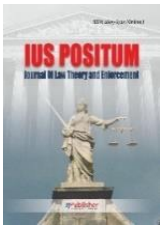

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Legal Certainty and Institutional in Coherence in Surabaya Hajj Embarkation-Debarkation Health Service 2026

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ABSTRACT

Hajj health services represent public service delivery within an international mass gathering, demanding cross-sectoral coordination, resource rediness, service continuity, and legal certainty. These complexities escalated in 2026 due to institutional restructuring and regulatory dynamics in Indonesia. This study evaluates the coherence among legal frameworks, institutional governance, and health practices at Surabaya Embarkation and Debarkation. Using a qualitative evaluative design based on document analysis and secondary data, the research found that while services operated through an inter-institutional network, gaps persisted in health assessment continuity, ambulance capacity, transitional logistics, staff facilities, and information system integration. Legal audits revealed that revoked regulations remained referenced in operational documents and organizational changes occurred during active debarkation, creating variable legal certainty. These findings highlight the need for regulatory harmonization, clear authority interfaces, transitional SOPs, resource strengthening, and data interoperability for future Hajj health governance.

Keywords: *Hajj Debarkation, Hajj Embarkation, Hajj Health Services, Health Governance, Health Policy, Legal Certainty*

INTRODUCTION

Hajj is one of the world's largest annual international religious mass gatherings, and its health services demand cross-sectoral coordination, resource readiness, service continuity, and legal certainty.[1] These challenges became more complex in 2026 because Indonesia's Hajj health governance operated during an institutional transition. Presidential Regulation Number 92 of 2025 established the Ministry of Hajj and Umrah, while health quarantine units faced regulatory changes during the operational period.[2] At Surabaya Embarkation and Debarkation, these dynamics shaped how health services were planned, delivered, coordinated, and accounted for. This context makes legal certainty and institutional coherence central to evaluating Hajj health services.[3]

The regulatory landscape in 2026 was layered and temporally sensitive. Law Number 17 of 2023 on Health was in force and had revoked Law Number 6 of 2018 on Health Quarantine, meaning the revoked law could not serve as a standalone legal basis for 2026 operations.[4] In the Hajj sector, Law Number 14 of 2025 strengthened the institutional framework for Hajj and Umrah organisation.[5] Meanwhile, Minister of Health Regulation Number 10 of 2023 remained in force during embarkation but was amended by Minister of Health Regulation Number 8 of 2026 during active debarkation.[6] Some operational documents also continued to cite regulations that had already been revoked.[7] These conditions raise questions about norm validity, authority, procedural clarity, and implementation consistency.

Previous studies on Hajj health have largely focused on disease risk, mortality, surveillance, vaccination, environmental health, and clinical preparedness.[8] Indonesian research has examined istithaah policy implementation, surveillance and flight eligibility, comorbidities, and hygiene and sanitation at

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[1] Ziad A Memish et al., "Mass Gatherings Medicine: Public Health Issues Arising from Mass Gathering Religious and Sporting Events," *The Lancet* 393, no. 10185 (May 2019): 2073–84, https://doi.org/10.1016/S0140-6736(19)30501-X.

[2] Abdulaziz Mushi et al., "A Longitudinal Study Regarding the Health Profile of the 2017 South African Hajj Pilgrims," *International Journal of Environmental Research and Public Health* 18, no. 7 (March 31, 2021): 3607, https://doi.org/10.3390/ijerph18073607.

[3] Brian McCloskey et al., "Confronting Heat-Related Illnesses and Deaths at Mass Gathering Religious and Sporting Events," *The Lancet Planetary Health* 8, no. 8 (August 2024): e522–23, https://doi.org/10.1016/S2542-5196(24)00161-X.

[4] "Undang-Undang (UU) Nomor 17 Tahun 2023 Tentang Kesehatan," Pub. L. No. 17 (2023), https://peraturan.bpk.go.id/Details/258028/uu-no-17-tahun-2023.

[5] "Undang-Undang (UU) Nomor 14 Tahun 2025 Tentang Perubahan Ketiga Atas Undang-Undang Nomor 8 Tahun 2019 Tentang Ibadah Haji Dan Umrah," Pub. L. No. 14 (2025), https://peraturan.bpk.go.id/Details/331538/uu-no-14-tahun-2025.

[6] Undang-undang (UU) Nomor 17 Tahun 2023 tentang Kesehatan.

[7] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM," *Journal of Law Theory and Law Enforcement*, January 11, 2023, 1–10, https://doi.org/10.56943/jlte.v2i1.227.

