LSH

Heard at Field House

On 5 February 2003

AA (Article3 – HIV/AIDS) Chad
CG [2002] UKIAT 08004
CC 08120-02

IMMIGRATION APPEAL TRIBUNAL

Date Determination notified:
01/04/2003

Before:

Mr G Warr (Chairman)
Mr P Rogers, JP
Mr R Baines, JP

Between

AHMET TIDJANI ADOUM

APPELLANT

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

RESPONDENT

DETERMINATION AND REASONS

1. The appellant, a citizen of Chad, appeals the determination of an Adjudicator (Miss J E Perrett) who dismissed the appellant's asylum and human rights appeals. The appellant was HIV positive and is said now to have developed AIDS. Leave to appeal on asylum grounds was refused. Leave to appeal was granted on Article 3 points only.

2. The appellant was represented by Miss G Oliso of the Refugee Legal Centre while Miss A Green appeared for the Secretary of State.

3. The appellant was born in Chad on 30 August 1981. He said his family had gone to Nigeria when he was 7. Following the death of his father in 1988 the appellant went to Benin while the rest of his family returned to Chad as did the appellant when he was 17. An unusual feature of the case before the Adjudicator was that it was admitted by his representatives that 50% of his original claim was false for reasons which are set out in the determination (from which

it is apparent that the Adjudicator rejected the other 50% also). As we have observed, there is no appeal before us on the factual issues in relation to the asylum claim.

4. The Adjudicator summarised the evidence and gave her conclusions in the following extract from her determination:

> 13. The respondent was unaware at the time of his decision as to the appellant's state of health. I have read the reports of Dr Fairley with care. The letter of 10 April 2002 sets out background and treatment of the appellant's condition. He has a moderately impaired immune system and is receiving antiretroviral combination therapy. Without this treatment Dr Fairley considers that the virus would reactivate and continue to cause further damage to the immune system. Dr Fairley in his report of 11 June 2002 give slightly more detail in this regard. He explains that without treatment, the appellant would be at risk of an opportunistic infection or tumour within the following few months or years. He indicates that some of these infections may be fully treatable whereas other infections have a prognosis of weeks to months. On average most patients would have died within 2 to 3 years of an AIDS related illness. Dr Fairley also addresses the issue of life expectancy when a patient has the assistance of the present combination therapy. Dr Fairley cautious given the treatment is of relatively recent origin. He states that some patients have lived longer than 7 years and it is expected that they will live for many decades if not their normal life expectancy. He also points out that some patients may develop resistance to the medication and so succumb to the HIV infection.
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> 14. It is against this background that I assess what treatment is available in Chad. The CIPU report is brief in this regard and is set out at paragraph 4.18. The RLC lodged a bundle of documents relating to the strategies and treatment of AIDS/HIV in Africa, all of which I have read and not just to join the portions highlighted . On page 4 of the bundle it appears that Chad is likely to join the UNAIDS programme known as Accelerated Access for procuring the anti-viral therapy (ARV). In other countries which have adopted this agreement it appears that a patient's socio-economic status is taken into account is considered before a decision is taken on whether they are eligible for treatment. The final paragraph on page 4 considers that while the UN's global fund has yet to make a difference 2002 is likely to see more donations to governments through this. On page 5 it is suggested that the African countries may start production of the drugs themselves in 2002. The conclusion is however, that

most governments would find it impossible to treat a great proportion of their HIV population.

