Policy

Dokumen ini telah ditandatangani secara elektronik menggunakan sertifikat elektronik
yang diterbitkan oleh Balai Besar Sertifikasi Elektronik (BSrE), Badan Siber dan Sandi Negara (BSSN).

ANNEX

QUESTION 1.
Is it true that the Ministry of Health is "punishing" physicians and health policy scholars who criticize its policies?

ANSWER
Ministry of Health attaches great importance to the merit system in the talent development and the evidence policies to advance a more equal, affordable and better quality of health services across the country.

Civil servant rotation is a routine practice within the Health Ministry. These rotations are solely based on organisational needs and conducted under existing regulations. The civil servants are prohibited from refusing assignment to any places across the country, unless there is evidence of maladministration.

Since 2024, approximately 150 civil servant physicians have undergone routine rotations to address workforce and specialist distribution gaps across Ministry's hospitals. Of these, only one physician (Dr. dr. Piprim Basarah Yanuarso) has formally objected to the policy and filed complaints with the administrative court. Civil servants, however, retain the right to raise concerns through judicial channels. Below is the clarification for each accusation.

No	Name	Allegations	Government Response
1	Prof. dr. Zainal Muttaqin, SpBS(K), PhD	Dismissed from Kariadi General Hospital because of an article	• Disinformation • Employee status: part time physician under temporary contract
2	Prof. Dr. dr. Budi Santoso, SpOG(K)	Removed from His Position as Dean of the Unair School of Medicine	• Disinformation • The appointment and removal of the Dean fell under the authority of the university's Rector. The Health Minister has no authority at all over university management**.** The removal took place on 3 July 3rd, 2024 and was subsequently revoked on July 9th 2024.
3	Dr. dr. Piprim Basarah Yanuarso, SpA(K)	Transferred to Fatmawati General Hospital and then dismissed	• Civil servant is required under regulation to accept any assignment to any places in the country

ANNEX

			• Piprim is assigned to a hospital in Jakarta which is one-hour drive from his previous hospital. • Piprim filed complaint with the administrative court, and the Ministry is in the process of filing a review with the court
4	Dr. dr. Hikari Ambara Sjakti, SpA(K)	Transferred to RSAB Harapan Kita	• The individual was transferred to another hospital in Jakarta. • Hikari is assigned to a hospital in Jakarta which is one-hour drive from his previous hospital. • He never filed any formal complaint over his transfer.
5	Dr. dr. Raden Suhartono, SpB, SubspBVE(K)	Suspended from clinical teaching duties at RSCM	• Disinformation • Minister of Health does not have any conflict with Suhartono, and he never filed any formal complaint.
6	Dr. dr. Fitri Hartanto, SpA(K)	Transferred from Kariadi General Hospital	• Civil servant is required under regulation to accept any assignment in any places in the country • Fitri is assigned to a hospital in Yogyakarta which is three hour drive away from his previous hospital • He never filed any formal complaint
7	dr. Rizky Adriansyah, M. Ked(Ped), SpA(K)	Dismissed from Adam Malik General Hospital	• Disinformation • The individual was employed as a part-time physician under a non-permanent contractual arrangement.

Judicial proceedings concerning Dr. dr Piprim Basarah Yanuarso

a. The Supreme Court ruled the Ministry's transfer decision invalid.
b. The Ministry is pursuing further legal appeal through a judicial review with the administrative court.
c. The Ministry intends to file a petition before the administrative court seeking a ruling on the enforceability of the dismissal decision, citing alleged violations of civil service attendance regulations (specifically, 10 consecutive days or 28 cumulative days of

unjustified absence within one year). The Ministry maintains that Dr. Piprim accepted the dismissal, as he did not submit an administrative objection or initiate legal proceedings to challenge the decision.

d. Dr. Piprim submitted a request to withdraw his pension funds in July, which the Ministry interprets as his acceptance to the termination of his civil service employment.

QUESTION 2.

What steps is the Ministry of Health taking to implement the Constitutional Court's ruling regarding the independence of the Health Professional Collegium?

