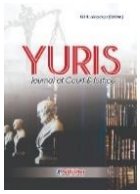

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Legal Protection and Health Right of Elderly Hajj Pilgrims: Surabaya Socio-Legal Study 1447H

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ABSTRACT

The Elderly-Friendly Hajj policy requires legal and health-service arrangements that respond to the vulnerabilities of older pilgrims while preserving equality, dignity, and safety. This study examines legal protection and the fulfillment of health rights of Hajj pilgrims aged sixty years and above at the Surabaya Embarkation and Debarkation Point during the 1447 H/2026 CE Hajj season. It employs a document-based empirical socio-legal design using secondary administrative data from the Surabaya Health Quarantine Center Hajj health-services report, primary legal materials, and relevant scholarly literature. Data were analysed descriptively and mapped against statutory duties, health-service standards, and principles protecting vulnerable groups. The findings show that older pilgrims constituted a substantial share of outpatient service users and hospital referrals, particularly during debarkation. Documented forms of protection included priority examinations, outpatient care, referral, fitness-to-fly assessment, Mecca Route services, and debarkation care However, the records also identified limitations relating to ambulance capacity, facility safety and accessibility, mobility support, administrative and digital barriers, and consistency of health istithaah assessments. The analysis indicates that legal protection has been operationalised across several dimensions, but the available administrative evidence does not establish comprehensive fulfillment or service quality. The study proposes a risk-responsive legal protection approach integrating accessibility, mobility, chronic disease management, referral, dignity, and continuity of care throughout the Hajj journey..

Keywords: *Elderly-Friendly, Elderly Hajj Pilgrims, Legal Protection, Right to Health, Socio-Legal Study.*

INTRODUCTION

The Hajj constitutes one of the largest annual mass gatherings in the world, bringing together millions of pilgrims from diverse backgrounds within a physically demanding and environmentally challenging setting. Among this population, elderly pilgrims represent a particularly vulnerable group whose health needs require specialized attention. In Indonesia, the proportion of elderly Hajj pilgrims has continued to rise, with approximately twenty-five percent of pilgrims classified as elderly and a substantial majority presenting with comorbid conditions.[1] This demographic shift has prompted the Indonesian government to adopt the "Elderly-Friendly Hajj" policy, which seeks to ensure that elderly pilgrims can perform their religious obligations safely and with dignity.[2] However, the mere existence of such a policy does not guarantee that the health rights of elderly pilgrims are adequately protected in practice.

Previous studies have examined various dimensions of Hajj health services, yet significant gaps remain in the literature. Research on Hajj epidemiology has identified high prevalence rates of diabetes and hypertension among pilgrims, establishing a clear link between age, chronic disease, and adverse health outcomes.[3] Studies on mobility and gerontology have demonstrated that elderly pilgrims often require assistance with mobilization even when they remain independent in daily activities.[4] Policy-oriented research has evaluated the implementation of Hajj health regulations, highlighting coordination challenges among stakeholders.[5]Legal scholarship has examined the *istithaah* framework as a mechanism for ensuring health fitness prior to departure.[6] In addition, Sarbini and Hartantien conducted a study on the legal protection of vulnerable groups' rights

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[1] Kesehatan Kementerian, "Wujudkan Haji Ramah Lansia Dan Disabilitas 1446h/2025m Ini Kebijakan Strategis Kemenkes Dalam Penyelenggaraan Kesehatan Haji," 2025, https://kemkes.go.id/eng/wujudkan-haji-ramah-lansia-dan-disabilitas-1446h-2025m-ini-kebijakan-strategis-kemenkes-dalam-penyelenggaraan-kesehatan-haji.

[2] Badrah Uyuni and Mohammad Adnan, "A Dynamic Hajj Fiqh for Elderly: A Study of Indonesian Pilgrims," *International Journal of Emerging Issues in Islamic Studies* 4, no. 1 (July 29, 2024): 54–68, https://doi.org/10.31098/ijeiis.v4i1.2325.

[3] Saber Yezli et al., "Prevalence of Diabetes and Hypertension among Hajj Pilgrims: A Systematic Review," *International Journal of Environmental Research and Public Health* 18, no. 3 (January 28, 2021): 1155, https://doi.org/10.3390/ijerph18031155; Meity Ardiana et al., "The Impact of Classical Cardiovascular Risk Factors on Hospitalization and Mortality among Hajj Pilgrims," ed. Francesco Giallauria, *The Scientific World Journal* 2023 (April 18, 2023): 1–9, https://doi.org/10.1155/2023/9037159.

[4] Vitriana Biben et al., "Independence Status, Communication and Mobilization Profiles of Indonesian Hajj Pilgrims," *Indonesian Journal of Physical Medicine and Rehabilitation* 12, no. 01 (June 28, 2023): 81–91, https://doi.org/10.36803/indojpmr.v12i01.346.