[8] Memish et al., "Mass Gatherings Medicine: Public Health Issues Arising from Mass Gathering Religious and Sporting Events."

embarkation points.[9] Scholarship in legal theory and law enforcement adds another layer: legal implementation problems often stem from legal culture and the gap between formal norms and administrative practice, while legal certainty in public services depends on regulatory harmonisation, institutional capacity, and the harmonisation of norms with societal values.[10] Nevertheless, existing studies rarely connect these legal and governance concerns to operational administrative data across both embarkation and debarkation during an institutional transition.[11]

A clear research gap therefore remains. In the identified literature, there is limited research that simultaneously evaluates operational health service governance, temporal validity and regulatory coherence, interinstitutional authority distribution, both embarkation and debarkation phases, and institutional changes in Indonesian Hajj organisers using administrative data as implementation evidence.[12] The gap is not the absence of governance or legal studies on Hajj, but the lack of analysis of how governance gaps and regulatory implementation gaps interact within a single embarkation‑debarkation service chain during a transition period.[13]

This study offers novelty by integrating legal certainty into governance evaluation. Norms are not merely mapped as law in the books but are tested against clarity of authority, procedures, resources, information interoperability, accountability mechanisms, and operational practice as law in action.[14]The study also combines a temporal legal validity audit with a service system evaluation across two operational phases. In doing so, it connects 2026 institutional transition analysis, regulatory dynamics, simultaneous embarkation‑debarkation evaluation, and the use of administrative data to identify governance and regulatory implementation gaps.[15]

The objective of this study is to map and analyse the regulatory framework applicable to Hajj health services in 2026, evaluate health service governance during the pre-embarkation, embarkation, and debarkation phases at Surabaya, identify gaps between legal norms, authority distribution, standard operating procedures or operational guidelines, and service practices, and assess institutional capacity in terms of human resources, financing, facilities and infrastructure,

[9] Mushi et al., "A Longitudinal Study Regarding the Health Profile of the 2017 South African Hajj Pilgrims."
[10] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[11] Resham B Khatri et al., "Contribution of Health System Governance in Delivering Primary Health Care Services for Universal Health Coverage: A Scoping Review," ed. Masoud Behzadifar, *PLOS ONE* 20, no. 2 (February 28, 2025): e0318244, https://doi.org/10.1371/journal.pone.0318244.
[12] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[13] Salwa Aulia et al., "FAIR PLAY PRINCIPLES IN GOOD GOVERNANCE: COMPARATIVE REGULATIONS AND IMPLEMENTATION IN INDONESIA AND MALAYSIA," *Journal of Law Theory and Law Enforcement* 5, no. 1 (January 15, 2026): 1–18, https://doi.org/10.56943/jlte.v5i1.923.
[14] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[15] Aulia et al., "FAIR PLAY PRINCIPLES IN GOOD GOVERNANCE: COMPARATIVE REGULATIONS AND IMPLEMENTATION IN INDONESIA AND MALAYSIA."

logistics, services, surveillance, information systems, coordination, and accountability.[16] The main research question is how coherent the legal framework, institutional governance, and service implementation practices are at Surabaya Embarkation and Debarkation in 1447 H/2026 M, and what gaps require improvement.[17]

The conceptual contribution of this research lies in treating legal certainty as part of governance evaluation, while its policy contribution lies in employing a temporal legal validity audit alongside a service system evaluation.[18] This approach allows institutional and regulatory changes to be read according to their effective dates and implementation consequences. Practically, the findings are expected to inform regulatory harmonisation, clear authority interfaces, transitional SOPs, resource strengthening, data interoperability, and future Hajj health governance.[19]

LITERATURE REVIEW

International scholarship on mass gathering medicine has produced a robust body of knowledge on health risks, surveillance needs, and emergency preparedness during religious and sporting events. Research has extensively examined infectious and non-communicable disease patterns, heat-related illnesses, vaccination coverage, and meningococcal carriage among Hajj pilgrims.[20] Studies on health system governance further demonstrate that effective service delivery during mass gatherings depends on clear authority distribution, workforce competence, financing certainty, and inter-agency coordination.[21] In the Indonesian context, research has explored istithaah policy implementation, surveillance and flight eligibility determination, and hygiene and sanitation at embarkation points, confirming that port health units play a critical role in health information management and pilgrim health protection.[22] However, these studies predominantly adopt epidemiological or clinical perspectives, leaving the legal and institutional dimensions of Hajj health governance comparatively underexamined.

Indonesian legal scholarship has begun to address governance and regulatory challenges in public services, particularly through analyses of legal culture and the gap between formal norms and administrative practice. Sulaksono argues that

[16] Undang-undang (UU) Nomor 17 Tahun 2023 tentang Kesehatan.
[17] Undang-undang (UU) Nomor 17 Tahun 2023 tentang Kesehatan.
[18] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[19] Aulia et al., "FAIR PLAY PRINCIPLES IN GOOD GOVERNANCE: COMPARATIVE REGULATIONS AND IMPLEMENTATION IN INDONESIA AND MALAYSIA."
[20] McCloskey et al., "Confronting Heat-Related Illnesses and Deaths at Mass Gathering Religious and Sporting Events"; Mushi et al., "A Longitudinal Study Regarding the Health Profile of the 2017 South African Hajj Pilgrims."
[21] Khatri et al., "Contribution of Health System Governance in Delivering Primary Health Care Services for Universal Health Coverage: A Scoping Review."
[22] Muchammad Shidqon Prabowo, "The Role of Local Authorities in Protecting Hajj Pilgrims in Indonesia : A Legal Protection Perspective," *Jurnal Daulat Hukum* 9, no. 2 (2026): 612–30, https://doi.org/http://dx.doi.org/10.30659/jdh.v9i2.54179.

