Upper Tribunal
(Immigration and Asylum Chamber) **Appeal Number: PA/13502/2018**

THE IMMIGRATION ACTS

Hearing at Field House	**Decision & Reasons Promulgated**
On the 17th November 2021	**On the 19 April 2022**

Before

UPPER TRIBUNAL JUDGE MANDALIA

Between

JI
(ANONYMITY DIRECTION MADE)

Appellant

and

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation:
For the Appellant: Dr S Chelvan and Mr J Rylatt, instructed by Bristol Law Centre
For the Respondent: Ms Z Ahmad, Senior Home Office Presenting Officer

DECISION AND REASONS

Anonymity

As this a protection claim, it is appropriate that an anonymity direction is made. Unless and until a Tribunal or Court directs otherwise, the appellant is granted anonymity. No report of these proceedings shall directly or indirectly identify her or any member of

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her family. This direction applies amongst others to all parties. Failure to comply with this direction could lead to contempt of court proceedings.

Background

1. The appellant is a national of Uganda. Her appeal against the respondent's decision to refuse her claim for international protection was dismissed for reasons set out in the decision of First-tier Tribunal Judge Davidge promulgated on 27th August 2019. Although the appeal was dismissed on international protection grounds, Judge Davidge accepted the appellant will face very significant obstacles to integration on return to Uganda, such that the requirements to be met by an applicant for leave to remain on private life grounds are met. The appeal was allowed on Article 8 private life grounds. The respondent does not challenge the decision to allow the appeal on Article 8 grounds.

2. Permission to appeal the decision to dismiss the appeal on international protection grounds was granted by Upper Tribunal Judge Jackson on 18th October 2019. The appeal was considered by me without a hearing under Rule 34 of The Tribunal Procedure (Upper Tribunal) Rules 2008. The respondent accepted Judge Davidge materially erred in her consideration of the background and expert evidence relied upon by the appellant. The decision of Judge Davidge was set aside for reasons set out in my error of law decision. I directed the decision will be remade in the Upper Tribunal.

3. The matter was listed for a resumed hearing before me on 17th November 2021. At the conclusion of the hearing I reserved my decision. I informed the parties that my decision and reasons will follow in writing and this I now do.

The appeal before me

4. The respondent accepts the appellant is a national of Uganda. The respondent considered the appellant's claim that she would be at risk

upon return because she is a 'vulnerable disabled woman' who suffers from homozygous sickle cell disorder, a hereditary disease which requires treatment and medication, and because of the state of her mental health. The respondent rejected the appellant's claim that she is a refugee because the respondent concluded her claim is not based on a fear of persecution in Uganda because of her race, religion, nationality, membership of a particular social group or political opinion.

5. The appellant has appealed under s82(1) of the Nationality, Immigration and Asylum Act 2002 against the decision of the respondent to refuse her claim for asylum. The appellant claims to be a refugee whose removal from the UK would breach the United Kingdom's obligations under the 1951 Refugee Convention.

6. The appellant bears the burden of proving that she falls within the definition of "refugee". In essence, the appellant has to establish that there are substantial grounds for believing, more simply expressed as a 'real risk', that she is outside of her country of nationality, because of a well-founded fear of persecution for a refugee convention reason and she is unable or unwilling, because of such fear, to avail herself of the protection of that country.

The evidence

7. The appellant's representatives have filed and served a consolidated bundle comprising of 2 parts. The 'Agreed Consolidated Bundle (1)' comprises of some 442 pages and the 'Agreed Consolidated Bundle (2)' comprises of some 538 pages. The bundles include the material that was previously before the First-tier Tribunal and further material that is relied upon by the appellant that post-dates the decision of the First-tier Tribunal. A further supplementary bundle was filed on 15th November 2021. I have also been provided with a 'skeleton argument & chronology' comprising of some 35 pages, and a bundle of authorities comprising of 20 Tabs. I also have a copy of the respondent's bundle.

8. The appellant has previously filed four witness statements that were before the First-tier Tribunal. They are dated 18th June 2018, 13th August 2018, 12th March 2019 and 30th May 2019. Two statements have also been made by her father. The first is dated 24th May 2018 and the second is dated 9th March 2019. For the avoidance of doubt I have read those statements and had regard to the evidence set out by the appellant and her father in reaching my decision. Given the volume of material, it is entirely impractical for me to refer to all the evidence and background material that it before this Tribunal in this decision. However, for the avoidance of any doubt, I have carefully considered the evidence and background documents set out in the consolidated bundles, whether expressly referred to in this decision or not.

9. The appellant has made applications under Rule 15(2A) to rely upon evidence that post-dates the decision of the First-tier Tribunal. The appellant's reliance upon that further evidence was not opposed by Ms Ahmad, and it is admitted.

Dr Tom Latham

10. Dr Latham is a Consultant Haematologists employed by the University Hospitals Bristol and has been involved in the care of the appellant. In his letter dated 25th May 2018, Dr Latham confirms:

> "[The appellant] has homozygous sickle cell anaemia. This is an inherited blood disorder which has been lifelong. The condition typically manifests with episodes of severe pain and sufferers are also at risk of long-term complications such as bone damage, stroke, kidney failure and respiratory failure.
>
> [The appellant] has a very severe phenotype. She has had admissions to hospital with painful sickle cell crisis and infections. She also has avascular necrosis of her hips, has had a previous hip replacement and is due to have the other hip replaced at the beginning of June."

11. Dr Latham notes that there has been a marked improvement in her condition since she started a programme of exchange transfusions every eight weeks, and her hospital admissions have been much reduced since

then. He notes the appellant still has reduced mobility due to her hip and has daily carers to support her at home. He goes on to say:

> "I would consider that there would be a deterioration in her condition if she was unable to access exchange transfusions. She would have an increase in severe pain crises and would need increased admissions to hospital for opiate analgesia. It would be likely that she would be at increased risk of having more serious complications such as a chest crisis or stroke."

12. Dr Latham has provided various updates. In his letter dated 25th February 2019, he reported that there had been no significant changes to the appellant's sickle cell anaemia since his letter of 25th May 2018. He noted she had had further admissions to hospital with painful crises but there was no material change to her underlying condition. Again, he expressed the opinion that it is likely there would be a deterioration in her sickle if the exchange transfusions were discontinued. In an update dated 26th October 2020, Dr Latham confirmed that the appellant's condition and prognosis remains essentially similar to that previously reported. He noted the appellant has been diagnosed with recurrent cholecystitis, a common complication of sickle cell disease, and is on the waiting list for a cholecystectomy. He confirmed that a previous attempt at stopping exchange transfusions was followed by an increase in hospital admissions.

13. Most recently, in a letter dated October 2021, Dr Latham reports that there have been no significant developments in the appellant's sickle cell anaemia since his previous letter dated 26th October 2020. He states the appellant remains a high user of healthcare services with a number of emergency admissions for care. He maintains the opinion that if the appellant's exchange transfusion programme is discontinued, there would be an increase in severe pain. He states the appellant needs opioid analgesia to manage episodes of painful crisis and it is unclear whether opioid analgesia would be readily available in her country of origin. He states:

> "My opinion is that if she had a lack of access to exchange transfusion there would be a high risk of a serious deterioration in her health and reduction in life expectancy. This point is distinct from 2 above since it

relates to the unavailability of exchange transfusion, even in an emergency situation. Exchange transfusion is a life-saving emergency treatment for the most severe complications of sickle cell anaemia such as stroke and chest crisis. She has objective evidence of complications of sickle cell disease, aside from her episodes of pain."

14. Dr Latham considers the appellant vulnerable since she has frequent need for emergency and unplanned healthcare. He considers her to be coping reasonably well with her condition and states that she is very capable of accessing help when she considers it is necessary to meet her needs.

Dr Olusola Olowookere

15. Dr Olusola Olowookere is a Consultant Psychiatrist. He has provided what is said to be an 'Amended Report' dated 2nd November 2021 [AB1/144]. In section 6 of his report he sets out the material that he was provided with, including a report prepared by Dr Prangnell dated 30th January 2019.

16. Dr Olowookere completed a 'video link consultation' for the purposes of an assessment on 23rd October 2021. His opinions and recommendations are set out in section 16 of his report. In his opinion, the appellant is suffering from 'Major Depressive Disorder of a Severe Degree' based on classical symptoms of Clinical Depression which include low mood lasting more than two weeks, hopelessness, poor appetite, suicidal ideation and a feeling that life is not worth living. He states, at [16.3], that the nature of the appellant's current illness is chronic, and severe. In his opinion, the appellant's current risk of committing suicide is high. She has no plans but has thoughts about suicide every day. He states, at [16.7], that the appellant has started Cognitive Behavioural Therapy (CBT), and, at the time of the assessment, she had completed two sessions. She needs to have at least twelve. In his professional opinion, the commencement of psychological intervention (CBT) should be beneficial and would help the appellant's mental health. Dr Olowookere noted the appellant has reported no significant improvement on current medication and suggested a review of her antidepressant. He concludes that the combination of medication

and psychological intervention will provide a good prognosis. He records the appellant is focussed and committed to her recovery but as she is a very vulnerable person with a lot of disabilities, her capacity to cope can fluctuate.

The Psychological Assessment by Dr Simon Prangnell

17. Although not included in the appellant's consolidated bundles, a 'Psychological Assessment Report' has previously been prepared by Dr Simon Prangnell, a Clinical Neuropsychologist, following an assessment of the appellant on 26th January 2019. It is a report that was before Dr Olowookere and for the sake of completeness, it is appropriate to refer to it in this decision. In his report Dr Prangnell confirms that the appellant's first contact with mental health services occurred in March 2018 after she telephoned her GP and reported feeling suicidal. A referral was made by her GP to the secondary mental health services, and she was assessed by the crisis team. In section 2.2 of his report, Dr Prangnell refers to the support and treatment provided to the appellant from the local mental health services. Dr Prangnell sets out his opinion in section 5 of his report. He confirms the appellant has a diagnosis of major depressive disorder with anxious distress. He records that the appellant's history, presentation and mood questionnaire scores indicate that these problems are severe and disabling. He expresses the opinion that her prognosis with her current treatment regime (antidepressant medication only) is poor and that without a comprehensive care plan that includes psychological, social and psychiatric care that is able to accommodate her additional physical health needs, it will continue to deteriorate. He expresses the opinion that without her current treatment regime, the appellant's mental health will deteriorate more rapidly, and her risk of suicide will increase. Dr Prangnell states that the cause of the appellant's psychological distress is multifactorial. She has experienced multiple psychological stressors including; migrating to a country where she had no family or network of friends; the death of several siblings including her brother, to whom she

was very close; marital breakdown; and chronic ill-health including significant pain.