[5] 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.

[6] Arsita Rasmi and Mohammad Jamin, "Legal Protection of Pilgrims on Health *Istithaah* Standards in Indonesia," *International Journal of Law, Crime and Justice* 1, no. 2 (June 30, 2024): 203–12, https://doi.org/10.62951/ijlcj.v1i3.133.

and found that protective frameworks must address structural barriers that impede equal access, particularly for groups such as the elderly.[7] Lestari and Prasetyo examined the implementation of healthcare facilities for pregnant prisoners and concluded that the state's obligation to provide health services to vulnerable populations requires not only formal recognition but also practical implementation on the ground.[8] These studies establish a foundation for examining legal protection and health rights in contexts where vulnerability intersects with state obligations, yet neither directly addresses the specific situation of elderly pilgrims at the embarkation and debarkation phases.

The novelty of this study lies in its integration of three previously disconnected domains: actual administrative service data from a specific embarkation and debarkation locus, the normative framework governing health rights and protection of vulnerable groups, and an evaluation of the Elderly-Friendly Hajj policy within a single socio-legal analytical framework. While clinical literature identifies risks and policy literature explains implementation processes, these streams rarely engage with empirical service data from operational Hajj health facilities. This study bridges that divide by mapping documented service indicators against statutory obligations and health service standards, thereby producing a more comprehensive account of whether legal protection has achieved substantive operational effect.

The research gap addressed here is not merely the absence of prior scholarship, but rather the absence of integration between multiple analytical dimensions. Existing studies have separately examined the clinical vulnerabilities of elderly pilgrims, the legal framework of *istithaah*, and the policy discourse of elderly-friendly Hajj. What remains unexplored is how these dimensions interact in practice at the operational level. Specifically, there is a lack of empirical analysis concerning whether the legal rights of elderly pilgrims translate into actual service provision, whether institutional capacity is sufficient to meet identified needs, and whether normative commitments correspond to documented outcomes. The embarkation and debarkation phases represent critical transition points where these questions become particularly salient, as elderly pilgrims move between healthcare systems, geographic regions, and phases of service delivery.

The objective of this study is therefore fourfold. First, it aims to identify the forms of legal protection that have been operationalized for elderly Hajj pilgrims at the Surabaya Embarkation and Debarkation Point during the 1447 H/2026 CE Hajj season. Second, it seeks to assess the empirically observable dimensions of health

[7] Dr. Sarbini and Sinarianda Kurnia Hartantien, "LEGAL PROTECTION OF VULNERABLE GROUPS' RIGHTS IN GENERAL ELECTIONS," *Journal of Court and Justice* 2, no. 2 (June 27, 2023): 14–23, https://doi.org/10.56943/jcj.v2i2.336.

[8] Yashinta Dwi Lestari and Dr. Dossy Iskandar Prasetyo, "IMPLEMENTATION OF GRANTING HEALTHCARE FACILITIES RIGHTS FOR PREGNANT FEMALE PRISONERS AT CLASS II A SURABAYA WOMEN'S PENITENTIARY," *Journal of Court and Justice* 2, no. 2 (August 15, 2023): 36–43, https://doi.org/10.56943/jcj.v2i2.362.

rights fulfillment based on documented service indicators. Third, it evaluates the correspondence between normative obligations and actual practice, identifying areas of successful implementation as well as gaps requiring attention. Fourth, it formulates policy recommendations oriented toward strengthening a risk-responsive approach to legal protection that integrates accessibility, mobility, chronic disease management, referral systems, dignity, and continuity of care throughout the Hajj journey.

This study contributes to the field by developing the concept of risk-responsive legal protection, which moves beyond a priority-only approach based solely on chronological age. The proposed Integrated Elderly Hajj Health Protection Framework offers a conceptual structure linking risk identification, accessibility, mobility, chronic disease management, safety, referral, information provision, dignity, institutional coordination, and continuous service auditing. While this framework is presented as a conceptual policy model rather than an experimentally validated intervention, it provides a foundation for future research and policy development. By grounding the analysis in actual administrative data from a specific Hajj season, the study maintains transparency regarding both its empirical basis and its analytical limitations, thereby offering a replicable methodology for evaluating legal protection in mass gathering health contexts.