Indonesia's legal system remains repressive because the three components of legal structure, substance, and culture have not developed in equilibrium, resulting in weak implementation and enforcement.[23] A comparative study on fair play principles in good governance similarly underscores that legal certainty in public administration requires regulatory harmonisation, institutional capacity, and the alignment of norms with societal values.[24] These contributions establish a conceptual foundation for evaluating legal certainty beyond mere formal validity, directing attention to how norms operate in practice. Nevertheless, this legal literature has not been systematically connected to the operational realities of mass gathering health services, particularly in the context of Hajj embarkation and debarkation.

A clear research gap therefore persists at the intersection of legal governance and Hajj health service delivery. Existing studies on Hajj health remain largely focused on disease risk and clinical outcomes, while governance research on Indonesian Hajj has concentrated on institutional coordination and regional authority without integrating a temporal audit of regulatory validity or examining both embarkation and debarkation phases simultaneously.[25] The lack of analysis on how regulatory implementation gaps interact with governance gaps within a single service chain during institutional transition limits the evidence base for policy reform. This study addresses that gap by evaluating the coherence between legal frameworks, institutional governance, and health service practices at Surabaya Embarkation and Debarkation during the 1447 H/2026 M Hajj season, with particular attention to how regulatory changes and institutional restructuring shaped service delivery across both operational phases.

RESEARCH METHODOLOGY

This study employs a qualitative evaluative research design based on document analysis and secondary administrative data, combined with legal and policy analysis. The design takes the form of an evaluative case study of the Hajj health service delivery system at Surabaya Embarkation and Debarkation for 1447 H/2026 M, integrating statute, conceptual, and policy implementation approaches without employing interviews, field observations, or individual clinical data.[26] The evaluative design compares three layers of evidence: normative standards (legal provisions, policies, and guidelines in force); institutional and operational design (authority distribution, resources, and coordination mechanisms); and implementation evidence (administrative data, documented activities, and service

[23] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[24] Aulia et al., "FAIR PLAY PRINCIPLES IN GOOD GOVERNANCE: COMPARATIVE REGULATIONS AND IMPLEMENTATION IN INDONESIA AND MALAYSIA."
[25] Prabowo, "The Role of Local Authorities in Protecting Hajj Pilgrims in Indonesia : A Legal Protection Perspective."
[26] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."

outputs).[27] The research site was purposively selected because 2026 represents a period of institutional transition and because the embarkation-debarkation sequence enables assessment of governance continuity across both phases.

All research data are secondary, comprising the BBKK Surabaya 2026 administrative report; statutory regulations from official sources such as JDIH and Peraturan BPK; operational decrees, guidelines, and SOPs; international documents, particularly the International Health Regulations; and peer-reviewed literature on health governance, Hajj services, mass gathering medicine, and legal certainty. The unit of analysis is the health service delivery system, disaggregated into analytical subunits: regulations and mandates, coordination, human resources, financing, facilities, logistics, service processes, referral systems, surveillance, information systems, accountability, responsiveness, and follow-up.[28] Documents were selected using purposive sampling with referential tracing. Inclusion required temporal application to 2026, relevance to Hajj health services, origin from involved agencies, or peer-reviewed status. Excluded sources included news reports, blogs, duplicates, and revoked regulations without operational relevance.[29] Extraction used structured forms for administrative data (activity phase, type, resources, indicators, counts, problems, follow-up) and legal documents (identity, hierarchy, norm, authority, obligations, effective date, amendments, implementation evidence).

Administrative data were analysed descriptively through frequencies, proportions, and consistency examination, with percentages recalculated where denominators were clearly identifiable. A data consistency audit was conducted through applying, recalculation, comparison, and discrepancy classification. Data quality was assessed through completeness, internal consistency, plausibility, and source traceability.[30] Legal analysis proceeded through seven stages: regulatory inventory, hierarchical analysis, validity status audit, vertical synchronisation, horizontal synchronisation, authority analysis, and regulatory gap analysis. Temporal analysis divided the service sequence according to effective dates of rules, recognising that law in the books may differ from administrative interpretation and actual approaches.[31] Governance analysis employed twelve dimensions assessed through the chain: legal norm → mandate → resources → processes → outputs → problems → conformity → gaps → implications.[30]

[27] Aulia et al., "FAIR PLAY PRINCIPLES IN GOOD GOVERNANCE: COMPARATIVE REGULATIONS AND IMPLEMENTATION IN INDONESIA AND MALAYSIA."
[28] Khatri et al., "Contribution of Health System Governance in Delivering Primary Health Care Services for Universal Health Coverage: A Scoping Review."
[29] Memish et al., "Mass Gatherings Medicine: Public Health Issues Arising from Mass Gathering Religious and Sporting Events."
[30] Mushi et al., "A Longitudinal Study Regarding the Health Profile of the 2017 South African Hajj Pilgrims."
[31] McCloskey et al., "Confronting Heat-Related Illnesses and Deaths at Mass Gathering Religious and Sporting Events."

Conformity was classified as "conforming," "partially conforming," "gap identified," or "cannot be assessed," following established approaches in health system governance evaluation. Document triangulation was conducted across four levels: source, internal, temporal, and conceptual.[32] This study uses only institutional documents, regulations, and aggregated administrative data; it does not involve participant recruitment, primary data collection, or access to personal identities, so individual informed consent was not required. Research ethics principles are applied through proper attribution, transparent reporting, and prohibition against data manipulation. [33] Quality control was maintained through an audit trail with four working documents: register, extraction sheet, regulatory log, and inconsistency log.