18. Dr Prangnell agrees with the opinion of Tim Bailey, a senior practitioner in the Bristol Crisis Team, that the appellant is at moderate risk of attempting and completing suicide. He notes that the appellant cites her mother as the only protective factor preventing her from acting on her suicidal thoughts and he believes that if the appellant's mother were to die, there is a very high risk that the appellant will attempt suicide. He also expresses the opinion that if the appellant is removed from the United Kingdom and is unable to access effective and regular treatment for her physical health, she is at high risk of suicide.

19. Dr Prangnell was instructed to provide his view on the appellant's vulnerability and mental capability to cope with stressful and life-threatening circumstances, for example, severe discrimination and/or difficulty in accessing healthcare services and medical treatment as a lone woman with disabilities. He said, at [5.7.1] and [5.8.1]

> "5.7.1 … I believe that she has limited psychological resilience to cope with additional stressful or life-threatening circumstances. The stigmatisation and discrimination she cited in her position statement would likely precipitate a further decline in her mental health.
>
> 5.8.1 From her account of the social perception of physical disability and mental health problems in Uganda I believe that she is vulnerable to stigmatisation and discrimination. Not accessing treatment is likely to lead to a worsening of her physical and mental health which would only exacerbate this situation."

Elaine West

20. I have in the papers before me a letter dated 5th October 2010 from Elaine West, a Senior Recover Navigator employed by the Wellness and Recovery Service, 'Second Step'. Second Step is a short term (6-8 weeks) service and helps clients to 'Navigate' their mental health and current situation after an assessment and identification of issues to work with. Following a referral by the appellant's GP in May 2021, the appellant received support with her mental health in dealing with day-to-day problems stemming from

her housing situation and her physical health. The support provided to the appellant ended on 1st September 2021.

Broadmead Medical Centre

21. The appellant's GP, Dr Jenny Schaefer has provided two letters. The first is dated 28th October 2020 and the second is dated 6th October 2021. Dr Schaefer reported in October 2020 that the appellant continues to have recurrent vaso-occlusive crises for which she requires morphine and oxygen in hospital. She also reports that the appellant has recurrent pain and inflammation of the gallbladder due to her sickle-cell anaemia. It is said that the appellant was re-referred to secondary mental health services in May 2020 for suicidal ideation, although in October 2020 she did not appear to be receiving ongoing care from them.

22. In her most recent letter Dr Schaefer confirms the appellant's general health has continued to deteriorate and that she is still experiencing hip and back pain despite a total hip replacement in June 2018. The letter confirms the appellant requires a six weekly red cell exchange programme to reduce the frequency of vaso-occlusive crises due to sickle-cell disease. Dr Schaefer states the appellant is experiencing depression and is overwhelmed due to her multiple conditions. She states the appellant requires significant medical input from both specialists and generalist clinicians to remain well both physically and mentally. She is said to be extremely vulnerable to deterioration in her health even if she were to move away from Bristol, as the interplay of the various services and the appellant's engagement and trust with each of them, has taken time to develop.

Support needs

23. An assessment has been completed by Bristol City Council under the Care Act 2014. The appellant's eligible needs and the support provided to her are set out in the assessment completed by Kate True on 18th May 2018

which has subsequently been reviewed. The most recent review was carried out by a practitioner in 2021.

The reports of Alex Ntung

24. I have been provided with a number of reports prepared by Mr Alex Ntung, "a Country Expert witness specialising in the Great Lakes region of Africa, specifically political and security risks, cultural, linguistic, religious and ethnic issues in Litigation". He is said to be a 'political and security risks analysist' at the Expert and Advisory Research Services. The first of his reports is dated 30th April 2018 *(signed on 30th March 2018)*. Mr Ntung has lived and worked in the Great Lakes Region of Africa (DRC, Rwanda, Uganda and Burundi) for many years and experienced conflict at first hand and witnessed its impact on the region. He states, at [7], that he has developed an in-depth knowledge of the historical political, security, economic, cultural and linguistic aspects of these countries. He confirms, at [8], that he now lives in the UK but maintains strong links with the Great Lakes region, particularly DRC, Uganda, Burundi and Rwanda.

25. Mr Ntung's understanding of the background to the appellant's claim is set out at paragraphs [17] to [22] of his report. He confirms, at [23], that he has been instructed to address whether there is a real and foreseeable risk that the appellant would face (inhumane treatment or degrading treatment) if she is forcibly removed to Uganda. He identifies the particular areas that he is instructed to comment on. I will not burden this decision with all of the questions that are asked, and the opinion expressed but I have considered them all. Mr Ntung confirms that he has conducted in-depth investigations in social and health related issues and political and security risks. He claims the uniqueness he brings, is his ability to access local trusted and credible contacts, and an understanding of political, social and cultural situations. Insofar as his understanding of Ugandan health services is concerned, he has conducted a series of telephone interviews with Mrs Ruth Nankanja, Executive Director of one of the main two national advocacy charities specialising in sickle-cell

anaemia in Uganda, and a UK based medical professional, Mr Fakirini Ramadhani, with extensive experience in sickle-cell anaemia in Africa.

26. At paragraph [57] Mr Ntung states that ‘Sick cell anaemia disease’ is one of the main causes of high rate of mortality in Uganda *(according to the Uganda the Sick Cell Rescue Foundation 13.5 % of Uganda’s population has a sickle cell trait)* and the disease impacts all religions, tribes, social classes and communities in Uganda. He states, at [58], that there is only one public hospital (Mulago, in the capital city of Kampala) which is “*specialise in sick (sic) cell anaemia*”, but it has a serious capacity issue (20,000 registered sick cell patients) and 200 admitted every week. Other clinics are private, and affordability depends on each patient’s economic status. At paragraph [64], Mr Ntung refers to another source which states that the sickle cell clinic at Mulago receives at least 50 new patients every month, pointing to a rising trend. It is located nearly 5 hours drive from Tororo (where the appellant comes from) if using private transport, and up to 8 hours by public transport.

27. Mr Ntung was asked whether women with disabilities, particularly sickle cell anaemia, are discriminated against in Uganda. He states:

> “70. Those suffering sick cell anaemia or mental health are often blamed on witchcraft or sorcery or other supernatural causes. People with sick cell anaemia health problems are therefore more likely to end up in homes of traditional healers than in hospitals.
>
> …
>
> 73. …”when confronted with symptoms of sick cell anaemia or mental disorders, many believe them to be associated with witchcraft and sorcery and, rather than seek medical treatment, they turn to traditional healers. Indeed, most people use highly unorthodox methods to cure the illness or to extract what some believe are demons. Those who are suffering from sick cell anaemia and mental health problems are often physically abused and accused of spiritual possession. The beatings and other related abuse are justified or believed to be not about harming the suffered but to inflict pain to a “spirit inside him or her”.

28. As to the availability of medical care for women with sickle cell anaemia, Mr Ntung emphasised at [75] that generally, there is not a gender related discrimination with regards to access to medical care for women suffering from sick cell anaemia. The two risks affecting women are during

pregnancy and if living in a rural inaccessible area. Mr Ntung states that he has interviewed Mrs Ruth Nankanja, the Executive Head of Sick Cell Anaemia Association in Uganda. She has confirmed that Mulago Hospital remains the only national referral and teaching hospital. Over 20,000 sick cell patients are registered there and on average the hospital sees 200 patients 5 days a week (Monday to Friday only). At paragraph [86] Mr Ntung confirms *"there is a discrimination of sickle cell anaemia based on social and cultural stigma"*, but this has nothing to do with being a woman or man.

29. Asked if there are any treatments or therapies beneficial to women with sickle cell anaemia that are not available in Uganda, Mr Ntung states, at [83] that the main issue is not about men or woman but the limited availability of treatments in Uganda for everyone.

30. Mr Ntung was then instructed to prepare an addendum report to address the psychological assessment, and to independently examine the conditions in Uganda relevant to the risk upon return. Having considered the content of the Psychological Assessment prepared by Dr Simon Prangnell, at paragraphs [47] to [53] of his report dated 13th March 2019, Mr Ntung refers to a deep-rooted stigma from society, which causes communities and families to hide their relatives affected by mental health illnesses for fear of being labelled as outcasts, 'untouchables', cursed or bearers of misfortunes. At paragraphs [54] to [58], Mr Ntung concludes as follows:

> "54. … According to various senior medical professions, which I have interviewed, and based on my existing knowledge, there is no adequate medical care for people with sick cell anaemia. Challenges and obstacles, she is likely to face have been discussed in this report.
>
> 55. In my view, there is a risk of discrimination amounting to suffering harm amounting to inhumane or degrading treatment of return to Uganda. Furthermore, social and infrastructural amenities are lacking for disabled women. In this regard, movement and enjoyment of public life is extremely limited.
>
> 56. Women with disabilities are perceived to be less productive, dependent and do not need existence. Women with disabilities are subject to an unfair hearing, sexual harassment, brutality, neglect, oppression, and

frustration. Various discriminations subjected to women can lead to other illnesses.

57. People with disabilities do experience discrimination especially in terms of accessing various services, including accommodation and employment. There is no statutory service committed to support such vulnerable people. Justice mechanism is extremely weak. People with mental health illness experience serious exclusion and cultural stigma.

58. In my opinion, considering [the appellant's] vulnerability and the country situation, there many *(sic)* risks: she may be

- sexually abused,
- physically and emotionally exploited and abused
- Homeless (would not be able to access welfare support) - could experience extreme hardship and poverty
- experience gender-based violence (SGBV)"

31. Mr Ntung was then instructed to comment on the evidence relied on by the respondent, in particular the references by the respondent to charities supporting those with sickle cell disease in Uganda, charities supporting mental health in Uganda, and medication available in Uganda. He has provided a further report dated 26th December 2020. Mr Ntung states that he has interviewed two specialists in Sick Cell Disease in Uganda: Mr Fikirini Ramadhani, currently working with the National Health Service (NHS) as Sick Cell Disease nurse, and Dr Arthur Kwizera, a Ugandan based medical doctor. They both note that Sick Cell Disease remains a leading public health problem in the sub-Saharan Africa. It is the most common genetic disease prevalent in the region with over 20% of Ugandans having this genetic trait.