LITERATURE REVIEW

The existing scholarship on elderly Hajj pilgrims can be grouped into four interrelated domains, namely clinical epidemiology, gerontological and functional studies, health policy implementation, and legal analysis of protection frameworks. Clinical and epidemiological research has consistently established that advanced age constitutes a dominant risk factor for adverse health outcomes during the Hajj. A systematic review of fifty eight observational studies found that pilgrims aged sixty years and above face a three to eight fold increased mortality risk compared to younger pilgrims. Cardiovascular disease accounted for thirty eight to forty two percent of all deaths, while hypertension prevalence reached 71.34 percent among elderly pilgrims.[9]Another systematic review and meta-analysis focusing specifically on Indonesian Hajj pilgrims identified advanced age, diabetes mellitus, obesity, and family history as major risk factors for hypertension. The pooled odds ratio for diabetes mellitus was 1.86.[10] These findings demonstrate that the clinical vulnerability of elderly pilgrims emerges from the interaction between pre-existing

[9] Hafiz Anugrah Mursyid and Yessica Sheila Sitompul, "What Is The Prevalence of Acute Cardiovascular Events among Elderly Hajj Pilgrims (≥60 Years), and What Are The Associated Risk Factors? : A Systematic Review," *The International Journal of Medical Science and Health Research* 39, no. 2 (April 9, 2026): 1–50, https://doi.org/10.70070/dqbmkn79.

[10] Muhammad Abdillah Roikhan and Faza Saiqur Rahmah, "Risk Factors for Hypertension in Indonesian Hajj Pilgrims: A Systematic Review and Meta-Analysis," July 2, 2025, https://doi.org/10.1101/2025.07.01.25330661.

chronic conditions and the environmental and physical demands of the Hajj. Beyond clinical parameters, gerontological research has illuminated functional dimensions of vulnerability that are often overlooked in purely diagnostic assessments. A study of Indonesian pilgrims found that while the majority were independent in activities of daily living, a substantial proportion nonetheless required mobility assistance. This indicates that functional dependency and diagnostic status do not always align.[11] Research involving over three thousand pilgrims aged sixty and above further underscores the importance of cognitive dimensions in preparedness and support. Vulnerability thus encompasses sensory, cognitive, and mobility domains that extend beyond disease classification.[12]

From a legal and policy perspective, the protection of elderly pilgrims' health rights rests on a layered normative framework. The 1945 Constitution guarantees the right to health services, the right to facilitation and special treatment in the pursuit of equality and justice, and protection from discriminatory treatment. Law No. 13 of 1998 on Elderly Welfare establishes the sixty year threshold for elderly status and mandates comprehensive healthcare rights.[13] The *istithaah* framework, governed by Ministry of Health Regulation No. 15 of 2016, functions as a preventive mechanism linking health fitness assessment to the safe performance of the Hajj. Its legitimacy depends on individualized assessment and not on age based restriction.[14] Policy oriented research has evaluated the implementation of Hajj health regulations and identified persistent coordination challenges among stakeholders. Legal scholarship has examined the *istithaah* framework as a mechanism for ensuring health eligibility prior to departure.[15] Two recent studies provide additional foundations for the present inquiry. Sarbini and Hartantien examined the legal protection of vulnerable groups' rights and found that protective frameworks must address structural barriers impeding equal access for groups including the elderly.[16] Lestari and Prasetyo investigated the fulfilment of healthcare facilities for pregnant prisoners and concluded that the state's obligation to provide health services to vulnerable populations requires practical implementation beyond formal recognition.[17] These contributions establish a

[11] Biben et al., "Independence Status, Communication and Mobilization Profiles of Indonesian Hajj Pilgrims."
[12] Amar Mohammad A. Alkhotani et al., "Cognitive Impairment among Older Adults' Pilgrims during Hajj: A Cross-Sectional Study of Prevalence and Associated Factors," *BMC Geriatrics* 25, no. 1 (December 1, 2025): 988, https://doi.org/10.1186/s12877-025-06690-2.
[13] "Undang-Undang Dasar (UUD) Tahun 1945 Dan Amandemen Nomor - Tentang UUD 1945 Dan Amandemen" (n.d.), https://peraturan.bpk.go.id/Details/101646/uud-no--; "Undang-Undang (UU) Nomor 13 Tahun 1998 Tentang Kesejahteraan Lanjut Usia," Pub. L. No. 13 (1998), https://peraturan.bpk.go.id/Details/45509/uu-no-13-tahun-1998.
[14] "Peraturan Menteri Kesehatan Nomor 15 Tahun 2016 Tentang *Istithaah* Kesehatan Jemaah Haji" (n.d.), https://peraturan.bpk.go.id/Details/113016/permenkes-no-15-tahun-2016.
[15] Rustika et al., "An Evaluation of Health Policy Implementation for Hajj Pilgrims in Indonesia"; Arsita Rasmi and Mohammad Jamin, "Legal Protection of Pilgrims on Health *Istithaah* Standards in Indonesia."
[16] Sarbini and Hartantien, "LEGAL PROTECTION OF VULNERABLE GROUPS' RIGHTS IN GENERAL ELECTIONS."
[17] Lestari and Prasetyo, "IMPLEMENTATION OF GRANTING HEALTHCARE FACILITIES RIGHTS FOR PREGNANT FEMALE PRISONERS AT CLASS II A SURABAYA WOMEN'S PENITENTIARY."

scholarly tradition of examining legal protection and health rights in contexts where vulnerability intersects with state obligations. Neither study directly addresses the operational dimensions of elderly Hajj pilgrims at embarkation and debarkation.