RESULT AND DISCUSSION

The findings of this study are derived from the extraction and analysis of the Report on the Provision of Health Services at the Surabaya Embarkation‑Debarkation Point for the Year 1447 AH/2026 AD, verified against official legal sources and reconciled across tables and narratives. The presentation of results is limited to administrative facts, normative status, implementation evidence, and documented problems; interpretation of causes, governance consequences, and theoretical implications is placed within this discussion section.

Regulatory and Institutional Architecture

The 2026 Hajj health service organisation at Surabaya operates within two intersecting regulatory regimes: the Hajj governance regime and the health sector regime. In the first regime, Law Number 14 of 2025, effective since 4 September 2025 as the third amendment to Law Number 8 of 2019 on Hajj and Umrah Organisation, establishes the institutional framework. Presidential Regulation Number 92 of 2025 establishes the Ministry of Hajj and Umrah, while Minister of Hajj and Umrah Regulations Number 2 and 3 of 2025 govern vertical institutions and regular Hajj organisation, respectively.[34] In the health regime, Law Number 17 of 2023 on Health is in force and has revoked Law Number 6 of 2018 on Health Quarantine, meaning the latter cannot serve as a positive legal basis for 2026 operations.[35] Critically, Minister of Health Regulation Number 10 of 2023, concerning the organisation of Technical Implementation Units in health quarantine, remained in force during embarkation but was amended by Minister of

[32] Sulaksono, "LEGAL CULTURE DECONSTRUCTION IN INDONESIAN LEGAL SYSTEM."
[33] "World Health Organization. (2025). International Health Regulations (2005), as Amended in 2014, 2022 and 2024.," 2025, https://www.who.int/health-topics/international-health-regulations#tab=tab_1.
[34] "Peraturan Presiden (Perpres) Nomor 92 Tahun 2025 Tentang Kementerian Haji Dan Umrah," Pub. L. No. 92 (n.d.), https://peraturan.bpk.go.id/Details/331574/perpres-no-92-tahun-2025.
[35] Undang-undang (LAW) Nomor 17 Tahun 2023 tentang Kesehatan.

Health Regulation Number 8 of 2026, enacted on 15 June and promulgated on 18 June 2026, while Surabaya debarkation continued until 1 July 2026.[36]

The legal audit also revealed that several regulations cited in operational documents had been revoked prior to operations. The report referenced Minister of Health Regulation Number 45 of 2014 for surveillance activities, yet this regulation was revoked by Minister of Health Regulation Number 1 of 2026, promulgated on 21 January 2026, before embarkation commenced.[37] Similarly, Minister of Health Regulation Number 2 of 2023 on environmental health was cited, although it had been revoked by Minister of Health Regulation Number 3 of 2026. [38] The legal audit also revealed that several regulations cited in operational documents had been revoked prior to operations. The report referenced Minister of Health Regulation Number 45 of 2014 for surveillance activities, yet this regulation was revoked by Minister of Health Regulation Number 1 of 2026, promulgated on 21 January 2026, before embarkation commenced.

Table 1 Regulatory, Authority, and Implementation Matrix

Regulation/Instrument	Status in 2026	Key Change	Impact on Governance
Law No.17/2023	Effective	Revoked Law No.6/2018 (Health Quarantine)	Legal basis for health functions
Law No.14/2025	Effective	3rd amendment to UU 8/2019	New Ministry of Hajj and Umrah
Minister of Health of Regulation No.10/2023	Effective during embarkation	Amended by Minister of Health of Regulation No. 8/2026	Organisational change mid-debarkation
Minister of Health of Regulation No.1/2025	Effective before operations	Revoked Minister of Health Regulation No.45/2014	Updated surveillance framework
Minister of Health Regulation No.3/2026	Effective before embarkation	Revoked Permenkes 2/2023	Updated disease control framework

Source: Author's compilation from BBKK Surabaya Report (2026) and official legal databases (JDIH, Peraturan BPK, Peraturan.go.id)

[36] "Peraturan Menteri Kesehatan Nomor 8 Tahun 2026 Tentang Perubahan Atas Peraturan Menteri Kesehatan Nomor 10 Tahun 2023 Tentang Organisasi Dan Tata Kerja Unit Pelaksana Teknis Bidang Kekarantinaan Kesehatan," Pub. L. No. 8 (2026), https://jdih.kemkes.go.id/documents/peraturan-menteri-kesehatan-nomor-8-tahun-2026.

[37] "Peraturan Menteri Kesehatan Nomor 1 Tahun 2026 Tentang Kejadian Luar Biasa, Wabah, Dan Krisis Kesehatan," Pub. L. No. 1 (2026), https://peraturan.bpk.go.id/Details/344092/Minister of Health Regulation-no-1-tahun-2026.

[38] "Peraturan Menteri Kesehatan Nomor 3 Tahun 2026 Tentang Penanggulangan Penyakit," Pub. L. No. 3 (2026), https://peraturan.bpk.go.id/Details/350854/Minister of Health Regulation-no-3-tahun-2026.