32. Mr Ntung states that the care available is mainly supportive and whilst the charities mentioned by the Home Office do indeed exist, their capacity is extremely limited and depends on external resources and funding frequently discontinued. At paragraph [14] he states:

> "... Although Sick Cell Disease is a major public health concern in Uganda, both charitable or public sector interventions currently in place are not adequate to address the current burden. As demonstrated in my previous report, the main drug for the treatment of sickle cell disease is often not on the list of the most important drugs in Uganda, and the medication is often not available. Nor can many Ugandans afford the high costs of treatment."

33. At paragraph [20], Mr Ntung states:

> "[The appellant's] condition predisposes her to chronic pain and thus she requires some long-term opioids. Unfortunately, such a strong pain relief medicine is rarely available in most Ugandan's primary care settings or charities. Another important barrier to care for [the appellant] will be her frequent hospital visits. Patients with sickle cell disease have more frequent hospitalisations than other patients with chronic medical conditions. The charities suggested by Home Office do not have sufficient capacity to treat the condition effectively."

34. Finally, I have in the papers before me an 'update report' dated 28th October 2021 that has been provided by Mr Ntung [AB1/205]. He refers to the negative impact that the Covid-19 pandemic has had upon healthcare services in Uganda, which, he believes, would increase her vulnerabilities and risks if she was to be returned.

Sharifu Tusuubira, Uganda Sickle Cell Rescue Foundation

35. Sharifu Tusuubira is the Executive Director of the Uganda Sickle Cell Rescue Foundation ("USCRF"), an organisation working to promote awareness, sensitisation and fighting sickle cell disease in Uganda. He is described in the letter as a biomedical scientist with over eight years of experience, who provides a first-hand narrative through his work and personal lived experiences. He states USCRF supports treatment and management through the provision of basic medications like folic acid and painkillers. However, that support is prioritised or limited only to families that "cannot afford" and is now focused upon rural sickle-cell clinics where there is more need. USCRF does not provide red blood cell exchange transfusions, a service that he states was introduced in late 2018 and is currently only being offered at the 'Joint Clinical Research Centre'. The service is said to cost $700 per session, and thus is very expensive with limited accessibility for patients in Uganda. Mr Tusuubira refers to the status of blood transfusions in Uganda and a general shortage of 'blood stock', which limits access to chronic care patients specifically where transfusion therapy is required. However, he states, sickle-cell patients are able to access the blood products in times of emergencies.

36. Regarding the treatment and management for sickle-cell care, he refers to the sickle-cell clinics across the country established by organisations like

USCRF for paediatric care, but states, adult care for sickle-cell disease is not available in Uganda. Patients are left with no option but to see adult physicians, whose sickle-cell management experience is limited. He claims Uganda also has limited expertise of haematologists who can help take care of adult sickle-cell patients, although in 2017 the Uganda Cancer Institute started an adult haematology/oncology fellowship to help bridge the gap. He states the situation is aggravated by limited and inaccessible forms of social support structures to aid sickle cell patients and families to cope better with the psychosocial burden of the disease. He states; *"In addition, this has been coupled with stigmatisation and discrimination of people living with sickle-cell disease often causing isolation from family and society.".* Mr Tusuubira states disease modulating drugs like hydroxyurea are not currently on the essential medicines list and therefore not supplied by the Ministry of health to sickle-cell patients. The drug has to be purchased from private pharmacies at a cost of $0.5 per capsule. Adults require not less than two capsules per day, and the cost is prohibitive and limits the care available in Uganda.

<u>The issues in the appeal</u>

37. In the appellant's skeleton argument it is submitted that the thrust of the appellant's case before the Upper Tribunal is to highlight the need for an 'Intersectional approach to Refugee Status Determination'. It is said that the claim for international protection continues to be made on the basis that the appellant would face a real risk of persecution from non-state actors on return to Uganda, on the basis of her membership of a particular social group. The appellant puts her case on two bases, namely that there is sufficient evidence to show, to the lower standard, that the appellant:

    a. would face a real risk of persecution in Uganda as a member of a particular social group, namely a person with disabilities: and/or

    b. would face a real risk of persecution in Uganda arising from the "double bind" of being both: i) a woman: and ii) a person with disabilities.

The parties submissions

38. Briefly put, on behalf of the appellant it is submitted that it is uncontroversial that sickle cell disease or sickle cell anaemia is a hereditary blood disorder, and as such an immutable characteristic. It is submitted that the respondent does not challenge the previous finding of the First-tier Tribunal that there would be very significant obstacles to the appellant's integration into Uganda. It is submitted that on return to Uganda the appellant will, in addition, face discrimination. Therefore, on the evidence before the Upper Tribunal, the appellant is a refugee.

39. Alternatively, the appellant submits the Tribunal should adopt 'The Double Bind' intersectional approach. As a person living with a disability (sickle cell disease), and as a 'woman' the appellant is a member of two particular social groups ("PSG"), that creates a third PSG, "where the discrimination and persecution targeted towards the PSG is based on these innate characteristics".

40. Dr Chelvan refers to the decision of the Upper Tribunal in DH (Particular Social Group: Mental Health) Afghanistan [2020] UKUT 223, in which the Upper Tribunal followed the obiter comments made in the House of Lords in Fornah v SSHD [2007] 1 AC 412, that interpreted the two elements outlined in Article 10(d) of the Qualification Directive (2004/83/EC) as alternatives, in order to comply with international law. Dr Chelvan submits the appellant has a diagnosis of sickle cell anaemia that is a chronic and life-threatening disease punctuated by crises that has required acute admission as an in-patient. He refers to the evidence of Sharifu Tusuubira that the situation for those with sickle cell anaemia in Uganda is *"aggravated by limited and inaccessible formal social support structures to aid sickle cell patients and families cope better with the psychosocial burden of the disease"* and that *"this has been coupled with stigmatization and discrimination of people living with sickle cell disease often causing isolation from family and society"*. In addition, Dr Chelvan submits the appellant has a diagnosis of 'Major Depressive Disorder' that is said to be 'severe' and has limited mobility and associated pain

notwithstanding one total hip replacement. Dr Chelvan submits the evidence before the Tribunal establishes the appellant requires significant medical input from both specialist and generalist clinicians to remain well both physically and mentally, which "makes her extremely vulnerable to deterioration in her health even if she were to move away from Bristol. Furthermore, he submits, the evidence of Mr Alex Ntung clearly establishes the extreme discrimination that persons with disabilities are likely to encounter in Uganda. It follows, Dr Chelvan submits in his skeleton argument, that conducting the factual analysis required, the appellant is a member of a PSG in Uganda as a person with disabilities:

> "The Appellant satisfies both limb 1 and limb 2 of Article 10(1)(d) of the Qualification Directive, on the basis that:
>
> a. *An innate characteristic or a common background that cannot be changed* – the Appellant's diagnosis of sickle cell anaemia, an incurable disease, constitutes an innate characteristic that cannot be changed, as does her chronic mental health diagnosis and mobility issues as arising from the same; and
>
> b. *A distinct identity in the relevant country because they are perceived as being different by the surrounding society* – as identified above, the country evidence reflects that persons with disabilities face significant discrimination in Uganda, reflecting societal perception of "difference" or as being an "outsider".

41. Dr Chelvan refers to Article 9(1) of the Council Directive 2004/83/EC on minimum standards for the qualification and status of third country nationals or stateless persons as refugees ("the Qualification Directive") and submits that the starting point for the Upper Tribunal's analysis of whether the appellant has a well founded fear of persecution must be the detailed and undisturbed findings of FTTJ Davidge leading to her conclusion that the appellant would face "very significant obstacles to integration" should she return to Uganda. Dr Chelvan submits the accumulation of factors including the vulnerability of the appellant and the discrimination and stigmatization the appellant will suffer on return to Uganda, is such that it amounts to persecution. He submits it is equally clear that this treatment would be directly, causally linked to the appellant's membership of a PSG, namely as a person with disabilities.

42. In the alternative, Dr Chelvan submits the Tribunal should adopt "The 'Double Bind' Intersectional Approach. Dr Chelvan submits that in addition to being part of a PSG in Uganda by virtue of her disability, the appellant falls into a situation of "double-bind" in that she is also a woman, a distinct and separate PSG. In the specific context of Uganda, it is submitted that this gives rise to a further, and more specific, third PSG (a person who lives with disabilities, who is a woman). Dr Chelvan submits that on the evidence before the Tribunal it is clear that as a woman living with a disability, there is a real risk due to her vulnerability, to social marginalization leading to a greater risk of sexual violence without effective state protection. The medical evidence relied upon by the appellant evidences her inability to relocate to another part of Uganda. The letter from Dr Schaefer dated 6th October 2021 notes that the appellant is *"extremely vulnerable to deterioration in her health even if she were to move away from Bristol"*. Dr Chelvan submits that taking account of all the relevant circumstances pertaining to the appellant, particularly the state of her medical conditions and the circumstances in Uganda, it would be unreasonable and unduly harsh for the appellant to relocate. On that basis, the appellant is a Refugee.

43. Before me, Dr Chelvan also adopted the skeleton argument prepared by his instructing solicitor that appears at pages 84 to 100 of the consolidated bundle. It is submitted that women with disabilities in Uganda form a PSG for the purposes of the Refugee Convention. It is said that the evidence before the Tribunal illustrates that women with disabilities in Uganda share innate characteristics that cannot be changed and that women with disabilities in Uganda have a distinct identity that is perceived differently in that society.

44. Dr Chelvan submits the First tier Tribunal has already made an unchallenged finding that the appellant would face "very significant obstacles to integration" should she return to Uganda, and that is a finding that assists the appellant. He submits, relying upon the decision of the Court of Appeal in SSHD v Kamara [2016] EWCA Civ 813, it is already

accepted therefore that the appellant would be treated as an 'outsider'. Furthermore, the UN Committee on the Rights of Persons with Disabilities has published four decisions, that are identified in paragraph [40] of his skeleton argument with respect to disability, and the right to non-refoulment. He submits that none of those decisions undermine, or contradict the submissions advanced on behalf of the appellant. When pressed, he accepted that none of those decisions establish a proposition of law but, he submits, they do demonstrate the approach taken in respect of those that require treatment which would not be available. My attention was also drawn to a case note prepared by Dr Chelvan titled 'W (Zimbabwe) - Disability and the Refugee Convention: determination and case note of 15 February 2016'. The note relates to an unreported decision of the First tier Tribunal (W v SSHD (AA/10877/2014) in which the respondent accepted that the appellant, who had a congenital medical condition where the digits of her hand were joined and malformed at birth, was a member of a particular social group. That is to say, people with a disability. Dr Chelvan accepts that I have not been provided with any of the underlying material relating to the claims set out in paragraph [2] of that note. In any event, Dr Chelvan submits the unreported decision of the FtT in W v SSHD demonstrates the 'intersectional approach' that can and should be adopted for the determination of refugee status. There, the FtT accepted the appellant would have to live in Zimbabwe with her disability without any medical help in coping with that disability meaning that she would be unlikely to be able to maintain effective employment even if she were able to find such employment.