The literature reviewed above reveals a significant integrative gap. Clinical and epidemiological studies have identified risks with increasing precision. Legal scholarship has articulated the normative foundations of protection. However, these streams rarely engage with actual administrative service data from operational Hajj health facilities. The strength of the clinical literature lies in risk identification. The strength of policy literature lies in explaining implementation processes. Legal scholarship provides the necessary normative foundation. What remains unexplored is how these dimensions interact in practice. The central concern is whether the legal rights of elderly pilgrims translate into actual service provision, whether institutional capacity is sufficient to meet identified needs, and whether normative commitments correspond to documented outcomes. The embarkation and debarkation phases represent critical transition points where these questions become particularly salient. Elderly pilgrims move between healthcare systems, geographic regions, and phases of service delivery. This study addresses that gap by integrating administrative service data with socio-legal analysis. It thereby produces a more comprehensive account of whether legal protection for elderly pilgrims has achieved substantive operational effect.

RESEARCH METHODOLOGY

This research is a document-based empirical socio legal inquiry. It relies on secondary data and document analysis. The approaches applied are statutory, conceptual, empirical, policy, and rights based, as each dimension requires. The design is descriptive analytical and does not test causal relationships. The substantive locus is Hajj health services at Surabaya Embarkation and Debarkation during 1447 H/2026 CE. These services cater to pilgrims from East Java, Bali, and East Nusa Tenggara. The phrase "research location" refers to the service locus reflected in the documents, not to a site of primary data collection. The main empirical source is the Health Service Report of the Surabaya Embarkation and Debarkation Point for 1447 H/2026 CE, compiled by BBKK Surabaya.[18] Normative sources comprise the 1945 Constitution, Law No. 13 of 1998, Law No. 39 of 1999, Law No. 25 of 2009, Law No. 17 of 2023, Law No. 14 of 2025, and Ministry of Health Regulations No. 15 of 2016 and No. 62 of 2016.[19] Secondary materials cover

[18] Balai Besar Kekarantinaan Kesehatan Surabaya, "Laporan Penyelenggaraan Pelayanan Kesehatan Haji Embarkasi–Debarkasi Surabaya Tahun 1447 H/2026 M," 2026, https://bbkk-surabaya.go.id/laporan/.

[19] Undang-undang Dasar (UUD) Tahun 1945 dan Amandemen Nomor - tentang UUD 1945 dan Amandemen; Undang-undang (UU) Nomor 13 Tahun 1998 tentang Kesejahteraan Lanjut Usia; "Undang-Undang (UU) Nomor 39 Tahun 1999 Tentang Hak Asasi Manusia" (1999), https://peraturan.bpk.go.id/Details/45361/uu-no-39-tahun-1999; "Undang-Undang Republik Indonesia Nomor 25 Tahun 2009 Tentang Pelayanan Publik.," Pub. L. No. 25 (2009); "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; "Undang-Undang (UU) Nomor 14 Tahun 2025 Tentang Perubahan Ketiga Atas Undang-Undang Nomor 8 Tahun 2019 Tentang

health law, Hajj administration, gerontology, public health, and mass gathering medicine. Document based analysis allows integration of policy, administrative, and normative information while preserving the origin and context of each data point.[20]

The empirical unit of analysis consists of service indicators reliably attributable to pilgrims aged sixty and above. These indicators include outpatient visits, hospital referrals, Mecca Route services, unfit to fly status, age disaggregated mortality, and information on mobility, accessibility, facilities, and service barriers. Older pilgrims are operationally defined as those aged sixty and above. Data were included only when the report explicitly used this category or provided individual ages allowing definitive classification. Age categories spanning the threshold were not estimated. Information was extracted from narratives, tables, figures, problem statements, conclusions, and recommendations. Each indicator was recorded with source references, age group, numerator, denominator, service phase, and normative relevance. Key figures were cross checked, percentages were recalculated where possible, and discrepancies were retained as data issues instead of being silently corrected. Analysis uses simple frequencies and proportions. Inferential statistics were not conducted because the data are aggregate and lack individual-level datasets. Proportions of older service users are therefore not interpreted as incidence, prevalence, or relative risk.