Operationally, the head of BBKK Surabaya and staff served as the Health Section of the Hajj Organising Committee for Surabaya Embarkation. BBKK conducted third-stage health examinations, polyclinic services, simple laboratory tests, referrals, environmental health and vector surveillance, epidemiological surveillance, and health functions at the Mecca Route area. The Ministry of Hajj and Umrah assumed responsibility for Hajj organisation, dormitory management, and, in 2026, took over certain health logistics functions previously held by the Ministry of Health. Inter-agency coordination involved the Ministry of Hajj and Umrah, the Ministry of Health, BBKK Surabaya, provincial and district health offices, hospitals and clinics, laboratories, Juanda Airport authorities, immigration, customs, catering providers, and other institutions.

This gap raises important theoretical questions about the nature of legal certainty in transitional regulatory environments. Drawing on Gustav Radbruch's legal philosophy, legal certainty *Rechtssicherheit* constitutes one of the three fundamental pillars of law alongside justice and purposiveness.[39] Lon L. Fuller's principles of legality offer a complementary perspective: the obsolete-reference gap violates at least two of Fuller's eight principlesnon-contradiction and congruence between official action and declared rules.[40] Lawrence M. Friedman's legal system theory provides a third analytical layer, diagnosing the gap as a failure of legal culture the persistence of old regulatory references reflects a cultural lag within implementing agencies, reinforced by inadequate socialisation, insufficient training, or a perception that new regulations are less operational than their predecessors.[41] This cultural lag may also indicate a weakness in legal structure, specifically the absence of effective mechanisms to ensure that regulatory changes are systematically communicated and integrated into operational practice.

For Indonesia as a rechtsstaat (a state based on the rule of law), the obsolete-reference gap has significant normative implications. The 1945 Constitution mandates that Indonesia is a state founded on law, requiring not only the existence of formal legal norms but also their consistent application and accessibility.[42] When operational documents of a public service of national importance, such as Hajj health services continue to reference revoked regulations, the state fails to meet its

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[39] Gustav Radburch, *Rechtsphilosophie*, 1st ed. (C.F. Müller Juristischer Verlag, 1987), https://books.google.co.id/books/about/Rechtsphilosophie.html?hl=id&id=8hxAqHr8A5UC&redir_esc=y.

[40] Lon L. Fuller, *The Morality of Law*, Revised Ed (Yale University Press, 1969), https://www.jstor.org/stable/j.ctt1cc2mds.

[41] Lawrence M. Friedman, "On Legal Acts," in *The Legal System: A Social Science Perspective* (Russel Sage Foundation, 1987), 14–16, https://books.google.co.id/books?id=pvIWAwAAQBAJ&printsec=frontcover&hl=id#v=onepage&q&f=false.

[42] Jimly Asshiddiqie, "Konstitusi Indonesia Dari Masa Ke Masa," in *Konstitusi Dan Konstitusionalisme Indonesia* (Sinar Grafika, 2011), 45, https://books.google.co.id/books?id=QXtWEAAAQBAJ&printsec=copyright&hl=id#v=onepage&q&f=false.

constitutional obligation to provide legal certainty. This failure risks transforming legal certainty from a substantive constitutional guarantee into a formal promise that is not consistently realised in practice, suggesting that Indonesia's legal system continues to face challenges in ensuring that legal norms are not only enacted but also effectively implemented and consistently followed across all levels of government administration.

Resource Governance

During embarkation, 231 health personnel were involved (180 BBKK staff and 51 assisting personnel), operating in two 12-hour shifts with 65 daily positions. Debarkation involved 214 personnel (176 BBKK staff and 38 assistants) in 60 daily positions. Budget realisation reached Rp1,071,683,000 (94.79%) from a ceiling of Rp1,130,568,000 for embarkation, and Rp874,480,000 (89.36%) from Rp978,570,000 for debarkation. The Hajj dormitory provided 16 buildings with 550 rooms, accommodating 2,194 beds, while polyclinic facilities included examination rooms, observation rooms, a simple laboratory, and pharmacy services.[43]

Ambulance capacity proved insufficient for all embarkation service points, requiring support from hospital and clinic partners and reflecting a dependency gap rather than absence of evacuation systems. This dependency had cascading effects: referral delays during peak hours increased the workload on polyclinic staff, who were already operating under a 12-hour shift pattern with inadequate rest facilities, some personnel were reported resting on floors in workspaces, raising workforce sustainability concerns.[44]

Similarly, medicines and health logistics underwent a transitional mechanism in 2026, with procurement responsibility shifting from the Ministry of Health's pharmaceutical unit to the Ministry of Hajj and Umrah. BBKK acted as end-user and reported utilisation to the new ministry, but the handover process lacked clear SOPs, creating uncertainty in drug availability that directly affected polyclinic services and referral pathways. At debarkation's conclusion, remaining medicines were returned through this handover process, yet the report itself identified the mechanism as requiring clearer procedures, reflecting a transitional governance gap. These interconnections demonstrate that governance reform cannot address ambulances, staff welfare, and logistics as isolated issues; rather, they must be approached as components of an integrated service system where failure in one dimension cascades across others.