ANSWER

1. Prior to the enactment of 2023 Health Law and the ensued Government Regulation on Health, Collegium of health professionals was already not in an independent footing as they were subordinate to or part of medical organizations or associations. Legally, such establishment is not accountable to the public. The leadership of the Collegium was appointed at the time without a transparent process.
2. Following the enactment of the Health Law, the Collegium was granted greater independence, and its governance became more transparent and accountable to the public as they part of state institution.
3. The Constitutional Court's decision did not dissolve the current Collegium system nor remove its board members. The decision merely stripped the Ministry of Health of its authority to select candidates for the Collegium board and to establish a new type of Collegium.
4. The Ministry of Health is currently revising Government Regulation on Health in collaboration with relevant ministries and agencies to ensure legal certainty and alignment with the respective Constitutional Court ruling.

QUESTION 3.

What is the Ministry of Health's response to the policy on hospital-based residency programs, which has been widely opposed by medical professors and academics?

ANSWER

1. **Specialist physician shortage and maldistribution, and the needs for reform**
   Indonesia faces not only a projected shortage of nearly 65,000 specialists by 2032, but also significant geographical disparities in the distribution of specialist physicians, particularly in underserved regions. For more than 20 years, Indonesia's specialist residency had not adhered to global best practice, in which the pathway of specialist training for physician must registered with universities and had to pay a huge amount of tuition to the universities. This has dramatically hindered the production of more specialist. But under the 2023 Health Law, the government has an option to introduce a new pathway of specialist training through hospital in a bid to speed up the production of specialist as well as ensuring its distribution.

ANNEX

2. Hospital-Based Specialist Education

a. The hospital-based specialist education pathway, is designed to expand training capacity and complement, not replace, the existing university-based system. Indonesia has historically required specialist medical trainees to pay tuition fees to the universities providing their education, whereas many other countries provide financial incentives or remuneration to specialist trainees.
b. The program broadens opportunities for qualified doctors, with potential affirmative prioritisation for underserved regions and post-training service obligations for designated participants.
c. The pathway introduces financial support arrangements. Tuition, remuneration, scholarships, and funding are applicable.
d. The hospital-based pathway is limited to doctors from underserved regions, and it will not compete with universities in attracting participants.
e. Hospital organising such program is courted by the attainment of international accreditation from the Accreditation Council for Graduate Medical Education International (ACGME-I), as well as national accreditation from LAM-PTKes. These accreditation requirements demonstrate that the expansion of hospital-based education remains firmly committed to maintaining educational standards and quality.

QUESTION 4.

Genomic data is being collected on a large scale, while systems for governance, regulation, oversight, and data protection are considered to be unprepared. How is BGSi governance and security of the genomic data that has already been collected being managed?

ANSWER

The the COVID-19 pandemic has boosted Indonesia's capability on genome sequencing. Indonesia is determined to leapfrog in science and technology capabilities to identifythe type or variant of the virus, and also to provide precision medicine. Moreover, it supports the government’s responsibility to monitoring the public health emergencies and emerging diseases.

The Biomedical and Genome Science Initiative (BGSi) was established to strengthen Indonesia's capacity in genomic research and precision medicine. This leapfrogging initiative seeks to support the development of more targeted healthcare services while strengthening national scientific and technological capabilities.

The Government of Indonesia recognises that genomic data is highly sensitive personal information and that its collection and use require robust institutional governance, clear legal safeguards, and appropriate technical security measures.

The Government also recognises the importance of addressing the governance challenges associated with large-scale genomic data collection. These include institutional oversight, data protection, participant consent, research access, cybersecurity, and the equitable distribution of benefits arising from genomic research.

