Analysis of Case Law (2006–2026)



Asylum Applicants with Medical Conditions

November 2026

EUROPEAN UNION AGENCY FOR ASYLUM

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Note

The cases presented in this report are based on the EUAA Case Law Database, which contains summaries of decisions and judgments related to international protection pronounced by national courts of EU+ countries, the Court of Justice of the EU (CJEU) and the European Court of Human Rights (ECtHR).

The database serves as a centralised platform on jurisprudential developments related to asylum, and cases are available in the Digest of cases (all registered cases presented chronologically by the date of pronouncement) and the Search page.

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Methodology

This report presents judgments and decisions pronounced by national courts of EU+ countries, the Court of Justice of the EU (CJEU), the European Court of Human Rights (ECtHR) and the UN treaty bodies concerning different aspects of the international protection procedure involving applicants with serious somatic and psychiatric disorders. Cases concerning medical conditions in detention, the transfer of beneficiaries of international protection between Member States and cases concerning humanitarian or national forms of protection for rejected asylum applicants with a medical condition are largely out of the scope of this report. However, the latter are considered, when relevant, in Section 6 on returns.

The report follows the medical categorisations of the International Classification of Diseases (ICD-11) by the World Health Organisation (WHO) and the selected cases cover 2006-2026. The examples are not exhaustive but provide a comprehensive overview of the main trends and challenges faced by national and European courts when examining cases concerning an applicant for international protection with a medical condition.

The cases are drawn from various sources, including EUAA networks of asylum officers, judges, members of courts and tribunals, independent experts and civil society organisations. We are grateful for their time and effort in sharing this jurisprudence.

Introduction



Courts play a central role in aligning human rights law with the rules of the Common European Asylum System (CEAS) when it comes to establishing standards and safeguards for asylum applicants with a serious medical condition. Medical conditions may give rise to special procedural needs and they impact the rights and obligations of applicants at each stage of the asylum procedure.

This report explores areas in which medical conditions may have an impact on international protection procedures by analysing the landmark jurisprudence from the European Court of Human Rights (ECtHR) and the Court of Justice of the European Union (CJEU), and case law across EU+ countries (EU Member States, Iceland, Norway and Switzerland). In addition, the report includes selected decisions from the UN Human Rights Committee, the UN Committee on the Rights of Persons with Disabilities (CRPD) and the UN Committee against Torture (CAT).

The ECtHR landmark ruling of *Paposhvili v Belgium* (Grand Chamber, No 41738/10, 13 December 2016) established that removing a seriously ill person may violate Article 3 of the European Convention if it would cause a risk of a serious, rapid and irreversible decline in health, resulting in intense suffering or a significant reduction in life expectancy. The high threshold developed in this case was then confirmed for mental illnesses in *Savran v Denmark* (Grand Chamber, No 57467/15, 7 December 2021), and although it was initially developed for removals to third countries, it inspired the CJEU standards for the transfer of applicants for international protection between EU+ countries (*C.K. and others v Slovenia*, C-578/16 PPU, 16 February 2017).

Furthermore, ECtHR case law on the removal of rejected applicants for international protection shaped the principles and procedural safeguards related to the assessment of medical evidence, standards of proof and the shifting of the burden of proof (*RJ v France*, No 10466/11, 19 September 2013).

On the other hand, CJEU jurisprudence established that although it is generally for the applicant to submit all elements needed to substantiate the application, even when they have a medical condition, and if they fail, it is the duty of the Member State to cooperate actively with the applicant when the elements provided are not complete, up to date or relevant (*M.M. v Minister for Justice, Equality and Law Reform*, C-277/11, 22 November 2012, concerning Directive 2004/83; *Ramodi and Karkik*, C-7/25 and C-8/25, 12 November 2026, concerning Directive 2011/95/EU). After *M.M.,* subsequent CJEU case law extended the investigative obligation of authorities to include ordering medical examinations for the applicant where there is evidence of mental health problems resulting potentially from a traumatic event which occurred in the country of origin and the use of a medical report is necessary or relevant (*X v International Protection Appeals Tribunal, The Minister for Justice and Equality, Ireland, The Attorney General,* C-756/21, 29 June 2023), and also clarified that national courts of first instance must have the power to order a medical examination of the

applicant when they consider it to be necessary or relevant for the assessment of the application (*B.F. v Kypriaki Dimokratia [Barouk]*, C-283/24, 3 April 2025).

This jurisprudence has inspired some of the provisions which were included in the EU Pact on Migration and Asylum, extending the protection afforded to applicants with special procedural or reception needs. In this new body of EU legislation, to identify vulnerabilities, including any medical conditions, the Screening Regulation provides preliminary health and vulnerability checks (Article 12), as part of screening that must be completed within 7 days at the external border or within 3 days within the territory (Article 8) before an applicant is channelled to the asylum or the return procedure.

Importantly, the Asylum Procedures Regulation (APR) strengthened procedural safeguards through Article 20(3). It introduced a mandatory 30-day deadline to assess in-depth if an applicant for international protection has special procedural needs, with the assessment beginning as early as possible after the application is made. The assessment may be based on visible signs, the applicant's statements or behaviour, or any relevant documents, and the competent authority may refer the applicant, subject to their prior consent, to a medical practitioner or psychologist for advice (Article 20(2) and (4)). The assessment must be reviewed where the applicant's circumstances change or where, after it has been completed, the need for special procedural guarantees becomes apparent (Article 20(3)).

Once a medical condition is identified, which renders the applicant in need of special procedural guarantees, Article 21(1) of the APR requires authorities to provide support to ensure that an applicant can present all relevant elements of their claim for international protection. The APR also requires Member States to exempt applicants from accelerated and border procedures if the necessary support cannot be provided (Article 21(2)) or when medical reasons, including mental health, require an exemption (Article 53(2)(c) concerning medical reasons for not applying the border procedure, including mental health reasons; and Article 53(2)(d) which excludes the border procedure where the necessary support cannot be provided to applicants in need of special procedural guarantees).

In addition, the Asylum and Migration Management Regulation (AMMR) built on the CJEU's *C.K.* jurisprudence and switched from the 'systemic flaws' requirement under the Dublin III Regulation to providing that a transfer cannot take place to the Member State identified as responsible to examine the application if there is a real risk of exposing the person to inhuman or degrading treatment (Article 16(3)).

Nonetheless, challenges remain at the national level. Not all European jurisprudence was codified in the Pact and there are still aspects which have not yet been reviewed by European courts, which may be applied differently across national courts of EU+ countries. Furthermore, the inherent nature of cases concerning medical conditions pose challenges to the authorities and to judges, since the effects of certain somatic or psychiatric disorders may be difficult to fully understand, rendering the assessment of the risk of being exposed to inhuman or degrading treatment for this category of applicants intrinsically difficult.

First, the report looks at how national courts interpret threshold criteria for the severity of a disease that would prevent a transfer from taking place to the responsible Member State. The report also examines the duty to exchange information with the receiving Member State and any heightened precautionary measures which should be in place to carry out the transfer *(see Section 1).*

The analysis of jurisprudence also provides a comparative assessment of what forms of protection are recognised for applicants based on their medical condition. A medical condition does not constitute one of the five grounds of persecution, but refugee status based on membership of a particular social group or subsidiary protection due to a risk of deterioration of health as a result of an intentional deprivation of healthcare may be provided *(see Section 2).*

There are many evidentiary challenges that applicants, authorities and courts face in medical asylum claims, as well as a variety of procedural safeguards that must be ensured for applicants with a medical condition throughout the asylum procedure *(see Section 3).* On the burden of proof, balancing the applicant's duty to cooperate and provide medical certificates with the state's duty to investigate is an area in which jurisprudence reveals that it is not easy to have a unified approach in national systems that are organised differently from one another, with more or less reliance on state medical institutions or private independent bodies.

The report also explores the authority's obligation to provide adequate medical care in reception and the limits of that obligation *(see Section 4)* and looks at how medical conditions may impact the rights related to family reunification of beneficiaries of international protection *(see Section 5).*

Finally, the standards for a return to a country of origin are considered (Section 6), in particular the severity of a disease that would prevent a return to a country of origin, how courts assess the factors that are relevant to determine availability and accessibility of healthcare in a country of origin, and the challenging task of predicting future health degradation by both authorities and courts.

While most of the jurisprudence examined in this report was pronounced before the Pact on Migration and Asylum came into application on 12 June 2026, the case law under analysis follows the standards set by the CJEU and ECtHR, which were in large part codified in the Pact instruments, making this jurisprudence even more relevant for future cases.

Topic and location in report	Test/principle applied	Authoritative jurisprudence
Transfer to responsible Member State (Section 1)	Real and proven risk of a significant and permanent deterioration of health; transfer suspended while the person is unfit.	CJEU, *C.K.*, C-578/16 PPU
Refugee status (Section 2.1)	Particular social group: shared characteristic and distinct identity in the country of origin.	CJEU, *X, Y and Z*, C-199/12 to C-201/12
Subsidiary protection, Article 15(b) **(Section 2.2)**	Intentional deprivation of health care by an actor of serious harm.	CJEU, *M'Bodj*, Grand Chamber, C-542/13 CJEU, *MP*, C-353/16
Subsidiary protection, Article 15(c) **(Section 2.3)**	A serious illness may be a personal circumstance that increases exposure to indiscriminate violence	CJEU, *Elgafaji*, Grand Chamber, C-465/07 CJEU, *X, Y and their six children v State Secretary for Justice and Security*, C-125/22
Asylum procedures **(Section 3)**	Medical evidence must be assessed as part of the credibility assessment, not after it. The duty of cooperation may require the determining authority to obtain a medico-legal report where there is evidence of mental health problems potentially resulting from a traumatic event in the country of origin and such a report is necessary or relevant. A court of first instance must have the power to order a medical examination and must carry out a full and *ex nunc* examination regardless of the grounds raised in the appeal. A medical certificate whose findings create a strong presumption of ill-treatment requires the authorities to dispel the doubts it raises.	CJEU, *X*, C-756/21 CJEU, *B.F [Barouk],* C-283/24 CJEU, *Ramodi and Karkik*, C-7/25 and C-8/25
Reception conditions **(Section 4)**	Whether the authorities, once aware of the medical needs, took all reasonable medical measures.	ECtHR, *E.F. v Greece,* No 16127/20 citing Yoh-*Ekale Mwanje* v *Belgium*, No 10486/10
Returns **(Section 6)**	ECtHR: Risk of serious, rapid and irreversible decline in health resulting in intense suffering, or significant reduction in life expectancy; then availability and accessibility of treatment; then individual assurances if serious doubts persist. CJEU: Serious risk of grave and irreversible deterioration of health (remedy with suspensive effect); rapid, significant and permanent increase in pain.	ECtHR, *Paposhvili,* No 41738/10, and *Savran,* No 57467/15, Grand Chamber judgments CJEU, *Abdida*, Grand Chamber, C-562/13 CJEU, *LM*, C-402/19 CJEU, *X*, Grand Chamber, C-69/21

1. Dublin transfers of applicants with a medical condition



A transfer to the Member State responsible for the assessment of an asylum application operates under the principle of mutual trust. This is based on an understanding that all EU Member States offer similar conditions to applicants for international protection as their systems are presumably in line with EU asylum law and human rights safeguards.

The Dublin III Regulation did not specify when a transfer could take place due to a medical condition, but Article 3(2)(2) set up a framework that allowed for such cases. It provided that a transfer is not possible when there are systemic deficiencies in the asylum procedure or reception conditions of the responsible Member State, which would expose the person to a risk of inhuman or degrading treatment within the meaning of Article 4 of the EU Charter. The CJEU's jurisprudence in the landmark case *C.K. and others v Slovenia* established that even where there are no systemic deficiencies, the transfer of an applicant with a particularly serious mental or physical illness would amount to inhuman or degrading treatment if it would result in a real and proven risk of a significant and permanent deterioration of health. Where that risk cannot be excluded by precautions, the transfer must be suspended for as long as the applicant is unfit to be transferred.

This judgment is reflected in the AMMR, which shifts the focus from proving systemic flaws in the asylum or reception system of the receiving country to a focus on the individual and the risk of a severe deterioration of their health. The AMMR now provides that a transfer cannot take place to the Member State responsible if there is a real risk of exposing the person to inhuman or degrading treatment (Article 16(3)).

In addition, the judicial review of a transfer of a person with a medical condition takes into account general principles from human rights law, which include the best interests of the child, family unity and the child's developmental needs.

This section outlines the standard-setting jurisprudence of the CJEU and the threshold of serious illness, especially in cases concerning transfers of applicants with a psychiatric condition, how national courts have applied the obligation to exchange information between Member States, the court's assessment of precautionary measures to carry out a transfer and the quality and depth of individual guarantees which are provided. It explores also the burden of proof and evidentiary considerations and shows that cases involving psychiatric conditions are most demanding, both in terms of evidence and precautionary measures.

1.1. CJEU landmark rulings

The CJEU had a significant role in clarifying that systemic flaws in the responsible Member State (Article 3(2)(2) Dublin III Regulation) is not the only factor that can suspend a transfer (*C.K. and others v Slovenia*, C-578/16 PPU, 16 February 2017). The grounds that preclude a

transfer must extend also to situations when an applicant suffers from a health condition, whether somatic or psychiatric. The CJEU decision followed the standard-setting jurisprudence of the ECtHR in *Paposhvili* v *Belgium* (No 41738/10, 13 December 2016; see Section 6.1), which was aimed to returns to third countries.

C.K. and others v *Slovenia*, C-578/16 PPU, 16 February 2017

This landmark ruling established that **the transfer of an asylum seeker with a particularly serious mental or physical illness which would result in a real and proven risk of a significant and permanent deterioration of the applicant's state of health would constitute inhuman or degrading treatment**. The authorities must eliminate any serious doubts about the impact of the transfer by taking the necessary precautions; where those precautions are not sufficient, the transfer must be suspended for as long as the applicant is unfit to be transferred.

In this case, there were no indications of systemic deficiencies in Croatia, the responsible Member State, which had also assured the Slovenian authorities that the applicants would receive accommodation, adequate care and the necessary medical treatment.

The case concerned a woman who had given birth after a high-risk pregnancy and was soon after diagnosed with post-natal depression and periodic suicidal tendencies. The psychiatrist found that the deterioration in her psychological state could result in aggressive behaviour towards herself and others, which may require hospital care. The psychiatrist advised that the applicant and her child remain at the reception centre in Ljubljana to receive care. According to several medical opinions, her poor state of health was mainly caused by uncertainty regarding her status and the resulting stress.

The ruling clarifies **evidentiary standards**, sets out the **obligations** of Member States and the **precautionary measures** to take to avoid inhuman or degrading treatment during and after a transfer.

The CJEU noted that the authorities and courts cannot ignore **objective evidence** provided by an applicant, such as medical certificates, showing the seriousness of the state of health and the significant and irreversible consequences to which the transfer may lead. When such evidence is presented, certain **obligations are triggered for the Member States**:

- To assess the risk that such consequences could occur when deciding on the transfer or, in the case of a court, when reviewing the legality of the transfer decision;
- To carry out a thorough assessment to dispel any serious doubts about the impact of the transfer on the state of health of the person; and
- To consider all significant and permanent consequences that may arise from the transfer.

In the case of serious psychiatric illnesses, it is not sufficient to consider only the consequences of physically transporting the person from one Member State to another. The authorities must verify if the state of health of the person can be protected appropriately and sufficiently through precautionary measures and if so, implement **precautionary measures before, during and after a transfer**:

- **Before a transfer:** The transferring Member State must communicate the applicant's state of health to the responsible Member State within a reasonable time before the transfer, including relevant aspects of the illness and care required so that immediate healthcare is provided after the transfer (codified in Article 50 of the AMMR, which provides that information shall be transferred through a common health certificate with

the necessary documents attached, with the explicit consent of the applicant or of the representative; lack of consent or refusal to consent does not prevent the transfer);

- **During a transfer**: The transferring Member State must ensure that the applicant is accompanied during transportation by adequate medical staff with the necessary equipment, resources and medication to prevent the worsening of the condition or violence towards themselves or others;
- **After a transfer** (continuity of healthcare): The transferring Member State must be able to ensure that the applicant receives care upon arrival in the responsible Member State.

Importantly, where precautions are not sufficient, the authorities must suspend the transfer for as long as the state of health renders the applicant unfit for a transfer. If the transfer still takes place in such exceptional circumstances, the resulting inhuman and degrading treatment would be attributable solely to the first Member State, not to the Member State responsible under the Dublin III Regulation.

The CJEU increased protection for the fundamental rights of applicants with a medical condition, on the basis of Article 4 of the EU Charter, interpreted in line with Article 3 of the ECHR and the *Paposhvili* judgment, but it also set certain **limits**:

- The CJEU emphasised the exceptional character of the situation, so only very serious risks of a violation of an absolute right would prevent a transfer; still, both somatic and psychiatric conditions could lead to such a risk.
- The threshold is high; a Dublin transfer must not proceed if it poses a 'real and proven risk' of 'significant and permanent' deterioration of health. Conversely, a transfer would not be suspended for every instance of a deterioration of health.
- The CJEU recalled the strong presumption that the medical treatment offered to applicants in the Member States will be adequate, since they are bound by the reception directive to provide the necessary health care. However, it acknowledged that, for certain acute and specific illnesses, appropriate treatment may be available only in certain Member States and that the transfer of a person whose state of health is particularly serious may in itself result in a real risk of inhuman or degrading treatment, irrespective of the quality of the reception and the care available in the Member State responsible.

There is also an **important consequence** that flows from the impossibility to carry out the transfer of an applicant due to a medical condition:

- If the state of health is not expected to improve in the short term, or the suspension for a long period would risk worsening the condition of the applicant, the requesting Member State **may examine** the application by making use of the discretionary clause in Article 17(1) of the Dublin III Regulation;
- **If the transfer deadline expires, responsibility would transfer automatically** to the requesting Member State (see now Article 46(2) of the AMMR).

A second CJEU ruling shed light on the impact of **non-voluntary psychiatric hospitalisation** ordered while the time limit is approaching for a transfer to the responsible Member State (*IA v Bundesamt für Fremdenwesen und Asyl (BFA, Austria)*, C-231/21, 31 March 2022).

***IA* v *Bundesamt für Fremdenwesen und Asyl (BFA, Austria)*, C-231/21, 31 March 2022**

The CJEU ruled that extending a Dublin transfer deadline (within the meaning of Article 29(2) of the Dublin III Regulation) is possible in case of imprisonment, only when an applicant is imprisoned in the context of criminal proceedings for committing an offence. Psychiatric detention, even when ordered by a court, does not extend the time limit. As a result, transfers may become time-barred during the necessary psychiatric treatment.

The case concerned a Moroccan applicant who was going to be transferred from Austria to Italy but was committed to a psychiatric hospital in Vienna. Austrian authorities then informed the Italian authorities that the time limit was extended from 6 months to 1 year, based on Article 29(2) of the Dublin III Regulation (extension of the time limit if a transfer cannot be carried out due to imprisonment). The applicant claimed that the transfer which took place after the 6-month period was unlawful.

1.2 Application of the *C.K.* standards by national courts

National courts have applied the standards set by CJEU jurisprudence in *C.K.* when examining whether applicants with a medical condition can be safely transferred to the responsible Member State and if their medical condition would be given due consideration without discrimination when compared to nationals of the Member State, and have access to medical treatment after the transfer. These aspects, together with the burden of proof and evidentiary aspects, are examined in Sections 1.2.1-1.2.6.

1.2.1. Serious illnesses and serious risk of permanent deterioration of health

National courts have confirmed the high threshold provided by the CJEU in *C.K.,* noting that a transfer is not suspended for every type of serious illness or deterioration of health.

For example, a risk of suicide is not in itself a basis to suspend a transfer. In a case concerning an Afghan applicant with post-traumatic stress disorder (PTSD) and a high risk of suicide, the Swiss Federal Administrative Court (FAC) considered that the applicant's medical condition did not reach the threshold for a violation of Article 3 of the ECHR as applied by the ECtHR in *Paposhvili v Belgium* to render the transfer illegal from the outset (F-4128/2021, 10 March 2023). It did however annul the decision on a Dublin transfer to Croatia due to an insufficient factual assessment of the medical condition. The applicant's health had seriously deteriorated as she was hospitalised four times in 1 year, could not live without antidepressants and was under psychiatric follow-up. Travel was not contraindicated according to the latest medical document, but the risk of suicide persisted and she required ongoing, extensive medical care.

The same court assessed a case concerning a Guinean applicant with anxiety, sleep disorders, PTSD, moderate depressive episodes and lumbar pain, and confirmed the Dublin

transfer decision to Spain (F-5575/2020, 16 November 2020). One of the medical documents referred to mental health deterioration and self-harming thoughts, but FAC concluded that the conditions would not lead to a serious risk of a permanent deterioration of the applicant's state of health. Based on the medical certificates submitted on appeal, FAC observed that the applicant had been prescribed medication to treat the conditions and had regular check-ups. It considered that from a medical point of view the applicant did not need to stay in Switzerland and could treat the conditions in Spain. In addition, the applicant failed to show how a transfer would seriously jeopardise his health.

Similarly for somatic conditions, the Supreme Administrative Court in Czechia considered that the transfer of an applicant who underwent a retroperitoneal lymphadenectomy, received chemotherapy and had a spinal injury would not constitute inhuman or degrading treatment. However, echoing *C.K.*, the court emphasised that the state of health is dynamic, can change over a period of time and advised the authorities to monitor the progress of the applicant until the transfer would take place and reconsider it if the medical evolution would indicate a risk of ill treatment (1Azs 398.2017, 7 December 2017).

However, in Italy, the Tribunal of Rome annulled the Dublin transfer to France of an applicant suffering from a severe form of PTSD with self-harming behaviour, for which he was receiving psychiatric and pharmacological treatment, and the Supreme Court of Cassation rejected the appeal of the Ministry of the Interior as inadmissible and found that the *C.K.* principles were applicable. The Supreme Court of Cassation noted that the tribunal had not treated the state of health as automatically precluding the transfer but examined the nature and seriousness of the condition and concluded that the state of health was incompatible with a transfer, given the potential deterioration stemming from past trauma and a preexisting psychiatric condition, as well as from uncertainty surrounding the applicant's status (No 18927/2024, 5 April 2024).

To suspend a transfer, the threshold is set high with serious illnesses and serious risk of a permanent deterioration of health. Therefore, cases involving suicide risk and psychiatric conditions with ongoing specialised treatment often require psychiatric expert evidence to rule on the legality of the transfer decision. This approach may differ from somatic cases, in which existing medical records may suffice (e.g. for cardiovascular or musculoskeletal diseases) to determine if a permanent deterioration of health would take place. On the other hand, in somatic cases, the assessment focuses on the continuity of medical treatment, while in psychiatric cases, there may be added dimensions, such as whether the transfer is to a location that led to trauma, has specific environmental triggers (flashbacks) or interrupts therapy treatment. Thus, an individual assessment of the case is needed and there are no prescribed formulas that would determine whether the transfer is annulled or suspended simply based on whether the condition is somatic or psychiatric.

1.2.2. Provision of healthcare in the responsible Member State

In addition to assessing the seriousness of the condition, courts look at whether due consideration will be given by the responsible Member State to the medical condition after a transfer and whether care will be provided. In March 2025, the Czech Regional Court in Brno annulled the transfer to Poland of a Ukrainian applicant with a spinal injury and paraplegia in the lower limb. It concluded that the information obtained by the ministry on the treatment of

applicants with disabilities in Poland was insufficient. The court noted that it was not clear what 'partial accessibility' for persons with disabilities entailed in practice in the reception centre of Biała Podlaska, and that in their response, the Polish authorities had not described whether personal assistance to persons with disabilities was sufficiently provided. Furthermore, the court noted statements from the Commissioner for Human Rights which indicated limited readiness from the Polish authorities to accommodate persons with disabilities. Based on this, the court remanded the case back to the administrative authority for further investigation (41 Az 3/2025-236, 28 March 2025).

The Slovenian Supreme Court considered that a transfer was possible to Croatia in April 2024 in a case concerning an applicant with chronic hallucinatory psychosis (VS00075109, 22 April 2024). The court considered that the applicant had access to the required medical treatment and care in Croatia (regular check-ups and Abilify medication), though it referred the case back to the lower court to ensure evidentiary safeguards and to clarify the claims about a permanent deterioration of health by appointing medical experts.