[43] Khatri et al., "Contribution of Health System Governance in Delivering Primary Health Care Services for Universal Health Coverage: A Scoping Review."
[44] Thawab Alrabie et al., "Preparedness and Experiences of Healthcare Professionals during the Hajj Mass Gatherings: A Qualitative Study," *BMC Health Services Research* 26, no. 1 (March 17, 2026): 576, https://doi.org/10.1186/s12913-026-14390-9.

Service Delivery Governance

During embarkation, 44,017 individuals underwent third-stage health examinations (43,253 pilgrims, 301 PHD/PIH, and 463 cluster officers), with 44,000 ultimately departing. Fifteen individuals were declared unfit to fly for health reasons, and 17 did not depart (15 health-related, 2 non-health). The report recorded 34,064 high-risk pilgrims (77.39% of those examined) a figure that, given the scale of comorbidities, demanded substantial resource Polyclinic visits totalled 1,459, with hypertension (725), anaemia (105), diabetes mellitus (85), diarrhoea (63), and pulmonary tuberculosis history (54) as the most frequent diagnoses. Notably, 723 visits (49.6%) were from pilgrims aged 60 years or older, and 71 of 129 referrals originated from this same age group. This concentration of demand among elderly pilgrims with chronic conditions has direct implications for service planning prioritising antihypertensives, strengthening geriatric competencies, and ensuring access to specialised care. The elderly population not only drives clinical demand but also disproportionately strains referral networks, requiring an integrated response that combines pharmaceutical supply, workforce training, and hospital agreements.[45]

The istithaah (health fitness) assessment revealed persistent gaps: pilgrims who had been deemed fit at regional level still required in-depth health evaluation at embarkation. This finding echoes prior research identifying implementation challenges in istithaah policy and inter-sectoral collaboration.[46] The gap here is not that embarkation finds sick pilgrims; clinical changes can occur at any time; but that the report itself identified some cases as conditions that should have been better evaluated at the regional level, indicating a continuity gap in health assessment.

Pregnancy screening of 11,776 women of childbearing age identified nine pregnancies; seven were declared fit to fly and two unfit based on gestational age. The report recommended re-screening one week before departure, suggesting a temporal screening gap where results obtained too far in advance lose relevance for dynamic conditions.

The food poisoning incident in Cluster SUB 36 illustrated both response capacity and preparedness gaps. Fifty-three cases were reported; 33 had analysable identities at the polyclinic, while 20 had been managed by cluster officers without complete individual data. No referrals or deaths were reported. Response included coordination, therapy, food sample testing, and follow-up monitoring. However, rectal swabs could not be collected because sampling kits were unavailable at the time, and laboratory funding readiness was identified as an issue. This illustrates a preparedness gap in diagnostic capacity, consistent with findings from mass

[45] Khulud K. Alharbi et al., "Disease Burden and Pattern of Healthcare Utilization Among Pilgrims During Hajj 2024: A Cross-Sectional Analysis," *Annals of Global Health* 92, no. 1 (March 9, 2026): 25, https://doi.org/10.5334/aogh.4956.

[46] Rustika Rustika et al., "An Evaluation of Health Policy Implementation for Hajj Pilgrims in Indonesia," *Journal of Epidemiology and Global Health* 10, no. 4 (2020): 263, https://doi.org/10.2991/jegh.k.200411.001.

gathering surveillance literature highlighting coordination as a frequently reported challenge.[47]

Debarkation Service Governance

Debarkation occurred from 1 June to 1 July 2026, with 43,895 pilgrims arriving through Juanda International Airport. Temperature screening identified 72 persons with temperature ≥37.5° C, and 102 underwent further examination; all 102 COVID-19 antigen tests were negative. PCR testing of 102 samples found 5 COVID-19 positive, 29 Influenza A positive, 9 Influenza B positive, and 8 MERS-CoV negative. Twenty-seven notification letters were issued to local health offices. Polyclinic visits numbered 224, with 162 (72.32%) from those aged ≥60 years; respiratory disorders were the most frequent diagnosis group. Referrals totalled 65, with 50 from the elderly group. Eight deaths were recorded during debarkation (one on aircraft, seven in hospital).[48]

The All Indonesia/SSHP self-declaration system showed 35,879 of 43,895 arrivals (81.74%) completed the form, while 8,016 did not. Identified barriers included elderly pilgrims lacking smartphones or digital literacy, misunderstanding questions, duplicate entries, broad symptom categories generating many alerts, and limited BBKK access to download data for filtering and analysis. While the report attributes these barriers primarily to pilgrim characteristics such as age and digital literacy a more critical reading suggests that the system design itself is problematicA nationally scaled digital surveillance system that lacks an assisted pathway for elderly users, fails to provide automated duplicate detection, and does not grant operational units the data access authority necessary for their surveillance functions cannot be considered fit for purpose. The inability of BBKK officers to download and filter SSHP data for real-time analysis means that surveillance alerts cannot be effectively verified or acted upon, potentially delaying outbreak detection and response. This illustrates a data governance gap where responsibility for surveillance is assigned without commensurate data access authority a governance deficit that transforms a potentially valuable surveillance tool into a source of incomplete and unactionable information.

