SC (HIV Positive - HR Breach) Zimbabwe [2003] UKIAT 00015

IMMIGRATION APPEAL TRIBUNAL

Date heard: 4 February 2003
Date notified: 25/06/2003

Before:-.

DR H H STOREY (Chair)
MR A A LLOYD JP
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Between

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And

SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

DETERMINATION AND REASONS

1. The appellant, a national of Zimbabwe, has appealed with leave of the Tribunal against a determination of Adjudicator, Mr G W Manchester, dismissing the appeal against the decision by the respondent refusing to grant leave to enter on asylum grounds. Mr A Russel of Counsel instructed by Purcell Brown & Co Solicitors represented the appellant. Miss M Banwait appeared for the respondent.

2. The Tribunal has decided to dismiss this appeal.

3. In view of serious inconsistencies in the account given by the appellant the adjudicator made adverse credibility findings against the appellant. The grounds do not effectively challenge those findings. They relied on three different contentions.

4. One contention was that, having found the appellant had been the victim of a violent assault and was a low level supporter or member of the MDC, the adjudicator should have accepted she would face a real risk of persecution at the hands of ZANU-PF or war veterans. However, Mr Russel did not seek to develop that ground before us and rightly so. The adjudicator did not consider the violent assault was shown to be connected with any attack by ZANU-PF or war veterans. It is plain from the objective country materials that the mere fact of being a low-level member

of the MDC is not enough to demonstrate a real risk of persecution or treatment contrary to one's human rights. Mr Russel certainly adduced no evidence to persuade the Tribunal to take a different view of this matter.

5. A second contention was that the adjudicator should have allowed the appeal in the light of the existence of a Home Office policy of not returning failed asylum seekers to Zimbabwe. However, this contention has already been considered and rejected by the Tribunal in a number of decisions, the most recent being *Ncube* [2002] UKIAT 05806. Mr Russel did not raise any fresh arguments on this matter.

6. The third contention was that the adjudicator had failed to take into consideration that the appellant suffered from HIV and, following *D v UK*, should therefore have been found to face a real risk of exposure to inhuman and degrading treatment upon return because of the lack of adequate treatment in Zimbabwe. In support he produced a letter from the appellant's GP dated 21 February 2002 confirming she had been diagnosed as HIV positive.

7. The first thing we would observe about this letter is that, despite its date, there is no record of it being placed before the adjudicator. Furthermore, the appellant made no mention of being HIV positive in her oral testimony and her Counsel appears to have been unaware at this fact.

8. The second thing we would observe is that this letter on its own established only that the appellant has been diagnosed as HIV positive, was currently anaemic has a recurrent cough and was currently under the care of Dr L M Short a Consultant in GU Medicine. It did not tell us how advanced her condition was or what regime of treatment she is receiving. Given that the appellant's representatives had had ample time to adduce further medical evidence, we told Mr Russel we were not prepared to adjourn this case, although we would grant 10 days in which any further evidence could be adduced.

9. Subsequently, we received from a Consultant in GU-Medicine from Calderdale and Huddersfield NHS Trust dated 7 February 2003. The letter explained that in February 2002 she was found to be HIV positive. In view of an abnormal chest x-ray she was checked for tuberculosis but there was no evidence of any and her chest x-ray has improved since commencing anti-retroviral therapy. She had been significantly immuno-compromised and as had a high viral load but both are said to have significantly lowered since she began anti-retroviral treatment. The letter concludes:

> "She is generally keeping much better and is currently on Trizivir which is a combination of Zidovudine, Lamivudine and Abacavir. This she was required to take lifelong in order to remain in good health.
>
> It would be extremely unlikely that S would be able to continue on her current therapy if she was to return to Zimbabwe. This would obviously have a significant impact on her life expectancy and likelihood that she would develop and (sic) AIDES related illness."

10. From the above we are prepared to accept that the appellant is HIV positive and has been since February 2002. However, the adjudicator cannot be blamed for not considering this matter, as it was not put before him. Nevertheless, it remains that we must consider whether this fact renders the decision made against this appellant contrary to her human rights. We have jurisdiction to consider this matter under s. 65(3) of the 1999 Act.

11. Mr Russel sought to persuade us that there would be a breach of Art 3 because on return to Zimbabwe the appellant would not have access to adequate treatment. We can now see that that is also the view of the appellant's Consultant. However, there is nothing in his letter to indicate that he has any expertise about the medical situation in Zimbabwe. The only specific objective source directly placed before us, the April 2001 CIPU Bulletin, it is stated that basic treatment for infections related to HIV is available. But owing to the volume of cases, patients are often discharged early from hospital and antiretroviral therapy is only available privately and at high cost. On the basis of this information we infer that whilst tests for HIV are available and there is a supply of antiretroviral drugs, their cost can make them inaccessible to numbers of people.

12. Mr Russel contended that the case of *D v UK* and the outline of case law contained in the latest edition of Macdonalds at paragraphs 3.31 and 12. 179 supported the appellant's contention that the decision was in breach of her human rights.

13. In considering this issue we have to follow the guidance set out by the Court of Appeal in *K v SSHD* [2001] Imm AR 11 and by the Tribunal in *Chihota* (01/TH/3312) and *Tawengwa* [2002] UKIAT 05597. The latter two furnish more details of the nature and availability of treatment for HIV in Zimbabwe. We take from these decisions that problems of cost of treatment in the country of origin alone are not enough to establish a violation of Art 3 or Art 8. *D v UK*, being a case in which basic treatment was unavailable, has limited application to situations where some level of treatment does exist.

14. In this case, there would be some level of treatment available in Zimbabwe. Furthermore, on the appellant's own account she would not be entirely without family support upon return to Zimbabwe. The adjudicator did not accept her own account of deaths in her family, but even on her own account she had an aunt living there. We note also that the appellant had been able in the past to travel in and out of Zimbabwe and that when she came to the UK it was for a sightseeing visit. These facts in our view were an indication of some level of personal or family finances. They are also relevant when considering the issue of access to the continuance of anti-retroviral treatment, which this appellant plainly needs. Whilst it is evident that the treatment the appellant is receiving in the United Kingdom is considerably better than in Zimbabwe, the facts of this case do not establish that her return to Zimbabwe would place her at risk of treatment contrary to her human rights.

15. For the above reason this appeal is dismissed.

DR H H STOREY
VICE-PRESIDENT