A similar conclusion was reached in March 2024 by the Icelandic Immigration Appeals Board through a structured approach (No 287/2024). The case involved a Palestinian child with Duchenne Muscular Dystrophy who could benefit from procedural safeguards and adequate medical assistance in Spain. The Appeals Board reviewed extensive information and medical evidence to conclude that Spain was leading research into this disease, and the child would have access to hospitals specialising in the treatment of the illness and access to medicines according to the list of available medications in Spain, although he would have to pay for the medical services. Icelandic legislation states that a treatment is not considered to be inaccessible if an applicant must pay for it. The board also analysed the current stage and required treatment for the condition of the applicant. Although the child had been advised to undergo gene therapy and was taking the steroid Prednisolone to help with mobility, he was not under any special supervision or treatment for Duchenne Muscular Dystrophy in Iceland. Thus, the child was not struggling with a sudden and life-threatening illness for which treatment was only available in Iceland and not in the receiving state. After examining whether there was any discrimination in receiving the required medical services in the receiving state, the board did not find evidence that the applicant would face difficulties in Spain or have significantly worse access to healthcare than Spanish nationals.

Finally, the Federal Administrative Court in Switzerland highlighted the role and expertise of non-governmental organisations that provide care in reception centres (F-1301/2025, 8 December 2025). The court confirmed a transfer to Romania of an applicant who had attempted suicide upon being escorted for a transfer, as it noted that the Romanian medical infrastructure provided sufficient access to healthcare. The court considered in particular the role of the ICAR Foundation, which had long-term expertise and offered psychological care for victims of torture and trauma in asylum reception centres.

1.2.3. Information exchange as part of the duty to investigate the availability of medical treatment and care in the receiving state

Two separate aspects of the obligation to inform and exchange health information were examined: whether the determining authority must contact the receiving authorities before deciding and the consequences of omitting known health information from the transfer forms.

On the first aspect, the Icelandic Immigration Appeals Board clarified in March 2024 that the duty to investigate does not require the determining authority to contact the receiving authorities directly to obtain information about the applicant's access to essential social and health services and the willingness of the authorities to provide these services (No 287/2024). According to the Appeals Board, deficiencies in pre-transfer communication may be remedied at the appellate stage.

On the second aspect, procedural deficiencies in information-exchange between Member States prior to a transfer was sufficient to preclude a transfer according to the Administrative Tribunal of Luxembourg (Case No 53015, 25 June 2025). The court decided to annul a Dublin transfer to Bulgaria for an applicant who suffered from a mental health condition (reactive depressive mood, anxiety, stress-induced psoriasis, persistent depressive symptoms and suicidal ideation) on the grounds that the Luxembourgish authorities did not include the applicant's mental health information in the transfer forms, although they were aware of it through medical documents and family notifications.

1.2.4. Heightened precautionary measures to carry out a transfer

The Swiss Federal Administrative Court has stressed that applicants with a psychiatric condition which require ongoing specialised care need heightened precautionary measures to carry out a transfer, beyond the standard measures set out in *C.K*. Precautionary measures include immediate psychiatric follow-up after the transfer has taken place, supervision at all times and continuous communication between the two national authorities.

This was noted by the Swiss Federal Administrative Court when it annulled the decision to transfer to Croatia, and referred the case back to the State Secretariat for Migration (SEM), in the case of an applicant with PTSD and at high risk of suicide, in addition to returning to a country where she alleged sexual violence (F-4128/2021, 10 March 2023). The court considered the elements to be 'very specific and exceptional', which required a specific framework beyond standard accompanying measures. For any future transfer, the court required as instructions binding on SEM, the presence of a Swiss medical team to supervise the applicant continuously during the execution of the transfer, immediate psychiatric follow-up upon arrival (noting that merely communicating to the receiving authorities the applicant's medical condition was not sufficient) and continuous administrative communication. Importantly, FAC acknowledged that the applicant's therapists should prepare her for the transfer, but this was not enough.

Questions on whether the adoption of precautionary measures is sufficient to preclude the risk posed by the transfer or whether the entire impact of the transfer decision, and not merely the impact of the actual transfer, must be assessed when an appeal is lodged against the

transfer decision, were raised before the CJEU by the District Court of the Hague, seated in Roermond (NL23.17939, 22 October 2025; registered before the CJEU under C-675/25, Abrazov). The Dutch court noted that receiving a transfer decision or the suspension of the transfer may in itself entail a real and proven risk of a substantial and irreversible deterioration of the applicant's state of health, or at least contribute significantly to such deterioration. Thus, the question is raised as to whether a court must consider *ex officio* other elements besides the precautionary measures.

The EUAA Recommendations on Transfers under the Asylum and Migration Management Regulation (1 October 2026) are relevant in this area.

1.2.5. Quality and depth of individual guarantees

The requirement of individual guarantees originates in the ECtHR's Grand Chamber judgment in *Tarakhel v Switzerland* (No 29217/12, 4 November 2014). The ECtHR ruled that there would be a violation of Article 3 of the European Convention if a couple and their six minor children were returned to Italy under the Dublin II Regulation without the Swiss authorities having first obtained individual guarantees from Italy that the applicants would be taken charge of in a manner adapted to the age of the children and that the family would be kept together.

The quality and depth of individual guarantees are relevant to decide whether a transfer can take place. In a case involving an applicant suffering for more than 10 years from paranoid schizophrenia, the Administrative Court of Slovenia held that a letter of acceptance of responsibility from Croatia requesting prior notification of health issues did not constitute an individual guarantee of adequate medical care before the transfer could proceed (UP00085385, 11 March 2025).

Similarly, the Regional Administrative Court of Braunschweig in Germany considered that individual guarantees were not met and annulled a decision on a Dublin transfer to Croatia of a mother and her child with a severe disability due to epilepsy (2 A 26/22, 24 May 2022). In their reply letter, the Croatian authorities mentioned that the applicants would be granted access to the international protection system and accommodation, their human rights would be respected, Croatia respects the *non-refoulement* principle and it is the only Member State with an independent mechanism to monitor the behaviour of police officers of the Ministry of the Interior in the field of international protection. The court highlighted that this letter did not meet the criteria of an individual declaration of guarantee in favour of the applicants as it only provided general statements, did not address the fact that the applicants were Dublin returnees who have been already victims of police violence in Croatia, and most importantly, the applicant's child required particularly protected accommodation and medical care.

1.2.6. Burden of proof and evidentiary considerations

1.2.6.1. Shifting burden of proof

According to the Dutch Council of State, in cases involving the transfer of applicants with a medical condition, it is for the asylum applicant to substantiate that the medical care required for their serious physical or mental condition is lacking in the Member State responsible. This then shifts the burden of proof to the state to show that the respective medical care is actually

available. This was confirmed in a judgment from February 2022 (202100625/1/V3) where the council noted that an annual AIDA update report submitted by the applicant was concrete evidence that, in practice, there were no specialised Eye Movement Desensitisation and Reprocessing (EMDR) treatments available in Malta for trauma victims. This shifted the burden of proof to the state to demonstrate that the care in Malta was adequate. The court noted that the state's references to web pages of the Maltese Ministry of Health and EMDR-Europe were insufficient, as the first web page was inaccessible and the second merely stated that Malta was one of the members of EMDR-Europe, which was not sufficient to show that EMDR therapy or other appropriate treatment options were available for the foreign minor in Malta or that she would actually have access to them as a Dublin claimant.

1.2.6.2. Heightened duty to investigate in cases of seriously ill children

For the Dublin transfer of seriously ill children, the Dutch Council of State has stressed the need for a more proactive investigation by authorities and the obligation to give accompanied children under 12 years the opportunity to express their views freely (Dutch Council of State, 202404064/1/V3, 20 August 2025). In another judgment, the same court noted that, in view of the child's best interests, a more active attitude is expected from the authorities when investigating the available treatment options (202100625/1/V3, 24 February 2022).

1.2.6.3. Use of objective evidence within the meaning of *C.K.:* Medical evidence and expert testimonies

In terms of investigative standards in cases involving psychiatric conditions, psychiatric expert testimony is heavily relied on during appeal proceedings, along with opinions of medical advisory bodies. This was illustrated by judgments in Slovenia from the Administrative Court, in the case of an applicant who suffered for more than 10 years from paranoid schizophrenia and did not suffer acute psychosis prior to the transfer (UP00085385, 11 March 2025) and from the Supreme Court, in a case where the authority failed to appoint medical experts to assess an applicant with chronic hallucinatory psychosis (VS00075109, 22 April 2024). Both judgments highlight the role of medical certificates and expert testimonies as objective evidence when deciding on a transfer, considering the CJEU judgment in *C.K.*

In contrast, the Dutch Council of State did not consider objective evidence within the meaning of *C.K.* to include a father's statement that the eldest child had threatened suicide and had nightmares upon learning of the transfer decision to Croatia (202404064/1/V3, 20 August 2025). The court held that the applicant must produce objective evidence, meaning medical evidence, showing the particular seriousness of the state of health and the substantial and irreversible consequences of a transfer. It emphasised that the minister was not under the obligation to medically examine children in view of a transfer, but at the same time, the court found that the minister was under the obligation to give accompanied children under the age of 12 the opportunity to express their views freely.

This section shows that the ECtHR's *Paposhvili* high threshold of serious illness and risk of permanent deterioration of health inspired the CJEU's *C.K.* high threshold for the transfer of applicants with a medical condition between Member States. It has permeated the area of Dublin transfers, going beyond the initial ruling related to returns to third countries. In the decisions examined, it is consistently applied by national courts, which regularly find that a transfer will not be suspended for every type of serious illness or deterioration of health.

While the quality and depth of individual guarantees provided by administrative authorities varied among Member States, national courts played a significant role at the appeal stage. Specifically, courts ensured that individual circumstances were genuinely considered in the guarantees and highlighted that general statements about access to the international protection system and accommodation were not sufficient.

The decisions examined addressed different aspects of the duty to inform and exchange health information: an Icelandic administrative appeals body held that deficiencies in pre-transfer communication may be remedied at the appellate stage, while a Luxembourg court annulled a transfer because known health information had been omitted from the transfer forms.

Currently, a pending referral to the CJEU highlights an area which may need further clarification, and that is if courts must consider *ex officio* the entire impact of the transfer decision (for example receiving a transfer decision) and not merely the impact of the actual transfer.

2. Grounds for international protection applied to applicants with a medical condition



Under the 1951 Refugee Convention, the recast Qualification Directive (QD) and the Qualification Regulation (QR), a medical condition does not constitute one of the five grounds of persecution. However, courts of EU+ countries have recognised that certain conditions may be socially stigmatising to such a degree in a country of origin that they warrant the designation of an applicant as a member of a particular social group within the meaning of Article 10(1)(d) of the recast QD and Article 10(1)(d) of the QR. In fact, Recital No 40 of the QR states that "depending on the circumstances, disability could be a characteristic for the purpose of defining a particular social group".

The CJEU judgment in *X, Y and Z* (C-199/12, C-200/12, C-201/12, 7 November 2013) was instrumental in this area as, although it concerned sexual orientation, it established the two cumulative conditions that must be met for membership of a particular social group:

- Members of the group share an innate characteristic, or a common background that cannot be changed, or 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 country of origin by virtue of that characteristic being perceived as different by the surrounding society.

As shown in this section, national courts have assessed whether these conditions apply to cases concerning applicants with HIV, albinism, developmental anomalies, diseases of the nervous system (for example epilepsy), psychiatric disorders and facial deformities as a 'common characteristic' or 'an inherent characteristic that cannot be disposed of'. Furthermore, national courts have considered paranoid schizophrenia to constitute "an immutable characteristic beyond the ability of the applicant to change". According to the courts, persecution of these profiles of applicants may be based on actions deriving from:

- Discrimination, social prejudice, stigma, isolation and ostracisation;
- The legal and policy frameworks in the country of origin, how they are applied in practice and whether they affect all spheres of an applicant's life; and
- Access to treatment.

In these cases, courts have also assessed the availability of an internal protection alternative. A few cases mentioned that applicants could not be expected to relocate internally due to widespread stigma associated with an illness. Under Article 8(5)(b) of the QR, the determining authority must take into account the personal circumstances of the applicant, including health, when assessing an internal protection alternative.

The EUAA Practical Guide on Membership of a Particular Social Group (second edition, 26 May 2025) applies the same structure to persons living with disabilities and illness *(see Section 4.5)*.

If the conditions to grant refugee status are not met, a person with a serious illness may qualify for subsidiary protection if they would face serious harm upon a return to their country of origin (Article 15, recast QD and QR). An individual may qualify for subsidiary protection if their state of health would deteriorate in the country of origin as a result of an intentional deprivation of healthcare (Article 15(b), recast QD and QR). This was established in the CJEU judgment in *M'Bodj* v *Belgium* (Grand Chamber, C-542/13, 18 December 2014), and its subsequent judgment in *M.P.* v *Secretary of State for the Home Department (UK)* (C-353/16, 24 April 2018) explained that the intentional deprivation of appropriate care for the physical and mental after-effects of torture are confirmed if national authorities of the country of origin are not prepared to provide for rehabilitation for a victim of torture at risk of suicide or it is apparent that they have a discriminatory policy on access to healthcare, making it more difficult for certain ethnic groups or certain groups of individuals to obtain access to appropriate care.

These CJEU standards have been frequently cited by national courts when applying the recast QD to applicants with a medical condition. Some courts did not apply the intentionality criterion altogether and focused directly on Article 3 of the ECHR or applied a cumulative approach by considering the individual vulnerability due to the medical condition, other individual factors and the situation of healthcare in the country of origin, which would collectively expose the applicant to inhuman or degrading treatment upon a return. The EUAA Practical Guide on Qualification for International Protection (9 June 2026, Section 5.2.2) also considers that the unavailability of appropriate healthcare is an important consideration for *non-refoulement* under Article 3 of the ECHR, but it does not fall under Article 15(b) of the QR unless the applicant is intentionally deprived of healthcare.

Article 15(b) was applied to applicants with lymphoma, severe spinal cord injuries, parasitic diseases, anxiety and mental health conditions. It was also applied with varied results to cases related to diabetes mellitus, and it was rejected in cases concerning applicants with chronic heart failure and psychotic disorders.

In addition, the serious illness may be one of the individual elements which, alone or taken cumulatively with others, expose a person to a serious and individual threat to their life in a context of indiscriminate violence (Article 15(c), recast QD). The CJEU judgments in *Meki Elgafaji and Noor Elgafaji* v *State Secretary for Justice and Security* (C-465/07, 17 February 2009) and *X, Y and their six children* v *State Secretary for Justice and Security* (C-125/22, 9 November 2023) are the most relevant on this topic. Regarding Article 15(c), the EUAA Practical Guide on Qualification for International Protection (9 June 2026, Section 5.3.4) lists health and disability among personal circumstances that may increase the applicant's exposure to indiscriminate violence.

To determine the need for international protection, an applicant's medical condition must be assessed in light of objective medical country of origin information (MedCOI) on the treatment of people with the particular medical condition in the country of origin. The cases examined in

this section show that national courts often consulted WHO reports, EUAA MedCOI reports and UNHCR Guidelines on International Protection No 2 (concerning membership of a particular social group)[1] to determine whether an applicant with a medical condition is perceived as different by the surrounding society in the country of origin and subsequently persecuted based on that.

While this report does not examine judgments analysing the application of Articles 12 (exclusion from refugee status) and 17 (exclusion from subsidiary protection) of the recast QD when an applicant suffers from a serious mental health condition, an analysis on this topic is available in EUAA's report on Interpretation and Application of Exclusion Grounds in International Protection: Analysis of case law (2020-2026) (September 2026).

Lastly, while explored in a limited manner under Section 6 concerning returns, some Member States also provide national forms of protection for seriously ill applicants, complementing the protection options under CEAS. For example, in the case of an applicant who had lived in Italy for 7 years, victim of labour exploitation and suffering from pseudoarthrosis, the Italian Supreme Court of Cassation ruled that the requirements for special protection (a national form of protection) must be assessed as a whole, not as isolated individual elements (No 27184/2024, 27 September 2024).

2.1 Refugee status: Membership of a particular social group for applicants with a medical condition

The case law concerning claims for refugee status examined below is grouped based on whether protection was provided or denied and by medical condition.

2.1.1 Infectious diseases: Human Immunodeficiency Virus (HIV) infection

HIV was recognised by the Belgian Council for Alien Law Litigation (CALL) as an "inherent characteristic that the applicant cannot dispose of", shared with other seropositive people as "a common medical history that cannot be undone" (No 258 932, 2 August 2021). The court noted that although being infected with HIV is not an innate characteristic, it does not result from common characteristics, is not related to sexual orientation and does not constitute a fundamental element of one's identity, still the two conditions in the CJEU jurisprudence concerning membership of a particular social group (*X, Y and Z*, C-199/12, C-200/12, C-201/12, 7 November 2013) are fulfilled for seropositive people, because the list of conditions provided in that jurisprudence is not exhaustive.

On the other hand, relying on the EASO Guidance on membership of a particular social group (March 2020), the Tribunal of Bologna considered in several judgments that since some conditions and serious illnesses, such as HIV/AIDS, could be considered a common background that cannot be changed, these applicants belong to the particular social group of

[1] UNHCR, Guidelines on International Protection No. 2: "Membership of a Particular Social Group" Within the Context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol Relating to the Status of Refugees, HCR/GIP/02/02, 7 May 2002.

HIV patients which are discriminated by the Nigerian society, in violation of their right to food, housing, study and work (4660/2022, 26 January 2024; 4109/2023, 21 March 2025).

National courts found, based on COI and the personal circumstances of the applicant, that seropositive persons were perceived differently in Angola (Italy, Tribunal of Bologna, 5571/2021, 12 July 2024), Côte d'Ivoire (Belgium, CALL, No 258 932, 2 August 2021; Italy, Tribunal of Bologna, 6216/2024, 26 September 2025), Nigeria (Italy, Tribunal of Milan, R.G.29929/2023, 3 July 2024) and Ukraine (Italy, Tribunal of Salerno, 4512/2022, 20 April 2022). For example, based on COI, the Tribunal of Milan concluded that an HIV infection was often associated with immoral behaviour, particularly linked to homosexuality, which is proscribed in Nigeria (R.G.29929/2023, 3 July 2024). The court noted that this leads to substantial social stigma, workplace discrimination, job loss, discrimination to access employment, denial of medical treatment, difficulty in accessing care, prolonged waiting times and high costs. Thus, the applicant was granted refugee status.

Similarly, the Tribunal of Salerno noted that seropositive individuals were exposed to discriminatory and stigmatising acts upon a return to Ukraine, resulting in hampered access to housing and the labour market, as well as the intentional refusal of life-saving treatment (4512/2022, 20 April 2022). Specifically, the court considered the EASO MedCOI Ukraine FFM Report: Healthcare reform and economic accessibility (February 2021) to confirm the frequent failure of medical professionals in Ukraine to uphold the confidentiality of medical diagnoses.

A cumulative approach was applied by the International Protection Administrative Court (IPAC) in Cyprus, which granted refugee status to a Guinean applicant because the cumulation of his health status (HIV-positive) and sexual orientation (homosexual) placed him within a particular social group which faced heightened risk (4676/22, 30 May 2025). In this case, COI confirmed that in Guinea homosexuality was criminalised and stigmatisation was widespread, including within healthcare services. The court noted that, while the availability of HIV treatment may exist in theory, practical access in Guinea was deeply limited by social discrimination, fear of exposure and systemic inadequacies. Therefore, a return would likely result in inhuman or degrading treatment, contrary to Article 3 of the ECHR.

2.1.2. Genetic disorders affecting the skin: Albinism

Albinism is a congenital disorder characterised by the partial or complete absence of melanin pigment in the eyes, hair and skin, which may cause vision problems and white or yellow hair, reddish, violet, blue or brown eyes, and pale skin. The condition has been recognised by some EU+ national courts as an innate characteristic that distinguishes albinos as members of a particular social group, for example in Cameroon, Egypt and Nigeria. Courts in Austria, France, Germany and Italy have recognised refugee status for albino applicants under Article 10(1)(d) of the recast QD.

When establishing membership in a particular social group, the French CNDA (16017097, 13 February 2017, concerning a Nigerian albino), the Italian Tribunal of Milan (No 11274/2021, 22 October 2022, concerning a Christian Copt Egyptian albino) and the German Administrative Court of Aachen (2 K 1175/10. A, 18 December 2012, concerning a Cameroonian albino applicant) set out two cumulative conditions: an innate, immutable characteristic of

missing skin pigmentation and a distinct identity because society perceives the albino group as different. In addition, the Austrian judgment of the Federal Administrative Court (I421 2199802-1, March 2019) addresses the issue of imputed membership and the aspect of being "perceived as different by the surrounding society", as the Nigerian applicant in the case did not have the typical albino profile. The applicant's skin was not uniformly white, only had whiter hands and feet, and suffered from nystagmus (involuntary side-to-side eye movement), but the court considered it plausible that Nigerian society would classify him as an albino even in the absence of a clear albino profile, as he was perceived as different give his lighter skin complexion and nystagmus.

Regarding the risk of persecution in the country of origin, the German Administrative Court of Aachen noted that, although not every single act suffered by the applicant could constitute persecution, taken cumulatively, they were so serious that they violated the applicant's human rights. Following a similar cumulative approach, the Tribunal of Milan noted that the acts of repeated discrimination, verbal aggression and social isolation suffered by the applicant in the past and the conditions under which he would find himself if returned constituted a serious violation of his fundamental human rights when analysed as a sum of several measures. Thus, while having a formal legislation in place, the tribunal considered that the Egyptian state lacked a regulatory system capable of substantially protecting the applicant. Lastly, the tribunal also considered the conditions the applicant would face upon return, namely isolation, barriers to education and employment, as part of that cumulative assessment.

The judgments also consistently found that legal protection in the country of origin does not automatically translate into effective protection, especially for Cameroon and Egypt, while for Nigeria the Austrian Federal Administrative Court assumed that the authorities were generally willing and able to protect against actions of non-state actors, but departed from this conclusion because the applicant had been detained by police on account of his appearance.

2.1.3 Diseases of the connective tissue: Visible facial deformities

Other medical conditions considered to satisfy the first limb of membership of a particular social group test include visible facial deformities, neurofibromatosis, epilepsy, schizophrenia and schizoaffective disorder in cases from Belgium and Italy.

While it could not be deduced from the evidence submitted that all people with visible facial deformities are systematically considered witches and persecuted as a group for that reason in Côte d'Ivoire, CALL ruled that an applicant had a well-founded fear of being persecuted for being considered a witch due to her facial deformities (No 307 471, 29 May 2024). The court noted that it could not be excluded that the applicant would not be accused of sorcery and persecuted, as she was in a precarious situation, without social or family support, in the process of divorce, seriously ill, a mother of two young children, perceived as 'cursed' by close relatives, with visible symptoms such as 'red and bulging eyes', suffering from frequent loss of consciousness, paralysis and with a permanently impaired speech.

To establish membership of a particular social group, CALL noted that people suffering from mental conditions and severe and visible physical disorders share a common characteristic and are perceived as different by Ivorian society. It held that the applicant had sufficiently

established that, due to her visible physical deformities and psychological issues, she was perceived as a witch and was at risk of being exposed to harmful practices and intersecting forms of discrimination upon a return.

2.1.4. Developmental anomalies: Neurofibromatosis

The profound societal stigma surrounding visible skin tumours caused by neurofibromatosis Type 1 led the Tribunal of Milan to conclude that a Nigerian applicant belonged to a particular social group and upon a return would face treatment amounting to persecution (23993/2019, 27 October 2025). The tribunal relied on the investigation carried out during administrative and judicial proceedings by the EUAA MedCOI team, which reported that skin changes, especially when disfiguring, profoundly affect body image, which would lead to social stigma and the society mistakenly tended to associate neurofibromatosis with infectious diseases such as leprosy or tuberculosis.