Legal content analysis examined rights holders, duty bearing entities, services for at-risk populations, accessibility, safety, *istithaah*, and continuity of care. Relevant standards were compared with empirical data using four categories, namely fully implemented, implemented with limitations, possible normative-empirical gap, and not evaluable due to inadequate information. Triangulation was conducted among BBKK narratives, tables, and conclusions, between cited regulations and primary legal sources, and between BBKK data and scholarly literature. Selection bias was addressed by not treating service users as representative of all older pilgrims. Classification bias was mitigated through consistent application of the sixty year threshold. Interpretive bias was addressed by separating administrative findings, legal norms, and authors' interpretation. The inquiry did not involve interviews, surveys, focus group discussions, participant observation, intervention, or specimen collection. The data are secondary and non-identifiable, so no ethical approval number, exemption, or informed consent is reported. Such requirements are not applicable to this document based design.

Ibadah Haji Dan Umrah," Pub. L. No. 14 (2025), https://peraturan.bpk.go.id/Details/331538/uu-no-14-tahun-2025; Peraturan Menteri Kesehatan Nomor 15 Tahun 2016 tentang *Istithaah* Kesehatan Jemaah Haji; "Peraturan Menteri Kesehatan Nomor 62 Tahun 2016 Tentang Penyelenggaraan Kesehatan Haji," Pub. L. No. 62 (2016), https://peraturan.bpk.go.id/Details/139488/permenkes-no-62-tahun-2016.

[20] Reyhane Izadi et al., "Qualitative Document Analysis on Iranian Contents and Trends of Population Policies: Lessons Learned and Avenues for Future," *Heliyon* 9, no. 6 (June 2023): e17377, https://doi.org/10.1016/j.heliyon.2023.e17377.

RESULT AND DISCUSSION

Profile of Elderly Pilgrims and Service Utilization

The third-stage health examination recorded a total of 44,017 pilgrims. The report cites an overall elderly proportion of 25 percent, though the denominator and contextual basis of this figure are insufficiently specified to establish it as a proportion specific to Surabaya Embarkation.[21] Accordingly, this figure was not used to calculate the absolute number of elderly pilgrims within the locus of this study. At embarkation, 1,459 outpatient visits were recorded, of which 723, or 49.55 percent, involved pilgrims aged sixty years and above. At debarkation, 224 outpatient visits were recorded, of which 162, or 72.32 percent, involved pilgrims within this age group. This difference reflects a shift in the age composition of service users between the two phases, namely a higher concentration of elderly pilgrims seeking care upon return. The pattern does not indicate an increase in morbidity risk but rather demonstrates that elderly pilgrims constitute a substantial proportion of service users at both transition points.

Hospital referrals similarly reveal a notable pattern. Of the 129 hospital referrals recorded at embarkation, 71, or 55.00 percent, involved pilgrims aged sixty years and above. Within this group, 45 cases were recorded as outpatient referrals and 26 as inpatient admissions. At debarkation, 50 of 65 referrals, or 76.92 percent, involved pilgrims within this age group, of which 18 cases were recorded as inpatient admissions. These findings demonstrate that elderly pilgrims require referral services at rates that exceed their proportion in the general pilgrim population.

Health risk status and predominant diagnoses provide additional context. A total of 34,064 pilgrims were recorded as high risk during the third stage health examination. The report, however, does not provide a complete cross-tabulation between age and risk status. This figure therefore cannot be treated as representing the number of high-risk elderly pilgrims specifically. The most frequently recorded diagnoses at the embarkation outpatient clinic include hypertension with 725 cases, anemia with 105 cases, diabetes mellitus with 85 cases, diarrhea with 63 cases, and history of tuberculosis or positive acid-fast bacilli status with 54 cases. At debarkation, the most frequently recorded diagnoses include acute respiratory infection with 71 cases, hypertension with 24 cases, chronic obstructive pulmonary disease with 20 cases, diabetes mellitus with 13 cases, and influenza with nine cases.7As diagnostic data were not cross tabulated by age, these conditions cannot be categorized as diagnoses predominant among elderly pilgrims specifically.

Seven of the fifteen recorded unfit to fly cases could be confirmed as involving pilgrims aged sixty years and above. At debarkation, the eight recorded deaths involved pilgrims aged 60, 61, 63, 63, 69, 69, 70, and 72 years,

[21] Balai Besar Kekarantinaan Kesehatan Surabaya, "Laporan Penyelenggaraan Pelayanan Kesehatan Haji Embarkasi–Debarkasi Surabaya Tahun 1447 H/2026 M."

respectively.These findings are descriptive in nature and do not establish a causal relationship among age, service provision, and health outcomes. The documented forms of priority service include health screening, outpatient care, supporting diagnostic services, referral, Mecca Route services, fit to fly assessment, debarkation care, and evacuation. The report further identifies the need for dedicated teams to support the mobilization and facilitation of elderly pilgrims. However, quantitative data on the number of elderly pilgrims requiring, and subsequently receiving, mobility assistance are not available.