15. In 1999 2.69% of the adult population in Chad were estimated to have an HIV infection. The National Strategic Plan Against Aids for Chad is at page 19 of the bundle. 18 priorities are set out. ARV is not shown as a priority in the table but on page 25, one of the targets is to "Improve the management of HIV/AIDS using essential drugs at lower cost. It is also hoped to supply hospitals for the managements of HIV/AIDS hospitals. There is a target that by 2003, 100% of health structures will be able to manage HIV/AIDS. This policy document appears to bear out the report at page 4 that the government is looking to obtain essential drugs under the UNAIDS programme. On age 29, there is a press release that the World Bank had approved the second population and AIDS project which bears out the report at page 5 about further contributions being received. The report at page 31 is dated 1999 and refers to a programme due to close in 2001. It is clear that this has been continued or replaced. Having read al the material, it is clear the Government of Chad in conjunction with a number of organisations are taking the HIV aids situation most seriously and is not only addressing the issue of those already with HIV but also looking at preventing it in the first place by targeting those groups most at risk. Interestingly, in the year the report was written, HIV contracted through blood transfusions was given as nil. The appellant's case seems to be very much a "one off" according to health records. I do not accept that there is no funding in place or any will on the part of the government to assist those with AIDS. The picture is far more upbeat than the situation as presented by Mr Marshall on behalf of the appellant. I accept that the abrupt withdrawal of treatment could result in illness or death. It is not a case however, of no treatment being available but of treatment being one of a number of measures taken by the government. I accept that it may be the case that treatment in the UK may be considerably better in the UK in Chad but it does not follow from this that to return the appellant would be to put him at risk of treatment that fell within Article 3 of the Human Rights Convention. The appellant's doctor had diagnosed HIV but the appellant refused to believe him. The appellant did not therefore put himself in a position of knowing whether any treatment would have been offered. Certainly, the appellant does not now say, "The Doctor told me I was HIV positive but refused or was unable to treat me". The appellant has not yet developed AIDS, he has family in Chad who would be able to provide support. I had no evidence that he would be shunned. I am not

satisfied the appellant can show substantial grounds for believing that there would be a real risk of his suffering inhuman and degrading treatment if now returned to Chad.

5. The application for leave to appeal to the Tribunal was received on 25 September 2002 and the parties were notified that leave had been granted on 13 December 2002. They were also notified of the date of hearing on that date.

6. The appellant's bundle to the Tribunal was lodged on 22 January 2003. Among the documents relied on was fresh medical evidence. There is a letter dated 31 October 2002 from Dr Apaya apologising for the delay in submitting information. His report is also dated 31 October 2002. The appellant's bundle had not reached the Home Office.

7. There had been no application to the Tribunal in advance of the hearing to lodge fresh evidence. It was said that the new evidence was significant because the appellant was now diagnosed as having aids rather than simply being HIV positive

8. Miss Oliso invited us to rely on this new material. She submitted that the appellant had now got AIDS and would not be able to access medical care in Chad. Without treatment his condition would deteriorate. She also referred us to a letter from Dr Apaya dated 24 January 2003 which reads simply as follows:

   "I write to give my support to the above appeal and confirm that stopping HIV antiretroviral therapy will be detrimental to Ahmet's health."

9. Dr Apaya is a consultant physician in Genito-Urinary medicine. Miss Oliso relied on her skeleton argument and on the evidence concerning available treatment in Chad. She acknowledged that the appellant had family in Chad – a mother, four sisters and a brother. Miss Green objected to the reception of the report which had been submitted late and in breach of the rules on practice directions. It had been available long before it was submitted.

10. The treatment being received by the appellant was the same treatment as he had been receiving when the hearing had been before the Adjudicator. The report was more of a letter than a full medical report. In most reported cases far fuller medical evidence had been provided. A full CD4 count was provided. There was not nearly enough information in the letter to enable the Tribunal to consider the appellant's claim to have full blown AIDS. If the evidence was admitted at all not much weight should be attached to it.

11. Miss Green was asked what the Home Office policy was in relation to AIDS sufferers. Miss Green, having taken instructions, informed

us that there was a serious deceases policy rather than a policy confined to AIDS. If someone had a serious decease and had not very long to live then the Home Office would give careful consideration whether they should be allowed to stay.

12. Miss Green submitted that the facts should be distinguished from the case of **D v United Kingdom** [1997] 24 EHRR 423. She also referred us to **K v Secretary of State** [2001] Imm AR 11 where the Court of Appeal had to consider the question of whether it would be inhuman or degrading treatment to send the appellant back to Uganda on the grounds that he may or may not be able to afford all the treatment that he required. Miss Green submitted that the appellant did not meet the high threshold set down in the case law and the Adjudicator had not erred.