2.1.5 Diseases of the nervous system: Epilepsy

Based on COI and MedCOI, the Tribunal of Milan concluded that the actions directed at people with epilepsy in Guinea, which are based on rooted perceptions and societal attributions about the condition, amounted to persecution (39278/2019, 19 September 2020). According to COI, living with epilepsy in West Africa is attributed to supernatural phenomena and witchcraft, including being cursed and punished for the past. In addition, many traditional healers had widely promulgated the belief that epilepsy is spread by bodily fluids, resulting in limited contact with people with epilepsy and a reduced willingness of bystanders or family member to offer help when witnessing a seizure. These elements led the court to conclude that the applicant could be considered to belong to a social group which is clearly distinct from the remaining Guinean population.

Furthermore, the court held that such severe discriminatory actions by family members, members of the social group toward each other and the majority of the population would lead the applicant to isolation and social stigmatisation, preventing him from accessing health services, work, and exercising civil and political rights, thus amounting to persecution.

2.1.6 Psychotic disorders

The Belgian CALL granted refugee status to an applicant suffering from schizophrenia, holding that he had a well-founded fear of persecution linked to his membership to the particular social group of people suffering from mental disorders in Mali (No 302 297, 27 February 2023). CALL observed that the mental health condition of the applicant had manifested in his adult life; thus, it was not possible to conclude that it was an innate condition. Similarly to the case mentioned above concerning HIV (No 258 932, 2 August 2021), a somatic condition, CALL was consistent in its interpretation of mental conditions as it considered that the applicant's schizophrenia did not meet the remaining conditions of the first limb of Article 10(1)(d) of the recast QD but rather it was an "inherent characteristic that he cannot dispose of". Therefore, membership of a particular social group was confirmed even when the condition was not congenital, reasoning that the non-exhaustive nature of Article 10(1)(d)

allows for a “common medical history that cannot be modified” which is shared with others suffering from schizophrenia.

Based on documents submitted by the parties about people with mental disorders in Mali, the council ruled that this group was perceived as different by Malian society, thus constituting the particular social group of persons suffering from mental disorders in Mali.

Furthermore, CALL noted that the unstable security situation in Mali could exacerbate the symptoms of schizophrenia and medical care could be difficult to access, potentially worsening his symptoms if therapy were to be discontinued. These intersecting factors demonstrated that the applicant’s return to Mali would make his life intolerable and justified a well-founded fear of persecution. Lastly, the court ruled that these factors also indicated that the applicant would not be able to find effective protection from Malian authorities.

Similarly, the tribunals of Milan and Bologna in Italy granted refugee status to applicants from The Gambia, Guinea and Nigeria who were suffering from a schizoaffective disorder and respectively schizophrenia, considering that they had a well-founded fear of persecution for belonging to the group of people suffering from mental disorders (50610/2017, 25 June 2025, concerning an applicant from The Gambia; 7249/2020, 9 February 2024, concerning an applicant from Guinea; 4502/2019, 27 February 2022, concerning an applicant from Nigeria). These decisions noted that society perceives people with mental disorders as different and ‘less humane’ than others. Specifically, in decision No 50610/2017, the Tribunal of Milan noted that in The Gambia this belief that mental illness rendered people less humane, was exacerbated by cultural beliefs associating mental illness with witchcraft. On the well-founded fear of the applicant, the court noted that government authorities enforced the Suspect Lunatic Act, a law from 1917 which discriminates against people with mental disorders in all spheres of life. In addition, the court held that the other persecutory actor could be most of the Gambian society which, holding such beliefs, could subject the applicant to actions directly threatening his physical integrity as an ill person.

In contrast, CALL rejected refugee status for an applicant from Bangladesh with a psychotic disorder with a paranoid component, accentuated by cannabis use (No 304082, 28 March 2024), finding that his condition was not congenital or immutable; it was considered that the condition could be stabilised even if a long follow-up of at least 5 years would be necessary. The applicant had not shown that he had an innate characteristic or a common background or that he shares a characteristic fundamental to his identity. CALL acknowledged that, according to country of origin information, people with psychological problems may be stigmatised in Bangladesh and that mental health problems are taboo, but found that not all persons with such problems who are perceived as different are subjected to acts of persecution. While people with psychological conditions can be stigmatised in Bangladesh, there are specialised hospitals, albeit with limited capacity, which are publicly funded. According to the court, this last aspect indicated that authorities were investing in a solution to address the health situation of people with schizophrenia. Although the court acknowledged that people with psychological conditions may be perceived as different, it was not conclusive that they would harm them based on the perception.

2.1.7 Complex profiles of mental and physical disabilities

Two decisions show how courts approach membership of a particular social group when the applicant has a complex profile of mental and physical disabilities: defining the group based on the applicant's disability or medical condition and highlighting that the conditions in the country of origin were defined not merely by deficient healthcare, but also by persecution through violence, abuse, stigmatisation and discrimination stemming from social beliefs about those conditions. Furthermore, they also show the cautious approach when assessing a risk of persecution of children with complex disabilities, in line with the need for particular care for this profile of applicants.

In a recent case concerning a Rwandan child with a complex profile including blindness, hearing impairment and severe developmental delays, the Belgian CALL granted refugee status as it concluded that his medical profile made it impossible to rule out exposure to violence rooted in witchcraft beliefs (No 333 143, 23 September 2025). Citing the EASO Guidance on membership of a particular social group (March 2020) which highlights that certain mental and physical disabilities can constitute an innate characteristic (for example a person who is born blind, deaf or with developmental impairments), CALL concluded that the Rwandan society perceives children with disabilities as different. Any interruption in care and in multidisciplinary support was likely to aggravate the developmental disorders from which the applicant already suffered severely.

Identifying the group more broadly, the Tribunal of Bologna reached a comparable conclusion, as it recognised refugee status to a minor from Ghana, holding that he belonged to the particular social group of people with mental disorders at risk of persecution in prayer camps and care centres in Ghana. The applicant had a serious congenital heart disease which led to prolonged cardiac arrest and comatose state, ICD implantation and post-anoxic encephalopathy, which left him totally dependent on continuous assistance. COI showed that people with severe mental disorders were exposed to general poor healthcare and to persecution through chaining, confinement in cages, and physical and moral deprivations in centres where the seriously ill persons were supposed to receive necessary care. Thus, the case highlighted that care settings may actually be sites where the person runs the risk of persecution rather than receiving protection. Both families and communities exposed these persons to negative attitudes and stigmatisation, and the authorities did not offer protection or reintegration into society. It therefore concluded that the applicant faced a real risk of persecution rather than just a lack of adequate care (N. R.G. 15416/2019, 27 January 2023).

2.2. Subsidiary protection: Serious harm under Article 15(b) of the recast QD

The following sections show how the CJEU's 'intentional deprivation' standards in *M'Bodj v Belgium* (Grand Chamber, C-542/13, 18 December 2014) and *M.P. v Secretary of State for the Home Department* (C-353/16, 24 April 2018) were applied by national courts, with various results, to applicants with lymphoma, severe spinal cord injuries, parasitic diseases, anxiety and mental health conditions, diabetes mellitus, chronic heart failure and psychotic disorders.

The Italian Supreme Court of Cassation has highlighted, for instance, the general principle that, for the purposes of international protection and particularly for subsidiary protection, when an applicant alleges a documented psychiatric condition and a risk upon return of serious harm consisting of inhuman and degrading treatment due to the lack of psychiatric care in the country of origin, or due to discriminatory legislation against persons with mental health conditions or serious human rights violations committed against them without adequate protection from the State, the court must carry out an *ex officio* investigation into the conditions faced in the country of origin by persons suffering from conditions identical or similar to those of the applicant (No 3036/2026, R.G. 13186/2025, 3 February 2026).

Also notable are the lack of application of the intentionality criterion by the Federal Administrative Court in Austria or the use of a cumulative assessment approach by the Belgian CALL and the Independent Appeals Committee in Greece.

2.2.1 CJEU standards for the application of Article 15(b) of the recast QD to medical conditions cases

In *M'Bodj v Belgium* (Grand Chamber, C-542/13, 18 December 2014), the CJEU held that the deterioration of a person's health due to a lack of appropriate treatment in the country of origin does not, in itself, constitute 'serious harm' under Article 15(b) of Directive 2004/83, unless the applicant is intentionally deprived of healthcare by an identifiable actor of persecution within the meaning of Article 6 of Directive 2004/83. The CJEU noted that the list of actors of serious harm in Article 6 of Directive 2004/83 supports the view that the harm must take the form of conduct on the part of a third party and that it cannot simply be the result of general shortcomings in the health system of the country of origin.

Subsequently, the CJEU judgment in *M.P. v Secretary of State for the Home Department* (C-353/16, 24 April 2018) introduced important nuances, establishing criteria to examine such an intentional deprivation. The case concerned an applicant who suffered severe psychological effects due to torture in Sri Lanka and, if returned, could be substantially aggravated and lead to a serious risk of his committing suicide. While acknowledging that continuous psychological trauma and a risk of suicide could not, in themselves, be regarded as inhuman or degrading treatment inflicted in the country of origin, the CJEU noted that it is for the national court to ascertain, in light of all current and relevant information, in particular reports by international organisations and non-governmental human rights organisations, whether, the applicant is likely to face a risk of being intentionally deprived of appropriate care for the physical and mental after-effects of torture. That will be the case, inter alia, where:

- The person is at risk of suicide because of the trauma resulting from torture by the authorities of the country of origin, and it is clear that those authorities, notwithstanding their obligation under Article 14 of the UN Convention against Torture, are not prepared to provide for rehabilitation; or
- It is apparent that the authorities of the country of origin have adopted a discriminatory policy towards healthcare, making it more difficult for certain ethnic groups or groups of individuals to access appropriate care for the physical and mental after-effects of torture perpetrated by those authorities.

The use of 'inter alia' indicates that these scenarios are illustrative, not exhaustive. The CJEU also referenced *M'Bodj* to remind that Article 3 of the ECHR precludes, in very exceptional cases, the removal of seriously ill person, which does not mean that the person should be granted subsidiary protection. Referring to *C.K.* (C-578/16, 16 February 2017) and *Paposhvili* (No 41738/10, 13 December 2016), the CJEU held that Articles 4 and 19(2) of the EU Charter preclude a Member State from expelling a third-country national where such expulsion would, in essence, result in significant and permanent deterioration of that person's mental health disorders, particularly where such deterioration would endanger their life.

2.2.2. Haematopoietic neoplasms (blood cancer): Lymphoma

The Federal Administrative Court in Austria granted subsidiary protection to an applicant with Hodgkin's disease, finding that upon return to India he would face a violation of Article 3 of the ECHR due to the lack of access to healthcare (W202 2226922-1/30E, 5 June 2023). The court cited a previous judgment of the Supreme Administrative Court of Austria which noted that interpreting Section 8(1) of the Asylum Act in conformity with the CJEU's interpretation of Article 15(b) in *M'Bodj,* requiring intentional deprivation of care, was *contra legem* under the national asylum law, so national law continued to apply until amended (Ro 2019/19/0006, 21 May 2019). Instead, the court relied directly on the prohibition of ill treatment under Article 3 of the ECHR and noted that the national Asylum Act allowed for subsidiary protection even when the risk is not caused by the conduct of a third party or from a threat in an armed conflict.

While the court noted that subsidiary protection should not be granted simply to receive medical treatment, which was also previously emphasised by the same court in 2017 for an Afghan minor with polyarthritis (W257 2144225-1, 28 November 2017), the court ruled that a violation of Article 3 could occur if there was a real risk that a seriously ill person would be exposed to a serious, rapid and irreversible deterioration in their state of health due to the lack of access to appropriate treatment in the country of destination, leading to intense suffering or a significant shortening of life expectancy. While India has a public healthcare system, the court found exceptional circumstances in the case because the required treatment for Hodgkin's disease could not be reliably accessed and the applicant lacked the financial means for private care. Thus, by applying the *Paposhvili* principles, this approach resulted in a more individualised, case-by-case assessment.

2.2.3. Disability: Severe spinal cord injury

The 10th Independent Appeals Committee in Greece granted subsidiary protection to a Moroccan applicant with a disability not due to intentional deprivation but considering a cumulative set of circumstances, based on Article 15(b) of the recast QD and Article 14(b) of Law No 4939/2022 (IP88371/2025, 11 February 2025*)*. The committee held that the combination of the applicant's severe medical condition which required ongoing specialised care, systemic deficiencies in Morocco's healthcare system, a lack of adequate rehabilitation and specialised care for spinal cord injuries, the absence of a family support network in Morocco and the reported barriers faced by people with disabilities to access services in Morocco constituted a set of cumulative circumstances that would expose him upon a return to a serious deterioration of his health and a treatment contrary to Article 3 of the ECHR.

2.2.4. Parasitic diseases: Schistosomiasis

The Athens Court of First Instance annulled a rejection decision for a Malian applicant with schistosomiasis and ordered the authority to take a new decision due to contradicting reasoning by the Appeals Committee (ΑΔ677/2025, 12 June 2026). Although the committee accepted that the health system in Mali was very limited, being difficult for the population to even access basic, minimal healthcare, the court noted that it failed to consider that, although the applicant treated his disease surgically, he continued to receive treatment in Greece upon which his state of health was dependent.

In addition, the committee referenced sources which showed progress in the provision of basic healthcare in Mali in recent years for women and young children, so for categories of people other than the applicant. The court concluded that the decision of the Appeals Committee did not sufficiently explain why the applicant was not at risk of inhuman or degrading treatment upon a return to Mali.

2.2.5. Mental health combined with other vulnerabilities

The Independent Appeals Committee in Lesvos granted subsidiary protection under Article 15(b) of the recast QD to an applicant from Sierra Leone, due to the risk of torture or inhuman or degrading treatment or punishment of the applicant in the country of origin (IE/374482/21.6.2024, 11 July 2024). The committee considered that the applicant was a victim of labour exploitation and trafficking, who had flashbacks, intrusive memories, nightmares, sleep disturbances, persistent sadness, fatigue, difficulty regulating emotion, confusion, sudden mood swings, anxiety and persistent fear. The committee took a 'cumulative assessment approach', applying Article 14(b) of Law No 4939/2022 when there is a combination of circumstances, such as severe individual vulnerability due to a medical condition requiring special care, other individual factors (e.g. absence of a support network), and systemic country of origin healthcare deficiencies, which would collectively expose the applicant to inhuman or degrading treatment upon a return.

2.2.6. Endocrine diseases: Diabetes mellitus

The National Court of Asylum (CNDA) in France applied the *M'Bodj* intentionality criterion and granted subsidiary protection to a Russian national suffering from a serious form of diabetes mellitus because, while the applicant was in custody in Russia, medical treatment was intentionally withheld from him several times (No 21019971, 7 December 2022). The court noted that the applicant's condition, together with his Grade 3 high blood pressure and Stage 1 chronic heart failure, was of a serious nature which required medical treatment and constant supervision. Based on OFPRA's research note on the "Russian Federation: Access to health in Russian prisons" (12 July 2021), the court concluded that there was a risk that this would occur again if the applicant was returned.

Instead, in Belgium, a cumulative set of factors were decisive in proving the risk of serious harm under Article 15(b) of the recast QD and Article 48/4(2)(b) of the Aliens Act (CALL, No 305 082, 18 April 2024). The applicant was medically monitored and received medication for Type 2 diabetes mellitus, arterial hypertension, ischemic heart disease and cutaneous candidiasis,

and had been under treatment for severe depression with suicidal thoughts since May 2023. To continue to be monitored and receive appropriate treatment in Afghanistan, the applicant would need to provide his medical records and images, thus disclosing the treatment received in Belgium. Citing the EUAA COI Report – Afghanistan: Key socio-economic indicators in Afghanistan and in Kabul City (August 2022), CALL noted that in some hospitals in Kabul mullahs linked to the Taliban took the place of health officials to manage facilities. Thus, the court held that it could be reasonably expected that he would have contact with the Taliban.

Moreover, considering the EUAA's Country Guidance: Afghanistan (January 2023), the court noted that people with mental health problems were often stigmatised in Afghanistan and abused by the community or family members. Although the specific circumstances could not be connected to a ground for persecution, CALL noted that taken cumulatively with the applicant's long-term exposure to Belgian society meant that he would stand out, with negative attention of members and supporters of the Taliban and plausibly be targeted and at real risk of serious harm. Thus, the real risk of serious harm arose from the risk of being targeted by the Taliban, to which the health condition contributed, rather than from deprivation of healthcare.

2.2.7. Diseases of the circulatory system: Chronic heart failure

IPAC in Cyprus rejected subsidiary protection for an applicant from the Democratic Republic of the Congo who had chronic heart failure (1593/2023, 6 October 2025). The court noted that the mere fact that a person suffers from a serious illness and needs medical treatment does not constitute grounds for granting international protection, even in the absence of appropriate treatment in the country of origin.

Applying the standard set by the CJEU in *M'Bodj,* the court noted that access to medical care must be intentionally hindered by a specific actor to be considered a serious harm, but the required medical treatments were available and accessible in the country of origin. Based on EUAA MedCOI, the court listed all the clinics and hospitals in Kinshasa that were offering hospital treatment by a cardiologist and an electrocardiogram, as well as the geographical location of all the pharmacies offering the active ingredients of the five medicines that the applicant was taking. Based on that information, IPAC concluded that medical monitoring/diagnosis, treatment services, and medicines, would be available to the applicant upon a return to Kinshasa, his habitual place of residence. Furthermore, the court made use of the EUAA MedCOI Report on the Democratic Republic of Congo DRC (August 2021) and considered that the applicant would have access to health care in his country of origin. In this respect, the court noted that the applicant did not have any serious form of disability or present any other vulnerabilities besides reduced exercise tolerance and shortness of breath, which was caused by the specific medical problem for which he was being treated. The court concluded that there were no compelling reasons to believe that he would face a real risk of being seriously harmed upon return.

2.2.8. Psychotic disorders: Schizophrenia

The Belgian CALL applied the intentionality criterion to an applicant with a psychotic disorder (No 304082, 28 March 2024). It held that the limited availability of psychological and psychiatric treatment in Bangladesh does not establish that the treatment is deliberately refused, and the applicant did not demonstrate that he would be deliberately refused medical treatment. The court also held that it was not competent to assess whether the applicant would need to resort to healers.

2.3 Subsidiary protection: Serious harm under Article 15(c) of the recast QD

When a case involves armed conflict in addition to the applicant's medical condition, courts assess whether these cumulative factors lead to a situation where the applicant is specifically affected by the level of indiscriminate violence in the country of origin. Belgian and Cypriot courts acknowledged the possibility of granting protection under Article 15(c) where a serious medical condition amplified the risk of serious and individual harm from indiscriminate violence. Protection was granted under Article 15(c) in cases concerning applicants from Cameroon with HIV, from Afghanistan with PTSD and dissociative disorders, and from Ethiopia for applicants with complex PTSD and psychosis.

2.3.1 CJEU standards for the application of Article 15(c) of the recast QD to medical conditions cases

A sliding scale[2] was established by the CJEU in *Meki Elgafaji and Noor Elgafaji* v *State Secretary for Justice and Security* (Grand Chamber, C-465/07, 17 February 2009), a case which did not concern a medical condition but which was applied by national courts in cases relating to illnesses. The court noted that the more the applicant is able to show that they are specifically affected due to factors particular to personal circumstances, the lower the level of indiscriminate violence required to be eligible for subsidiary protection. This reasoning was used when assessing if the illness, either alone or cumulatively with other individual circumstances, causes the applicant to be specifically affected by the level of indiscriminate violence in the country of origin, more so than for the rest of the population residing there.

In the more recent *X, Y and their six children* v *State Secretary for Justice and Security* (C-125/22, 9 November 2023), the CJEU clarified that the personal circumstances of an applicant constitute one of the relevant factors to determine eligibility for subsidiary protection, before identifying the type of serious harm. Furthermore, there is no hierarchy in the types of serious harm contained in Article 15 of the recast QD, and a single factor may serve to substantiate the existence of a real risk of suffering several types of serious harm.

[2] EASO Practical Guide: Qualification for international protection, April 2018.

2.3.2 Infectious diseases: HIV

The Administrative Court of Appeal in Cyprus upheld subsidiary protection for a Cameroonian HIV-positive woman based on the combination of indiscriminate violence in her region of origin (Kumba, South-West Cameroon) which significantly impacted the health system and basic services and infrastructure, her inability to access medical treatment given that only one in three medications was available in two cities in Cameroon and her individual situation as a single woman without family support (97/2024, 10 September 2025). The court highlighted that the health condition alone was insufficient to trigger protection, but her vulnerabilities, combined with armed conflict, exposed her to a serious and individual threat of serious harm.

2.3.3 PTSD and dissociative disorders

In January 2020, CALL in Belgium granted subsidiary protection under Article 15(c) of the recast QD to an Afghan applicant with PTSD and dissociative disorders, concluding that upon a return she would be exposed to a serious and individual threat due to her personal circumstances and indiscriminate violence (No 231907). The court noted the applicant's hearing impairment, dissociative disorders, difficulties in situating herself in time and space, and her characteristics of PTSD including blackouts. These factors would make it difficult for the applicant to avoid the risks of indiscriminate violence in Kabul, particularly in situations involving attacks and fighting, and to understand the threats posed by such violence.

More recently, in September 2025, CALL provided subsidiary protection to an Ethiopian applicant from Oromia with complex PTSD and psychosis, mutism, disorientation in time and space, dissociation, severe sleep deprivation, anxiety, apathy, social isolation, day-night inversion, strange behaviour and reportedly hearing voices (No 332 937, 18 September 2025). CALL found that, in the event of a return to his region of origin, where he would have no or limited access to treatment, the applicant's mental health would likely deteriorate, causing his symptoms to reappear or worsen. It concluded that this deterioration would impair his ability to assess and respond to risks arising from the security situation, thereby increasing his vulnerability, and held that there were substantial grounds to believe that the applicant would face a real risk of serious harm within the meaning of Article 48/4(2)(c) of the Aliens Act, even in the absence of an exceptionally high level of indiscriminate violence.

This section has shown that both refugee status based on membership of a particular social group and subsidiary protection may be provided to applicants with a medical condition. For refugee protection, the CJEU standard in *X, Y and Z*, designed for cases concerning persecution based on sexual orientation, is particularly relevant for certain medical conditions. In contrast, the CJEU framework to qualify for subsidiary protection if the state of health would deteriorate in the country of origin as a result of an intentional deprivation of healthcare has been sometimes not applied and national courts referred directly to Article 3 of the ECHR.

3. The impact of medical conditions on the asylum procedure



National authorities and courts have a positive obligation to proactively determine if an applicant needs special procedural guarantees due to a serious illness, mental disorder or disability, before taking a decision. They must identify the medical condition and assess its impact on the procedure and credibility of the applicant, including the applicant's capacity to participate in proceedings. In this area, a key standard established by the UN Committee against Torture (CAT) for applicants with psychological conditions is that complete accuracy can seldom be expected from victims of torture, and thus standard credibility assessment procedures should not be followed for such applicants (*H.U. v Finland*, No 1052/2021, 17 November 2023).

Authorities must also adapt the procedure, including by easing the burden of proof for persons with psychological conditions (see UNHCR Handbook on Procedures and Criteria for Determining International Protection, 2019) and properly examine and weigh the medical evidence produced or seek additional proof from other sources than the applicant. International standards guide the consideration of medical conditions and evidence in asylum procedures (see UN Istanbul Protocol).

At the EU level, the health and vulnerability check in the Screening Regulation and the obligation provided in Articles 20 and 21 of the APR, to assess if applicants for international protection have special procedural needs, facilitate the provision of support needed by applicants with a medical condition. During the personal interview for instance, support measures for applicants affected by PTSD may include providing additional breaks and a slower interview pace to recall and recount events fully and answer all questions. If an applicant is unfit or unable to participate due to circumstances beyond their control, the interview may be omitted. If there are doubts about an applicant's fitness or ability to be interviewed, the authority must consult a medical professional to establish whether the condition is temporary or permanent (Article 13(11) APR). Practical tips for case officers on taking trauma into account in the personal interview are set out in the EUAA Guidance on Mental Health and Well-being of Applicants for International Protection (November 2024).