ANNEX

1. Follow-up to the Ministry of Health's 2024 Policy Brief

Several key points challenged by the Coalition of Health Justice highlighted in the Policy Brief regarding the use of genome sequencing have been addressed as follows:

No	Issue	Follow Up
1	*no dedicated committee to implement the program;*	The dedicated committee for implementing the BGSi program is BB Binomika, an entity under the Ministry of Health, along with a special task force.
2	*limited laboratory infrastructure;*	BGSi has invested in the use of centrally managed high-throughput whole-genome sequencing (WGS) machines.
3	*a severe shortage of genomics and bioinformatics experts;*	BGSi collaborates with academics, research institutions, and the private sector to conduct bioinformatics analyses for BGSI programs.
4	*high costs of genomic services and research;*	Precision medicine services developed by hospitals serving as BGSi hubs are encouraged to be submitted to the Health Technology Assessment for consideration for adoption as a Ministry of Health program and/or funding through the National Health Insurance (JKN).
5	*limited digital infrastructure;*	BGSi has invested in the development of a centrally managed Data Access Platform (DAP).
6	*no specific regulation on legal framework governing genomic data*	Ministry of Health Decree No. 512 of 2025 on the governance of the BGSi program's implementation has been issued.
7	*low public understanding.*	BGSi continues to strive to raise awareness about its programs through social media and by participating in public events.

2. Governance and Risk Mitigation for the Use of BGSI Genomic Data

Information security has been strengthened in several areas:

a. Strengthening information security governance: BB Binomika, as the implementing agency for the BGSI program, is currently undergoing the ISO/IEC 27001:2022 certification process as part of its efforts to standardize risk management, information security policies, monitoring, incident response, and the ongoing evaluation of the effectiveness of security controls.

b. Technical and infrastructure safeguards: Implementation of encryption and pseudo-anonymization of sensitive data, network and server security, and data backup to ensure the confidentiality, integrity, and availability of genomic data. Data segregation and de-identification are implemented to reduce the risk of unauthorized access and disclosure of sensitive information.

c. Data access and usage controls: Implementation of the principle of least privilege and role-based access control to ensure that data access is granted on a limited basis in accordance with authority, duties, and the purpose of its use. Every data access and usage activity is accompanied by an audit trail to ensure that data usage is traceable, monitored, and accountable. Data use also adheres to

participant consent (informed consent), ethical approval, and applicable personal data protection regulations.

d. Data visitation: BGSI has adopted the principle of data visitation through the development of a Trusted Research Environment (TRE), which allows authorized researchers to perform genomic data analysis directly within a secure and controlled computing environment, without needing to download or transfer raw data outside the BGSI platform.

3. Data Ownership and Benefit Sharing

Rules regarding ownership and the distribution of benefits from derivative products. In the context of BGSi, ownership and the sharing of benefits from derivative products are regulated by Ministerial Decree No. 512 of 2025. Ownership of genomic data is under the control of the Ministry of Health, and external partners are granted only limited access.

QUESTION 5.

What is the Ministry of Health's response to the rising cost of health care and the fact that the Ministry's vertical hospitals are currently seen as prioritizing profit over patient care?

ANSWER

1. Misleading allegation of commercialization of the Ministry of Health's hospitals through high revenue targets

a. Before 2021, some hospitals under the Ministry of Health were poorly managed and some were on the verge of collapse due to mounting debts. Since then, reform has been launched to increase productivity and efficiency as well as root out corruption and nepotism. This move has annoyed many senior physicians, some even participate in the Coalition of Health Justice.

b. The goal of increasing revenue is not to turn public hospitals into purely profit-oriented institutions. The aim is to strengthen financial sustainability, improve governance, and ensure that hospitals are able to provide quality care for all patients, irrespective of their socio-economic status. This is important given the significant burden of providing care to patients under social health insurance, which requires efficient operational and financial management.

c. Unlike private hospitals, where hospital profits are funnelled to shareholders as dividends, hospitals under the Ministry of Health do not withdraw profits from the hospitals but reinvest them in:

1) Supporting cross-subsidies and improving access for underprivilege or uninsured patients or for patients with social security for health who are not fully covered by the insurance. For example, the Ministry's hospital RS Cipto Mangunkusumo National General Hospital spent US$85 million, or almost 90% of its profit last year to subsidize these patients.
2) Procuring modern medical equipment and upgrading facilities and infrastructure.
3) Improving the quality and efficiency of services.
4) Improving the welfare of medical and healthcare personnel.

d. The development of executive and premium services is one of the revenue diversification strategies aimed at encouraging the middle and upper classes to use public hospitals again, while reducing the need for medical treatment abroad and retaining foreign exchange. Profits from the executive service are used for the cross subsidies.