13. Miss Oliso accepted that she had been wrong not to submit the new material earlier. She submitted that the CD4 count not being stated was not a significant matter. What was significant was the AIDS diagnosis. The Chad government was only making progress. Only a very small number of people in Chad were receiving appropriate treatment. The general healthcare was very poor.

14. We reserved our determination and have given careful consideration to the arguments and the material placed before us.

15. Paragraph 22 of the Immigration and Asylum Appeals (Procedure) Rules 2000 sets down the requirements to be observed when fresh evidence is relied on. Where further evidence that was not before the Adjudicator is to be placed before the Tribunal written notice must be given. That notice “shall be given as soon as practicable after the parties have been notified that leave to appeal has been granted”.

16. Miss Oliso accepts that was not done. It is clearly of the highest importance in cases like this that the evidence is submitted at the earliest possible opportunity. The Home Office may well wish to give consideration to it and, possibly, call evidence of its own. Apart from the fresh evidence, the skeleton argument was not lodged until the hearing itself. The skeleton argument refers to the authorities without giving their references.

17. The second paragraph of the skeleton argument reads as follows:

“It is not disputed that the appellant is HIV positive and that he is receiving anti-retroviral treatment in the UK. The appellant contends that he suffers from AIDS. He argues that if returned to Chad, he would not be able to obtain the medication that he currently receives. Consequently he argues that as someone with an impaired immune system, he would become subject to opportunistic infections which would hasten his death.”

18. It is further submitted that there were 150,000 persons infected with HIV in Chad and that only 36 were receiving appropriate therapy. If returned to Chad, the appellant would not have access to medication that he needed to stop his immune system from deteriorating. Given the almost total absence of access to treatment and the huge cost of medication even at preferential rates, the appellant would not be able to continue with his treatment. Reliance is placed on the cases of **D** and **K** (cited above). It is pointed out, correctly, that the case of **K** was considered on judicial review rather than on appeal. The case dealt with an applicant from Uganda where there were, it was submitted, appropriate medical facilities. Chad was one of the world's poorest countries. The abrupt withdrawal of the appellant's treatment would hasten his death. The facts of the case was similar to those in **D**.

19. The Tribunal firstly would wish to observe that the facts are not similar to the case of **D**. In St Kitts there were no medical facilities and the appellant had spent some time in a hospice and was close to death – see paragraph 21 of the Court's judgment. It is also not without significance that the appellant in **D** had no family effectively to turn to in St Kitts. The position of the appellant is very different. He attended the hearing before us. He has many family members in Chad. The most recent evidence that we have from his consultant is that cessation of therapy "will be detrimental to Ahmet's health". In **D** the appellant had "become reliant on the medical and palliative care which he is at present receiving and is no doubt psychologically prepared for death in an environment which is both familiar and compassionate. Although it cannot be said that the conditions which would confront him in the receiving country are themselves a breach of the standards of Article 3, his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment." The Court emphasised in paragraph 54 of the judgment the "very exceptional circumstances" of the case. In **K** the Court of Appeal noted the argument that it would be inhuman or degrading treatment to return someone to a country where medication might be beyond their financial recourses and concluded that if the argument were accepted "we would be in effect adopting a rule that any country which did not have a health service which was available free to all people within its bounds would be a place to which it would be inhuman and degrading to send someone." The Court did not consider that the European Court of Human Rights would reach that conclusion. It stated that one should weigh up all the circumstances of the case as was done in the case of **D**. Counsel is right to point out that the Court was concerned with whether the Secretary of State's decision was irrational or not. For our purposes, we must consider all the evidence in the round and all the circumstances of the case reminding ourselves that this is a question of appeal and not review.

20. Included in the bundle prepared by Miss Oliso is a world bank project appraisal document on a proposed credit of $24.56 million to the Republic of Chad for a second population and AIDS project. The report is dated 13 June 2001. The language and acronyms are occasionally opaque but the general thrust of the report can be ascertained. Under the heading "Strategic Context" the report states as follows:

"With regard to HIV/AIDS, Chad has demonstrated its political commitment and ownership in the efforts to reverse the spread of the epidemic. The government urged IDA to make it the key development objective in the banks country assistance strategy."