When assessing the application, Article 24(1) of the APR provides that authorities must request a medical examination, where relevant for the assessment of the application and subject to the applicant's consent, for signs and symptoms that may indicate past persecution or serious harm. Medical examinations ordered by the authority must be minimally invasive, performed only by qualified medical professionals and conducted with full respect for dignity. The results of medical examinations must be provided to both the authority and the applicant as soon as possible and must be assessed together with the other elements of the application (Article 24(4)). Where no medical examination is carried out, applicants must be informed that they may arrange for one at their own cost (Article 24(3)).

The jurisprudence of ECtHR and the CJEU has examined these obligations with a particular focus on the role and weight of medical evidence in findings concerning credibility determinations and the duty of the authorities, the applicant and the courts to cooperate and obtain medical examinations. In turn, national jurisprudence reveals how all these obligations operated in practice at multiple stages highlighted in the sub-sections below. Essentially, courts have annulled decisions in which asylum authorities failed in their obligations to:

- investigate the applicant's capacity to participate in the interview and overall in the procedure, avoiding formalistic compliance, appointing a representative if needed and following-up on requests for medical evidence in order to establish the applicant's capacity;
- properly weigh medical evidence before reaching conclusions on credibility, not only selective areas of it, address contradictory medical evidence and respond to applicants' objections to expert opinions;
- adapt the procedure based on specific medical circumstances (e.g. inform applicants of the possibility of a medical examination, appoint a representative, adjust the interview, move from the accelerated to the regular procedure).

Lastly, although the national judgments analysed in this report do not address this aspect, medical conditions may also be relevant in subsequent applications. Under Article 55(5) of the APR, elements are considered new only when the applicant was unable, through no fault of their own, to present them in the earlier application, although elements that could have been presented earlier must still be taken into account when they significantly increase the likelihood of the applicant qualifying for international protection. The EUAA Practical Guide on Subsequent Applications (30 March 2026) considers mental health among personal circumstances that may explain why elements were not presented earlier, which the applicant must demonstrate and the authority must assess on a case-by-case basis *(see Section 2.1.1)*.

3.1. ECtHR standards: The role and weight of medical evidence in credibility determination

The case law of the ECtHR emphasises that medical evidence must be adequately considered in decision-making on international protection, including evidence of mental health issues, throughout the asylum procedure.

In a case which concerned the removal of a rejected asylum applicant, the ECtHR set fundamental rules on how to consider medical evidence of ill treatment in the evaluation of a claim for international protection (*RJ v France*, No 10466/11, 19 September 2013).

_RJ_ v _France_, No 10466/11, 19 September 2013

The applicant submitted a medical certificate drawn up by a doctor at Roissy ZAPI Medical Unit immediately after arriving at Roissy Charles de Gaulle airport. The certificate described fourteen burn wounds dating back several weeks, which caused significant pain requiring local and oral treatment.

The ECtHR ruled that:

- The medical certificate was a particularly important piece of evidence.
- The nature, seriousness and recent character of the injuries created a strong presumption of treatment contrary to Article 3 inflicted in the country of origin.
- Despite the submission of this certificate, national asylum authorities did not seek to establish the origin of the wounds and to assess the risks they revealed.
- Once the applicant produced evidence capable of showing substantial grounds for believing that he would face a real risk, it is for the government to dispel any doubts about it; by merely invoking the incomplete nature of the applicant's account, the government did not dispel the strong suspicions concerning the origin of the injuries.

The case reinforces the ideas that:

- A medical certificate is a particularly important piece of evidence in the file.
- Medical evidence must be examined even when the applicant's account is poorly substantiated.
- The authorities must address the origin of injuries documented in medical evidence and the risks they reveal.

3.2. CJEU standards: The duty to cooperate and to obtain medical examinations

The jurisprudence of the CJEU, in turn, has clarified the scope of the authority's investigative duties particularly regarding the duty to obtain medical examinations and has addressed how courts of first instance and appeal must exercise their powers in cases involving applicants with a mental health condition. These rulings have significant implications for procedural practices across EU Member States, establishing when authorities must proactively order medical assessments, how credibility must be evaluated in light of medical conditions and what powers reviewing courts must have to ensure effective remedies.

The CJEU jurisprudence established that it is generally for the applicant to submit all elements needed to prove their case, while the Member States has a duty to cooperate in determining relevant elements (*M.M. v Minister for Justice, Equality and Law Reform*, C-277/11, 22 November 2012, concerning Directive 2004/83; confirmed by *Ramodi* and *Karkik*, C-7/25 and C-8/25, 12 November 2026, concerning Directive 2011/95/EU).

_M.M._ v _Minister for Justice, Equality and Law Reform_, C-277/11, 22 November 2012

The CJEU ruled that:

- Under Article 4(1) of Directive 2004/83, although it is generally for the applicant to submit all elements needed to substantiate the application, it is the duty of the Member State to cooperate with the applicant at the stage of determining the relevant elements of the application, as the authorities may be better placed to gain access to certain types of documents.
- If, for any reason whatsoever, the elements provided by the applicant are not complete, up to date or relevant, the Member State must cooperate actively with the applicant, at that stage of the procedure, so that all the elements needed to substantiate the application may be assembled.

In 2026 in _Ramodi_ and _Karkik_, the CJEU confirmed and further developed this case law, holding that the authorities must include in the assessment all the evidence and elements submitted in support of the application, and a court of first instance must carry out a full and *ex nunc* examination regardless of the grounds raised in the appeal. When the rejection is coupled with a return decision, the court must verify *ex officio* whether the principle of *non-refoulement* precludes a return.

K and P [Ramodi and Karkik], C-7/25 and C-8/25, 12 November 2026

The cases concerned applications for international protection rejected under a national policy which considered that statements not substantiated by authentic and objectively verifiable documents or objective sources were deemed credible only if all the conditions of Article 4(5) of the recast QD were met.

The CJEU ruled that:

- The statements of an applicant are merely the starting point of the assessment, and the authorities are often better placed than the applicant to gain access to certain types of documents. When the elements provided are not complete, up to date or relevant, the authorities must cooperate actively with the applicant so that all the elements capable of substantiating the application may be assembled, and it would be contrary to Article 4 of the recast QD to consider it necessarily for the applicant alone to submit all the substantiating elements.
- Article 4(5) of the recast QD does not require the applicant's statements to be supported by authentic and objectively verifiable documents or other objective sources, and it does not allow the authorities to find the statements not credible and reject the application on the sole ground that the conditions of that provision are not met. When the cumulative conditions of Article 4(5) are not met, it may be for the Member State to cooperate with the applicant to assemble all elements capable of substantiating the application.
- Any document submitted by the applicant must be considered and assessed in cooperation with the applicant, even if authenticity cannot be established or its source cannot be objectively verified. The CJEU referred to the EUAA Judicial analysis on Evidence and credibility assessment in the context of the Common European Asylum System (17 February 2023) to exemplify the types of evidence.

- Regardless of the arguments and grounds expressly invoked in the appeal, a court or tribunal of first instance must carry out a full and *ex nunc* examination of both facts and points of law, including of international protection needs, on the basis of the material in the file as supplemented or clarified following adversarial proceedings.
- Where the rejection decision includes a return decision, the court must verify *ex officio* whether the principle of *non-refoulement* preclude the applicant's return. It is sufficient that the material in the file indicates a risk of a breach of the principle of *non-refoulement*.

In 2023, more than 10 years after *M.M.*, the CJEU extended the investigative obligation of authorities to include ordering medical examinations for the applicant and held that a false statement in the initial application, explained and withdrawn at the first available opportunity, is not capable, by itself, of preventing the establishment of the applicant's general credibility (*X v International Protection Appeals Tribunal, The Minister for Justice and Equality, Ireland, The Attorney General*, C-756/21, 29 June 2023).

***X* v *International Protection Appeals Tribunal, The Minister for Justice and Equality, Ireland, The Attorney General*, C-756/21, 29 June 2023**

The CJEU ruled that Article 4(1) of Directive 2004/83 on the duty of cooperation requires the determining authority to obtain:

- up-to-date information concerning all the relevant facts as regards the general situation prevailing in the country of origin of an applicant for asylum and international protection; and
- a medico-legal report on the applicant's mental health, when there is evidence of mental health problems resulting potentially from a traumatic event which occurred in the country of origin, where the use of such a report is necessary or relevant in order to assess, with the vigilance and care required, the applicant's genuine need for international protection, provided that the modalities of such use comply, inter alia, with the fundamental rights guaranteed by the EU Charter.

Furthermore, Article 4(5)(e) of Directive 2004/83 must be interpreted as meaning that a false statement, contained in the initial application for international protection, which was explained and withdrawn by the applicant for asylum at the first available opportunity, is not capable, by itself, of preventing the establishment of the applicant's general credibility.

The CJEU also held that a breach of the duty of cooperation found at a second level of judicial scrutiny does not necessarily entail, by itself, the annulment of the decision dismissing the appeal, since the applicant may be required to demonstrate that the decision might have been different in the absence of that breach.

Finally, the CJEU ruled on the competence of courts to order medical examinations, reinforcing the principle that procedural safeguards must be enforceable at the judicial review stage and ensuring that courts can gather necessary evidence to conduct a full and *ex nunc* examination of asylum claims (*B.F. v Kypriaki Dimokratia [Barouk]*, C-283/24, 3 April 2025). Later on, in *Ramodi and Karkik*, the CJEU held that a court of first instance must not confine itself to the arguments and grounds expressly put forward on appeal.

_B.F._ v _Kypriaki Dimokratia [Barouk]_, C-283/24, 3 April 2025

The case arose from a reference by IPAC in Cyprus which considered that it could not assess the credibility of the applicant, as the asylum authority had failed to carry out a psychological examination that could impact credibility. Under national law, the power to order a medical examination was reserved only for the asylum authority; the court could only request the reasons for the absence of a medical examination or annul the decision for such absence.

The CJEU ruled that national courts of first instance must have the power to order a medical examination of the applicant, where they consider that the use of that examination is necessary or relevant for the purposes of assessing that application.

The CJEU clarified that:

- Each Member State must lay down detailed procedural rules for medical examinations, which must not be less favourable than those governing similar domestic situations, and they must not make it excessively difficult or impossible in practice for an applicant to exercise the right to an effective remedy.
- The expression *ex nunc* entails that the court has the obligation to assess new evidence for an exhaustive examination of the asylum application, without referring the case back to the determining authority, and as soon as possible.
- The adjective 'full' means that the court must examine both the evidence that the determining authority considered or should have considered, and the evidence that has arisen following the adoption of the decision by the asylum authority.
- It is not necessary for the court that ordered the medical examination to approach a qualified health professional itself, the court may also order the determining authority to arrange the medical examination and to send the results to the court within a short period of time.

Therefore, the key takeaway is that courts must be able to fill in evidentiary gaps in medical assessments that occurred at the administrative stage.

3.3. Duty to identify special procedural needs and determine capacity to participate in the procedure

Courts have held that authorities must identify special procedural needs and determine the applicant's capacity to effectively participate in the asylum procedure, and they must do so by avoiding formalistic compliance, and follow-up on requests for medical evidence.

While cooperation between the applicant and the authority is expected, courts have held that an applicant with a serious mental health disorder cannot be expected to have the same level of cooperation in evidence-gathering as others. Courts across EU+ countries have recognised that psychiatric disorders and trauma-related medical conditions (e.g. PTSD, depression and intellectual disability) may legitimately explain inconsistencies, delayed disclosure of facts during asylum procedures and incoherence in applicants' statements. This principle was applied for example by courts in Belgium, Ireland, Italy and Sweden. The Italian jurisprudence is notable as it highlighted that the credibility evaluation should not rely solely on the lack of objective evidence. It should consider a reasonable effort to substantiate the request, an

appropriate justification for the lack of objective evidence, consistency with COI, timely submission of the request and intrinsic reliability. These criteria correspond to Article 4(5) of the recast QD, which, according to the CJEU, does not require statements to be supported by authentic and objectively verifiable documents and does not allow statements to be found not credible on the sole ground that its conditions are not met (*Ramodi* and *Karkik*, C-7/25 and C-8/25, 12 November 2026).

Furthermore, when a national authority cannot interview an applicant due to severe mental illness (e.g. a paranoid form of schizophrenia, Alzheimer's), courts in Slovenia and Switzerland held that the authorities could not dismiss the case due to the applicant's failure to establish the facts: the Slovenian court required the appointment of a representative and a psychiatric assessment of legal capacity and the Swiss court ordered the authority to determine the applicant's ability to participate in the proceedings. Moreover, a medical examination may be necessary to assess whether the interview or oral hearing must be omitted or if the applicant can be interviewed in person when they suffer from a medical condition allegedly preventing them from attending in person.

Courts have also highlighted that only formally complying with these obligations, by for instance filling in a statement of vulnerability or dismissing evidence on extremely formalistic requirements, may not be sufficient to dispel doubts about the applicant's capacity to participate in the proceedings (for example in Estonia).

Table 1. National case law on the duty to investigate and determine an applicant's capacity to participate in the asylum procedure.

Country of decision	Court, case and date of decision	Outcome
Belgium	CALL, *Applicant* v *Belgian State represented by the State Secretary for Asylum and Migration*, No 320 158, 16 January 2025	In the case of a Palestinian applicant with depression and PTSD, CALL ruled that applicants with special procedural needs must be identified as such before a decision is made, and considering the applicant's mental health issues, the CGRS had a duty to proactively identify these needs and cooperate with the applicant, especially given his limited capacity to participate in the procedure.
	CALL, *X* v *CGRS*, No 328 336, 17 June 2025	CALL held that the CGRS failed in its duty to inform the applicant of the possibility of undertaking medical tests at his expense when he mentioned memory issues due to COVID-19. CALL ordered the CGRS to take further investigative measures, noting the applicant had persistently mentioned amnesia, memory loss and mental fatigue, and had provided unusual and sometimes unintelligible answers in successive interviews, which suggested a cognitive disorder.

	CALL, *X v CGRS*, No 312 113, 29 August 2024	CALL ruled that the CGRS's conclusion that the applicant's cognitive impairments (paranoid and nightmare disorder) did not hinder her ability to make full statements was not supported by the available medical evidence. At her first interview, the applicant expressed difficulty speaking and potential memory loss due to her medication, prompting the case officer to interrupt the interview, an implicit acknowledgement that medical issues may affect her statements. Considering that the applicant was receiving psychological support, CALL concluded that her statements should not be relied upon and the condition may have also impacted her ability to provide consistent statements in the second interview.
	CALL, *X v CGRS*, No 270 812, 31 March 2022	CALL referred a case back to the CGRS to assess whether mental issues and intellectual disability should be taken into account, in addition to minority, when assessing the applicant's claim for international protection. The key issue in this case was to what extent the applicant's mental problems and intellectual disability may have had an impact on the course of the personal interview and on the applicant's ability to make complete statements.
Estonia	Tallinn Administrative Court, *X v Police and Border Guard Board*, No 3-23-656, 6 June 2023	In the case of an LGBTIQ person diagnosed with depression, the Tallinn Administrative Court ruled that if from the applicant's hearing it cannot be inferred whether the individual understands or acknowledges their need for help, it is for the determining authority to at least inform the applicant to contact the relevant national organisation for procedural support and a legal representative.
Ireland	High Court, *MR v IPAT and The Minister for Justice and Equality*, [2020] IEHC 402, 17 August 2020	The court ordered the IPO to establish a panel and undertake a medical examination to assess whether the applicant could be interviewed in person, as otherwise continuing to notify an applicant to present themselves while ignoring requests about medical fitness constituted procedural impropriety.
Italy	Milan Civil Court, *Applicant v Ministry of the Interior*, No 39278/2019, 19 September 2020	The Milan Civil Court held that the generic statements of a Guinean applicant were compatible with his memory problems linked to epilepsy.
	Tribunal of Rome, *A. v Ministry of the Interior and Territorial Commission of Rome*, R.G. 44337/2024, 9 June 2025	The Tribunal of Rome found the progressive disclosure of kidnapping and sexual violence by a South African unaccompanied child credible, in view of his young age, trauma and COI. The tribunal considered particularly significant the psychological report issued by the Frosinone Local Health Authority (ASL), which found symptoms consistent with exposure to potentially traumatic events, including intrusive memories, sleep disturbances, flashbacks, hyperarousal, tachycardia and nightmares. The tribunal considered it consistent that the applicant initially provided an account to the border police

		unrelated to the reasons for his flight, and that he was unable to disclose the traumatic experiences during the interview before the Territorial Commission, revealing the abuse only at a later stage.
Slovenia	*Applicant* v *Ministry of the Interior*, UP00049855, 6 September 2021	The Administrative Court in Slovenia concluded that when the applicant does not have the capacity to act or understand the procedure, a temporary representative should be appointed and the determining authority has a duty to verify *ex officio* whether an applicant diagnosed with a paranoid form of schizophrenia had the legal capacity to understand the proceedings. The determining authority had failed its duty to investigate by assuming that the applicant's difficult controllability and incomprehensibility were personality traits and not symptoms of her illness, and by wrongly refusing to appoint a psychiatric expert to evaluate legal capacity. In contrast, the report of the psychiatric expert appointed on appeal considered that the applicant could not understand the procedure, form and express her will independently, and answer questions about past events.
Sweden	Migration Court of Appeal *F.M.* v *Migration Agency (Migrationsverket)*, MIG 2022:4, 31 May 2022	The Migration Court of Appeal held that the lower court failed to consider whether the incoherent and contradictory information provided by a Somali applicant with a hearing impairment and using a language invented by him was due to communication difficulties rather than lack of credibility. At the interview, two deaf interpreters and two sign interpreters were present and the applicant had difficulty understanding the questions and was imitating the interpreters. The court also emphasised that a pending investigation into the applicant's disability, could have been significant to assess the need for protection. The court recalled that courts have greater investigative responsibility in asylum cases.
Switzerland	*A.* v *State Secretariat for Migration*, D-3593/2023, 7 July 2023	For an applicant who suffered dementia due to Alzheimer's disease, SEM waived the applicant's hearing upon noticing that he was confused and disoriented and rejected the asylum request. FAC reminded that Alzheimer's is a progressive brain disease that affects memory, thinking, orientation, perception, language and judgment, and ordered the authority to determine the applicant's ability to participate in the proceedings.

3.4. Properly weighing medical evidence before reaching conclusions on credibility

Courts have noted that, in cases concerning applicants with a medical condition, medical evidence must be made available and assessed when there is an ongoing credibility assessment and not after it.

This sequencing was confirmed by the Irish High Court which ruled that medical evidence must be considered at the time of assessing the applicant's credibility, not afterwards (*A.S.* v *International Protection Appeals Tribunal & Anor*, 2 February 2023). IPAT was obliged to consider a report submitted by the applicant from the National Centre for Survivors of Torture (SPIRASI) before making a definite conclusion on credibility. However, a medical report whose psychiatric details largely relied on the self-reported claims of the applicant could not support the applicant's narrative in circumstances where the overall credibility of the claim had been rejected (High Court, *O.R.A* v *International Protection Appeals Tribunal & Anor,* 20 July 2023). In line with this jurisprudence, IPAT's Guideline No 2025/2 on Medical evidence and medico-legal reports (29 August 2025) explicitly provides that a medico-legal report must be considered as part of the overall credibility assessment, and torture and other forms of ill treatment may impact a victim's behaviour, so no negative inferences should generally be drawn from the demeanour of such an applicant.

Courts have also dealt with the issue of how to evaluate reports from medical institutes. On this topic, the jurisprudence from the Dutch Council of State is relevant, as it concerns the evaluation of forensic reports from the Institute for Human Rights and Medical Research (iMMO), a private, non-profit organisation which assesses suspected victims of torture and inhuman treatment who request international protection. The Council of State ruled that the iMMO must demonstrate an individualised assessment specific to the condition of the applicant and its effects on the applicant, instead of relying on a general approach that PTSD impairs all aspects of memory equally (202104973/1/V2, 2 April 2025). The forensic psychiatry expert appointed by the court noted that:

- Traumatised persons may have difficulty recalling details of traumatic events, but overgeneralisation makes the main lines of their story stronger, clearer and better preserved.
- The impact of PTSD on memory varies greatly between individuals and PTSD alone does not automatically establish a memory disorder, so it is important to undertake a thorough individual investigation.
- Overreliance on general patterns results in overly general reports that are less useful for assessing credibility in individual cases.

Thus, the Council held that in a case involving an applicant alleging memory problems, the medical report must show how specific medical issues affect specific memory functions.

Complementing the Dutch approach, the Swiss FAC has consistently noted that PTSD may explain minor inconsistencies but not fundamental contradictions about the core elements of an asylum claim. Noting that a PTSD diagnosis could not prove the traumatic events, FAC

ruled that the assessment made by a specialist about the plausibility of events and the PTSD diagnosis represented only an indication and not evidence that could be taken into account in the context of the assessment of evidence (D-5781/2012, 8 May 2015 and D-1947/2023, 7 June 2023). Accordingly, FAC clarified that a PTSD diagnosis, as certified by a medical assessment, cannot prove an alleged ill treatment in the country of origin since doctors cannot certify specific external events described by an applicant based on their symptoms (D-5781/2012, 8 May 2015). Similarly, although SEM agreed that a traumatised person's statements can lead to inconsistencies, the applicant's statements proved extremely poor. There were significant contradictions on the main elements of the asylum application, which the diagnosis of PTSD could not explain (D-1947/2023, 7 June 2023).

National courts have analysed whether a medical certificate constitutes a new element that significantly increases the likelihood of qualifying for international protection. CALL ruled that medical certificates which are brief, general and vague do not constitute new elements that significantly increase the likelihood of qualifying for international protection (No 313 833, 1 October 2024). CALL acknowledged that the applicant suffered from PTSD but found that the certificate was not drawn up in accordance with the Istanbul Protocol, which affects the weight given to such medical evidence in the overall credibility assessment.

In the case of an Ethiopian applicant who alleged to have PTSD as a result of torture, the Swiss FAC clarified that an expert report drawn in accordance with the Istanbul Protocol may be awarded greater scientific weight, while the assessment of whether and to what extent it effectively contributes to establishing the credibility of the alleged events is subject to the principle of free assessment of evidence, considering that it constitutes only one piece of evidence amongst others. The court held that, while the specificity of the injuries reported showed that the alleged physical and sexual violence was plausible, the report could not veraciously establish that the specific scars were circumscribed to the Ethiopian context, nor assigned a specific date for forensic medical purposes (D-3995/2021, 20 March 2023). Thus, the expert report cannot, in itself, determine the credibility of the factual elements, but rather constitutes one piece of evidence amongst others.

National courts have also reminded administrative and judicial authorities of their duty to follow through with ordered medical evidence and to address contradictory medical evidence and an applicant's objections to medical evidence. The Court of Appeal in Cyprus remitted a case for re-examination with proper consideration of the medical and psychological evidence, ruling that although the Refugee Law does not impose a duty to order a medical examination, once a referral is made, any reversal of that decision requires proper reasoning (137/2023, 21 May 2025). In addition, the Supreme Administrative Court of Austria for instance recalled that the lower court had the duty to address the parties' submissions insofar as they may be relevant to establishing the facts, and when there are contradictory findings in the medical evidence, it may not disregard significant allegations or requests for evidence from the applicant without investigation and providing reasons (Ra 2024/18/0480, 1 September 2025). Specifically, when an expert opinion does not answer whether the absence of symptoms is due to genuine recovery and the applicant specifically raises this objection citing a risk of abrupt discontinuation of antipsychotic medication, the court cannot disregard the objection.

3.5. Adapting the asylum procedure

Accelerated procedures must ensure a fair and comprehensive examination and allow applicants enough time to gather supporting evidence. If this is not possible, the authorities must move to the regular procedure. The High Court in Ireland ruled that accelerated safe country processing must ensure a fair and comprehensive examination and the International Protection Office (IPO) breached its duty of cooperation by deciding without awaiting a psychological report that could have affected the credibility assessment (*E.I. v Chief International Protection Officer and Anor*, [2025] IEHC 690, 5 December 2025).

Similarly, the District Court of The Hague reminded that, if sufficient support cannot be provided under the border procedure, EU law requires moving to a standard asylum procedure, which allows for more time and resources to assess the application. It ruled that the authorities were also obliged in the border procedure to investigate whether special procedural guarantees were necessary, such as additional medical advice or spreading the interview over several days (NL24.22954, NL24.22955, 5 July 2024). In this case, a medical report issued by Medifirst advised that the applicant should only be asked simple questions due to her fluctuating concentration and delayed understanding, but the report was insufficiently considered.