2. The case of patient Yurizal Tri Chaerawan at Dr. Cipto Mangunkusumo National General Hospital (RSCM)

a. A holder of social security health insurance (BPJS), died on 31 July 2026 after reportedly waiting approximately eight hours at the Emergency Department, for an inpatient bed. The case triggered public criticism concerning patient access, the quality of BPJS services, hospital capacity, and the professional conduct of healthcare workers.
b. According to RSCM, Yurizal required a High Care Unit (HCU) bed rather than an ordinary inpatient room. HCU capacity was limited and the patient had serious underlying conditions, including a malignant condition.
c. As a national referral centre, RSCM requires referral coordination to assess its capacity, particularly when BOR reaches 90–100% and patients require complex, multidisciplinary care.
d. The patient presented with complex medical conditions and a number of comorbidities, and was referred to palliative care.

3. Normalization of a 10–20% increase in drug prices

a. The pharmaceutical industry's dependence on imports remains relatively high at around 90%, with the value of pharmaceutical imports in 2024 reaching USD 1.37 billion. In this context, fluctuations in the rupiah exchange rate affect the cost of procuring raw materials, packaging materials, and finished pharmaceutical products.
b. Nevertheless, since 2025, the Ministry of Health has been streamlining healthcare spending through the consolidation of drug and medical device procurement at hospitals, which has driven down the prices of these items. The types of drugs and medical devices being consolidated are based on an analysis of spending data for the highest-cost items. According to the analysis, the consolidation has proven to yield significant efficiencies, with potential savings of more than Rp1.8 trillion over the two-year implementation period—equivalent to 38.70% of the initial total spending.

ANNEX

QUESTION 6.

What is the Ministry of Health's response to criticism that it has failed in its management of recent earthquake, forest and land fires, food poisoning incident from the Free Meal Program (MBG), and the fragmentation of primary care services due to the establishment of KDKMP?

ANSWER

1. **The Nusa Tenggara Timur Earthquake**
   The claim that the government has not been transparent in its handling of the NTT earthquake disaster is not supported by the facts. The Ministry of Health released health data on the victims during a press conference at the BNPB Building on September 10, 2026, including information on the distinction between direct and indirect victims while they were in evacuation centers.
   a. An earthquake measuring magnitude 7.7 in East Nusa Tenggara on August 15, 2026, affected seven regencies. The government recorded the fatalities in two categories:
      1) Immediate deaths, namely those caused by being struck by building debris and trauma sustained during the earthquake.
      2) Indirect deaths, such as disaster-related deaths, primarily occurred among survivors who were ill at the time of or after the disaster, including those with heart disease and hypertension.
   b. To protect survivors, the Ministry of Health has put the following measures in place:
      1) Logistics
         a) Set up two field hospitals, in Aeramo (Nagekeo) and at the Ruteng Regional General Hospital/ Surgical procedures were performed there for seriously injured victims, operational within four days after the incident.
         b) Delivered 10 field hospital tents.
         c) Delivered 16,000 masks and 444 supplementary food packages (PMT) for vulnerable groups.
      2) Human Resources
         a) Deployed 366 medical personnel in two waves (206 on August 24, 2026, and 160 on September 7, 2026).
         b) Deployed 868 health volunteers
      3) Health Initiatives
         a) Managing illnesses in the refugee camps (respiratory infections, diarrhea, and skin diseases). Data on the incidence of these illnesses was presented at a press conference on September 10.
      4) Coordination Across Ministries and Agencies
         a) Activating the Health Emergency Operations Center (HEOC) in Nagekeo.
         b) Led weekly coordination meetings with the Ministry of Public Works and the provincial, regency, and city health departments to repair damaged community health centers (39 of the 43 severely damaged community health centers were identified in a letter from the Ministry of Health).
   c. The number of internally displaced person fell from more than 150,000 to 46,461 as of September 15, 2026, as services and housing were restored.