Implementation of Legal Protection Norms

The mapping of normative rights and implementation indicators reveals a varied landscape of compliance. Health services and specialized services for the elderly have been implemented within documented dimensions. Screening, outpatient care, referral, and priority access are available. Special treatment to achieve substantive equality has also been implemented, with priority screening documented for elderly pilgrims. The third stage health examination, which recorded 44,017 pilgrims examined, demonstrates implementation of health examination and *istithaah* requirements. Flight safety assessment, with 15 cases assessed as unfit to fly, has been implemented. Access to curative services and referral services has been realized, with pilgrims aged sixty and above utilizing outpatient clinics and being recorded among both embarkation and debarkation referrals.

Mobility and accessibility present a different picture. The need for mobility assistance has been acknowledged by BBKK, but data on fulfillment are unavailable. This dimension cannot be fully assessed. Facility safety has been implemented with limitations, as evaluation indicates certain elements of elderly safety remain in need of improvement. Evacuation readiness has likewise been implemented with limitations. Referral transport is operational, but BBKK states ambulance capacity remains insufficient. Continuity of *istithaah* assessment reveals a potential implementation gap. Cases exist in which current condition was assessed as inconsistent with prior status. Administrative and digital access also cannot be fully assessed. Barriers include unrecorded age specific data, and elderly specific data remain unavailable.

The documentary evidence demonstrates implementation across screening, prioritization, outpatient care, referral, Mecca Route services, and fit to fly assessment. At the same time, the report records limitations in ambulance capacity, aspects of facility safety that remain in need of improvement, unmet mobility assistance needs for which sufficiency data are unavailable, digital access barriers, and inconsistencies in *istithaah* assessment. These limitations are categorized as implementation shortcomings or potential implementation gaps, namely areas requiring attention, and not as findings of legal violation.

Gaps Between Standarts and Implementation

The BBKK findings reveal a marked concentration of pilgrims aged sixty years and above among users of outpatient and referral services, particularly during the debarkation phase. This finding should be read as a utilization pattern, that is, a reflection of service demand, and not as a measure of prevalence or risk. It is consistent with international literature indicating that elderly pilgrims and those with chronic disease require adaptive resource planning,[22] as well as with Indonesian evidence on the relevance of age and cardiometabolic factors to Hajj health outcomes.[23] Legally, these characteristics do not justify a generalized assumption that all elderly pilgrims are incapacitated. The obligation to protect must be responsive to the combination of age, disease, functional status, mobility, and actual need presented by each pilgrim. The implication is that age should serve as an entry point for screening and accommodation, including the provision of targeted support, and not as a sole basis for restriction.

Within this framework, priority screening, *istithaah* evaluation, and fit to fly assessment constitute forms of preventive protection.[24] They aim to identify conditions that may threaten safety prior to the subsequent phase of travel. Law No. 14 of 2025 establishes health status as a prerequisite for departure and explicitly provides specialized services for elderly pilgrims and those with high risk health conditions.[25] Appropriate preventive protection, accordingly, consists of individualized risk assessment accompanied by proportionate accommodation or restriction. A determination of unfitness to fly may constitute a legitimate protective measure where it is grounded in clinical condition and accompanied by accountable communication of the decision. The available data further indicate that elderly pilgrims did, in practice, make substantial use of outpatient and referral services. This constitutes evidence of actual access along certain dimensions, though not proof of access that is comprehensively adequate. The BBKK data provide no information on unmet need, waiting times, pilgrim experience, communication quality, or the clinical quality of services rendered. The right to health services under Article 28H(1) of the 1945 Constitution must be read in conjunction with Article 28H(2), which concerns special treatment to secure equal opportunity and benefit.29 Within this context, accessibility encompasses physical access, procedural and queuing arrangements, information and communication, administrative and digital dimensions, and the capacity of pilgrims to reach referral services. The difficulties experienced by some elderly pilgrims in completing

[22] 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.
[23] Ardiana et al., "The Impact of Classical Cardiovascular Risk Factors on Hospitalization and Mortality among Hajj Pilgrims."
[24] Rustika et al., "An Evaluation of Health Policy Implementation for Hajj Pilgrims in Indonesia."
[25] Undang-undang (UU) Nomor 14 Tahun 2025 tentang Perubahan Ketiga atas Undang-Undang Nomor 8 Tahun 2019 tentang Ibadah Haji dan Umrah.

digital health administration illustrate that digitalization may itself generate additional barriers where assisted access is not provided.[26] The mobility assistance needs acknowledged by BBKK carry independent legal significance, as limitations in movement may impede the exercise of rights that are formally available.[27] Mobility should accordingly be regarded as a component of accessibility and safety, namely a fundamental aspect of dignified care, and not merely a matter of comfort. Law No. 14 of 2025 places responsibility for safety from departure from Indonesia through to return, and Article 34 affirms the provision of health services prior to departure, during the stay in Saudi Arabia, and following return to Indonesia. [28] This normative structure supports an understanding of continuity of care as a systemic obligation, that is, a sustained responsibility across phases, and not a series of disconnected episodes of care.