In matters of interpretation, placing an interpreter on a specific side of the applicant and instructing them to speak loudly may be necessary in the case of an applicant with hearing impairment and psychotic disorder (Belgian CALL, No 304082, 28 March 2024).

Lastly, for applicants with a psychiatric illness, the Czech Supreme Administrative Court identified the additional procedural guarantees, besides the ones provided to other applicants, in *X.Y. v Ministry of the Interior* (5 Azs 156/2023-32, 18 September 2023), concerning a Russian national with paranoid schizophrenia and Grade II disability who was placed in a psychiatric hospital for a total of 4 years. The procedural guarantees include:

- Possibility for staff to consult specialists on specific matters, in particular on the applicant's state of health;
- Providing information adapted to the applicant's disorder;
- Conducting the interview in an appropriate manner, in the presence of family members when appropriate or third parties such as a psychologist or a doctor, or not conducting it at all if the person is unfit to be interviewed;
- Conducting the personal interview in consultation with experts to determine how to ask various questions and how to consider the applicant's diagnosis;
- The authorities must order a professional medical examination to ascertain the current medical condition and specific manifestation of the diagnosis in order to determine how it may affect the interview and the extent to which the statements may be relied on for the examination of the application;
- Appointing a guardian for administrative proceedings if the applicant lacks capacity; and

- The court's obligation to conduct a full and *ex nunc* examination on appeal, including carefully assessing the applicant's new statements made on appeal and, if needed, appointing an interpreter for judicial proceedings.

The Supreme Administrative Court of Czechia applied the same framework and further extended the procedural safeguards to the fact that the interview should not have been conducted by a male interviewer without a prior assessment of the applicant's health condition. The case concerned a Russian woman suffering from borderline personality disorder, anxiety, depression, ADHD and a history of self-harm (*A.S. v Ministry of the Interior*, 5 Azs 332/2024 - 48, 24 October 2025).

Jurisprudence shows that there is a duty to cooperate to obtain medical evidence, which must be applied throughout the procedure. Medical conditions impact the credibility assessment, progressive disclosure of claims and the burden of proof. For this reason, there is a duty to investigate the applicant's capacity to participate adequately in proceedings.

The following converging principles were identified across the jurisprudence of EU+ countries, the CJEU and the ECtHR:

- A medical diagnosis triggers a duty to investigate by the authorities and courts, including by obtaining a medico-legal report where there is evidence of mental health problems potentially resulting from a traumatic event and where such a report is necessary and relevant.
- The duty to investigate must be fulfilled effectively not formalistically, even in border and accelerated procedures. If this cannot be provided, authorities must transition to the regular asylum procedure.
- Authorities and courts must effectively engage with medical evidence before a credibility finding is reached and, according to the CJEU, all evidence and elements submitted in support of the application, including documents whose authenticity cannot be established, must be included in that assessment.
- Contradictory medical evidence and an applicant's objections to expert conclusions in medical reports must be addressed by the authorities and courts. Deciding without awaiting medical reports, particularly in the accelerated procedure, constitutes a breach of the duty to cooperate. However, according to the CJEU, a breach of the duty of cooperation found at a second level of judicial scrutiny does not necessarily, by itself, lead to annulment, since the applicant may be required to show that the decision might have been different (*X*, C-756/21). The evaluation of medico-legal reports and other medical evidence is one of the areas in which challenges still remain, with the Istanbul Protocol being unevenly integrated in the assessment.

- Psychiatric conditions can explain inconsistencies in statements. Some courts, notably the Swiss Federal Administrative Court, have held that they cannot explain contradictions in the core elements of a claim for international protection, while the UN Committee against Torture stressed that complete accuracy can seldom be expected from victims of torture (*H.U. v Finland*, No 1052/2021, 17 November 2023).

- Authorities must provide special procedural safeguards, which may include adjusting interview conditions, spreading interviews across multiple sessions, and moving from the accelerated to the regular procedure.

- To ensure an effective remedy, courts at first instance must have the power to order medical examinations if necessary. Article 67(3) of the APR requires a full and *ex nunc* examination of both facts and points of law, at least before a court or tribunal of first instance, using the wording of the CJEU in *B.F. [Barouk]* when interpreting Article 46(3) of the recast APD. The CJEU has since held that the court of first instance must carry out the examination regardless of the grounds expressly raised in the appeal and must not be confined by them. Furthermore, when the negative decision is coupled with a return decision, the court must verify of its own motion whether the principle of *non-refoulement* precludes a return (*Ramodi* and *Karkik*).

The EUAA Judicial analysis on vulnerability in the context of applications for international protection (February 2023) and the Judicial analysis on evidence and credibility assessment in the context of the Common European Asylum System (February 2023) can assist in providing guidance for courts on the assessment of medical conditions and medico-legal reports, while the International Association of Refugee Law Judges (IARLJ, now the International Association of Refugee and Migration Judges, IARMJ) Guidelines on the Judicial Approach to Expert Medical Evidence (2010) may provide additional guidance on adequately considering medical conditions and evidence procedurally.

4. Reception conditions for applicants with medical disorders



Vulnerable persons, including individuals with a medical condition, may have special reception needs, which Member States must identify through an individual needs assessment. Furthermore, they must be provided with healthcare, including mental healthcare if needed, reception conditions that ensure at least their subsistence, protect their physical and mental health, and provide emergency care and essential treatment for illnesses and serious mental disorders (Articles 19, 22 and Recitals 46 and 47 of the RCD 2024).

A novelty in the Pact's RCD 2024 is that it replaces the concept of vulnerable persons with applicants with special reception needs. It includes a list of categories of applicants who are likely to have special reception needs, including persons with disabilities, persons with serious illnesses and persons with mental disorders including PTSD (Article 24(c), (i) and (j)). It specifies that an assessment of special reception needs must be carried out within 30 days of the making of the application, be individual, based on visible signs, statements or behaviour, and conducted by appropriately trained staff. For those for whom special reception needs have been identified, the directive mandates that they are provided with the necessary rehabilitation and assistive medical devices (Article 22 of the RCD 2024).

The RCD 2024 expanded the healthcare that must be provided to applicants by including sexual and reproductive healthcare and stipulates that it must be of adequate quality, for example by referring to specialist practitioners (Article 22 of the RCD 2024). The directive calls for a continuity of healthcare, regardless of where the applicant is required to be present in accordance with the AMMR (Article 22(1)). Safeguards have also been put in place for specific treatment for minors who reach the age of majority (Article 22(2)).

Moreover, the specific special reception needs and the principle of proportionality must be taken into consideration when reducing or withdrawing material reception conditions, ensuring, under all circumstances, that access to healthcare is preserved.

The EUAA Operational Standards and Indicators on Reception including Vulnerability-related Aspects (27 April 2026) highlights these obligations as operational standards, including access to necessary healthcare for adults, at least emergency care, essential treatment of illnesses and serious mental disorders (Standard 104), necessary medical and psychological treatment and care for applicants with special needs (Standard 105), continuous and timely identification of applicants in a vulnerable situation (Standard 138) and referral, when necessary and with the applicant's consent, for further assessment or support (Standard 143). Of further relevance, the EUAA Guidance on Mental Health and Well-being of Applicants for International Protection (November 2024, Parts I-III) aims to improve the provision of psychosocial support.

The application of most of these obligations has already been judicially reviewed by courts in EU+ countries. This section thus focuses on the standards set out in the jurisprudence of the ECtHR concerning states' positive obligation to provide adequate medical care when they are aware of medical needs, but also on the limits of the states' obligation to prevent the suicide of an applicant with a psychiatric condition. Furthermore, the section below also discusses how courts assessed the obligation to provide accommodation adapted to a particular medical condition, as well as the obligation to cover the costs of medical procedures and treatments, with a focus on surgery considered necessary for a progressive condition and hormone therapy for gender transition. Finally, the section briefly considers the issue of withdrawal of reception conditions when the applicant suffers from a medical condition.

4.1. States' obligation to provide adequate medical care under the ECHR

The ECtHR has addressed reception conditions for seriously ill applicants in few but significant cases. The court has underscored the obligation of states to act with diligence and provide adequate medical care and living conditions to seriously ill applicants. The main point of the court's jurisprudence is that the lack of reasonable measures when authorities are aware of medical needs will lead to a violation of Article 3 of the ECHR. While the mere deterioration of the state of health is not sufficient to establish a violation of Article 3, the question is whether the authorities took all the reasonable medical measures to prevent the progression of the illness (*E.F. v Greece*, No 16127/20, 5 October 2023, citing *Yoh-Ekale Mwanje v Belgium*, No 10486/10, 20 December 2011).

Two cases stand out on this topic, in which the court found violations of Article 3 of the ECHR, as the authorities failed in their obligation to protect the applicant's health. In both cases it was considered that the authorities did not take reasonable medical measures to prevent the progression of the illnesses:

- *A.R. and Others v Greece* (Nos 59841/19, 15782/20, 21997/20, 18 April 2024), where an applicant with chronic hepatitis B staying at a Multi-Purpose Reception and Identification Centre (RIC) received only paracetamol for 10 months for a serious conditions which was known to the authorities, until his transfer to the mainland for specialised medical services. The applicant was not given suitable medical supervision or proper treatment.
- *E.F. v Greece* (No 16127/20, 5 October 2023), where an applicant with HIV and non-Hodgkin lymphoma, in the Reception and Identification Centre of Moria, received antiretroviral treatment with a 6-month delay and only after developing severe symptoms. The court emphasised that the authorities were aware of her HIV infection since arrival and considered that the exceptional conditions due to the COVID-19 restrictions did not justify the delay, since a doctor had ordered her transfer before the centre closed. The ECtHR also found a violation of Article 13 in conjunction with Article 3.

The ECtHR case law also highlights that inadequate reception conditions can lead to medical conditions and a violation of Article 3 when authorities do not act with the required diligence. For instance, in *W.S. v Greece* (No 65275/19, 23 May 2024), the ECtHR ruled unanimously that Greece had violated Article 3 of the ECHR for failing to provide adequate reception conditions to an unaccompanied Afghan minor for over 1 month, during which time he attempted suicide

and was diagnosed with scabies. The court noted that the authorities were informed from the moment he lodged his asylum application about the applicant's situation and the fact that he was unaccompanied, without stable accommodation, access to basic necessities, and a permanent legal guardian.

Thus, under ECtHR's case law, when the authorities are aware of the medical conditions of applicants for international protection, an inadequate or delayed medical care response can constitute inhuman or degrading treatment if the authorities fail to take medical measures reasonably expected of them, while a deterioration of health is not in itself sufficient to establish a violation (*E.F.* v *Greece*).

4.2 Limits to the state's positive obligation to prevent the suicide of an applicant with psychological medical conditions

The ECtHR also considered the state's positive obligation to take preventative measures to protect the life of a person suffering from a psychological condition during the asylum procedure or removal process (*Hasani* v *Sweden*, No 35950/20, 6 March 2025).

Hasani v _Sweden_, No 35950/20, 6 March 2025

The applicant's brother committed suicide 2 days after the negative asylum decision was announced, while living in state-provided accommodation. The applicant's brother, who had arrived in Sweden as an unaccompanied minor, had a degenerative retinal disease, Retinitis Pigmentosa, and suffered from anxiety, depression, sleeping problems, concentration issues and had repeatedly attempted to harm himself. He had also expressed suicidal thoughts, including during asylum interviews, inter alia, related to his possible removal to Afghanistan and to his visual impairment.

In a judgment adopted by four votes to three, the ECtHR did not find a violation of Sweden's positive obligations under Article 2 of the ECHR. The ECtHR assessed that there were no signs of mental distress or suicidal tendencies in the month preceding the decision and no immediate signs in the days prior to place the authorities in a position to be responsible to prevent this risk.

The ECtHR noted however with concern the Migration Agency's lack of guidelines or routines for delivering negative decisions to asylum-seekers who have displayed suicidal tendencies and for contacts with psychological or psychiatric care institutions.

Dissenting opinion: Three dissenting judges argued that:

- The authorities could have taken reasonable measures to mitigate the risk of suicide, with a real prospect of altering the outcome or mitigating the harm (e.g. providing psychological or psychiatric support, assessing the mental state before announcing the decision, providing legal support and assistance when announcing the decision, monitoring the person after being given notice of the negative decision, putting the person in contact with psychiatric care services).
- While personal autonomy must be respected, in some circumstances it must be considered that a person suffering from mental health problems may be unable to make coherent complaints.

Therefore, for the ECtHR, awareness about the medical condition, or as in *Hasani*, of an imminent risk, remains a necessary condition to engage the state's obligation to actively take healthcare-related measures. The reinforced health and vulnerability check introduced by the Pact could fill the gap that remained under the previous legislation when the authorities did not carry out a systematic health check.

4.3. Accommodation in a structure adapted to the medical condition

A further obligation on authorities is to provide adapted accommodation that protects the applicant's dignity, where the need is justified by a medical condition. This also applies to beneficiaries of international protection, as shown below.

4.3.1 Diseases of the musculoskeletal system

In a case concerning a Palestinian applicant who had several medical conditions, including bullet wounds, chronic prostatitis, haemorrhoids, cardiopathies and fibromyalgia, the Labour Court of Liège (Belgium) emphasised that Fedasil was under the legal obligation to consider the medical profile of the applicant before designating a reception centre (23/1656/A, 24 October 2023). The applicant was allocated to a caravan-type accommodation without sanitary facilities which are easily accessible during the night. The location in Senonchamps was far from Brussels to access medical care, and the authority had failed to refer him to a psychologist. The court concluded that Fedasil had accommodated the applicant in conditions which were not in line with human dignity and ordered Fedasil to provide him with individual accommodation with access to sanitary facilities in Brussels or at most 1 hour from Brussels.

4.3.2. Psychiatric conditions

Similarly, for a beneficiary of international protection in need of psychosocial and sanitary assistance and psychotropic substances, the Regional Administrative Tribunal of Lazio in Italy ruled that the authorities must verify the possibility of accommodating the applicant in a structure equipped for psychosocial and sanitary assistance and to ensure that the structure was in contact with the local health authority and social services in case of an emergency (06862/2022, 8 September 2022).

4.4. Covering specific medical procedures and treatments

The issue of access to specific treatment and covering the costs of treatments, such as hormone therapy, or surgery was addressed by courts in Estonia and Germany respectively.

4.4.1 Hormone therapy for gender transition started before arrival in the Member State

The Tallinn Circuit Court in Estonia addressed the right of a transgender Russian applicant to be provided with hormone therapy for gender transition which he had started at age 14 in the Netherlands and Czechia (3-25-1872/7, 17 July 2025). While detained by the PBGB, the applicant requested the necessary treatment (Androgel) that an endocrinologist had refused to prescribe, with the reasoning that the applicant should start the diagnosis process from the

beginning and obtain approval from an expert committee. The applicant argued that under Article 19 of the recast RCD, applicants must be guaranteed medical care, including access to treatment started before arrival in the Member State.

The court ruled that the PBGB could not be obliged to provide the applicant with Androgel since it was not within its competence but within that of healthcare providers. It emphasised that, while the PBGB must ensure access to medical examinations and necessary healthcare, it is not competent to determine the necessity or content of medical treatment, which is a prerogative of medical professionals. It noted that a refusal by a healthcare provider to prescribe medication is not a denial of healthcare.

The court nonetheless made two very important observations. First, the court affirmed that when a person has access to a qualified specialist but is dissatisfied with the decision or treatment and wishes to seek a second opinion, there should be no valid reason to deny such an opportunity without strong justification. Second, it is unacceptable that insufficient attention had been given to a legitimate medical need, vital to the applicant, and that he had not received substantive responses to his requests. The court emphasised that the PBGB has both the ability and the duty to cooperate with the healthcare provider to find a reasonable solution to the applicant's problem, even if this means that it fulfils its obligation through a private healthcare provider.

4.4.2 Medically necessary surgery for a progressive musculoskeletal condition

In a significant case in Germany concerning an applicant whose asylum appeal was pending, the Lower Saxony-Bremen Regional Social Court assessed the obligation of the authorities to cover the costs of medically necessary surgery for a minor with a progressive musculoskeletal condition (L 8 AY 16/23 B ER, 20 June 2023). As a result of a chronic progressive disease caused by a gene mutation, the child had short stature, a severe bone growth disorder, a deformation of the thorax and a pronounced multidimensional axial deformity in the knee joints. The district authorities argued that the surgery was not essential to ensure the child's health or to address the child's special needs and that the state did not have to cover it since the child was under the obligation to leave the country.

The court ruled that the decision to withhold surgery was not objectively justified and rejected the argument that such costs should not be covered due to the minor's obligation to leave the country. The Senate of the social court highlighted that the Asylum Seekers Benefits Act provides a fundamental right to a decent subsistence level, and, in the court's reading of the UN Convention on the Rights of the Child (UNCRC), medically necessary treatment, according to the living conditions in Germany, may not be refused without a special justification. The court emphasised that the authority must specifically justify its refusal by referring to the circumstances of the individual case and the quality of the affected fundamental right. The court noted that, from a medical perspective, there were doubts about whether treating the applicant with analgesics was preferable to surgically correcting the deformations of the lower extremities which caused permanent pain. However, after surgery, the applicant would no longer need a wheelchair and may even be able to walk with little or no pain without aid. Given these circumstances and the applicant's expected longer stay in Germany, the court ruled that withholding the urgent medical measure for an underage applicant was not objectively justified.

4.5. Withdrawal of reception conditions when the applicant suffers from a medical condition

When material reception conditions have been withdrawn, courts have verified if the health condition of the applicant was taken into consideration and the impact of the medical condition on the applicant was assessed. The Regional Administrative Tribunal of Piedmont in Italy overturned a decision to withdraw reception conditions from an applicant with severe tuberculosis and in an anxious depressive state, finding that the decision was based only on the applicant's absence from the centre for 2 days, without an assessment of the impact of the disease on the conduct of the applicant and the suitability of the structure to host the applicant (01383/2018, 31 December 2018). Thus, the authorities must investigate the health profile of the applicant before withdrawing reception conditions.

At the EU level, the CJEU judgments of *Haqbin* (Grand Chamber, C-233/18, 12 November 2019) and *TO* (C-422/21, 1 August 2022) established that sanctions under the recast RCD, even for serious violence, cannot include the withdrawal of essential housing, food or clothing, and must instead uphold human dignity, proportionality, healthcare access and the best interests of vulnerable applicants (see EUAA, Jurisprudence on Material Reception Conditions in Asylum: Sanctions, Reductions and Withdrawals, November 2024).

Jurisprudence concerning healthcare for international protection applicants is based on the positive obligation of the authorities to diligently provide medical care once they are aware of an applicant's medical condition, and a failure to provide such care may lead to a violation of Article 3 of the Convention. The decisive issue is whether the authorities took all reasonable medical measures, while deterioration of health is not in itself sufficient (*E.F.* v *Greece*, No 16127/20, 5 October 2023). The ECtHR case of *Hasani*, which concerned suicide prevention, shows the limit of the authorities' obligation, which must be aware of an imminent risk to trigger the positive obligation under Article 2. However, as dissenting judges outlined, authorities should be aware that applicants with psychiatric conditions may have an impaired capacity to signal to others their distress. The vulnerability assessment under the Pact may help identify such applicants, while *Hasani* v *Sweden* points to the need for guidelines on delivering negative decisions to applicants who have displayed suicidal tendencies.

National case law applied these ECtHR principles by refining the obligations to provide accommodation and treatment according to the particular medical conditions. Furthermore, they also added a layer of case law concerning access to specific treatments (e.g. hormone treatment, surgeries), considering that state authorities have a duty to facilitate access to specialists, cooperate with healthcare providers and address legitimate medical needs, even while an appeal against a negative asylum decision is pending.

5. Content of international protection for beneficiaries with a medical condition



Specific provisions of CEAS envisage a series of rights and obligations to aid in the integration of beneficiaries with a medical condition. For example, family reunification may be considered for a close relative who was wholly dependent on the beneficiary before departure, and this dependency may be due to a serious or chronic illness that requires the care of the family member. The CJEU case law exceptionally expanded the standards in matters of family reunification for adult dependent siblings, while the ECtHR examined the application of the income requirement for family reunification in the case of beneficiaries of international protection with impaired mobility.

In addition, beneficiaries of international protection should receive treatment for a serious illness or access disability benefits under the same conditions as nationals. Beneficiaries with special needs, such as persons subjected to physical or psychological violence and persons with disabilities, must be provided with adequate healthcare, including the treatment of mental disorders. While the QR provides that Member States may limit social assistance for beneficiaries of subsidiary protection to core benefits (Article 31(2)), all beneficiaries must have access to healthcare under the same eligibility conditions as nationals (Article 32).

This section analyses jurisprudence concerning these standards and, in the absence of relevant national case law, it focuses only on case law from the CJEU, ECtHR and the UN Human Rights Committee which developed standards for family reunification and for reasonable accommodation for persons with disabilities in view of naturalisation.

5.1. CJEU standards: Family reunification with a seriously ill dependent

The CJEU, in Grand Chamber formation, went beyond a formal reading of the Family Reunification Directive to give effective protection to a right which would otherwise not apply to an adult sister, in a case concerning the right to family reunification for an unaccompanied minor refugee with his parents and his seriously ill dependent adult sister who could not be left alone without care in Syria (*CR, GF, TY v Landeshauptmann von Wien*, C-560/20, 30 January 2024). She suffered from cerebral palsy and was in permanent need of a wheelchair and daily personal care, including assistance when eating, by her parents.

In the exceptional circumstances of this case, the CJEU ruled that Article 10(3)(a) of the Family Reunification Directive must be interpreted as requiring a residence permit to be granted to the adult sister in such exceptional circumstances. The court also found that the requirement for the child or his parents to sufficient accommodation, sickness insurance and sufficient resources for themselves and the sister would be tantamount to depriving the child of the right. The court noted that it was practically impossible for an unaccompanied minor refugee

to meet such conditions and extremely difficult for the parents to meet those conditions before even having joined their child.

While the Family Reunification Directive remains unchanged, the Qualification Regulation provides that Member States may extend the rules on maintaining family unity to other close relatives, including siblings, who lived together as part of the family before the applicant's arrival on the territory of the Member State and who are dependent on the beneficiary of international protection (Article 23(7)). The provision therefore includes adult dependent siblings. However, Article 23 applies for derivative status for people already present in the Member State with the applicant, and not to adult dependent siblings who are in a third country.

5.2. ECtHR standards: Family reunification requirements for beneficiaries with impaired mobility

In two judgments, the ECtHR examined the balance between the interests of beneficiaries of international protection to family life and those of the state in controlling immigration (*D.H. and Others v Sweden*, No 34210/19, 25 July 2024; *Okubamichael Debru v Sweden,* No 49755/18, 25 July 2024). In both cases the applicants had lodged their requests for family reunification outside the 3-month deadline provided by Swedish legislation, which would have allowed them to be exempt from meeting a specific income threshold. They both argued that their medical conditions, namely reduced mobility in the right foot, a side effect from polio for the applicant in *D.H.,* and an eye condition for the applicant in *Okubamichael Debru,* were exceptional circumstances that should render the income requirement inapplicable to them since they could not work.

In both cases the ECtHR made reference to the standards it had previously set in *Dabo v Sweden* (No 12510/18, 18 January 2024). The court noted that national law, as amended in 2021, made it possible to grant full or partial exemptions from the maintenance requirement for exceptional reasons, for people who were unable to earn an income because of a permanent disability. However, while the medical conditions could affect their mobility, both applicants were capable of working, and they had not done all that they reasonably could to earn sufficient income to cover their family's expenses. Moreover, the applicants did not demonstrate that they had been treated differently because of their impaired mobility or incapacity to perform certain types of jobs. Regarding D.H., the court noted that she had been provided support to obtain employment (a special transportation permit, an electric moped and language classes). The court concluded in both cases that there was no violation of Article 8, as the authorities had struck a fair balance between the competing interests and had not overstepped the margin of appreciation. The complaints under Article 14 taken together with Article 8 were declared manifestly ill-founded.