Information System and Surveillance Governance

Multiple platforms were used in parallel: SIMHAJI, SISKOHATKES, SINKARKES, SKDR, All Indonesia/SSHP, spreadsheets, and manual records. The report explicitly stated that some variables required processing through a combination of SIMHAJI and spreadsheets, SSHP data was processed manually, and SISKOHATKES was entered after activities concluded. While cluster

[47] Farida Abougazia, Basma M. Saleh, and Sungsoo Chun, "Event-Based Surveillance in Mass Gatherings: A Global Scoping Review on Effectiveness, Scope, and Lessons Learned," *Frontiers in Public Health* 14 (February 17, 2026), https://doi.org/10.3389/fpubh.2026.1762219.
[48] Abougazia, Saleh, and Chun.

infographics were targeted for completion within two hours of pilgrims leaving the dormitory, post-hoc recording meant data were not always available in real-time for clinical decision-making at the point of care.

This fragmentation has cascading effects across multiple governance dimensions. This fragmentation has cascading effects: patient data may not follow referral pathways (risking redundant testing and miscommunication); post-hoc surveillance data entry undermines early warning functions (delaying outbreak detection); and manual reconciliation introduces errors and incomplete reporting (reducing data reliability for operational decisions). Thus, the fragmentation of information systems does not merely represent a technical inconvenience; it constitutes a data governance gap that weakens referral coordination, compromises outbreak detection, and reduces accountability through unreliable reporting [49]

Data inconsistencies were identified: the report narrative recorded 35,879 SSHP respondents, but the colour-coded summary showed 36,079 (200 persons discrepancy attributed to duplication but without sufficient evidence). Similarly, the summary reported 31 Influenza A positives while the detailed laboratory table recorded 29. These discrepancies underscore the need for routine data consistency audits as part of health information governance. The existence of multiple platforms does not itself constitute fragmentation; governance gaps emerge when the same variables require duplicate entry, data cannot be exchanged, access is unavailable to those who need it, or reconciliation must be done manually.[50]

Table 2 Documented Governance Problems, Operational Responses, and Recommended Follow-Up

Category	Problem	Response & Recomendation
Regulatory/Institutional	Drug handover mechanism unclear	Develop SOP for medicine handover and accountability
Clinical Governance	Istithaah continuity gap	Strengthen regional-to-embarkation health assessment
Clinical Governance	Pregnancy screening too early	Re-screen one week before departure
Resource Governance	Ambulance insufficiency; inadequate staff rest	Provide dedicated ambulances and staff accommodation
Environmental	Non-compliant facilities	Improve ventilation, waste, and water quality
Digital Governance	Multiple platforms; limited data access	Strengthen interoperability and role-based access

[49] Simon Nyarko et al., "Digital Health System Integration in Ghana: A Scoping Review of Governance Arrangements, Interoperability Aspirations, and Regulatory Gaps," *BMC Health Services Research* 26, no. 1 (March 9, 2026): 529, https://doi.org/10.1186/s12913-026-14324-5.
[50] Laura Buback et al., "Using the WHO Building Blocks to Examine Cross-Border Public Health Surveillance in MENA," *International Journal for Equity in Health* 24, no. 1 (February 6, 2025): 38, https://doi.org/10.1186/s12939-025-02393-7.

Category	Problem	Response & Recomendation
Preparedness	Food poisoning response gaps	Provide sampling kits and contingency plan

Source: BBKK Surabaya Report (2026)

Vulnerable Groups and Responsiveness

The 2026 theme "Inclusive Hajj Services for Older Persons, Persons with Disabilities, and Women" was suLaws and Regulationsorted by operational evidence: 34,064 high-risk pilgrims were recorded, and elderly pilgrims dominated service utilization 723 of 1,459 polyclinic visits and 71 of 129 referrals during embarkation; 162 of 224 polyclinic visits and 50 of 65 referrals during debarkation came from those aged ≥60 years. These data demonstrate concentrated demand among elderly pilgrims, consistent with international findings that comorbidities increase the likelihood of health problems during or after Hajj.[51] However, responsiveness cannot be measured only by queue priority; it must encompass physical access, mobilisation assistance, chronic disease medication availability, referral pathways, communication suLaws and Regulationsort, and information system design that accommodates older users. The SSHP experience illustrates this gap: reliance on smartphones and self-completion disproportionately burdens elderly pilgrims.[52]

Governance Gaps and Implications

Synthesising the findings, several types of governance gaps were identified. First, obsolete-reference gap: operational documents continued to reference revoked regulations (Laws and Regulations 40/1991, Minister of Health Regulation 45/2014, Law 6/2018). Second, transitional governance gap: handover mechanisms for medicines and logistics during institutional transition lacked clear SOPs; organisational change occurred mid-debarkation (Minister of Health Regulation 8/2026). Third, dependency gap: ambulance capacity relied on partner suLaws and Regulationsort for anticipated configurations. Fourth, continuity gap: health assessment and istithaah status showed discontinuity between regional and embarkation levels. Fifth, data governance gap: multiple platforms with manual reconciliation, limited access for surveillance functions, and unresolved inconsistencies. Sixth, preparedness gap: diagnostic sampling kits and laboratory funding were not available when needed during the food poisoning incident.