The report refers to an analysis of the health system in Chad carried out recently between the Ministry of Public Health and others. The analysis identified the weaknesses of the current health system and areas where improvements were needed. The Ministry had started to address the weaknesses as urgent priorities "because they will in effect block progress in the sector, will be a constant source of frustration for development efforts, and will jeopardise future efforts on the front of population and HIV/AIDS. As for the areas where improvement is still needed, the Ministry, which had taken steps for action and reform in certain areas, is starting a sustained action to develop health sector and put these improvements on a sustainable footing with the help of its partners…" Under the heading on page 6 of the report "AIDS Prevention and Mitigation" it is stated that the approach had been successful in increasing knowledge about HIV/AIDS and that today most Chadians know about the subject and the majority are aware about how HIV is transmitted. Many sectors and communities are presently involved in the HIV/AIDS Prevention and Mitigation activities. The report notes that the approach needed to be reinforced and be more focused in order to stop the progression of the epidemic. While there had been a notable improvement in recent years in terms of co-ordination more periodic and systematic mechanisms were required to involve all private sector stake holders and partners.

21. The AIDS epidemic had been spreading rapidly in Chad since 1986 but Chad's response to AIDS "has been rapid and determined even at a time [when] HIV prevalence was very low." The report states that as early as 1988 the National AIDS Control Commission was established, a body presided over by the Prime Minister. In 1994 seven Ministries participated in a national consensus workshop. The report goes on that the response in Chad to HIV/AIDS has been characterised by a broad partnership involving the government, NGOs, religious groups, civil society organisations, communities, people living with HIV/AIDS and local and international donors. Chad strengthened existing government entities responsible for implementing the mid-term plan and established a social fund to finance HIV/AIDS prevention and population activities. There was a national AIDS control strategic plan in 1999 building on previous AIDS programmes.

22. Miss Oliso acknowledges these matters but states that the appellant will not benefit as he has already got the illness. However, the report does indicate how very different the situation is from St Kitts. Quite apart from the fact that the appellant has family in Chad to support him, there are a number of other groups and organisations, governmental and non-governmental, who can no doubt provide some support. GlaxoSmithKline had introduced not for profit preferential prices for its HIV/AIDS medicines by up to 33%. Miss Olisso points out that the availability of the treatment is very low given the scale of the problem.

23. The Terence Higgins Trust points out that it is not always possible to predict the specific effects of withdrawing anti HIV therapy from a person with HIV. We have the letter from Dr Apaya that stopping HIV therapy "will be detrimental" to the appellant's health. We are invited to find that the appellant has AIDS on the strength of the document submitted in breach of the rules and late in the day. It is said that the appellant had responded very well to the treatment so far and that on his last testing his viral load was undetectable and that his CD4 count was rising. The drugs given to the appellant worked for approximately 2 years before resistance was developed. The doctor states that he had no evidence that the drugs were available in Chad (although he does not say that they were not available). It is the doctor's opinion that the immune system would further deteriorate if treatment was withdrawn "and he will no doubt be liable to opportunistic infections". The doctor believed this would make him ill and unlikely to live long.

24. We do share the concerns expressed by Miss Green about the shortness of this report quite apart from its late introduction into these proceedings. The appellant's position and circumstances do appear to us to be vastly different from those in **D**.

25. The Adjudicator went carefully through the evidence before her and reached conclusions which appear to us to be entirely correct. We have also reviewed the objective material and the fresh medical material. The Adjudicator commented that the appellant had not yet developed AIDS but we are far from confident that her decision would have been any different if the letter available to us had been placed before her.

26. It is right to stress that the threshold in these cases is high. **D** was an exceptional case. It is important that representatives should not encourage false hopes in the minds of appellants with HIV or even AIDS. The Court will and can only intervene in exceptional circumstances. It is not right or fair that appellants should have their expectations raised where their circumstances do not meet the demanding criteria that must be met for a successful outcome.

27. We consider that the Adjudicator correctly addressed herself on the issues in this case and correctly concluded as she did.

28. For the reasons we have given this appeal is dismissed.

G Warr
Vice President