45. Dr Chelvan submits that in SW (lesbians – HJ and HT applied) Jamaica CG [2011] UKUT 00251 (IAC), the Tribunal noted, at [75] his submission that "lesbians, as women and lesbians, suffered a double bind of expected norms from which they were protected in Jamaica only where they could demonstrate what had described as a 'heterosexual narrative'. There, the Tribunal was concerned with gender and sexuality, and here the Tribunal is concerned with gender and disability. Dr Chelvan also refers to academic material before the Tribunal in the form an essay published in the Journal

of International Women's Studies in December 2013 by Meremu Chikwendu, under the title: "Circular Consciousness in the Lived Experience of Intersectionality: Queer/LGBT Nigerian Diasporic Women in the USA". The essay highlights the lived experiences of six LGBQ women of the Nigerian diaspora where multiple intersectional positionings are in motion and by which their identities and self-definitions are constantly redefined; *"The way they relate to being Nigerian is informed by the way they relate to being queer, which is in turn informed by the ways they are marked as Black, which is in turn informed by their gender identity, and so on"*.

46. Finally, Dr Chelvan refers to the guidance published for Home Office Staff: "Medical claims under Articles 3 and 8 of the European Convention on Human Rights (ECHR) - Version 8.0**"** that addresses claims made on the basis that there are substantial grounds for believing that an individual would be exposed to a real risk of treatment contrary to Article 3, post the decision of the Supreme Court in AM (Zimbabwe) [202] UKSC 17, and the principles applicable to 'mental health cases'. Dr Chelvan submits the respondent has failed to adduce any evidence that undermines the evidence of the experts regarding the health of the appellant, the treatment available in Uganda, whether that treatment is accessible to the claimant in Uganda and the consequences of any reduced level of treatment on return.

47. In reply, Ms Ahmad makes no concessions regarding the evidence before the FtT leading to the decision to allow the appeal on Article 8 grounds but confirmed she does not seek to go behind the findings made leading to the decision to allow the appeal on Article 8 grounds. She adopted the respondent's reasons for refusal letter and submits there is no persecution in Uganda of those with sickle cell anaemia. She submits that in ZH (Women as Particular Social Group) Iran CG [2003] UKIAT 00207_the Tribunal said, at [79] and [80], that although discrimination, which can include a lack of state protection on the grounds of gender can identify a particular social group, the mere combination of those factors would not

necessarily suffice. The conclusion that they did in Pakistan in that case depended on the particular evidence as to the circumstances in Pakistan. A distinction must be made between women in different countries and requires some analysis of the material. It is sensitive to fact and degree, to the nature of the discrimination, its extent and intensity, to the availability of protection, and the degree of state assistance or indifference or furthering of the persecutory ill-treatment.

48. Ms Ahmad refers to headnote [4] of the decision in in DH (Particular Social Group: Mental Health) Afghanistan which states:

> "The assessment of whether a person living with disability or mental illness constitutes a member of a PSG is fact specific to be decided at the date of decision or hearing. The key issue is how an individual is viewed in the eyes of a potential persecutor making it possible that those suffering no, or a lesser degree of, disability or illness may also qualify as a PSG."

Ms Ahmad refers to paragraphs [79], [88] and [89] of the decision in which the Upper Tribunal said:

> "79. ….I accept the key issue is how an individual is viewed in the eyes of a potential persecutor making it possible that those suffering a lesser degree of illness may also face a real risk. This requires a fact specific assessment depending upon the nature of the illness, how it manifests itself, and country conditions. It is also the case that many problems experienced by those suffering mental health issues are as a result of ignorance grounded in a lack of understanding of an individual's mental health problems and how the same will, ordinarily, manifest themselves.
>
> …
>
> 88. Depending on the specific context in the country of origin and on personal circumstances, persons living with a serious mental illness may be perceived as being different by the surrounding society and thus, have a distinct identity in their country of origin. This is a fact specific assessment.
>
> 89. It is also the case that an appellant needs to establish that members of a PSG of 'persons living with a disability/mental health issues' will be exposed to acts of persecution, including severe violations of human rights from which there is no effective protection."

49. Ms Ahmad relies upon what is said at paragraphs [33] to [43] of the reasons for refusal letter, which she submits, refers to the incidence of sickle cell in Uganda and the treatment and support available in Uganda, including the work undertaken by USCRF to help people with sickle cell disease throughout Uganda with provision of treatment and medication for

those who are unable to afford it. The respondent also refers to the availability of mental health treatment and support in Uganda.

50. Ms Ahmad referred to a 'Response to an Information request: Uganda' dated 25th June 2019' on the subject of 'Women' and to a 'Response to an Information request: Uganda' dated 9th June 2020' again ,on the subject of 'Women'. The latter provides information upon 'Single mothers/women' in particular, and states, at [1.1.1] that although gender equality is guaranteed in the constitution and positive discrimination measures have been adopted, in practice, women continue to be disadvantaged. It is noted that the situation of educated urban middle-class women shows marked contrast to that of their rural counterparts, who in practice still face discrimination when it comes to property or land rights. It is noted that more than one in five (22%) of women aged 15 to 49 report that they have experienced sexual violence at some point in their lives.

51. Ms Ahmad submits that even if the appellant is able to establish that the treatment that she would require in Uganda is not accessible, the appellant is unable to establish the persecutory element required to establish she is a member of a PSG. Furthermore, she submits the Article 3 test referred to by the Supreme Court in AM (Zimbabwe) v SSHD [2020] 2 WLR 1152 still requires the appellant to establish that there is a real risk of her being exposed to a serious, rapid and irreversible decline in state of health resulting in intense suffering; or significant reduction in life expectancy. That remains a high threshold that Ms Ahmad submits, the appellant has not established on the evidence before the Tribunal.

52. In reply to the submissions made by Ms Ahmad, Dr Chelvan submits that in paragraph [42] of his judgment in HJ (Iran) v SSHD [2010] UKSC 3, Lord Rodgers said that at one time there would have been debate as to whether homosexuals constitute a "particular social group" for the purposes of the Convention. But, in more recent years, it has come to be accepted that, at least in societies which discriminate against homosexuals, they are indeed to be regarded as a particular social group. He said: "..*Indeed regulation 6(1)(e) of the Refugee or Person in Need of International Protection*

(Qualification) Regulations 2006 (SI 2006/2525) really puts the point beyond doubt by providing that, subject to an exception which is not relevant for present purposes, "a particular social group might include a group based on a common characteristic of sexual orientation". Dr Chelvan submits that undermines the respondent's reading of paragraph [89] of DH (Particular Social Group: Mental Health) Afghanistan. He submits disability itself can amount to vulnerable group status. The respondent accepted in her response to the appellant's grounds of appeal that the First-tier Tribunal judge had materially erred in her consideration of the background material and expert evidence relating to discrimination or mistreatment upon return to Uganda. In the grounds of appeal, the appellant had referred to the evidence including objective reports cited to support the 'high risks the appellant may face on return to Uganda'. That evidence was accepted by the First tier Tribunal Judge and led to the findings set out in paragraphs [46] and [47] of the decision and the conclusion that the appellant will face very significant obstacles to integration on return to Uganda.

53. Dr Chelvan drew my attention to the letter dated 8th October 2021 from Tom Latham. He expresses the opinion that if the exchange transfusion program were discontinued, there would be an increase in severe pain. A previous attempt to discontinue her exchange transfusions several years ago, resulted in increased frequency and duration of hospital admissions. Mr Latham expresses the opinion that if the appellant had a lack of access to exchange transfusion, there would be a high risk of a serious deterioration in her health and reduction in life expectancy. Exchange transfusion is a life saving emergency treatment for the most severe complications of sickle cell anaemia, and there is evidence of complications of sickle cell disease aside from the appellant's episodes of pain. Dr Chelvan submits that evidence is unchallenged, and although the appellant does not challenge the decision of the First-tier Tribunal to dismiss the appeal on Article 3 grounds, Article 3 is used here as a bridge to establish the appellant is a member of a PSG.

Discussion

54. The appellant does not challenge the decision of the First-tier Tribunal to dismiss the appeal on Article 3 grounds and I record from the outset that no separate argument is articulated on behalf of the appellant that she has an entitlement to humanitarian protection, even if she is not a refugee. The arguments presented before me focus upon whether the evidence establishes that the appellant is a member of a particular social group and whether what the appellant will face on return to Uganda, amounts to persecution within the meaning of the Geneva Convention.

55. Paragraph 328 of the Immigration Rules provides that all asylum applications will be determined by the Secretary of State in accordance with the Refugee Convention. The relevant provision of the Immigration Rules for present purposes is paragraph 334, which provides, insofar as is material to this appeal:

> "Grant of refugee status
>
> 334. An asylum applicant will be granted refugee status in the United Kingdom if the Secretary of State is satisfied that:
>
> .
>
> (ii) they are a refugee, as defined in regulation 2 of The Refugee or Person in Need of International Protection (Qualification) Regulations 2006;
>
> …
>
> (v) refusing their application would result in them being required to go (whether immediately or after the time limited by any existing leave to enter or remain) in breach of the Refugee Convention, to a country in which their life or freedom would be threatened on account of their race, religion, nationality, political opinion or membership of a particular social group."

56. A refugee is defined under the 1951 Convention relating to the Status of Refugees ("1951 Convention") as someone who has fled their country due to a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion". A person who satisfies that definition is a refugee and entitled to the rights and benefits set out in the Convention.

57. The Qualification Directive (Council Directive 2004/83/EC) (“the Directive”) laid down minimum standards applicable throughout the EU for the qualification or third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted. It did so by reference to the Geneva Convention as the cornerstone of the international legal regime. Article 9 of the Directive states:

Article 9

Acts of persecution

1. Acts of persecution within the meaning of article 1A of the Geneva Convention must:

(a) be sufficiently serious by their nature or repetition as to constitute a severe violation of basic human rights, in particular the rights from which derogation cannot be made under Article 15(2) of the European Convention for the Protection of Human Rights and Fundamental Freedoms ; or

(b) be an accumulation of various measures, including violations of human rights which is sufficiently severe as to affect an individual in a similar manner as mentioned in (a).