ANNEX

2. Care for Victims of Forest and Land Fires

a. Initiate 1,691 community health centers and 360 referral hospitals in 7 provinces on standby.
b. Monitor cases of acute respiratory infections (ARI) daily, with 433,162 cases recorded as of November 7 across 7 provinces.
c. Issue an early warning circular in May 2026 to health departments, hospitals, and community health centers regarding forest and land fires and preparedness.
d. Distribute more than 1.5 million medical masks and 208,000 N95 masks to affected provinces (as of October 31).
e. Prioritize the protection of vulnerable groups: infants, children, the elderly, pregnant women, people with asthma or COPD, and outdoor workers.
f. Provide additional oxygen, equipment, and medication, and setting up approximately 815 “oxygen houses” as clean-air rooms in 7 provinces.
g. Integrate disease surveillance with air quality data (PM2.5 and carbon monoxide) through the Public Health Emergency Operations Center (PHEOC).
h. Educate the public to limit outdoor activities and wear masks, and recommending distance learning in affected areas.
i. Intensively and actively coordinate with the National Disaster Management Agency (BNPB), the Meteorology, Climatology, and Geophysics Agency (BMKG), the Ministry of Environment, the Ministry of Forestry, and local governments on health mitigations.

3. Mitigation on Free Meal Program (MBG) Poisoning

a. The MBG Program is led by the National Nutrition Agency (BGN) as part of a collaborative system involving local governments, the Ministry of Health, the Indonesian Food and Drug Administration (BPOM), and 18 other ministries and agencies.
b. Since the program began, there have been 689 reported cases of MBG poisoning, affecting a total of 60,248 people.
c. The Ministry of Health is responsible for:
    1) Setting out standard of food safety and quality for local government health agencies to monitor and supervise.
    2) The standard requires food processing center (SPPG) to obtain Certificate of Hygiene and Sanitation Compliance (SLHS) from the local government health agencies as a token of complying with food safety and quality regulation
    3) Surveillance/data exchange
d. Food safety and quality assurance
    1) The Ministry of Health has tightened hygiene and sanitation standards for SPPGs, including 100% compliance with environmental health inspection requirements, a 4-hour food consumption limit, health examinations and certification for food handlers, monthly water testing, and vector control.
    2) Every case of food poisoning is addressed in collaboration with the local government’s health agencies, epidemiological investigations, laboratory testing, and environmental health inspections, as well as the imposition of administrative sanctions in accordance with regulations.

e. Surveillance and data exchange
   1) The Ministry of Health has developed a special MBG feature within the Early Warning and Response System to record and monitor cases of poisoning reported by community health centers, hospitals, provincial health offices, and laboratories.
   2) Each incident is analysed based on location, number of victims, severity, risk factors, and laboratory test results. Reports and analyses of poisoning cases are submitted to the BGN daily to serve as the basis for follow-up actions.
   3) Surveillance results are used to identify the causes of food poisoning and to strengthen food safety policies and SLHS requirements.
   4) The two-way data exchange between the Ministry of Health and BGN has been in place since March 2026, covering data on the nutritional status of mothers and infants as well as aggregate data on program beneficiaries. The integration continues to be developed to strengthen early detection, targeting accuracy, and response to cases of poisoning.

4. Proposal for village health clinic under the village cooperative program (KDKMP) would reassign medical and health personnel from Community Health Center

a. KDKMP was established through Presidential Instruction No. 9 of 2025 and is coordinated by the Ministry of Cooperatives. The Ministry of Health plays a role in supporting the accelerated implementation of the program by developing technical guidelines for village and subdistrict clinics and pharmacies, providing operational assistance, and coordinating management support and licensing facilitation for these facilities.
b. KDKMP is intended to be part of the integration of primary care services, not competitors to existing Community Health Centers.

QUESTION 7.
Is it true that Budi Gunadi Sadikin does not meet the criteria for nomination as WHO Director-General under EB97.R10 because he lacks a medical or health background?