[51] Mushi et al., "A Longitudinal Study Regarding the Health Profile of the 2017 South African Hajj Pilgrims."
[52] Ala'a Alquayt et al., "AI-Driven Healthcare Innovations for Enhancing Clinical Services during Mass Gatherings (Hajj): Task Force Insights and Future Directions," *BMC Health Services Research* 25, no. 1 (July 1, 2025): 876, https://doi.org/10.1186/s12913-025-13045-5.

Table 3 Causal Relationships Among Governance Dimensions

Primary Gap	Secondary Gap	Causal Mechanism	Evidence
Infrastructure Gap (Ambulance insufficiency)	Service Process Gap (Referral delays)	Lack of ambulances delayed referrals to hospitals	129 referrals; 5 ambulances needed but only through partners
Infrastructure Gap (Ambulance insufficiency)	Accountability Gap (Reduced trust)	Referral delays may reduce pilgrim trust	Not directly measured but potential issue
Workforce Concern (Inadequate rest)	Human Resources Gap (Staff fatigue)	12-hour shifts without adequate rest increase fatigue	Staff reported resting on floors
Data Governance Gap (Fragmented systems)	Surveillance Gap (Delayed reporting)	Post-hoc data entry hampers real-time surveillance	Multiple platforms used in parallel
Data Governance Gap (Fragmented systems)	Coordination Gap (Referral disruption)	Patient data cannot follow referral pathway	Data not shared with referral hospitals
Transitional Governance Gap (Logistics shift)	Logistics Gap (Medicine distribution delays)	Shift without transition SOPs caused delays	Report noted need for clearer SOPs

Source: Author's synthesis from BBKK Surabaya Report (2026) and governance analysis

These gaps are not all attributable to the 2026 institutional transition. Continuity issues in istithaah and regional coordination were identified in previous research and pre-date the restructuring.[53] The transition introduced new friction points particularly logistics, authorisation, and accountability chains, but also interacted with long-standing problems. This distinction is important for policy design: transitional problems can theoretically be resolved once SOPs and delegated authorities are established, while structural problems require deeper system redesign.[54]

Policy Implications and Recommendation

Three levels of reform are indicated. First, regulatory reform: pre-season legal validity audits should be conducted annually, with operational references locked before staff training. Revoked regulations should not resear as positive legal bases. Organisational changes near operational periods must include transition SOPs, effective dates, RACI matrices, and provisions for handling ongoing matters.[55]

[53] Rustika et al., "An Evaluation of Health Policy Implementation for Hajj Pilgrims in Indonesia."
[54] Ghadah Alsaleh et al., "The Hajj Legacy and Saudi Arabia's Exemplary Response to COVID-19," *Frontiers in Public Health* 13 (June 2, 2025), https://doi.org/10.3389/fpubh.2025.1520179.
[55] Erik O. Eriksen, "Three Modes of Administrative Behaviour: Differentiated Policy Implementation and the Problem of Legal Certainty," *Journal of European Public Policy* 30, no. 12 (December 2, 2023): 2623–42, https://doi.org/10.1080/13501763.2022.2125047.

Second, operational governance: coordination should move from incidental to structured incident command with activation thresholds, contact lists, function assignments, and after-action reviews. Ambulance capacity should be determined through risk analysis and formal agreements with partners. Staff suLaws and Regulationsort for 12 hour shifts requires auditable rest standards. Istithaah requires closed-loop referral and fitness review connecting regional health offices, embarkation, hospitals, and cluster officers.

Third, digital governance: rather than adding new aLaws and Regulationslications, reform should begin with data architecture; single source of truth, unique identifiers, common data dictionaries, automated validation, and role based access. Existing platforms can retain specific functions if data exchange occurs through standardised interfaces without re-entry. For elderly pilgrims with digital limitations, SSHP should provide an assisted pathway through cluster officers; system success should be measured not only by completion rates but also by completeness, validity, and usability for health decisions.[56]

CONCLUSION

This study evaluated the coherence between legal frameworks, institutional governance, and health service practices at Surabaya Embarkation and Debarkation during the 1447 H/2026 M Hajj season. The findings reveal persistent governance gaps: discontinuities in health assessment, insufficient ambulance capacity, transitional logistics challenges, inadequate staff facilities, and fragmented information systems. These gaps demonstrate that operational service delivery does not automatically translate to effective governance, as capacity may conceal structural weaknesses in coordination, resource allocation, and information management.

From a legal certainty perspective, the temporal audit revealed that several regulations referenced in operational documents had been revoked prior to operations (obsolete-reference gap), and regulatory changes occurred during active debarkation (transitional governance gap), creating variable legal certainty. The analytical framework identifying six gap types offers a diagnostic tool for evaluating public health services during institutional transition, enriching the literature on regulatory governance in mass gatherings. Recommendations include pre-season legal audits, transition SOPs, structured incident command systems, closed-loop referral systems, and data architecture reform. Despite limitations secondary data, single-case design, and absence of primary data the findings underscore that governance reform requires a systems approach addressing interconnections among regulatory clarity, resource availability, information interoperability, and service delivery processes. Future research should extend this

[56] Alquayt et al., "AI-Driven Healthcare Innovations for Enhancing Clinical Services during Mass Gatherings (Hajj): Task Force Insights and Future Directions."

framework to other embarkation hubs and incorporate primary data to strengthen the evidence base for mass gathering health governance.

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