2. Acts of persecution as qualified in paragraph 1, can, inter alia, take the form of:

(a) acts of physical or mental violence, including acts of sexual violence;

(b) legal, administrative, police, and/or judicial measures which are in themselves discriminatory or which are implemented in a discriminatory manner;

(c) prosecution or punishment, which is disproportionate or discriminatory;

(d) denial of judicial redress resulting in a disproportionate or discriminatory punishment;

(e) prosecution or punishment for refusal to perform military service in a conflict, where performing military service would include crimes or acts falling under the exclusion clauses as set out in Article 12(2) ;

(f) acts of a gender-specific or child-specific nature.”

…

58. Article 10 deals with the ‘reason’ for the persecution and insofar as relevant to this appeal states:

Article 10

Reasons for persecution

1. Member States shall take the following elements into account when assessing the reasons for persecution:

…

(d) a group shall be considered to form a particular social group where in particular:

members of that group share an innate characteristic, or a common background that cannot be changed, or share a characteristic or belief that is so fundamental to identity or conscience that a person should not be forced to renounce it, and

that group has a distinct identity in the relevant country, because it is perceived as being different by the surrounding society;

depending on the circumstances in the country of origin, a particular social group might include a group based on a common characteristic of sexual orientation. Sexual orientation cannot be understood to include acts considered to be criminal in accordance with national law of the Member States: Gender related aspects might be considered, without by themselves alone creating a presumption for the applicability of this Article;

…

2. When assessing if an applicant has a well-founded fear of being persecuted it is immaterial whether the applicant actually possesses the racial, religious, national, social or political characteristic which attracts the persecution, provided that such a characteristic is attributed to the applicant by the actor of persecution.

59. The Refugee or Person in Need of International Protection (Qualification) Regulations 2006/2525 2006 ("the 2006 Qualification Regulation") implemented the Qualification Directive. Regulation 3 sets out who, for the purposes of the Regulations, can commit "persecution or serious harm:

"**3. Actors of persecution or serious harm**

In deciding whether a person is a refugee or a person eligible for humanitarian protection, persecution or serious harm can be committed by:

(a) the State;

(b) any party or organisation controlling the State or a substantial part of the territory of the State;

(c) any non-State actor if it can be demonstrated that the actors mentioned in paragraphs (a) and (b), including any international organisation, are unable or unwilling to provide protection against persecution or serious harm.

60. Regulation 5 defines an act of persecution:

5.— Act of persecution

(1) In deciding whether a person is a refugee an act of persecution must be:

(a) sufficiently serious by its nature or repetition as to constitute a severe violation of a basic human right, in particular a right from which derogation cannot be made under Article 15 of the Convention for the Protection of Human Rights and Fundamental Freedoms; or

(b) an accumulation of various measures, including a violation of a human right which is sufficiently severe as to affect an individual in a similar manner as specified in (a).

(2) An act of persecution may, for example, take the form of:

(a) an act of physical or mental violence, including an act of sexual violence;

(b) a legal, administrative, police, or judicial measure which in itself is discriminatory or which is implemented in a discriminatory manner;

(c) prosecution or punishment, which is disproportionate or discriminatory;

(d) denial of judicial redress resulting in a disproportionate or discriminatory punishment;

(e) prosecution or punishment for refusal to perform military service in a conflict, where performing military service would include crimes or acts falling under regulation 7.

(3) An act of persecution must be committed for at least one of the reasons in Article 1(A) of the Geneva Convention.

61. Regulation 6 refers to the reasons for persecution and states insofar as is relevant:

6.— Reasons for persecution

(1) In deciding whether a person is a refugee:

(a) the concept of race shall include consideration of, for example, colour, descent, or membership of a particular ethnic group;

…

(d) a group shall be considered to form a particular social group where, for example:

i) members of that group share an innate characteristic, or a common background that cannot be changed, or share a characteristic or belief that is so fundamental to identity or conscience that a person should not be forced to renounce it, and

(ii) that group has a distinct identity in the relevant country, because it is perceived as being different by the surrounding society;

(e) a particular social group might include a group based on a common characteristic of sexual orientation but sexual orientation cannot be understood to include acts considered to be criminal in accordance with national law of the United Kingdom;

…

(2) In deciding whether a person has a well-founded fear of being persecuted, it is immaterial whether he actually possesses the racial,

religious, national, social or political characteristic which attracts the persecution, provided that such a characteristic is attributed to him by the actor of persecution.

62. I pause to note at this point that in DH (Particular Social Group: Mental Health) Afghanistan [2020] UKUT 223, Upper Tribunal Judge Hanson addressed the divergence between the Directive and the Refugee Convention and found, at [71], that the correct manner in which Article 10(1)(d) of the Directive and the related 2006 Qualification Regulation should be interpreted, is by replacing the word “and” appearing between Article 10(1)(d)(i) and (ii) with the word “or”, creating an alternative rather than cumulative test.

63. It is for the appellant to establish, to the lower standard, an entitlement to refugee status as a member of a particular social group. At paragraphs [23] to [40] of her decision, Judge Davidge set out the undisputed facts. Insofar as relevant to the claim for international protection being advanced by the appellant, they are:

(i) The appellant is a Ugandan National.

(ii) The appellant was born, as asserted, in 1977, in Tororo, Uganda.

(iii) The appellant entered the United Kingdom in 2005 as a student.

(iv) Prior to her arrival in the UK in October 2005, the appellant lived with her parents and siblings in the family home.

(v) The appellant was born with the hereditary disorder sickle cell anaemia and with the passage of time her condition has progressed to a chronic and life-threatening disease, punctuated by crises requiring acute admission as an inpatient.

(vi) Sickle cell anaemia is classed as a disability in terms of the equal treatment and discrimination provisions of UK law.

(vii) In March 2018, as a result of a deterioration in mental health and assessment in the face of suicide ideation, the appellant received crisis support in respect of her mental health including the provision of appropriate ground floor housing, and support in the home.

(viii) The appellant has an NHS diagnosis of severe depression, with, in September 2018, a moderate risk of attempting and completing suicide.

(ix) In a report, Dr S Prangnell, a clinical neuropsychologist, concludes that were she unable to access treatment and the benefit from the associated respite, the appellant's risk of attempting suicide would elevate to high.

(x) The appellant's cognitive abilities have been affected by fatigue, multifactorial psychological distress, and the side-effects of opiate medication which the reports referred to as being at a high level and used as pain relief.

(xi) The appellant has had one full hip replacement.

(xii) The appellant worked for the civil service in Uganda prior to her arrival in the United Kingdom and was receiving treatment at a private clinic in Kampala for sickle-cell anaemia.

(xiii) The appellant has both her parents still living in Uganda. Her father is in his 80s. Her mother has had a stroke and the appellant's father is her carer.

(xiv) As well as pharmacological treatment, the appellant is receiving, at six weekly intervals, a total blood exchange transfusion. Her treatment commenced while she had leave to remain in the United Kingdom.

64. I have already set out the expert evidence before me at some length in this decision. There is nothing within the updated evidence that is before the Tribunal that casts any doubt upon what were characterised by Judge Davidge as the undisputed facts, and I adopt those facts as my starting point. The respondent does not challenge the medical evidence regarding the appellant's mental health, and I accept the appellant has been diagnosed with a 'Major Depressive Disorder of a severe degree. In her update Dr Jenny Schaefer refers to the ongoing deterioration in the appellant's physical and mental health, and I accept the appellant requires significant medical input from both specialists and generalist clinicians to remain well both physically and mentally.

Membership of a particular social group

65. "Membership of a particular social group" is one of the five grounds enumerated in Article 1A(2) of the 1951 Convention. The UNHCR 'Guidelines on International Protection: "Membership of a particular social group" within the context of Article 1A(2) of the 1951 Convention' note that the 'PSG' ground is the ground with the least clarity and is not defined

by the 1951 Convention itself. It is however being invoked with increasing frequency in refugee status determinations, with States having recognised women, families, tribes, occupational groups, and homosexuals, as constituting a particular social group for the purposes of the 1951 Convention. As the UNHCR guidelines recognise, to preserve the structure and integrity of the Convention's definition of a refugee, a social group is not a 'catch all' and cannot be defined exclusively by the fact that it is targeted for persecution.

66. In SSHD v K and Fornah v SSHD 2006 UKHL 46, it was common ground that the applicants had a well-founded fear of persecution if returned to their home country (Iran and Sudan). The issue was whether the well-founded fear of being persecuted was for reasons of membership of a particular group. In paragraph [12] of his judgment, Lord Bingham referred to the leading domestic authority: the decision of the House of Lords in R v Immigration Appeal Tribunal, ex p Shah; Islam v SSHD [1999] 2 AC 629. There, the House of Lords held that women in Pakistan constitute a particular social group. At paragraphs [13] and [14] Lord Bingham said:

> "13. Certain important points of principle relevant to these appeals are to be derived from the opinions of the House. First, the Convention is concerned not with all cases of persecution but with persecution which is based on discrimination, the making of distinctions which principles of fundamental human rights regard as inconsistent with the right of every human being: pp 651, 656. Secondly, to identify a social group one must first identify the society of which it forms part; a particular social group may be recognisable as such in one country but not in another: pp 652, 657. Thirdly, a social group need not be cohesive to be recognised as such: pp 643, 651, 657. Fourthly, applying *Applicant A v Minister for Immigration and Ethnic Affairs* (1997) 190 CLR 225, 263, there can only be a particular social group if it exists independently of the persecution to which it is subject: pp 639-640, 656-657, 658.
>
> 14. In *Shah and Islam*, the House cited and relied strongly on *In re Acosta* (1985) 19 I&N 211, a relatively early American decision given by the Board of Immigration Appeals. Construing "membership of a particular social group" ejusdem generis with the other grounds of persecution recognised by the Convention, the Board held the expression to refer to a group of persons all of whom share a common characteristic, which may be one the members cannot change or may be one that they should not be required to change because it is fundamental to their individual identities or consciences. The Supreme Court of Canada relied on and elaborated this approach in *Attorney-General of Canada v Ward* [1993] 2 SCR 689, 738-739, and La

Forest J reverted to it in his dissent in *Chan v Canada (Minister of Employment and Immigration)* [1995] 3 SCR 593, 642-644. The trend of authority in New Zealand has been generally in accord with *Acosta* and *Ward*: T A Aleinikoff, "Protected characteristics and social perceptions: an analysis of the meaning of 'membership of a particular social group'" *UNHCR's Global Consultations on International Protection,* ed Feller, Türk and Nicholson, (2003), pp 263, 280. The leading Canadian authorities were considered by the High Court of Australia in *Applicant A*, above, where the court was divided as to the outcome but the judgments yield valuable insights. Brennan CJ, at p 234, observed:

> "By the ordinary meaning of the words used, a 'particular group' is a group identifiable by any characteristic common to the members of the group and a 'social group' is a group the members of which possess some characteristic which distinguishes them from society at large. The characteristic may consist in any attribute, including attributes of non-criminal conduct or family life, which distinguish the member of the group from society at large. The persons possessing any such characteristic form a particular social group".