Broadly speaking, the principal gap identified in this study does not lie in the absence of applicable norms. Law No. 14 of 2025 already provides for the right to health services, specialized services for elderly and high-risk pilgrims, government responsibility, travel safety, and continuity of care. The difficulty lies instead in the translation of these norms into actual capacity, procedural consistency, and auditable indicators. This is reflected in the limitations in ambulance capacity, facility related aspects still requiring improvement, mobility needs that remain inadequately measured, and discrepancies in *istithaah* assessment outcomes across successive stages of screening. [29] These discrepancies in *istithaah* findings do not, in themselves, establish that an earlier regional determination was erroneous. Health status may change over time. Where such discrepancies persist, however, the system requires a feedback loop through which findings from embarkation stage screening can inform the evaluation and guidance provided at the regional level. It is also important to distinguish the concept employed in this article from the corresponding statutory terminology. The term "legal protection" as used in this study constitutes an academic framework grounded in Health Law. The elucidation of Article 41 of Law No. 14 of 2025 assigns a specific technical meaning to the term "legal protection." 35 This article accordingly does not seek to expand the meaning of that provision. It draws on the broader regime of health rights, specialized services, safety, and state responsibility as the basis for its analysis.

Priority services extended to elderly pilgrims, within this framework, do not constitute discrimination insofar as their purpose is to reduce factual barriers so that pilgrims may obtain equal opportunity for service. The normative basis for this lies

[26] Moonika Raja et al., "Older Adults` Sense of Dignity in Digitally Led Healthcare," *Nursing Ethics* 29, no. 6 (September 20, 2022): 1518–29, https://doi.org/10.1177/09697330221095140.
[27] Biben et al., "Independence Status, Communication and Mobilization Profiles of Indonesian Hajj Pilgrims."
[28] Undang-undang (UU) Nomor 14 Tahun 2025 tentang Perubahan Ketiga atas Undang-Undang Nomor 8 Tahun 2019 tentang Ibadah Haji dan Umrah.
[29] Balai Besar Kekarantinaan Kesehatan Surabaya, "Laporan Penyelenggaraan Pelayanan Kesehatan Haji Embarkasi–Debarkasi Surabaya Tahun 1447 H/2026 M."

in Article 28H(2) of the 1945 Constitution, which recognizes facilitation and special treatment in the pursuit of equality and justice, together with Article 28I(2), which prohibits discriminatory treatment in all its forms.[30] Analytically, legitimate differentiation in treatment must satisfy several conditions simultaneously. First, a genuine difference in factual need must exist, such as limitations in standing tolerance, stamina, or mobility. Second, the differential treatment must serve a legitimate purpose, namely safety and access. Third, the intervention must bear a rational relationship to the barrier addressed, such as the provision of priority lanes to reduce fatigue. Fourth, the measure must be proportionate and must not extinguish the rights of other pilgrims. Priority queuing for elderly pilgrims must not, accordingly, displace clinical triage, and age alone must not serve as the sole ground for restricting departure. This is the essence of substantive equality, namely treating differing needs differently, to the extent necessary, in order to produce more equal access for all.

Policy Recommendation Model

The findings of this study support a shift from a priority-only approach toward risk-responsive legal protection.[31] Age based priority remains relevant as an entry point for special accommodation. It is clinical need, functional status, mobility, cognition, medication, and accompaniment that should determine the intensity of support extended to each pilgrim. This model carries relevance beyond the Surabaya context alone, given that the challenges of population ageing, chronic disease, mobility, and service transition are by no means unique to a single embarkation point.

The proposed Integrated Elderly Hajj Health Protection Framework offers a conceptual structure linking risk identification, accessibility, mobility, chronic disease management, safety, referral, information provision, dignity, institutional coordination, and continuous service auditing. The architecture proceeds through seven interrelated stages, namely identification, preparation, protection at embarkation, maintenance during travel, reassessment at debarkation, return to care, and audit and improvement. This model integrates preventive, responsive, and corrective protection within a single structure. Age serves to open access to specialized accommodation. Risk determines the intensity of support provided. Rights establish the normative boundaries of permissible action. Service data provide the empirical basis for evaluation.