Thus, the beneficiaries' medical conditions were examined in both judgments as part of the fair balance under Article 8. The court however found that the applicants had not shown that they were incapable of working or that they had done all that could reasonably be expected of them to earn sufficient income. The court also considered that, after the 2021 amendment,

Swedish law allows full or partial exemptions from the maintenance requirement, for example for people with permanent disability.

5.3. Naturalisation of beneficiaries of international protection with a disability: The need for reasonable accommodation

A decision by the UN Human Rights Committee in 2022 (*JSKN v Denmark*, No 2754/2016, 25 October 2022) established important principles on reasonable accommodation for persons with disabilities that are relevant for naturalisation of beneficiaries of international protection.

The UN Human Rights Committee determined that Denmark violated Article 26 of the International Covenant on Civil and Political Rights (ICCPR) by refusing naturalisation to a stateless Palestinian with chronic PTSD and reduced cognitive function which prevented him from meeting Danish language proficiency requirements and had worsened his linguistic skills in both Danish and Arabic. The committee also held that the authorities failed to reason why they refused to apply an exemption in this case which was available in national law.

The committee recalled that neither the ICCPR, nor international law in general, prescribes specific criteria for granting citizenship through naturalisation, and that states are free to determine such criteria. However, when adopting and implementing legislation, states must ensure that distinctions based on individual characteristics, including disability, must be based on reasonable and objective grounds and serve a legitimate aim.

The common principle that derives from the case law presented above is that an individual application of family reunification and naturalisation criteria is essential to give effectiveness to the rights of beneficiaries in cases that involve medical conditions. Courts and authorities look at whether criteria, such as income or language requirements, may need to be relaxed when the beneficiary suffers from an illness that would objectively impede their fulfilment. They are not however extremely flexible with these criteria, since in the CJEU case the dependency of the sibling was very clear cut and medically it left no room for doubt, while in the ECtHR cases even partial mobility and capacity to work was sufficient where the applicants had not shown that they were unable to work.

6. Returns of seriously ill persons

Article 5 of the 2008 Return Directive establishes that Member States must consider the state of health of the person and respect the principle of *non-refoulement* when implementing a return, a core principle which has direct effect (CJEU, *M.D.*, C-528/21, 27 April 2023) and is maintained under the 2026 Return Regulation (the provision marked in the correlation table, Article 4, includes fundamental rights and does not expressly mention the state of health; note also the temporal application rules in Article 50 of the Return Regulation). However, it does not specify how those factors should be considered or what impact the consideration of those factors may have in enforcing a return decision. These aspects were developed by European and national case law.

The ECtHR with the *Paposhvili* two-stage test has set up the standard in this area, examining first the severity of the illness and the risk that a removal would trigger a "serious, rapid and irreversible decline in health" resulting in "intense suffering" or a significant reduction in life expectancy and, secondly, assessing whether treatment is available and accessible in the country of return. Together with the standards set by the CJEU, which interpreted the Return Directive and the prohibition of *refoulement* under Article 19(2) of the EU Charter, the two European courts have set up a framework to determine whether a return is possible if it would lead to a deterioration of health.

National courts follow this framework in general when assessing the return of rejected asylum applicants or when examining requests for national forms of protection based on medical reasons, though with differences in the extent to which the analysis is individualised to the applicant (e.g. more or less aspects considered when assessing the accessibility of treatment, such as geographic distance, financial resources, social/family networks, stigma towards the person and cognitive capacity of the person), higher or similar evidentiary standards for psychiatric conditions, value given to private medical reports and the quality of MedCOI. In this respect, EUAA MedCOI database has been relied on to assess the availability of treatments and medications in countries of origin, including by the ECtHR (*A.K.* v *France* and *S.N.* v *France*), while courts scrutinise the timeliness and specificity of the information. Its use helps to apply the *Paposhvili* principles and the principle of *non-refoulement*.

In addition to the medical condition being a barrier against a return when there is a risk of serious and irreversible deterioration of health, EU law also provides for the suspension of the enforcement of a return decision. Under Article 13(2) of the Return Directive, which is repealed with effect from 17 October 2027, competent judicial or administrative appeal bodies have the power to temporarily suspend the enforcement of a return, unless the Member State has provided for an automatic suspensive effect in national legislation. Under the 2026 Return Regulation, although Article 28 does not provide for an automatic suspensive effect of an appeal, it does state that Member States must ensure that the competent court or tribunal of first instance can suspend a removal prior to the enforcement of the decision, upon request of the third-country national or *ex officio* if the national law so provides. According to the same

article, Member States remain free to provide for an automatic suspensive effect of remedies before a court or tribunal of first instance.

The CJEU has also held, with reference to the recast APD, that when a negative asylum decision is coupled with a decision imposing an obligation to return, the court or tribunal of first instance must verify *ex officio*, on the basis of the material in the file as supplemented or clarified following adversarial proceedings, whether the principle of *non-refoulement* precludes the applicant's return. It is sufficient that the material in the file indicates a risk of a breach of that principle for the court to be required to verify *ex officio* (*Ramodi* and *Karkik*, C-7/25 and C-8/25, 12 November 2026). In the same judgment, the CJEU restated that, when there are substantial grounds for believing that a third-country national would face a genuine risk of treatment prohibited by Articles 4 and 19(2) of the EU Charter, that person cannot be the subject of a return decision, nor be removed, while that risk persists. Article 26(3) of the Return Regulation similarly requires compliance with the principle of *non-refoulement* to be verified when material in the file brought to the attention of the court, as supplemented or clarified following adversarial proceedings, suggests a risk of *refoulement*.

If a return is postponed, Article 14(1)(b) of the Return Directive and Article 11(6)(c) of the Return Regulation establish that emergency healthcare and the essential treatment of illnesses should be considered 'as far as possible' (under the directive) and must be taken into account (under the regulation). This is another topic that emerges from jurisprudence, and this section briefly considers the principles set out by courts on access to emergency healthcare for seriously ill persons during appeal proceedings and until the removal decision is enforced.

6.1. ECtHR standards for the return of seriously ill persons

The ECtHR's Grand Chamber judgment in *Paposhvili* v *Belgium* (No 41738/10, 13 December 2016) established the current standard to assess the return of seriously ill persons. The case concerned an applicant with chronic lymphocytic leukaemia, tuberculosis, chronic obstructive pulmonary disease and Hepatitis C. A first Chamber judgment did not find a violation of Article 3 in case of a removal, and the applicant died before the Grand Chamber judgment in his favour.

Paposhvili v _Belgium_ [Grand Chamber], No 41738/10, 13 December 2016

The ECtHR held that Article 3 would be violated if, as a result of a removal, the applicant risked being exposed to:

- a "serious, rapid and irreversible decline in health" resulting in "intense suffering"; or
- a significant reduction in life expectancy.

The analytical framework set up by the Grand Chamber in *Paposhvili* includes two stages: first, the applicant must establish that a removal would trigger the risks above, and second, the state must examine:

- the individual risk in light of the situation in the country of destination;

- assess the impact of a removal by comparing the state of health prior to a removal and how it would evolve after a transfer to the receiving state, by considering whether treatment is available (sufficient and appropriate for the treatment of the applicant's illness) and accessible to the individual (its cost, the existence of a social and family network, and the distance to be travelled to have access to the required care);
- if serious doubts persist after the relevant information has been examined, regarding the impact of removal on the person concerned, the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the person.

The ECtHR did not define the timeframe within which a deterioration of health must occur.

The court held that there would have been a violation of Article 3 if the applicant had been removed to Georgia without an assessment of the risk he faced in the light of the information concerning his state of health and the existence of appropriate treatment in Georgia, and a violation of Article 8 if he had been removed without an assessment of the impact of removal on his right to respect for his family life in view of his state of health.

Paposhvili was a significant step in providing protection to seriously ill persons in cases of a removal. Before this Grand Chamber judgment, protection under Article 3 was engaged only when a very high threshold was reached, in very exceptional circumstances when death was imminent. For instance, in 1997, the court had recognised that expelling a terminally ill person suffering from AIDS with no access to care in the destination country could violate Article 3 (*D. v the United Kingdom*, No 30240/96, 2 May 1997) and confirmed this very high threshold in 2008, in the case of an HIV-positive woman from Uganda whose life expectancy was less than 1 year if she did not receive continuous treatment and monitoring (*N v United Kingdom*, Grand Chamber judgment, No 26565/05, 27 May 2008).

At the time, the dissenting opinion of Judges Tulkens, Bonello and Spielmann did highlight that other factors beyond imminent death, such as a lack of medical and palliative care or the absence of psychological support, are relevant under Article 3.

Savran v _Denmark_ [Grand Chamber], No 57467/15, 7 December 2021

The ECtHR:

- confirmed that the two-stage *Paposhvili* test also applies to mental illnesses;
- held that the threshold test established in *Paposhvili*, rather than mentioning any particular disease, broadly refers to the irreversibility of the decline in health, a wider concept capable of encompassing a multitude of factors, including the direct effects of an illness and its more remote consequences; the court considers that the standard is sufficiently flexible to be applied irrespective of the nature of the illness;
- clarified that the returning State's obligations listed in paragraphs 187-191 of *Paposhvili* are relevant only after the threshold test has been met and emphasised the procedural nature of the Contracting States' obligations under Article 3 of the Convention in cases involving the expulsion of seriously ill persons.

Importantly, evidence of a risk of harm to others cannot satisfy the *Paposhvili* severity threshold, the focus must be on the risk to the applicants themselves.

However, in *Savran v Denmark*, the ECtHR found that the applicant, who suffered from a severe form of schizophrenia, had not proven that his removal to Türkiye exposed him to a serious, rapid and irreversible decline of health resulting in intense suffering, and much less to a significant reduction of life expectancy. The domestic courts had expressly relied on information from the MedCOI database when assessing whether the applicant could continue his treatment in Türkiye and the ECtHR, applying the *Paposhvili* framework, reached its conclusion after having reviewed the evidence before the domestic courts, while the applicant criticised the reliance on MedCOI materials. The court noted that, according to some of the relevant medical statements, a relapse was likely to result in "aggressive behaviour" and "a significantly higher risk of offences against the person" as a result of the worsening of psychotic symptoms. While those would have been very serious and had detrimental effects, the court held that they could not be described as "resulting in intense suffering". The court detailed that no risk existed of self-harm and, if a relapse were to take place, there was rather a risk of harming others. In addition, any immune deficiencies that may result from Leponex, one of the medications prescribed to the applicant, even if they occurred, were not irreversible or result in intense suffering or significant reduction in life expectancy, as the applicant would merely have to interrupt the medication. Thus, the circumstances of this case did not reach the threshold of severity under Article 3 of the European Convention.

Judge Serghides partly dissented, arguing that the adjectives qualifying the decline (*serious*, *rapid* and *irreversible*), suffering (*intense*) and reduction in life expectancy (*significant*) were an extraordinarily high – even impossible to achieve – threshold, a test with multiple sub-tests that could lead to an "absolute restriction extinguishing an absolute right".

While the Grand Chamber did not find a violation of Article 3, it did find, by 11 votes to 6, a violation of Article 8 due to the permanent entry ban against the applicant, a long-term settled migrant with schizophrenia. The court considered that the domestic authorities failed to take into consideration and balance the interests at stake and all relevant factors, including the applicant's lack of criminal culpability on account of his mental illness and the progress made after years of compulsory care.

The *Paposhvili* and *Savran* principles were applied in two committee judgments concerning the removal of applicants with mental illnesses to Guinea (*A.K. v France*, No 46033/21, 18 April 2024) and Senegal (*S.N. v France*, No 14997/19, 18 April 2024), finding no violation of Article 3 in case of a removal. The court noted that reports produced by the applicant in *A.K.* on the generally deficient health system in Guinea did not specifically address his pathology (chronic psychosis), and in *S.N.,* medical certificates concluding that treatment for schizophrenia was unavailable in Senegal were not based on any verifiable documentary sources and did not clearly address the irreversibility of the deterioration. In both cases, the court also noted that the documents produced by the government before it, including EUAA MedCOI, tended to demonstrate the availability, in Guinea and in Senegal, of the medical treatment required by the applicants' pathologies.

6.2. CJEU standards for the return of seriously ill persons

6.2.1. Risk of a grave and irreversible deterioration of health (from *Abdida* to *LM* and *VT*)

The CJEU Grand Chamber judgment which set up the EU standard framework on the return of seriously ill applicants was *Abdida* (C-562/13, 18 December 2014), which was then extended in *LM* (C-402/19, 30 September 2020) and reaffirmed in *VT* (C-641/20, 5 May 2021, Section 6.8).

Abdida [Grand Chamber], C-562/13, 18 December 2014

The case concerned a Nigerian national with HIV.

The CJEU ruled that:

- In the very exceptional cases in which the removal of a third-country national suffering from a serious illness to a country where appropriate treatment is not available would infringe the principle of *non-refoulement*, Member States cannot proceed with such removal; national legislation must provide for a remedy with suspensive effect against a return decision whose enforcement may expose the person to **a risk of a grave and irreversible deterioration of health**;
- On the remedy with suspensive effect and on the basic needs, including emergency health care, to be provided pending the appeal (Article 14(1)(b) of the Return Directive), see Section 6.8.

_LM_, C-402/19, 30 September 2020

The case concerned proceedings to withdraw social assistance from a third-country national after requests for leave to remain in Belgium on medical grounds for a father and his seriously ill daughter were rejected.

The CJEU extended the _Abdida_ principles to a third country national who is the parent of a seriously ill adult child, where the child is dependant on that parent and the enforcement of a return decision against the child may expose the child to a serious risk of grave and irreversible deterioration of health. The parent must be entitled to an appeal with automatic suspensive effect against the return decision that concerns them and benefit from the safeguards pending return under Article 14 of the Return Directive.

The CJEU stressed that Member States must ensure that:

- **As far as possible, family unity** with family members present in the territory is maintained; and
- Basic needs (**emergency healthcare and essential treatment**) are provided, and the **special needs of vulnerable persons** are considered, only when third-country nationals lack the means to meet their needs.

6.2.2. Real risk of a rapid, significant and permanent increase in pain caused by the illness (Grand Chamber judgment in *X*)

The easing of restrictions by the ECtHR was also mirrored by the CJEU in its Grand Chamber judgment in *X v Staatssecretaris van Justitie en Veiligheid* (C-69/21, 22 November 2022).

_X_ [Grand Chamber], C-69/21, 22 November 2022

The case concerned a Russian national with a blood disorder (Polycythaemia Vera, a rare form of blood cancer) who used therapeutic cannabis treatment as an analgesic in the Netherlands and argued that a deportation to Russia, where medicinal cannabis was banned, would expose him to severe pain and he would no longer be able to sleep or eat, resulting in depression and a risk of suicide.

The CJEU ruled that a third-country national who is staying illegally and suffering from a serious illness must not be removed when there are substantial grounds to believe that return would expose the person, due to lack of appropriate care in the receiving country, to a real risk of a **rapid, significant and permanent increase in the pain caused by the illness.**

The CJEU found that **two conditions** must be met **for the permanent increase in pain** to reach the severity threshold of Article 4 of the EU Charter:

- it must be established that the only effective analgesic treatment cannot be lawfully administered to the applicant in the receiving country; and
- the absence of the treatment must expose the applicant to pain of such intensity that it would be contrary to human dignity as it would cause serious and irreversible psychological consequences or even suicide, a matter for the national court to determine considering medical information.

A multitude of factors must be considered to determine the irreversibility of the increase in pain, including the direct effects and the more remote consequences of such an increase.

Also, **EU law prohibits the setting of a fixed period within which pain must occur.** Any time limit set by Member States must be only indicative and cannot relieve the authorities from fully assessing the individual's situation (on how the temporal element was examined at the national level, see the German Federal Administrative Court, 1 C 18.05, 17 October 2006). The increase in pain may be gradual and a certain period may be necessary for the increase to become significant and permanent, and national authorities must weigh the speed of deterioration against the intensity of the resulting pain.

The CJEU further held that the consequences of the removal order on the state of health cannot be taken into account solely in order to examine whether the person is able to travel. When the person's state of health so requires, the Member State must ensure healthcare not only during a removal but also after a removal in the receiving country. When serious doubts about the risk of a rapid, significant and permanent worsening of the illness or the pain caused by it cannot be ruled out, the competent authority may not adopt a return decision or remove the person.

Finally, the Return Directive does not require a Member State to grant a right of residence to a person who cannot be returned due to a real risk of a rapid, significant and permanent increase in the pain caused by the serious illness. However, the state of health of the person and the care received in the Member State must be considered, together with all other relevant factors, when examining whether the right to respect for private life under Article 7 of the EU Charter precludes a return decision or removal order, although the adoption of such a decision does not infringe that right on the sole ground that the person's health would deteriorate when the risk does not reach the severity threshold of Article 4 of the EU Charter.

Following the CJEU judgment, the Secretary of State revoked the return order and the referring court instructed the State Secretary to reassess the right of residence considering that therapeutic cannabis was prohibited in Russia (NL20.6998, 27 December 2022).

6.3. High threshold of severity for an applicant's illness

National courts have applied the *Paposhvili* and *Savran* tests, requiring a high threshold of severity for an applicant's somatic or psychiatric illness, when assessing the return of seriously ill applicants whose requests for asylum were rejected. There appears to be convergence among courts to apply this two-stage framework, first determining the severity threshold by identifying the illness of the applicant, its stage and the applicant's exact treatment.

6.3.1. Somatic conditions

Courts considered the severity threshold in cases concerning the following somatic conditions:

- Inflammatory diseases (e.g. sarcoidosis - the Federal Administrative Court in Austria, L530 1309578-5, 4 January 2022);
- Endocrine diseases (e.g. diabetes mellitus - the Administrative Court of Ansbach (Bavaria) in Germany, AN 9 K 15.30166, 13 December 2017; Dutch Council of State, No 202005727/1/V1, 26 May 2023);
- Leukaemia (Borgarting Court of Appeal, LB-2021-41807, 16 June 2021); and
- Diseases of the nervous system (e.g. cerebral palsy - the Czech Supreme Administrative Court, 5 Azs 70/2020-103, 21 January 2022).

Concerning diabetes mellitus, for instance, the German Administrative Court of Cottbus noted in the case of a Nigerian applicant that Type 2 diabetes mellitus met the severity threshold as it is a serious and life-threatening disease which can lead to death or serious health impairments if left untreated (9 K 1563/20, 1 October 2024). However, lumbar pain was not considered to attain a minimum level of severity or to be at a life-threatening stage for an applicant from Syria who had undergone back surgery in Türkiye and had received treatment in Syria for 4 years (Regional Administrative Court of Düsseldorf in Germany, 17 L 3613/25.A, 4 November 2025).

At the same time, courts have noticed that some conditions carry the risk that, although they are chronic, they can quickly become fatal in the absence of specialised medical treatment. This was noted by the Borgarting Court of Appeal in Norway in the case of an applicant with chronic myelogenous leukaemia (CML), a life-threatening cancer requiring continuous treatment (Case LB-2021-41807, 16 June 2021). The court examined the nature of the illness and the treatment options in his country of origin and held that the expulsion of a foreign national who had arrived in Norway as a child and had been repeatedly convicted was disproportionate under Section 70 of the Immigration Act, attaching great weight to the real risk that he would not have timely access to the necessary, specialised medical treatment and

the waiting time would lead to a fatal outcome. The court found it unnecessary to rule on protection against return under Article 3 of the ECHR.

Before *Paposhvili* and *Savran*, the German Federal Administrative Court had already considered the direct effects and the more remote consequences of an illness. The court ruled in a case concerning an Angolan applicant with sarcoidosis of the lungs and liver undergoing cortisone treatment. The court considered that the assessment must include all circumstances in the country of destination that may worsen the illness of the applicant, and not only the lack of treatment. For an applicant with sarcoidosis, this included the risk of additional infections such as tuberculosis, as left untreated, could render the condition life-threatening. The court noted that such risks must be considered when an infection is likely to occur within a foreseeable period after a return and would lead to a substantial deterioration of the illness (1 C 18.05, 17 October 2006).

6.3.2. Psychiatric conditions

Courts follow the ECtHR's *Savran* and the CJEU's *C.K.* assessment frameworks to determine the severity threshold in cases concerning psychiatric conditions, with or without suicide risk and suicidal ideation.

6.3.2.1. Paranoid schizophrenia

On paranoid schizophrenia, for example, the Supreme Court of Denmark considered that a Bosnian applicant's condition – coupled with the fact that he had been committed to a closed ward due to a deterioration of the condition during appeal proceedings and the fact that he committed serious crimes while he was in a psychotic condition – would be at a risk of intense mental suffering and suicide if the treatment was interrupted by expulsion, thus reaching the threshold set out in *Savran* (*T. v The Public Prosecutor's Office*, 82/2020, 13 June 2022). Noting that the decision on expulsion must be made based on information available at the time of adopting the decision and that the risk of relapse and flare-up of symptoms would be significant, the Supreme Court ruled that the expulsion of the applicant should be annulled.

6.3.2.2. Suicide risk and suicidal ideation

In the jurisprudence of courts of EU+ countries, suicidal thoughts, tendencies and ideation do not, in themselves, constitute an obstacle to a removal. Courts have generally required a concrete and real danger of suicide, and have examined whether it can be prevented by appropriate measures. The CJEU judgment in *C.K. and others v Slovenia* has been widely cited in this sense.

C.K. and others v _Slovenia_, C-578/16 PPU, 16 February 2017

The case concerned a decision on a Dublin transfer of C. K., H. F. and their child A. S. to Croatia. C.K had a high-risk pregnancy and difficulties following childbirth. Psychiatric documents indicated that she had suffered depression and periodic suicidal tendencies, attributable to the uncertainty about her status.

The CJEU ruled that:

- Member States must take concrete measures to prevent a suicide attempt; and
- Appropriate safeguards accompanying a removal can prevent a risk upon a return.
- Where such safeguards are not sufficient to rule out the risk, the transfer must be suspended for as long as the state of health renders the person unfit to be transferred (see Section 1.1).

Courts from Estonia and Switzerland have applied consistently the _C.K._ principle that a suicide risk does not automatically prevent expulsion if specific suicide-prevention measures are in place (see Supreme Court of Estonia, No 3-20-1115, 15 February 2023; Swiss Federal Administrative Court, E-38_2019, 22 October 2020 and E-1805/2025, 17 April 2025), while assessing options such as parental care and adapted travel arrangements.

The stable, safe and predictable care of parents for a child with suicidal thoughts was emphasised by the Supreme Court of Estonia (No 3-20-1115, 15 February 2023), because the court considered that by creating a stable, safe, and predictable living environment, such parental care would render the child's mental condition treatable in Russia. The court reminded that, according to Article 9 of the Return Directive, health-related obstacles do not automatically entail an annulment of a removal but rather a postponement. The court concluded that the expulsion orders and entry ban were lawful, though the authorities should reassess the child's health before enforcing the removal. The court also added that allowing parents to make decisions that harm their child's well-being to strengthen their asylum claim could encourage misuse of the asylum system.

Furthermore, suitable travel arrangements (e.g. the assistance of a psychiatric nurse during the travel) were required, in line with _C.K._, by the Dutch Council of State for an applicant's return to Türkiye while suffering from depressive episodes and PTSD (202002468/1/V3, 20 December 2023). Similarly, the Swiss Federal Administrative Court provided for special measures for a return to Sri Lanka if the applicant's condition required, considering that the woman was suffering from paralysis on one side of her body and had a mental disorder for which she was prescribed psychiatric treatment (E-38_2019, 22 October 2020). Regarding the resurgence of her depressive symptoms and the diagnosis of "unscripted suicidal intention conditioned by her possible return to Sri Lanka", the court ruled that the prognosis was too uncertain to conclude that a return was unreasonable and her mental disorders did not appear to be so serious to place her in real danger if she would return.

6.4. Availability of healthcare in the country of origin

The availability of healthcare includes expert medical care and providers, as well as specific medication for the condition. Courts examine whether the treatment is sufficient and appropriate in order not to lead to a "serious, rapid and irreversible decline in health" or to "a significant reduction in life expectancy". They consider the availability of treatment in state or private hospitals and alternative care facilities when the condition of the applicant requires such treatment, the availability of the actual medicine or substitute medicine, and claims about the quality of healthcare in the country of origin.