Dawson J (p 241) saw no reason to confine a particular social group to small groups or to large ones; a family or a group of many millions might each be a particular social group. Gummow J (p 285) did not regard numerous individuals with similar characteristics or aspirations as comprising a particular social group of which they were members: there must be a common unifying element binding the members together before there would be a social group of this kind."

67. Lord Bingham also noted the UNHCR's view that, whilst a social group could not be defined by the persecution, persecutory action towards a group might be a relevant factor in determining the visibility of the group in a particular society.

68. The relevant 'particular social group' identified by Dr Chelvan is first, that the appellant is "a person with disabilities" and/or second, the appellant, "as a person living with disability and as a woman" is a member of two PSG's creating a third PSG, where the discrimination and persecution is based on those characteristics.

69. I consider first whether the appellant is a member of a particular social group as a 'person with disabilities'. Dr Chelvan points to the two disabilities identified in the expert evidence before the Tribunal. The first is the hereditary 'sickle cell anaemia'. The second is the diagnosis of 'Major Depressive Disorder' of a severe degree and described as chronic and severe. The difficulty with defining the PSG as 'persons with disabilities' in the way contended for by Dr Chelvan is that there are

plainly a wide range of disabilities. It fails to have any regard to whether the disability is an innate or immutable characteristic. A short period of illness could not be described as an innate characteristic. Some disability, whether physical or mental may not be apparent to other members of society and others might be treatable and result in only limited periods of illness. It cannot in my judgment be said that everyone who has a physical or mental disability, or a combination of the two, is a member of a PSG. There are innumerable types of disabilities that can affect a human being. Some of these conditions are more common than others, and each is capable of being viewed differently in different societies. The characterisation of the PSG as 'persons with disabilities' in Uganda, in the way contended by Dr Chelvan here, is, in my judgment, too broad a category to be defined as a PSG for the purpose of the Refugee Convention.

70. For present purposes, I accept entirely the evidence of Dr Latham and the update provided by the appellant's GP, Dr Jenny Schaefer insofar as it relates to the appellant's physical health. I accept the appellant has homozygous sickle cell anaemia, an inherited blood disorder which has been lifelong. The evidence before me establishes, and I accept, that the appellant has continued to suffer crises requiring hospital admission and that she continues to receive a total blood exchange transfusion at six weekly intervals. In my judgement, homozygous sickle cell anaemia is an innate characteristic for the purposes of Regulation 6(1)(d)(i) of the 2006 Qualification Regulations and for that reason alone the appellant is a member of a PSG. There is no need for the appellant to establish that the group sharing that innate characteristic has a distinct identity in Uganda because it is perceived as being different by the surrounding society.

71. I accept the appellant's mental health has deteriorated since her arrival in the UK, in large part, because of the crises she has endured. Major Depressive Disorder is not congenital and is not an innate characteristic in the sense that it is something she was born with, in the same way as sickle cell anaemia. It is however now part of the appellant's background

that cannot be changed, although it can be managed, and according to Dr Olowookere a combination of medication and psychological intervention will provide a good prognosis. I accept that if those with a mental disability share a characteristic or are perceived as a distinct group by a particular society, they might also qualify as a PSG. Whether people that have a mental disability form a PSG is a question of fact. Some people may suffer from an episode of illness and make a full recovery. Others may have an enduring disorder which can be controlled to some extent by treatment. Others may have severe and enduring disorders which are characterised by repeated episodes involving abnormal behaviour even when treatment is available. Here, the evidence of Dr Olowookere, which I accept, is that the appellant is suffering from 'Major Depressive Disorder of a sever degree' that is chronic and severe. He states the appellant needs twelve sessions of CBT and at the time of his report, she had completed two sessions. In his opinion, the commencement of CBT should be beneficial to the appellant and the combination of medication and psychological intervention will provide a good prognosis.

72. In his first report, Mr Ntung noted, at paragraph [21], that the appellant claims asylum as a disabled woman from Uganda who fears persecution for reasons of membership of a particular social group (women with disabilities). Much of the focus of his report is upon the appellant's vulnerability as a lone woman (without family support) with sickle cell anaemia. I shall return to his opinions in that respect later in this decision. However, at paragraph [45], he refers to the appellant's mental health crisis and at paragraph [46] states:

> "…her mental health conditions would increase significantly vulnerabilities in Uganda… A Mental health strategy is available but there is a serious capacity issue in implementing this effectively nationwide. Tororo is not an exception"

73. At paragraph [47], Mr Ntung refers to underfunding in mental health services and states that given the scarcity of provisions in Uganda, it is unlikely the appellant would be able to access mental health facilities. At paragraphs [69] to [74] of his report, Mr Ntung considered whether

'women with disabilities particularly sickle cell anaemia', are discriminated against in Uganda. He expresses the opinion that people with disabilities may encounter extreme discrimination in accessing various services, including accommodation and employment. He states that suffering 'sick cell anaemia' or 'mental health' is often blamed on witchcraft or sorcery or other supernatural causes. He states, at [71], that the main discrimination affecting people with disabilities is a lack of accessible infrastructure and facilities adequate to respond to individual needs. At paragraphs [73] and [74], Mr Ntung states:

> "73. … when confronted with symptoms of sickle cell anaemia or mental disorders, many believe them to be associated with witchcraft and sorcery and, rather than seek medical treatment, they turn to traditional healers. Indeed, most people use highly unorthodox methods to cure the illness or to extract what some believe are demons. Those who are suffering from sickle cell anaemia and mental health problems are often physically abused and accused of spiritual possession. The beatings and other related abuse are justified or believed to be not about harming the suffered but to inflict pain to a "spirit inside him or her".
>
> 74. The patient would generally experience extreme devaluation, rejection and inclusion in their own communities, which often leads to serious harm as a result of being socially and culturally disadvantaged and a loss of social status. Such patients are perceived as being a curse to their families or a danger to their communities. This often leads to people denigrating, mocking or harassing them."

74. In his second report dated 13th March 2019, Mr Ntung considered, *inter alia*, the psychological assessment report prepared by Dr Simon Prangnell. At paragraph [47] of that report Mr Ntung refers to a 'deep-rooted stigma from society', which causes communities and families to hide their relatives. At paragraph [50] he states that he has personally witnessed such abuses and the traditional attitudes toward those who suffer from mental health illness. At paragraph [51] he states:

> "Those suffering mental health problems are often chained to rusted home or hospital beds, beaten, isolated in dark corners of churches or rooms at home, abused by entire societies or thrown out of the family home as they are considered to be shameful and a curse for future generations. Others are locked away to live behind the bars of filthy prisons or in isolated traditional "healing" places/cells.

75. Mr Ntung focuses upon ‘mental health disorders’ generally, and he fails to make any distinction at all between a mental disability that might cause an individual to transgress social norms, such a schizophrenia or psychosis, and a mental disability such as a severe Major Depressive Disorder, where, as here, the appellant is described by Dr Olowookere as having a persistent feeling of sadness, hopelessness, poor appetite, suicidal ideation and a feeling that life is not worth living. How the former is viewed by society in Uganda and thus how they will be treated is likely to differ from how the latter are viewed and treated in Uganda. There is no evidence before me of any abnormal behaviour the appellant displays because of her mental health that would attract the attention of the authorities or non-state actors of persecution. In fact the evidence before me is that the commencement of CBT should be beneficial to the appellant and the combination of medication and psychological intervention will provide a good prognosis overall. However for present purposes, I am satisfied that the onset and deterioration in the appellant’s mental health is linked to the underlying sickle cell disease and the crises that the appellant has since endured. On the evidence before me relating to the general attitudes towards those with sickle cell anaemia and mental illness in Uganda, I am prepared to accept that the persecution the appellant fears is for reasons of her membership of a particular social group for the purpose of the Refugee Convention.

76. In the circumstances I can deal very briefly with the alternative basis upon which Dr Chelvan advances the asylum claim (‘Asylum Claim Two’). It is said that the appellant is a member of a particular social group, as person living with a disability. She is also a member of a particular social group as a woman. It is said that she is therefore a member of a third social group, ‘a woman with disabilities’. The characterisation of the appellant’s claim in the alternative, involving what is described by Dr Chelvan as adopting a ‘Double Bind’ intersectional approach’, is in my judgement, unhelpful.

77. Care needs to be taken not to lose sight of the main purpose of the refugee Convention and Directive which is to protect persons from being

persecuted. The Convention definition is narrow and excludes many displaced people. It is now well established the Convention is concerned with persecution which is based on discrimination and the making of distinctions which principles of fundamental human rights regard as inconsistent with the right of every human being. As the UNHCR guidelines recognise, to preserve the structure and integrity of the Convention's definition of a refugee, a social group is not a 'catch all'. In my judgment it is unhelpful to try and create a PSG upon the premise that an individual is already a member of a PSG but because they cannot establish that they will be subjected to persecution as a member of that PSG, they can rely upon the interconnected nature of social categorisations such as gender and disability as creating overlapping and interdependent systems of discrimination or disadvantage, to establish that they will be subjected to persecution.

78. Furthermore, in her witness statement dated 18th June 2018 the appellant states that she fears that if returned to Uganda, she will be mistreated and abused because she is a 'vulnerable disabled woman'. She states she is vulnerable because of her sickle cell anaemia, mobility issues and the state of her mental health. She states that if she returned to Uganda with her current mobility issues she would be targeted as people who use crutches *(my emphasis)* are treated differently. She states that "if someone has mental health problems, they are shunned" *(my emphasis)*. In paragraph [36] of her statement the appellant confirms her family is aware of her condition and she states her mother is not in a position to take care of her. She states that she has not told her family that she is suffering from mental health issues or that she is using crutches. She is scared to tell her family because of the perception towards people with disabilities *(my emphasis)*. On her own case, the appellant makes no claim that women with sickle cell anaemia or some concern about their mental health, are treated differently to men.