ANSWER
Under the WHO Constitution, member states, including Indonesia, recognize that health is not merely the absence of disease or infirmity, but is a state of complete physical, mental and social well-being. The Constitution stipulates many functions of the WHO that is based on the principle of cooperation among member-states and with others to assist Governments in carrying out their responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

It is based on these principles, the Government of the Republic of Indonesia nominates Minister Budi Gunadi Sadikin, who has an extensive experiences, dedicated leadership and proven track records to advance health and social measures for the health. And, high

moral and commitment to the global health to contribute to the mission and the advancement of WHO functions.

1. **Formal eligibility and nomination framework**
   a. Applicable criteria: WHO Executive Board Resolution EB97.R10 establishes the nomination and selection framework. It does not require candidates to hold a medical or health-sciences degree; assessment focuses on qualifications, experience, leadership, and capacity to fulfil the Director-General's responsibilities.
   b. Indonesia's nomination based on the President's official letter: Mr. Budi Gunadi Sadikin's candidacy was formally submitted through the Permanent Mission of Indonesia in Geneva under Letter No. 143/POL-II/VIII/2026.
   c. WHO nomination process: On 31 October 2026, WHO published seven nominated candidates, including Mr. Budi. This confirms his inclusion in the process, not WHO endorsement of his qualifications.

2. **Leadership qualifications beyond clinical expertise**
   a. Institutional leadership: The WHO Director-General's responsibilities extend beyond clinical medicine to strategic leadership, organisational management, financial stewardship, health diplomacy, and international cooperation.
   b. International precedents: The professional backgrounds of current and former health ministers, as well as WHO Director-General Dr. Tedros Adhanom Ghebreyesus, demonstrate that leadership in health institutions is not exclusively associated with medical qualifications.
   c. Assessment principle: These precedents establish the relevance of diverse professional backgrounds, but each candidate's suitability must be assessed against their individual experience and demonstrated capabilities.

3. **Institutional management and leadership experience**
   a. Private and public sector experience: Mr. Budi has held senior leadership positions at Bank Mandiri and PT MIND ID – a state holding company for mining, before serving as Indonesia's Minister of Health.
   b. Relevant competencies: His experience encompasses:
      1) Managing large and complex institutions.
      2) Embark institutional management reform
      3) Financial and resource management.
      4) Organisational transformation.
      5) Stakeholder coordination and strategic execution.
   c. Supporting evidence: A verified professional chronology, including specific responsibilities, organisational scale, and measurable achievements, is required.

4. **Track record in national health-system transformation**
   During his tenure as Minister of Health, Mr. Budi has overseen initiatives across six areas:
   a. Health financing and UHC: Strengthening the National Health Insurance (JKN) programme and healthcare access.

b. Healthcare infrastructure: Expanding hospital capacity and strengthening referral networks.
c. Health workforce: Addressing specialist shortages and geographical disparities.
d. Digital health: Developing SATUSEHAT and national health information infrastructure.
e. Pharmaceutical and medical device resilience: Strengthening domestic production and supply-chain capacity.
f. Preventive and primary healthcare: Expanding preventive services and strengthening primary healthcare delivery. Global health diplomacy and international cooperation

a. G20 Presidency 2022: Indonesia advanced discussions on global health architecture, pandemic preparedness, and international health cooperation through the G20 Health Working Group.
b. Multilateral engagement: Indonesia has participated in international initiatives covering health financing, pandemic preparedness, pharmaceutical development, and health-system strengthening.
c. Candidate's contribution: Mr. Budi's specific leadership responsibilities, diplomatic engagements, and contributions to these initiatives should be documented.

5. Relevance to WHO's future leadership

a. WHO faces interconnected challenges involving health inequalities, financing constraints, health emergencies, health-system resilience, and technological transformation.
b. The Government considers Mr. Budi's experience in institutional management, national health-system transformation, and international cooperation relevant to these responsibilities.
c. His candidacy is submitted for independent consideration by WHO Member States through the established selection process.

6. Ministers of Health Around the World with Various Background

It has become common for health ministers in various countries not to have a background in medical sector. Some examples include Singapore, Thailand, United Kingdom, Japan, United States, Australia and Germany.