6.4.1. State and private hospitals or clinics

Treatment may be available in state hospitals or private hospitals or clinics. For instance, the Regional Administrative Court of Weimar in Germany granted a deportation ban to a family from a Kurdish autonomous region in Iraq due to the serious psychological illness of one of the applicants, including recurrent depressive disorder, PTSD, pain disorder and psychotic factors (5 K 158/20 We, 5 April 2023). Although psychological and psychiatric treatment were generally available and free of charge in state hospitals, the court noted that it was not sufficient and appropriate given that MedCOI reports on Iraq highly criticised shortcomings in psychiatric care and medication shortages.

Moreover, treatment in state hospitals was of poor quality and private clinics charged a fee; there were long waiting times for inpatient treatment, and in some cases, patients had to pay for medication, complicated treatments and examinations. Consequently, the court concluded that the applicant was at risk of a drastic deterioration in her state of health due to a lack of medication and waiting times. Considering also the financial burden of covering the treatment, the court held that the family would face a situation that threatened its subsistence and was therefore entitled to a ban on deportation.

For somatic conditions, the Swedish Migration Court of Appeal concluded, based on EUAA MedCOI, that Iraq lacked specialised paediatricians for the treatment of metabolic diseases and kidney transplants, including pre- and postoperative care for paediatric patients, were not available. In the case of a 2-year-old Iraqi with a rare disease that could potentially evolve into total kidney failure, the court found that he would need to undergo dialysis or a kidney transplant in the near future. The care was vital for him, and even a short break in the current care was considered to pose a great risk to his health. The country information also indicated that dialysis machines were available in Iraq, but the demand exceeded the capacity and many people did not receive the treatment they needed. The court concluded that, although the best interests of the child do not imply in themselves a right to a residence permit, in this particular case, they outweighed the conflicting financial interest in saving the costs of medical treatment (MIG 2021:18, 17 December 2021).

6.4.2. Use of the black market and unofficial channels

Without engaging with the alternatives of public or private systems, the Swedish Migration Court of Appeal emphasised the official manner in which care is available. In the case of a Mongolian applicant who risked developing acute leukaemia, the court noted that when

assessing whether care is available, it is not decisive whether the care is provided within the framework of public healthcare or in some other way; instead, it must be provided in a not too uncertain way in an official manner.

The court considered that the fact that Glivec, the necessary daily medicine, was only available in the 'unlicensed market' may mean that access to necessary care is too unreliable for a person who has an extensive need for care or is in need of specialised care or drug treatment. The court noted that the applicant had made it probable that Glivec was not in the official drug register in Mongolia, which meant that the applicant would have to use unofficial channels and engage in illegal activities. The court highlighted that it is not reasonable to force an applicant to resort to unofficial channels that touch the boundary of legality or to violate domestic regulation and risk sanctions in order to obtain the necessary healthcare (MIG 2010:23, 25 October 2010).

6.4.3. Alternative care facilities and social and educational conditions for applicants with physical and mental disability

Besides mainstream treatment facilities, an applicant's medical condition may demand alternative care facilities or specific social and educational conditions. The Czech Supreme Administrative Court stressed the relevance of alternative care facilities for a child with a severe disability of cerebral palsy (5 Azs 70/2020-103, 21 January 2022). While the lower authorities had assumed, without evidence, that alternative care facilities existed in Bishkek, the Supreme Administrative Court ruled that a new decision based on up-to-date information on healthcare for children with disabilities in Kyrgyzstan had to be taken, which would also consider social and educational conditions for a child with a physical and mental disability in a context where the country had not ratified the UN CRPD.

6.4.4. Original and substitute medicine

Courts may differ in their approach to analysing the availability of medicine in the country of origin, as some courts look only at the national list of medicine (see Administrative Court of Melun in France, No 2304132, 26 September 2024), while others cross-check further evidence on availability. For example, the Saxon Higher Administrative Court examined the EUAA's MedCOI and additional MedCOI, noting that medicine in Russia for depression and severe Chronic Obstructive Pulmonary Disease (COPD) with chronic pain is generally free but can often be inconsistent and insufficient (6 A 9/18.A, 2 August 2023).

Furthermore, in the French case law examined, applicants had to prove not only that healthcare and the medication for their conditions is not available in the country of origin, but also that any potential substitute medicine would result in exceptionally serious consequences or is not available in the respective market.

Regarding substitute medicine, in a case concerning a Cameroonian applicant with schizophrenia who needed hospitalisation, the French Administrative Court of Rennes upheld OFII's refusal to grant a residence permit on medical grounds (2400157, 17 April 2024). The applicant argued that his required long-term medication, Trévicta, was unavailable in Cameroon and discontinuing it would endanger his health and physical integrity. To

substantiate his allegations, he submitted medical certificates, a prescription and an email from the laboratory marketing the pharmaceutical product.

However, based on the observations and documents produced by OFII, the court noted that the active ingredient in Trévicta (paliperidone) could be replaced by another molecule (risperidone), with a similar pharmacological activity. The court consulted two entries from 2023 in the EUAA MedCOI database and found that the substitute medicine and psychiatric follow-up were available in hospitals in Yaoundé and Douala. Furthermore, the court found that the applicant did not prove that switching from Trévicta to risperidone would result in exceptionally serious consequences.

6.4.5. Differences in healthcare standards in the country of origin and the host country

Courts of EU+ countries have consistently held that differences in the level of health services provided between the host country and the country of origin do not constitute, in themselves, a sufficient reason to establish a violation of Article 3 of the ECHR and Articles 4 and 19(2) of the EU Charter (e.g. Athens Administrative Court of Appeal, ΔΠΑ 531/2020, 27 January 2021; Austrian Federal Administrative Court, W257 2144225-1, 28 November 2017). Sufficiency and appropriateness of treatment is the standard, while equivalence of treatment standards is not a requirement when assessing the risk of ill treatment upon a return. Nonetheless, in several cases concerning myelogenous leukaemia, adenocarcinoma and chronic allergic asthma, courts assessed claims related to different healthcare standards.

In a case presented before the Norwegian Borgarting Court of Appeal (LB-2021-41807, 16 June 2021) involving myelogenous leukaemia (blood cancer), a chronic but potentially fatal disease, the court held that the equivalence of treatment standards may be decisive for a chronic disease that can rapidly develop into a fatal disease with significantly inferior treatment options. This assessment was made in the context of the proportionality of an expulsion under Norwegian law, while under Article 3 of the ECHR and *Paposhvili*, the benchmark is not the equivalent level of care existing in the returning State, but rather whether care is sufficient and appropriate.

Referring to chemotherapy treatment for adenocarcinoma in Georgia, the Federal Administrative Court (FAC) in Switzerland noted that the quality of medical care differed between the two countries, although the same chemotherapy treatment (FOLFOX) was available in Georgia as in Switzerland (D-5768/2024, 3 October 2024). According to the court, this was an indication that the quality of medicine in Georgia did not appear to be inadequate for cancer treatment and the applicant had used it before leaving the country. The court held that additional medical investigations were not necessary, and according to EUAA MedCOI on Georgia, such tests were available in Georgia. Taking into consideration accessibility elements, FAC concluded that it was not necessary for the applicants to remain in Switzerland and the chemotherapy treatment did not fall within the concept of 'essential treatment' which would not be available in the country of origin if a removal was enforced.

Finally, in a case concerning chronic allergic asthma for an applicant from Bangladesh, the Bordeaux Administrative Court of Appeal in France, in a judgment that was later overturned, decided that a residence permit on medical reasons must be provided, as access to care and

the quality-of-care services were not comparable to European standards (20BX02193, 20BX02195, 18 December 2020). While medication was available, the applicant could face difficulties in replacing parts such as pipes for his respiratory equipment.

The high level of fine particulate matter pollution in Bangladesh was relevant in this judgment, based on evidence from the doctor in charge of the Médecins du Monde care centre in Toulouse which noted that in Bangladesh the level of fine particles of pollutants was one of the highest in the world and asthma-related mortality was much higher than in France. The court noted that the applicant's health condition would worsen due to such pollution. However, a year later, the French Council of State annulled the decision of the Bordeaux Administrative Court of Appeal and ruled that exogenous factors such as the quality of medical care and the level of atmospheric pollution should not be considered (No 449917, 30 December 2021). The court held that, to rule otherwise would considerably broaden the right to residency for foreigners who require medical care and would potentially open new delicate debates, both before the administration and before courts, regarding the potential contribution of a given factor to the improvement or worsening of the patient's condition, especially since these factors are generally variable within a country (e.g. access to drinking water in a particular region, air pollution in a specific urban area), which is the scale at which accessibility of care must be considered.

6.4.6. Evidentiary considerations

A divergence apparent from the analysis of case law is that courts apply the second step of the *Paposhvili* test, the availability and accessibility of medical care, with various degrees of individualisation and evidentiary requirements. Some courts consider theoretical availability of medical care and provide minimal individualisation for the specific case, considering reports on the general healthcare situation in a country of origin as opposed to reports on specific medical conditions affecting the applicant. At the same time, courts differ in their approach to the use of state medical advisory opinions, sometimes giving them more weight than to private medical reports.

The use of reports on the general situation of healthcare in a country of destination, instead of documents analysing the situation specifically with reference to the medical condition affecting the applicant, was held to be insufficient for an accurate assessment in a case presented before the UN Committee on the Rights of Persons with Disabilities (*Z.H. v Sweden*, Communication No 58/2019, 6 September 2021) concerning an Afghan national with PTSD, psychotic symptoms, paranoid schizophrenia and suicide risk. Drawing on *Paposhvili* and *Savran*, the committee found that the national authorities had used reports on the general situation of access to healthcare in Afghanistan, which revealed a limited availability of psychiatric care and access to medication. The committee independently consulted additional reports (e.g. WHO Afghanistan Country Office 2019, December 2018); EASO, Afghanistan: Key socio-economic indicators, August 2020), which showed a lack of trained psychiatrists, social workers and psychologists, insufficient infrastructure for psychiatric care, a lack of awareness about mental health issues, and very limited resources covering a population of 30 million people. The committee noted that such information cast serious doubt on the availability of healthcare, and Swedish authorities were under the obligation to consider the extent to which

the applicant would have access to the required care, and if serious doubts persisted, to obtain individual assurances from Afghanistan.

In addition, courts somewhat vary in the weight given to medical advisory opinions from state medical institutions (e.g. OFII in France, BMA in the Netherlands) compared to private medical reports. Only in a few cases it was observed that private medical reports override state medical reports (e.g. Toulouse Administrative Court of Appeal, 24TL01866, 21 October 2025). In some cases, courts gave more weight to records from public institutions than to private medical records (e.g. Saxon Higher Administrative Court, 6 A 9/18.A, 2 August 2023, which gave more evidentiary weight to recent hospital records, rather than a private medical report diagnosing complex PTSD).

At the ECtHR, the OFII medical opinions were considered to be objectively serious and of quality, as they were delivered on the basis of a law from 2016 which had established an institutionalised procedure to ensure reliability and impartiality of medical opinions. In addition, the court considered that EUAA MedCOI presented by the government tended to demonstrate the availability of the required treatment in the country of origin (*A.K. v France* and *S.N. v France*). By contrast, medical certificates submitted by the applicant, issued by the treating psychiatrist, which concluded that treatment was unavailable in Senegal without relying on any verifiable documentary source, and an opinion by the *Comité pour la santé des exiles* (COMEDE) relying only on general indicators such as the number of doctors in the country, were considered insufficient to substantiate the claim (*S.N. v France*).

Doubts regarding the availability of treatment are sometimes interpreted in favour of the applicant. For example, the Borgarting Court of Appeal in Norway found, based on additional information provided by a country analyst of Landinfo on specific health services available for cancer treatment in specific locations in the country of origin, that it was unclear and unlikely that there was treatment for leukaemia in the region (LB-2021-41807, 16 June 2021). Even if it could be assumed that the applicant would receive adequate treatment outside of some regions, there was a limited number of places, which did not cover actual needs, waiting lists and it was unclear whether the applicant had a network of contacts to help in accessing the treatment. The court thus concluded that there was a real risk that the applicant's leukaemia would develop from the chronic to fatal phase upon a return to his country of origin and the real risk must be given great weight in the proportionality assessment.

6.5. Accessibility of healthcare in the country of origin

Further divergences among EU+ countries which are apparent from the analysis of case law concern the accessibility of medical care, as some courts noted an insufficient focus on accessibility or an omission of this aspect in the analysis made by national asylum authorities. In addition, some courts carry out more in-depth analyses of one or all of the factors relevant to accessibility (financial, geographic, social, cognitive, cultural or systemic factors).

6.5.1. Increased focus on availability and insufficient assessment of accessibility

The availability of medication was the focus of the analysis by the French Administrative Court of Caen in a case concerning a Georgian national with schizophrenia (No 2400407, 17 May 2024). The court highlighted the evidentiary strength of a favourable opinion from a medical panel of OFII, which gives rise to a presumption of existence or absence of a health condition that would justify the issuance or refusal of a residence permit. Together with MedCOI files which included links to websites of laboratories and pharmacies, there was strong evidence to conclude that medication, although marketed under a different name in Georgia, was available for the applicant's psychotic disorder. However, accessibility was discussed briefly, only with reference to the presumption noted above, and the court stated that it is incumbent upon the other party, in compliance with the rules relating to medical confidentiality, to produce all information enabling an assessment of the state of health and the existence or absence of appropriate and readily accessible treatment in the country of return.

In the Netherlands, the Council of State ordered the Secretary of State to re-examine the case of an Iraqi applicant suffering from schizoaffective disorder and severe paranoia by focusing on the lack of accessible care in Iraq upon a return (202104237/1/V2, 27 October 2022). The Council of State noted that the Secretary of State should have conducted further investigations and provided more detailed reasons why the applicant did not demonstrate that the treatment in Iraq was inaccessible to him due to geographic distance and an adequate support network, which consisted only of a nephew. The applicant's treating practitioner had highlighted that for treatment to be successful, he was dependent on a well-functioning support system. The Council of State ruled that these circumstances, along with the advanced age of the applicant, raised serious concerns about whether he would be able to access the medical treatment he needed in Iraq.

Similarly, the UN Committee on the Rights of Persons with Disabilities found that Sweden had inadequately evaluated the actual access to care in Lebanon for a Lebanese former combatant with PTSD and paranoid schizophrenia (*N.I. v Sweden*, Communication No 64/2019, 19 March 2025). While sufficient treatment was available in Lebanon for what was a life-threatening condition due to a risk of suicide as psychosis could be triggered by a removal, Sweden's assessment failed to fully consider crucial accessibility factors such as: the applicant's severely impaired cognitive function, the high cost of medication and treatment, the lack of contact with relatives in Lebanon, his inability to work, the social stigma attached to mental illness in Lebanon, documented evidence that his condition would worsen upon a return to Lebanon, and the impact of the challenging circumstances in the country on the actual provision of healthcare, including mental healthcare.

6.5.2. Work and financial capacity to cover the costs of treatment

To assess the accessibility of the treatment or medication, one of the elements examined by courts is the applicants' capacity to work and earn an income to cover the costs of treatment independently from social assistance. For support programmes, courts have referred to return assistance programmes and the possibility for the host EU+ country to provide financial grants to cover medications, as well as to financial programmes in the country of origin, financed by

the state (e.g. social assistance programmes) or private actors or institutions (e.g. welfare programmes).

Applicants must prove with evidence that they do not have the necessary resources to finance the required medical care, and a lack of details or evidence presented to the court may result in a dismissal of their claim of a lack of resources (see Administrative Court of Melun in France, No 2304132, 26 September 2024).

Furthermore, the capacity to work is examined by courts in relation to the medical condition invoked. The Federal Administrative Court in Austria referred to a Nigerian applicant's work and earning capacity as a person with sarcoidosis of the lungs and liver and pulmonary tuberculosis, finding that full-time work in moderate activities was possible (L530 1309578-5, 4 January 2022). To further finance treatment, the court indicated that, as part of the return assistance programme, the applicant could receive a financial grant to pay for the medication, which would cost EUR 384 annually. Although unrelated to medical conditions, the German Federal Administrative Court has also recognised that return assistance must be included in the assessment (1 C 10.21, 21 April 2022), and in a separate judgment concerning an Angolan applicant with sarcoidosis, it noted that inaccessibility of treatment due to financial or other personal reasons is a relevant factor for the assessment (1 C 18.05, 17 October 2006).

For an applicant from Bangladesh with insulin-dependent diabetes mellitus, the Administrative Court of Ansbach (Bavaria) in Germany considered, among other aspects, that neither the illness nor its therapy would hinder the applicant's ability to work, and thus he could reasonably be expected to finance the treatment upon a return (AN 9 K 15.30166, 13 December 2017). The court also noted that the applicant could not derive an individual right to protection from a situation of poverty to which large parts of the population in Bangladesh were exposed.

In contrast, citing the EUAA Medical Country of Origin Information Report on Nigeria (April 2022) for specific medication costs for Type 2 diabetes mellitus, the Administrative Court of Cottbus in Germany annulled a return decision, noting the high prices and costly specialist's visits. In addition, given the absence of relatives or a social network in Nigeria and the inability to work due to physical pain and disability, the court held that the applicant would not be able to afford the medicine for her diabetes mellitus if returned to Nigeria (9 K 1563/20, 1 October 2024). Similarly, the Tribunal of Bologna considered that the high cost of kidney transplants, expenses for preoperative and postoperative care, and the cost of medication for possible co-morbidities such as hypertension, diabetes mellitus and erythropoietin made it difficult or impossible for most patients to pay for treatment in Nigeria (No 6465/2022, 15 March 2023).

Specific financial programmes offered by the state or hospital or financial family support were also considered by courts. Concerning social assistance programmes, FAC in Switzerland confirmed a negative decision on asylum and the return of the applicant to Georgia, where chemotherapy treatment was available which could be financed through a social assistance programme. In addition, the court considered the applicant's financial assets and extensive family and social network (D-5768/2024, 3 October 2024).

With reference to a private welfare programme and family support, in a case concerning a Pakistani woman with diabetes mellitus and severe kidney damage who was on dialysis three times a week, the Council of State in the Netherlands held that the applicant failed to make it plausible that she did not have the financial means to pay for treatment, either through the Patient Welfare Programme at the Karachi hospital or financial support from her family (No 202005727/1/V1, 26 May 2023). However, the Council of State annulled the decision, holding that the State Secretary had not adequately reasoned why the treatment would be accessible to her for non-financial reasons, given the geographical distance and the fact that she was a single woman.

The effects of covering the financial burden of a medical treatment were also considered in relation to the effects on the family's capacity to ensure its subsistence. This was the case with an applicant from a Kurdish autonomous region in Iraq. The Regional Administrative Court of Weimar in Germany granted a deportation ban to the family due to the serious psychological illness of one of the applicants, including recurrent depressive disorder, PTSD, pain disorder and psychotic factors. Among various factors, it considered that the applicant's family would face a situation that threatened its subsistence if it had to cover the costs of the treatment, given the fees charged by private clinics or the fact that in some cases patients had to pay for medication and examinations (No 5 K 158/20 We, 5 April 2023).

Lastly, further practical measures, such as building up a supply of medication before leaving the host country and, if necessary, requesting the administrative authority to cover medication for a certain amount of time, were also found in case law (Swiss Federal Administrative Court, E-1805/2025, 17 April 2025).

6.5.3. Geographic and gender-specific accessibility barriers

Besides work and financial capacity, courts apply the *Paposhvili* geographic accessibility of treatment by looking at the distance that the applicant must travel to have access to the required care. In practice, this element usually also depends on the applicant's individual characteristics and the conditions in the country of origin. For example, the Saxon Higher Administrative Court (6 A 9/18.A, 2 August 2023) considered the availability of doctors in nearby villages in Russia and found that mental health treatment and free medications were available about 60 km from the applicant's hometown.

The Dutch Council of State provided a complex analysis considering multiple individual factors of accessibility in a case concerning a Pakistani woman with diabetes mellitus and severe kidney damage which required dialysis three times a week (No 202005727/1/V1, 26 May 2023). While the availability of the treatment in Karachi was confirmed based on advice from the Medical Advice Bureau (BMA) and on the fact that the applicant's brothers could contribute financially towards her treatment, the Council of State found that the State Secretary had not adequately reasoned why a single woman could be expected to settle near a hospital that was 1,147 kms from her hometown, considering that she could not support herself in Karachi due to her health conditions, one of her brothers was serving a life sentence and the other brother lived in a remote area with two children with disabilities.

6.6. Other factors considered by national courts

There are factors identified in the jurisprudence of EU+ countries which are not included in the *Paposhvili* standards as such. For instance, parental presence for seriously ill children may be derived from the best interests of the child principle (Article 3(1) of the UNCRC, Article 24(2) of the EU Charter, and Article 8 of the ECHR), while others arise from various claims made by the parties of the case (e.g. having had treatment for the same condition in the country of origin). These are examined below, while others were already mentioned in previous sections (e.g. the effects of pollution on respiratory diseases - see Section 6.4.5.).

6.6.1. Parental presence for seriously ill children

The best interests of the child under Article 3(1) of the UNCRC and Article 8 of the ECHR are engaged in cases involving seriously ill children or children whose parents have medical conditions that affect parental care.

Regarding parental care, the CJEU established in *LM* (C-402/19) the principles to follow for the removal of third-country national parents whose presence is essential for the care of a seriously ill adult child who is dependent on them (see Section 6.2.1).

From national courts, French case law is illustrative concerning rejected asylum applicants who then request a residence permit as parents of a seriously ill child. For instance, the Nantes Court of Appeal, examined the removal to Georgia of a father whose son suffered from severe autism, lead poisoning and other conditions. The OFII medical board opinion had found that the child required ongoing treatment, although the lack of care would not have exceptionally serious effects and the required medication aimed at behavioural regulation, not curative therapy. Taking this into account, as well as the fact that Georgia had recognised the child's disability, the court found that it had not been proven that there were deficiencies in the Georgian healthcare or educational monitoring system (25NT00823, 21 October 2025).

The same framework was applied with a different outcome by the Toulouse Court of Appeal in case 24TL01866 (21 October 2025), which did not concern behavioural but rather curative and rehabilitative multidisciplinary care. The court found that the spinal cord malformation (spina bifida) which caused a 6-year-old child paralysis of the lower limbs and a speech disorder had significantly improved through multidisciplinary treatment in France, and a return to Georgia would lead to regression in autonomy and physical function. The court considered that the opinion of the OFII medical board was overridden by evidence submitted by the applicants, including reports from neurology, neurosurgery, orthopaedic rehabilitation and school support services. In contrast to the above decision, in this case the court ordered the prefect to issue a provisional residence permit.

By contrast, in the case of a child with sickle cell disease and asthma, the Administrative Court of Melun in France confirmed the removal of an applicant and her children with reference to the Franco-Algerian Agreement, which does not extend medical stay rights to parents of ill children, only to the individuals themselves when their own health requires care that is unavailable in Algeria. The child's disease required regular hospitalisation and continuous medication, and certain medical authorities recognised that inadequate care could result in

exceptionally serious consequences. Still, the court found that the applicant's evidence was vague, as it referred in general to medication shortages but did not specify the availability for her treatment. The court considered that the applicant failed to demonstrate that her daughter could not receive appropriate treatment in Algeria. The court accepted OFII's position that Algeria has centres specialising in asthma and sickle cell anaemia, and medication was accessible according to the national list of drugs (No 2304132, 26 September 2024).

A further dimension, the interruption of the parent's psychiatric treatment upon a return to Russia, was added by the Latvian District Administrative Court among the factors to be considered in the evaluation of parental care and the risk of ill treatment (A42-01744-25/21, 16 September 2025). While not considered sufficient in itself to preclude a removal, the court considered that this aspect contributed to the finding that a removal would leave the children without adequate parental care, and combined with the possibility of subjecting the children to war propaganda in Russia, it reached the conclusion that there was a risk of persecution and consequently the applicants must be provided refugee status.

6.6.2. Previous treatment carried out in the country of return

Another aspect which is not commonly mentioned in judgments on the return of seriously ill persons concerns whether the applicant has undergone treatment in the country of origin before leaving. For example, the Czech Supreme Administrative Court emphasised that it is not decisive that a child suffering from cerebral palsy, a disease of the nervous system, accompanied by visual, hearing and mobility impairments, previously received certain medical care in Kyrgyzstan, but rather whether she will receive medical care if she returns, under what conditions and to what extent (5 Azs 70/2020-103, 21 January 2022).