79. In the first of his reports, Mr Ntung was asked whether women with disabilities (particularly sickle cell anaemia) are discriminated against in

Uganda. At paragraphs [69] to [72] he refers to the difficulties that may be encountered by "*those with disabilities*" and "*those suffering sickle cell anaemia*". At paragraph [75] he comments on whether there is appropriate medical care for women with sickle cell anaemia in Uganda. He states: *"..it is important to confirm that, generally, there is not a gender related discrimination with regards to access to medical care for women suffering from sick cell anaemia*". The risks arise during pregnancy and if living in a rural and inaccessible area. At paragraph [86] he addresses whether there is any discrimination against women with disabilities particularly sickle cell anaemia in relation to healthcare and medical provision. He states there is discrimination, "*but this is nothing to do with being a woman or man*" and "*access to healthcare and medical provision is scarce in Uganda whether you are a man or a woman".*

80. In the second of his reports, Mr Ntung refers to 'women with disabilities in Uganda' and at paragraph [32], he refers to a policy framework to protect people with disabilities but states none is specific to women or reinforced. Mr Ntung refers to disabled women having come together under an umbrella organisation, the National Union of Women with Disabilities of Uganda (NUWODU). Many of its activities are towards addressing discrimination against disabled women, gender-based violence and education of the disabled girl child. Throughout his reports Mr Ntung refers to "those suffering sickle cell disease" and "people with disabilities". People with those traits, regardless of gender, face the same difficulties in Uganda.

81. I have already found that the appellant is a member of a PSG for the purpose of the Refugee Convention because she has an innate characteristic. For the reasons set out above, I am not satisfied that appellant has established that as 'a woman living with a disability' she has a distinct identity in Uganda and will be perceived as being different by the surrounding society.

82. Although the appellant is a member of a PSG, establishing such membership is not sufficient to be recognised as a refugee. The appellant

must establish, to the lower standard, that she has a well-founded fear of persecution for reasons of her membership of that particular social group.

Persecution

83. Acts of persecution are defined within Regulation 5 of the 2006 Qualification Regulation as acts which are 'sufficiently serious' to constitute a 'severe violation of basic human rights'. This can be either in their 'nature or repetition' or through an 'accumulation of various measures'. Basic human rights are defined here as those which are non-derogable under Article 15 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. These include Article 3. Here, Dr Chelvan relies upon Article 3 as 'a bridge' to establishing that the appellant has a well-founded fear of persecution, but in my judgment it remains important not to conflate the test for establishing an Article 3 claim as now set out in AM (Zimbabwe) v SSHD [2020] UKSC 17 and the test for establishing a well-founded fear of 'persecution'. As I have already said, the appellant does not challenge the decision of the FtT to dismiss the appeal on Article 3 grounds.

84. I accept however that an accumulation of various measures allows for persecution to be established where there is a violation of human rights. In his report, Dr Latham refers to the serious deterioration that there would be in the appellant's health and reduction in life expectancy if the appellant did not have access to exchange transfusions, in an emergency situation. Exchange transfusion is a life-saving emergency treatment for the most severe complications of sickle cell anaemia. I note however that in his letter, Sharifu Tussubira refers to a general shortage of 'blood stock' which limits access to chronic care patients specifically where transfusion therapy is required. However, he confirms that sickle cell patients are able to access blood products in times of emergencies.

85. The meaning of persecution in Article 1(A)(2) is a question of law. Although there is no universally accepted definition of "persecution", the meaning of the word has been addressed in a number of cases, all of which emphasise

that "persecution" is a "strong word", and that the ill-treatment complained of must generally involve a reasonable likelihood of serious harm; Lord Bingham in Sepet & Bulbul v SSHD [2003] UKHL 15.

86. In Amare v SSHD [2005] EWCA Civ 1600, Laws LJ, *(with whom Mummery LJ and Wall LJ agreed)* addressed submissions made on behalf of the appellant as to relevant legal rights, and a "human rights based approach to persecution". He said:

> "26. I have no difficulty with a great deal of the case put forward by Ms Webber. Thus Lord Hoffmann's observation that "the concept of discrimination in matters affecting fundamental rights and freedoms is central to an understanding of the Convention" (*Ex p. Shah [1999] 2 AC 629* , 650–651) is of a piece with the proposition that refugee law aspires to protect values of basic human rights, which are affronted by practices of discrimination perpetrated or tolerated by the State. Discrimination against women and against homosexuals, and especially a mix of the two, may depending on the facts be particularly repugnant to these values. I would not with respect wish to differ, even were I free to do so, from the statements of Baroness Hale at paragraphs 32 and 36 of *Hoxha* which I have set out.
>
> 27. But the alignment of the State obligations imposed by the Refugee Convention with the protection of basic or fundamental human rights is subject to important qualifications. These are well known, and are no less important than the alignment itself. First is the fact that the Convention only requires protection to be afforded in case of particular violations of human rights norms: those arising "for reasons of race, religion, nationality, membership of a particular social group or political opinion". Secondly the violation, or rather prospective or apprehended violation, must attain a substantial level of seriousness if it is to amount to persecution. This latter proposition is vouchsafed by a number of statements in the texts upon which Ms Webber herself relies. As I have shown Schiemann LJ in *Jain* drew attention to references in *Shah and Islam* to the concept of serious harm, and to the comment of Staughton LJ in *Sandralingham and Ravichandran* that "[p]ersecution must at least be persistent and serious ill-treatment without just cause …". Lady Hale in *Hoxha* acknowledged at paragraph 36 that "the treatment feared has to be sufficiently severe". In *S in the High Court of Australia* McHugh and Kirby J stated that "[w]hatever from the harm takes, it will constitute persecution only if, by reason of its intensity or duration, the person persecuted cannot reasonably be expected to tolerate it."
>
> 28. These two limitations or, as I would prefer to call them, conditions of the scope of the Refugee Convention are in no sense ancillary or incidental. They are the very focus and expression of the distinct obligation of international protection accepted by the contracting States. Certainly, there is much learning to show that the Convention is to be treated over time as a living instrument and construed as such (see for example the passage from Schiemann LJ's judgment in *Jain* which I have cited). But this is no licence for the courts, in the cause of protecting or enlarging human rights, in effect to impose on the State obligations which in truth they have

not undertaken. In my opinion there is an important difference between the courts' approach to a measure which does no more nor less than establish rights and duties effective in, as it were, our unilateral domestic law and their approach to a measure consisting in an international agreement. In the first case, the courts' duty is to construe and apply the measure according to English canons of construction. In the second case, the courts must keep a weather eye on the fact that they are dealing with the product of negotiation between contracting States, which is likely to represent the reach of what the contracting States were able to agree. In *Hoxha* at paragraph 85 Lord Brown of Eaton-under-Heywood cited the observations of Lord Bingham of Cornhill made both in *Brown v Stott [2003] 1 AC 681* , 703 and in *European Roma Rights Centre [2004] UKHL 55, [2005] 2 AC 1* , paragraph 18:

> "'[I]t is generally to be assumed that the parties have included the terms which they wished to include and on which they were able to agree, omitting other terms which they did not wish to include or on which they were not able to agree', and caution is needed 'if the risk is to be averted that the contracting parties may, by judicial interpretation, become bound by obligations which they did not expressly accept and might not have been willing to accept'."

Mr Kovats also cited the observations of Lord Hope of Craighead in *Hoxha* at paragraphs 8–9, which with great respect I need not set out.

29. An instance of the former class of case is the Human Rights Act 1998 . It gives municipal effect to the principal provisions of the ECHR , and of course the ECHR is an international treaty. But once it is enacted as part of domestic law, the courts' concern is to construe and apply its provisions *as* English law (qualified by the obligation imposed by s.2 of the Act to take account of the Strasbourg jurisprudence). There is no analogue to the distinct necessity, arising in the second class of case, to mark and to respect the edge of a negotiated international consensus."

87. In HJ (Iran) Lord Hope too noted that 'persecution' has been recognised as a strong word. It will not cover each and any harm experienced by individuals seeking protection. At paragraph [13] Lord Hope said:

"To constitute persecution for the purposes of the Convention the harm must be state sponsored or state condoned. Family or social disapproval in which the state has no part lies outside its protection**.** As Professor J C Hathaway in *The Law of Refugee Status* (1991), p 112 has explained, "persecution is most appropriately defined as the sustained or systemic failure of state protection in relation to one of the core entitlements which has been recognised by the international community." The Convention provides surrogate protection, which is activated only upon the failure of state protection. The failure of state protection is central to the whole system: *Horvath v Secretary of State for the Home Department [2001] 1 AC 489* , 495. The question is whether the home state is unable or unwilling to discharge its duty to establish and operate a system for the protection against persecution of its own nationals."

Lord Hope said, at [16];

> "Thus international protection is available only to those members of the particular social group who can show that they have a well-founded fear of being persecuted for reasons of their membership of it who, owing to that fear, are unwilling to avail themselves of the protection of their home country. Those who satisfy this test cannot be returned to the frontiers of a territory where their life or freedom would be threatened on account of their membership of that group: article 33(1) . To be accorded this protection, however, the test that article 1A(2) sets out must first be satisfied. As Lord Bingham of Cornhill said in *Januzi v Secretary of State for the Home Department [2006] 2 AC 426* , para 5, the words "owing to well-founded fear of being persecuted for reasons of … membership of a particular social group" in the definition of "refugee" express a causative condition which governs all that follows."

88. The concept of persecution for the purposes of the Geneva Convention (and indeed the Directive and 2006 Qualification Regulations) requires that the ill-treatment the appellant will face on return must attain a substantial level of seriousness. Whether the ill treatment in a particular case amounts to persecution is a mixed question of fact and law. The key test is not what has happened to the appellant in the past, but whether there is a serious possibility or reasonable likelihood of persecution in the future. The conclusion as to whether the conduct amounts to persecution or not, is ultimately one of fact. As Ms Ahmad submits the threshold as to what amounts to persecution, is a high one. It is now well established that the harm feared must be of sufficient severity.

89. The appellant was born on 26th July 1977 and lived in Tororo, Uganda, until her arrival in the UK on 15th October 2005 on a student visa. She was 28 years old when she arrived in the UK. In a witness statement dated 18th June 2018, the appellant confirms that prior to her arrival in the United Kingdom, she was working as a civil servant and living in the family home, with her parents and siblings. She states that her health was much better at that time. The appellant refers to one hospital that help patients with sickle cell anaemia based in Mulago, Kampala. She states she rarely attended the clinic in Mulago for a number of reasons including the distance involved. She lost one of her siblings several years ago, and since her arrival in the UK, in 2007, two more of her siblings passed away. The time following the death of her siblings has been difficult and stressful for her, and her health has since deteriorated both physically and mentally.