Targeted geriatric screening within this model is not intended to impose an obligation to conduct a comprehensive geriatric assessment on every pilgrim aged sixty years and above.[32] A more proportionate approach involves initial screening across domains of operational relevance, including mobility, cognition, medication,

[30] Undang-undang Dasar (UUD) Tahun 1945 dan Amandemen Nomor - tentang UUD 1945 dan Amandemen.
[31] Uyuni and Adnan, "A Dynamic Hajj Fiqh for Elderly: A Study of Indonesian Pilgrims."
[32] Bonnie C. Sohn et al., "Clinician's Guide to Geriatric Assessment," *Mayo Clinic Proceedings* 99, no. 11 (November 2024): 1773–84, https://doi.org/10.1016/j.mayocp.2024.08.017.

multimorbidity, and individual need. This is followed by more in depth assessment where indications warrant. These findings should nonetheless be read against several limitations inherent in the study's design. The data employed are drawn from a single organizational locus, namely the Surabaya Embarkation and Debarkation Point.[33] Although this locus serves pilgrims from several provinces, service characteristics, resource availability, and referral systems may differ at other embarkation points. The data are, moreover, secondary in nature and predominantly administrative or aggregate. The source report does not provide a population denominator for elderly pilgrims compatible with every indicator examined. This study is therefore unable to calculate relative risk or elderly specific prevalence. This study likewise did not obtain the direct perceptions of elderly pilgrims themselves, nor did it conduct interviews with service personnel. This research design, accordingly, does not permit causal attribution with respect to morbidity, mortality, or other outcomes. The strength of this study lies, instead, in its integration of actual 2026 administrative data with legal and policy analysis. This enables a transparent evaluation of the relationship between normative obligations and genuinely documented evidence of implementation.

CONCLUSION

This study finds that legal protection for elderly Hajj pilgrims at the Surabaya Embarkation and Debarkation Point during the 1447 H/2026 CE Hajj season has achieved operational manifestation through health and *istithaah* screening, priority service provision, outpatient care, referral, fit-to-fly assessment, Mecca Route services, and debarkation care. Pilgrims aged sixty years and above constitute a substantial proportion of service users across the age-stratified indicators examined. The documented forms of protection demonstrate that age functions as an entry point for accommodation and screening. However, the available data do not support the conclusion that every dimension of health rights has been optimally fulfilled. The principal gaps identified concern ambulance capacity, aspects of facility safety and accessibility, the measurement of mobility needs fulfillment, administrative and digital barriers, and the consistency of *istithaah* assessment across successive stages. These findings constitute implementation gaps or capacity limitations and do not establish any violation of law.

The contribution of this article lies in its integration of BBKK administrative data from 2026 with legal, policy, gerontological, and mass-gathering health analysis through a socio-legal approach. The study proposes a shift from a priority-only approach toward risk-responsive legal protection that integrates accessibility, mobility, chronic disease management, referral, dignity, and continuity of care throughout the Hajj journey. The proposed Integrated Elderly Hajj Health Protection Framework offers a conceptual structure linking risk identification, accessibility, mobility, chronic disease management, safety, referral, information

[33] Balai Besar Kekarantinaan Kesehatan Surabaya, "Laporan Penyelenggaraan Pelayanan Kesehatan Haji Embarkasi–Debarkasi Surabaya Tahun 1447 H/2026 M."

provision, dignity, institutional coordination, and continuous service auditing. Age serves to open access to specialized accommodation. Risk determines the intensity of support provided. Rights establish the normative boundaries of permissible action. Service data provide the empirical basis for evaluation.

Several limitations should be acknowledged. The data were drawn from a single organizational locus, namely the Surabaya Embarkation and Debarkation Point. Service characteristics, resource availability, and referral systems may differ at other embarkation points. The data were secondary and predominantly administrative or aggregate. The source report did not provide a population denominator for elderly pilgrims compatible with every indicator examined, so this study could not calculate relative risk or elderly specific prevalence. This study also did not obtain the direct perceptions of elderly pilgrims or conduct interviews with service personnel. Experiences relating to dignity, communication, discrimination, waiting times, satisfaction, unmet need, and specific operational rationales could not be directly assessed. This research design does not permit causal attribution with respect to morbidity, mortality, or other outcomes. Future studies should expand the analysis to multiple embarkation points and employ primary data collection methods, including interviews and surveys with pilgrims and health personnel. Longitudinal designs could track health outcomes across the full Hajj journey and assess the effectiveness of specific interventions. Comparative studies across different embarkation loci could identify contextual factors that shape the implementation of elderly-friendly Hajj policies. Such research would strengthen the evidence base for risk-responsive legal protection and support the continuous improvement of health services for elderly pilgrims.

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