By contrast, to assess whether it was necessary for the applicant to remain in Switzerland for chemotherapy for adenocarcinoma, rather than go back to Georgia, FAC in Switzerland considered, among various factors, that the applicant had undergone the same treatment before leaving the country of origin (D-5768/2024, 3 October 2024). In another case, the same court in Switzerland rejected the appeal of a Sri Lankan national who was paralysed on one side of her body and had a mental disorder for which she was prescribed psychiatric treatment. While it did not explicitly refer to treatment followed in the country of origin, the court noted that the applicant had lived all her life in Sri Lanka with the condition, completed university education, gained meaningful employment and built a social network (E-38_2019, 22 October 2020).

6.6.3. Other individual characteristics and social stigma

The applicant's individual characteristics and profile, such as gender (see Section 6.5.3), sexual orientation and gender identity (see Swiss Federal Administrative Court, E-1805/2025, 17 April 2025), the use of their mother tongue to interact with medical personnel (see Saxon Higher Administrative Court, 6 A 9/18.A, 2 August 2023), cognitive capacity, as well as social stigma for persons with the respective medical condition, were also taken into consideration when assessing the return of a seriously ill person. For example, the UN Committee on the Rights of Persons with Disabilities found that Sweden had inadequately evaluated the actual access to care in Lebanon for a former combatant with PTSD and paranoid schizophrenia,

considering among others, the applicant's severely impaired cognitive function and the social stigma attached to mental illness in Lebanon (*N.I.* v *Sweden*, No 64/2019, 19 March 2025).

6.7. Diplomatic assurances

In *Paposhvili*, the ECtHR noted as a last step of the analysis that if serious doubts persist about the risk of ill treatment upon a return for a person with a medical condition, the returning State must obtain individual and sufficient assurances from the receiving State, as a precondition for removal, that appropriate treatment will be available and accessible to the person.

Drawing on *Paposhvili* and *Savran*, the UN Committee on the Rights of Persons with Disabilities held that the deportation of an Afghan national with PTSD, psychotic symptoms, paranoid schizophrenia and suicide risk would violate his rights under Article 15 of the Convention on the Rights of Persons with Disabilities (*Z.H.* v *Sweden*, Communication No 58/2019, 6 September 2021). The committee noted that the Swedish authorities were under the obligation to consider the extent to which the applicant would have access to the required care and, if serious doubts persisted, to obtain individual assurances from Afghanistan. The committee noted that such individual assurances would have been particularly important, considering that he left Afghanistan when he was 13 years old and reports indicated that returnees may face challenges in accessing healthcare services.

6.8. Automatic suspensive effect of appeals and access to healthcare pending a removal

The ECtHR Grand Chamber judgments of *Paposhvili* and *Savran* do not explicitly mandate a suspensive effect of appeals against the return of seriously ill applicants. However, its jurisprudence concerning Article 13 in conjunction with Article 3 of the European Convention requires an effective remedy with a suspensive effect for applicants challenging their expulsion or return when an arguable claim under Article 3 is raised, which includes serious medical cases. As recalled by the CJEU in *Abdida*, the ECtHR has held that Article 13 requires a remedy enabling suspension of enforcement of the removal measure *ipso jure* where there are substantial grounds for believing that the person would face a real risk of ill-treatment contrary to Article 3 (*Gebremedhin [Gaberamadhien]* v *France*, No 25389/05; *Hirsi Jamaa and Others v Italy* [GC], No 27765/09). The CJEU was inspired by these principles set up in the ECtHR jurisprudence and applied them to medical cases in *Abdida* (Grand Chamber judgment) and *VT* (order).

Abdida [Grand Chamber], C-562/13, 18 December 2014

The case concerned a Nigerian national with HIV.

The CJEU recognised that:

- National legislation must provide for a remedy with **suspensive effect** against a return decision whose enforcement may expose the third-country national to a serious risk of grave and irreversible deterioration of the state of health;
- The authorities must provide **emergency healthcare and basic needs** during the appeal (Article 14(1)(b) of the Return Directive).

_VT_, C-641/20, 5 May 2021

An Iraqi national suffered from a serious illness while he had his refugee status withdrawn because spent some time in his country of origin to attend a funeral.

The CJEU reaffirmed the obligations arising from *Abdida* and added in VT that:

- The automatic suspensive effect also applies when the return decision follows the withdrawal of refugee status;
- The suspensive effect entails a **provisional right of residence and the ability to meet basic needs** until a decision is made on the remedy;
- A national court hearing a dispute whose outcome is linked to a possible suspension of the return decision must consider that the appeal has **automatic suspensive effect** provided that the appeal contains arguments, which do not appear manifestly unfounded, that enforcement of the decision would expose the person to a serious risk of severe and irreversible deterioration of health.

Although the Return Directive does not require that the remedy provided for in Article 13(1) should necessarily have a suspensive effect, the remedy must be consistent with effective judicial protection under Article 47 of the EU Charter and must not allow a removal to a state when there is a serious risk of being subjected to inhuman or degrading treatment, as provided in Article 19 of the EU Charter.

Regarding Member States' obligation to provide for the basic needs of a third-country national, the CJEU in *Abdida* held that it is for the Member States to determine the form in which provision for the basic needs of the third country national concerned is to be made.

Applying Article 9 of the Return Directive, the Supreme Court of Estonia referred to *Abdida* by noting that the postponement of a removal, rather than an annulment of the removal, must be applied to cases with health-related concerns (No 3-20-1115, 15 February 2023). This approach should be read in light of *X* (C-69/21, 22 November 2022), in which the CJEU held that, where serious doubts regarding the risk cannot be ruled out, the competent authority may not adopt a return decision.

Under the 2026 Return Regulation, Article 11(1)(a) provides that a removal must be postponed when it would violate the principle of *non-refoulement*. Article 5(10) adds that competent authorities are not precluded from issuing a return decision when there is an obstacle to the removal and, when a risk of *refoulement* is identified for the country of return designated in the return decision, a removal to that country must be postponed under Article 11(1)(a). In contrast, the CJEU judgment in *X* (C-69/21, 22 November 2022), delivered under the Return Directive, held that Article 5 of the Return Directive precludes a return decision from being taken or a removal order from being made for a third-country national who is staying illegally and suffering from a serious illness, when there are substantial grounds to believe that the person would be exposed to a real risk of a rapid, significant and permanent increase in pain caused by the illness and when serious doubts about such a risk cannot be ruled out. Also, in *AA* (C-663/21, 6 July 2023, not concerning a medical condition) the CJEU held that Article 5 precludes the adoption of a return decision where it is established that removal to the intended country of destination is precluded by the principle of *non-refoulement* for an indefinite period.

6.9. Burden of proof

A shifting burden of proof applies in medical return cases according to the ECtHR *Paposhvili* and *Savran* judgments. The applicant must first establish a *prima facie* case and produce evidence of substantial grounds for believing that there is a real risk of serious, rapid and irreversible decline in health resulting in inhuman or degrading treatment. The applicant must adduce evidence capable of demonstrating such grounds, typically through reliable medical certificates; it is then for the authorities of the returning State to verify whether appropriate care is generally available and sufficiently accessible to the applicant, and to dispel any doubts. Once a *prima facie* case is established and the applicant raises serious doubts, the burden shifts to the returning state to actively verify and challenge the claims to dispel those doubts.

Drawing on *Paposhvili* and *Savran*, the UN Committee on the Rights of Persons with Disabilities confirmed a similar approach to the burden of proof. For example, the committee found that the applicant had discharged his burden of proof although he had PTSD, psychotic symptoms and paranoid schizophrenia, but Sweden had failed to dispel doubts about the risks he would face upon a return to Afghanistan (*Z.H. v Sweden*, Communication No 58/2019, 6 September 2021). The committee found first that Swedish authorities linked Z.H.'s mental illness and suicidal ideation to his disappointment at his asylum process instead of objectively assessing it individually, which in turn unreasonably weakened his claim. The committee also found that the authorities had held that the necessary medical care would be available upon a return; however, the basis for this assessment were reports on the general situation of access to healthcare in Afghanistan, so it consulted additional reports on Afghanistan's healthcare system, which cast serious doubt on the availability of healthcare.

In national case law, the Dutch Council of State clarified that the standard of proof in such cases is 'plausibility', meaning that the applicant must make it plausible that they run a real risk within the meaning of Article 3 of the ECHR on account of poor health conditions, without having to provide clear proof (202005727/1/V1, 26 May 2023). Nonetheless, vague or general

evidence which does not address the specificity of the applicant's case may be considered insufficient. For example, in a case concerning a child with sickle cell disease and asthma, the Administrative Court of Melun in France considered that the applicant's evidence was vague, as it referred in general to medication shortages but did not specify the availability for her treatment, and the court considered that the applicant failed to demonstrate that her daughter could not receive appropriate treatment in Algeria (No 2304132, 26 September 2024).

Importantly, national case law has highlighted that the applicant's medical condition itself may affect the applicant's ability to defend their case. The Dutch Council of State ruled in this sense in a case concerning an Iraqi national with severe paranoia and schizoaffective disorder, noting that these medical conditions which distorted the applicant's perception of reality made it highly uncertain that the applicant had the ability to demonstrate that he had no income and no social network in Iraq (202104237/1/V2, 27 October 2022). In this case the Council of State ordered the State Secretary to reinvestigate accessibility, as it considered, in line with *Paposhvili*, that it was the obligation of the state to dispel doubts where they persist.

The return of seriously ill applicants who have been denied international protection follows the ECtHR *Paposhvili* framework, later confirmed and extended in *Savran* and closely mirrored by the CJEU in *Abdida* and *X* v *Staatssecretaris*.

The above analysis shows that national courts converge on the application of this framework:

- Courts apply the *Paposhvili* and *Savran* analytical framework to cases concerning both somatic and psychological medical conditions, following the same sequence, assessing the severity threshold before the availability and accessibility of treatment.
- Suicidal ideation is not sufficient to constitute an obstacle to a removal; courts require an immediate and concrete risk of suicide.
- Differences in healthcare standards between Member States and the country of destination do not constitute by themselves a violation of Article 3 of the ECHR.
- A rigid time limit cannot be imposed by national law for the deterioration of an applicant's health (CJEU, *X*, C-69/21, 22 November 2022).

At the same time courts diverge in specific aspects of its application and the case law also identifies such differences in the practices of national asylum authorities. Certain challenges in harmonisation remain, which is important in view of the implementation of the Pact:

- The depth of the analysis of the availability and accessibility of medical care is different. Some administrative authorities and courts undertake an in-depth evaluation of whether the person has genuine access to treatment by taking into account non-medical factors, such as financial, geographic, social, cognitive, cultural or systemic factors. Others limit the analysis to theoretical availability and minimal individualisation

(e.g. considering only the availability of medication on a national drug list as sufficient). For the Pact implementation, the preliminary health and vulnerability checks under the Screening Regulation are not designed to carry out an assessment as complex as the one analysed in this report; however, they may form part of the later assessments under Article 20 of the APR and Article 25 of the RCD 2024 (Article 12(5) of the Screening Regulation). Where short time limits apply and a medical condition is not identified or adequately assessed during the screening or the asylum procedure, there is a risk that it is not examined before removal. The obligations to respect the principle of *non-refoulement* (Article 4 of the Return Regulation) and, from 17 October 2027, to refer the person to the appropriate procedure or assess compliance with that principle where relevant indications are raised (Article 10(7)) are safeguards against such a removal.

- Return assistance programmes that can cover the costs of treatment are sometimes included in the judicial analysis as an accessibility factor, considered more or less in-depth and usually as a suggestion to the authorities, while stigma is also an accessibility factor, considered by the UNCRPD and accepted by the ECtHR as a factual argument in support of an Article 3 complaint (see *A.K. v France*, No 46033/21, 18 April 2024, for alleged stigmatisation of persons with psychiatric illness).

- Regarding evidentiary aspects, courts somewhat vary in the weight given to medical advisory opinions from state medical institutions embedded in the asylum procedure (e.g. OFII in France, BMA in the Netherlands) compared to private medical reports. Only in a few cases it was observed that private medical reports override state medical reports (e.g. Toulouse Administrative Court of Appeal, 24TL01866, 21 October 2025). The ECtHR for instance has noted that the opinions of OFII medical doctors have an objective guarantee of seriousness and quality as they are delivered under an institutionalised procedure to ensure their reliability and impartiality (*A.K. v France* and *S.N. v France*).

- While courts rely on MedCOI documents as a recognised source of quality and specific information, their scrutiny about the timeliness and specificity of COI differs. Further alignment and harmonisation among EU+ countries may be achieved by using EUAA MedCOI, on which the ECtHR has also relied (*A.K. v France* and *S.N. v France*).

The analysis also shows that national case law did not always result in successful asylum claims, but rather in the issuance or maintenance of medical residence permits or in the postponement of a removal pending an accessibility assessment under the *Paposhvili* framework. This is in line with the exception under the Return Directive and may be adapted by Member States implementing the Return Regulation in order to avoid a violation under the ECHR, given that the regulation eliminates the exception under Article 6(4) of the Return Directive, which allowed Member States to grant a residence permit or other authorisation for serious health conditions.

7. Conclusions



By analysing the jurisprudence of the ECtHR, the CJEU, the UN treaty bodies and national courts of EU+ countries, this report shows how medical conditions may be relevant throughout the entire asylum procedure. They may affect the rights and obligations of applicants, the channelling into the asylum procedure at the screening stage, the type of procedure applied to an applicant, the credibility assessment, the applicable grounds for protection, reception conditions, family reunification and ultimately the return of rejected asylum applicants. The report also shows that courts have progressively developed a coherent, though not fully harmonised, framework to address medical conditions in international protection.

The test introduced by the *Paposhvili* judgment (Grand Chamber), and its CJEU counterparts in *Abdida* and *LM* (for removals to third countries) and *C.K.* (for Dublin transfers), are now the common framework across EU+ countries that national courts apply, alongside national tests, for transfers of applicants to the responsible Member State and removals to third countries. This jurisprudence established high thresholds: under *Paposhvili*, removing a seriously ill person may violate Article 3 of the European Convention if it would result in a risk of a serious, rapid and irreversible decline in health, resulting in intense suffering or a significant reduction in life expectancy; under *C.K.*, the transfer of an applicant with a particularly serious mental or physical illness constitutes inhuman or degrading treatment if it would result in a real and proven risk of a significant and permanent deterioration in their state of health. Further principles were set up by both European courts on the duty to cooperate and ordering medical examinations, with the *Barouk* judgment from the CJEU explicitly recognising that courts of first instance must have the power to order a medical examination of the applicant when they consider it necessary or relevant for assessing the application. Recently, the CJEU confirmed the duty to cooperate and held that courts of first instance must carry out a full and *ex nunc* examination regardless of the grounds raised in the appeal (*Ramodi* and *Karkik*).

In the judgments analysed in this report, national courts have implemented these standards quite consistently, and they addressed different aspects of the duty to inform and exchange health information. Differences remain on whether failures in complying with the duty to inform and exchange health information may either be remedied on appeal or it may preclude a transfer. There are also differences in the quality and depth of precautionary measures taken by Member States prior to a transfer, as well as the individual guarantees provided in view of a transfer. A pending referral to the CJEU also highlights an area which may need further clarification - if courts must consider *ex officio* the entire impact of the transfer decision, including the effects of receiving a transfer decision, not merely the impact of the transfer.

For returns, courts consider that availability is not enough and they examine whether treatment and care facilities can be reached, whether applicants can financially afford the treatment and care, and when needed, whether accessibility is continuous. For example, reliability in the supply of medication from official channels, family support and social discrimination were deemed relevant in the assessment. Some differences were observed in the depth of the scrutiny given to the accessibility of treatment, the weight of medical

evidence (medical advisory opinions from state medical institutions compared to private medical reports), and the use of more or less recent MedCOI. On the latter, the EUAA MedCOI has been relied on by national courts and by the ECtHR as a source of information on the availability and accessibility of treatment in third countries and may fill a gap in much-needed and specifically-targeted medical information (see Annex on EUAA MedCOI). Awareness of EUAA MedCOI is especially relevant for both national asylum authorities and judges, particularly because once applicants with serious medical conditions establish a *prima facie* case concerning their health needs and the availability and accessibility of care in the country of origin, the burden of proof shifts to the authorities, which may be better placed to obtain MedCOI on these aspects.

The report also explored the rights to reception conditions, noting that national courts played an important role in defining the obligations of Member States with regard to healthcare in their jurisdictions (e.g. hormone treatment, surgeries), as well as procedural safeguards and adaptations that courts have identified as necessary in order to ensure that applicants with a medical condition may effectively participate and present their case in the asylum procedure.

On the grounds used by courts to provide protection for seriously ill applicants, the report noted that both refugee status based on membership of a particular social group and subsidiary protection may be provided. While only briefly explored in this report, some Member States also provide national forms of protection for this category of applicants, complementing the protection options under CEAS.

Compared to the previous CEAS, the provisions of the Pact modify the legal standing, processing, rights and safeguards for applicants with a serious somatic or psychological condition. While the Screening Regulation, the APR and the AMMR reflect several standards developed in the ECtHR and CJEU case law, small but important elements of the jurisprudence remain partially reflected, such as the standards for weighing contradictory medical evidence, the weight given to private medical reports or the relevant elements when assessing genuine accessibility of healthcare in the country of origin. The short deadline for screening also appears to be a potential challenge for Member States as it may be difficult to capture the complexity of some somatic or psychiatric disorders. Similarly, the APR's border procedure puts people with less obvious medical conditions (e.g. psychiatric illnesses, PTSD or chronic conditions) at risk of not being identified as applicants with special procedural needs. The risk is mitigated by the obligation not to apply the border procedure or to cease its application at any stage of the procedure when there are relevant medical reasons, including mental health reasons (Article 53(2)(d) of the APR). Considering the time limits for appeals and the rule on the suspensive effect under the Return Regulation (Articles 27 and 28, applicable from 17 October 2027), the focus on swift returns may also prejudice people with a serious medical condition, as they may not be able to secure expert medical evidence to support their stay, as it takes time to obtain such evidence.

Given these challenges for the interpretation of EU law and the difficulty for decision-makers to familiarise themselves with the intricate domain and specific terminology of somatic and psychiatric illnesses, continued reliance on EUAA resources (judicial analyses, MedCOI, practical guides and operational standards) and the IARMJ guidelines, alongside sustained dialogue between national courts, the CJEU and the ECtHR, remains essential to ensure a uniform implementation of the Pact.

Annex. EUAA MedCOI

A1. Definition of MedCOI

Medical Country of Origin Information (MedCOI) refers to information about availability and accessibility of medical treatments in third countries and information on the healthcare system and public health insurance. This information supports the national migration and asylum authorities in Europe to reach accurate and fair decisions in international protection and other migration procedures. MedCOI facilitates and supports decision-making processes but does not dictate decisions. MedCOI constitutes evidence in international protection and related procedures and is important to help make a fact-based assessment. MedCOI may also be used in the context of non-asylum related migration cases.

A2. Access to MedCOI

The EUAA produces and provides access to MedCOI. MedCOI is a service for national migration and asylum authorities, providing responses to requests for information about the availability and accessibility of medical interventions in countries of origin. According to the MedCOI Database Access Policy, access to the restricted section of the MedCOI Database is limited to designated employees of the EU+ authorities or any other body mandated by the EU+ countries, who are duly trained by EUAA.

MedCOI reports are publicly available via the EUAA website. Case-specific individual requests (see below) are only available in the MedCOI database.

A3. MedCOI products

The MedCOI database contains different types of products:

- Availability responses
- Accessibility responses
- Medical country reports (also available on the EUAA website)
- Fact finding mission reports (also available on the EUAA website)
- ICMPD products: quality reports, state practices and case law reports

Most responses are based on individual cases submitted by MedCOI users in EU+ member states. The **availability** of treatments and medications is checked first, using a standardised form and obtaining information from contacts in the country. Depending on the information needs of the requesting national migration authority, an accessibility request may then be initiated. In case the treatment availability is insufficient in the country of origin, no accessibility request is started.

Accessibility responses contain price information on treatments and medicines as well as information on the healthcare system and public health insurance. The information is sourced

through online research or directly from contacts in the country. The availability of the requested treatments and medications must be established first.

The two processes are separated, meaning that users must first submit an availability request and then an accessibility request.

Medical country reports contain information on the healthcare system, public health insurance, and treatment and medication accessibility for different medical fields or patient groups.

Fact finding mission reports are reports based on information collected during a field mission to the country.

The International Centre for Migration Policy Development (ICMPD) have produced reports on state practices and case law as well as provided external quality services in the form of quality reports on the MedCOI service. The reports are available in the restricted MedCOI portal.

A4. Scope of investigation

MedCOI investigates availability and accessibility of healthcare for third-country nationals in need to specialised medical treatment in third countries. Within a limited timeframe, the providers and researchers do their utmost to assess facilities that have information which is representative for the availability and accessibility in the requested country or requested region at the time of investigation.

The information does not claim to be exhaustive and does not constitute an exhaustive list of all the facilities in the country where the treatment could be available. When a treatment or medication is not found in one facility, another representative facility is consulted by the provider.

The assessments about treatments and medicines are limited to evidence-based medicine. The providers contracted by EUAA also do not assess whether the medical treatment meets the same standards as in EU+ countries. Additionally, only products legally available in the country are investigated.

General reports and case specific responses concern different kinds of assessments. Individual responses provide information tailored to that specific case profile, while reports provide general information that is more broadly applicable. For instance, depending on the severity of an individual case, treatment for certain conditions in an individual case may not be available in the country despite the presence of relevant specialists as indicated in a general report or in another case response.

Definition of availability

Availability is defined as whether medical treatment (including medication) for a specific case may be absent/present/sufficient or insufficient at least in a certain (public or private) medical facility at a certain time somewhere in the country of origin.

Definition of accessibility

Accessibility of healthcare is defined as whether an individual is able to, de facto, obtain medical treatment/medication given the person's financial situation, geographic location and irrespective of his/her race, religion, nationality, membership of a particular social group, or his/her political opinion, upon returning to his/her country of origin/residence.

A5. Guiding principles for MedCOI

The production of EUAA MedCOI reports and responses within the framework of a standardised process aims to guarantee the overall quality and acceptance by the target users. A full explanation is provided in the MedCOI Methodology (2025).

The following guiding principles are followed at each step of the MedCOI production process:

Scientific basis – i.e. only medical practices based on proven scientific methods should be considered and researched within the scope of MedCOI.

Neutrality and Objectivity – MedCOI should be produced in a neutral manner without seeking to favour a particular outcome or conclusion and remain fact-based and not influenced by emotions, speculation, personal or group-based prejudices, interests, or biases.

Relevance and Usability – to be closely connected to the fact, event, or matter in question and be relevant for the needs of the target users, mostly for the assessment of international protection needs. To ensure usability, MedCOI products should be easy to use with a language and structure that is accessible for the target users.

Transparency and Publicity – to be clear and open about the methods for how research decisions were made, information was obtained, assessed, and presented.

Validity and Quality – meeting the needs of the target users and of being methodologically, logically and factually sound.

A6. Quality control

Review

Peer review is a quality assurance and enhancement process in which the drafter(s) and peer(s) work together to ensure that the product meets the principles and quality standards set out in the EUAA MedCOI report methodology. All MedCOI products are peer reviewed by the EUAA MedCOI sector, minimum by one person.

Medical checks

Medical content is controlled either by direct check by a trained medical doctor, or through comparisons with already published similar content which has been previously medically checked.

External quality control of individual responses

Individual responses are quality controlled in two ways: internally, by following the peer review guidelines and performing medical checks by medical doctors (in case requester is not medically trained), and externally, through external audits. Further internal quality assurance takes place by regular quality evaluations with the contracted EUAA providers. External audits take place through verification research within countries of origin on a sample of responses in order to check the accuracy of individual MedCOI responses.

Verifying published MedCOI information

If information contradicting recently published MedCOI products is brought to the attention of the MedCOI team, the information will undergo crosschecking and verification procedures, provided that it is current, reliable, and traceable. The outcome of the verification, whether it entails a correction or confirmation, is always published on the MedCOI Portal.



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