90. Dr Chelvan submits the starting point for the Tribunal's analysis of whether the appellant has a well-founded fear of persecution for a convention reason is the unchallenged and undisturbed findings made by First-tier Tribunal Judge Davidge, that the appellant has established that she will face very significant obstacles to integration on return to Uganda. He submits the evidence before the Tribunal regarding the health of the appellant, the four reports prepared by Mr Ntung and the background material relied upon by the appellant establishes that there is a real risk of the appellant being subjected to treatment on return to Uganda that amounts to persecution.

91. I begin with the finding made by Judge Davidge that there would be very significant obstacles to the appellant's integration into Uganda. In reaching her decision, Judge Davidge had in mind, at paragraphs [46] and [47] of her decision, the challenges the appellant would face trying to manage the severity of her condition in the context of the Ugandan health and social support system, not with harm that is state sponsored, or state condoned, or serious ill-treatment without just cause. In reaching her decision on the Article 8 claim, Judge Davidge was addressing the test to be applied under paragraph 276ADE of the immigration rules as set out in Kamara v SSHD [2016] EWCA Civ 813 ; *"the idea of "integration" calls for a broad evaluative judgment to be made as to whether the individual will be enough of an insider in terms of understanding how life in the society in that other country is carried on and a capacity to participate in it, so as to have a reasonable opportunity to be accepted there, to be able to operate on a day-to-day basis in that society and to build up within a reasonable time a variety of human relationships to give substance to the individual's private or family life".* That is very different to the question that arises in Refugee convention claims where the focus is not upon whether the appellant is enough of in "insider", but whether the harm the appellant will suffer will be of such intensity or duration, that she cannot reasonably be expected to tolerate it. Judge Davidge was addressing an altogether different issue.

92. The harm the appellant will be exposed to upon return to Uganda as someone who has sickle cell anaemia and a 'mental health illness' is set out in the expert reports of Mr Ntung. His opinions and conclusions regarding the way in which people with disabilities in particular are treated in Uganda, are echoed in the background material that is referred to in paragraph [38] of the appellant's skeleton argument and there is nothing to be gained by my referring to that background material in this decision.

93. At paragraphs [39] to [47], Mr Ntung addresses "any particular vulnerability linked to being a lone woman (without family support) with sickle-cell anaemia, in particular any abuse that is likely.". Mr Ntung states, at [40], as a lone female (without family support) with sick cell anaemia disease, the appellant is likely to face stigma and social discrimination of people living with sickle cell disease. Mr Ntung states, at [41] and [42]:

> "41. The 'reason' associated with such stigma is that the families affected by such disease tend to be fearful of being labelled outcast or 'untouchable', cursed or bearers of misfortunes. As soon as a family member is diagnosed as sick cell anaemia carrier, relatives and neighbours are very likely to cut contacts with the family. Therefore, if she has no extended and community support, she would be extremely vulnerable. Tororo, where [the appellant] originally comes from, is a rural area 'town' - such stigma is much stronger in rural areas than in the cities.
>
> 42. As lone and vulnerable female, without any other form of employment, she will be unable, physically, to get involved in the day-to-day economic activities – it is important to note that 80% of Ugandans depend on agriculture for their livelihoods. Poverty affects particularly women in rural areas of Uganda. About 90% of rural women work in agriculture sector."

94. Mr Ntung also states, at [43], that as a lone vulnerable female, the appellant could be at risk of sexual exploitation, and at [44], that she could be at risk of domestic violence or sexual coercion. However, the appellant will not be a 'lone woman' without any family support on return to Uganda. Her parents continue to live in Tororo and although I accept they are elderly, there is nothing in the evidence before me to establish that they would not support the appellant. The appellant's parents have in the past, supported their children notwithstanding the struggles they have faced. In her witness statement, the appellant describes that when she was younger her family had to continuously reassure the appellant and her sister that

the family was not cursed and sickle-cell was a condition the appellant was born with, not a curse upon the family.

95. The appellant may be scared to tell her parents that she suffers from mental health issues and is using crutches, but there is nothing to suggest that if they were told, they would not support her. I do not accept the appellant's evidence that if her family knew that she has mental health problems, they would reject her. The appellant claims that she is aware of the stigma surrounding mental health in Uganda because even when she speaks to her family, they make comments about people who have gone 'mad'. She therefore feels unable to tell her family about her mental health problems. The appellant's mental health problems must be considered in context. She does not have a mental disability that might cause her to transgress social norms, or to display any abnormal behaviour so that her mental health would attract the attention of the local community. She has a severe Major Depressive Disorder, and the evidence is that the commencement of CBT should be beneficial to the appellant and the combination of medication and psychological intervention will provide a good prognosis overall. The appellant would, in Uganda, additionally have the emotional support of her family, and it is clear that her mother in particular, is someone that is uppermost in the mind of the appellant. She is cited in the report of Dr Prangnell as a 'protective factor' preventing the appellant acting on her suicidal thoughts.

96. Mr Ntung states the appellant's mental health conditions would significantly increase her vulnerabilities in Uganda. Asked whether the authorities in Uganda are likely to prevent or suitably prosecute the perpetrators of any abuse, and if not, why not, Mr Ntung notes there is a difference between the publicly spoken policies and their implementation, and states:

> "50. While the Uganda government and security institutions are well equipped with the right policies, their application is extremely insignificant. There is not effective protection from the Uganda police and/or other relevant authorities. Uganda government security forces have often failed

> to take adequate or effective steps to fully protect women experiencing domestic or sexual violence, either in Kampala (the capital city) or other parts of the country, including Tororo. I am aware, through my research and investigations, of many cases of gender-based violence and other widespread violations of human rights, but few perpetrators have been held to account."

97. The weight I attach to that opinion is limited. Mr Ntung fails to explain how he reached his opinion that the Ugandan government and security institutions application of the policies "is extremely insignificant", and he fails to explain how he reaches his opinion that the Ugandan government security forces fail to take adequate or effective steps to fully protect women experiencing domestic or sexual violence, either in Kampala or other parts of the country, including Tororo. He provides no statistics to support that opinion or even give any examples of steps taken by the state authorities and why he considers them to be inadequate. Furthermore, although he refers to research and investigations, none of that research or investigations is explained or elaborated upon.

98. Mr Ntung states that despite the existence of reporting units, violence against women is on the increase in Uganda, despite the presence of laws and policies to protect victims and survivors. The appellant was not subjected to domestic violence or any other form of sexual abuse or coercion when she previously lived in Uganda. I must however consider the risk that she would face upon return now, and on the evidence before me regarding the appellant's personal circumstances and the support available to her, I cannot conclude, even to the lower standard, that she would be subjected to domestic or sexual violence upon return.

99. At paragraphs [26] to [35] of his report dated 13th March 2019, Mr Ntung comments upon the 1951 Geneva Convention and its 1967 protocol relating to refugee protection. At paragraphs [32] to [35], he refers to problems that may be encountered by women with disabilities in Uganda and at paragraphs [36] to [41], he addresses the position of those with sickle cell anaemia in particular. He states:

> "36.… I have interviewed several senior health professionals in Uganda including Dr Arthur K. (he preferred to keep his identity anonymous). Health care through public hospitals is now expected to be free but prioritisation for sickle cell anaemia treatment has not happened and still a serious issue despite the prevalence being 20-30%. However, through public policies available on Internet resources, Uganda Ministry of health would claim that there is capacity to assist such patients, which is not the case.
>
> 37. Sometimes sickle cell anaemia patients require intensive care services, blood transfusions or broad spectrum antibiotics, which are almost absent in public facilities. Sicklers require frequent hospitalisations and outpatient visits and because of a lack of adequate healthcare system have an extremely poor life expectancy in Uganda.
>
> 38. There is a vulnerability, which arises from lack of access to medical treatment/healthcare services as a woman with sickle cell anaemia. For instance, lack of independence, requiring travelling large distances as a lone woman. Transportation system and facilities are not all extremely poor. From rural to hospital they may not be transportation at all.
>
> 39. The lack of ambulance service, a poor road network and absence of caregivers makes it very difficult for a sickler to get quality care. Worse still, the country's doctor to patient ratio means delays at emergency wards waiting to be seen, and worse still getting medication from outside pharmacies."

100. In his report dated 26th December 2020, Mr Ntung goes on to expand upon some of the opinions he expressed in his previous reports. He adds, at [21], that research shows that people with sickle cell disease *"are indeed discriminated not only among the population but also among health workers"*. He states that in Uganda, there are imbedded cultural beliefs and traditional practices that influence health-care providers' behaviour and attitude towards people affected with sickle cell disease. This is because of the notion that illness is attributed to "divine retribution" or the supernatural. He states, at [23], that stigma and myths about sickle cell disease are widespread in Uganda; and misconceptions are generalised not only among the population but also among health workers. Stigmatisation isolates sickle-cell patients and their families from society. Consequently, the appellant's return to Uganda might predispose her to abandonment by her family members, and society, which might impede her physiological well-being and, by extension, her quality of life. I do not accept the appellant would be abandoned by her family, who I have already said, have been supportive in the past. Mr Ntung concludes that in his opinion, the appellant is likely to face various treatments that could

mount to persecution as highlighted and recognised in the COI such as the impact felt by some claimants arising from the harm and discrimination inflicted upon them by external sources.

101. Having carefully considered all the evidence before me, I have stood back and considered whether the treatment the appellant fears on return to Uganda, passes the threshold test of being sufficiently serious or severe to constitute persecution within the meaning of the Geneva Convention. I do not accept the appellant has established, even to the lower standard, a well-founded fear of being persecuted for membership of a particular social group. Lord Hope said in HJ Iran, that family or social disapproval in which the state has no part, lies outside the protection of the Refugee Convention. In my judgment, the evidence does not establish that the appellant will be at risk of persecution or ill-treatment by the Ugandan state or non-state actors but demonstrates the difficulties that are likely to arise from lack of access to medical treatment/healthcare services as someone with sickle cell anaemia and mental health problems with symptoms exhibited by the appellant. I am not satisfied the threshold for establishing persecution has been crossed on the evidence before me. The appellant may well face some discrimination, but the discrimination does not arise from a legal or administrative measure implemented by the state that is implemented in a discriminatory manner. On the evidence before me I find that the ill treatment the appellant fears for reason of her membership of a particular social on return to Uganda, is not sufficiently serious to amount to persecution within the meaning of the Refugee Convention.

102. It follows that in my judgment, the appellant has not established that she is a refugee, and her appeal is dismissed.

NOTICE OF DECISION

103. The appeal is dismissed on Asylum grounds.

Signed **V. Mandalia** Date 28th March 2022

Upper Tribunal Judge Mandalia