Upper Tribunal
(Immigration and Asylum Chamber)

RS and Others (Zimbabwe – AIDS) Zimbabwe CG [2010] UKUT 363 (IAC)

THE IMMIGRATION ACTS

Heard at Field House

On 1- 3 March 2010

Before

SENIOR IMMIGRATION JUDGE ALLEN

SENIOR IMMIGRATION JUDGE LATTER

SENIOR IMMIGRATION JUDGE KEKIĆ

Between

RS, EC AND BR

Appellants

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

Representation :

For the Appellants: Ms K Monaghan QC, Ms S Knight and Mr A MacKenzie

instructed by Luqmani Thompson & Partners in the case of RS

instructed by Refugee & Migrant Justice in the case of EC

instructed by Harrison Bundey in the case of BR

For the Respondent: Ms E Grey and Mr C Thomann, instructed by the Treasury Solicitor

(1) A significant number of people are receiving treatment for HIV/AIDS in Zimbabwe, and hence a Zimbabwean returnee will not succeed in a claim for international protection on the basis of a diagnosis of HIV/AIDS unless their case crosses the threshold identified in N v United Kingdom .

(2) Though there is some evidence of discrimination in access to AIDS medication and food in Zimbabwe, it is not such as to show a real risk of such discrimination.

(3) The return to Zimbabwe of a Zimbabwean diagnosed with HIV/AIDS does not place the United Kingdom in breach of its obligations under the Disability Discrimination Act.

DETERMINATION AND REASONS

1. These are the appeals of three female Zimbabwean nationals born in June 1977, 24 September 1964 and 16 November 1957 respectively. They all claim to have a well founded fear of persecution if returned to Zimbabwe as they would be unable to demonstrate loyalty to ZANU PF, their removal would breach their human rights (Articles 3, 8 and 14) and their rights under section 21D and 21E of the Disability Discrimination Act 1995 would be breached. All three appellants are HIV positive and are receiving NHS treatment.

RS

2. This appellant was born in Chigutu. She was educated in Gokwe and last lived in Dema Seke, about an hour's journey from Harare. She arrived at Gatwick airport on 21 February 2001 to visit her husband who was a student here at that time (although in her subsequent asylum interview in October 2006, she claimed that he had returned to Zimbabwe in the year 2000). He had entered the UK as a visitor in February 2000 and thereafter remained as a student, with leave. The appellant was admitted as a visitor for six months and subsequently commenced Bible studies here as a result of which she was granted 12 months' leave as a student (until 30 September 2002). Their children remained living in Zimbabwe and were cared for by relatives in Dema. In August 2001 both she and her husband were diagnosed as HIV-positive and both commenced anti-retroviral treatment (ART). Her husband was said to have returned to Zimbabwe following the death of his father in 2002.

3. On 25 September 2002, before the expiry of her leave to enter, the appellant made an application to remain for a limited period to undergo private medical treatment. However, a letter from her former representatives accompanying her application form indicated that she was entitled to benefit from NHS treatment and the application was treated by the Secretary of State as having been made to receive free medical treatment for an indefinite period. The appellant stated on her application form that she intended to leave the UK in October 2005 and that she received £600 every month from a relative or friend. A letter dated 16 September 2002 from her consultant, Mr Derrick Evans of Southend Hospital, confirmed that although she had been diagnosed with HIV in August 2001, she had probably had the disease for approximately seven or eight years.

4. The application was refused on 5 January 2004. The Secretary of State balanced the compassionate aspects against the need to maintain immigration control. He considered that the resources of the NHS were limited and that it would be unrealistic to expect the NHS to treat everyone who could not obtain treatment of a similar standard in their own country. He considered that the medical evidence indicated that the appellant was fit to travel, and that she had been working for a long period of time. He noted that medical treatment was available in Zimbabwe and that the appellant's husband, three children and other family members lived there. He noted that the appellant's studies had been funded by her sisters-in-law, P (in the USA) and M (in the UK), and that funds were said to be available for the cost of private treatment in the UK. He considered there was no reason why these funds could not be provided to the appellant in Zimbabwe particularly as treatment would be cheaper there than in the UK. He concluded that the immigration rules made no provision for leave to be granted for the purpose sought and that under the applicable policy, this was not a case where exceptional leave should be granted.

5. An appeal was lodged against that decision and came before Mr Gillespie, sitting as an adjudicator at Hatton Cross on 21 October 2004. In support of her appeal, the appellant provided a statement dated 11 October 2004. She maintained that she had been born in Chigutu, a rural district about 110 km south-west of Harare. Her parents were alive and lived in Gokwe, several hundred kilometres west of Harare. They moved there in 1990. She claimed to have one sister and four brothers; a fifth brother

had died the previous year. Her sister, J, was married and had four children. Her brother L was also married with two children. These siblings lived with their families in Gokwe. Her three younger brothers were unmarried and lived with their parents. Two of them were still at school. The rest of her siblings were unemployed. The appellant stated that she had lived in Gokwe until 1995 when she was married and went to live in Dema. She has two children. They are currently looked after by her sister-in-law, F. The appellant claimed that she and her family had always been MDC supporters. This had caused problems with food distribution in the village. When food arrived it was distributed according to a list drawn up by regional ZANU PF supporters who were able to identify the families who did not regularly attend their meetings. They were then put last on the list. She maintained that in August 2004 her brother-in-law was killed and his house was burnt down. The hospital refused to treat him because he was an MDC supporter and he died of his injuries. She stated that her husband had come here to visit his sister and had subsequently obtained a student visa to study English on a three-year course. He stayed with his sister M, with whom the appellant also lived after her arrival. M was recognised as a refugee in 2002. The appellant stated that her husband returned to Zimbabwe in August 2002 following the death of his father and was not receiving any treatment as there was none available in his area.

6. The Adjudicator found that the appellant would not have access to consistent and adequate ART in Zimbabwe and that her family was not affluent and could not guarantee financial assistance. He noted that the appellant’s mother-in-law was said to have fallen seriously ill while visiting P in the USA and the appellant maintained that the claim in her application form that she received £600 a month had been fabricated by her previous representatives. He found that on return to Zimbabwe it was likely that the appellant would live in circumstances of privation. He found that she would be unable to access private treatment. He considered there would be a rapid decline in the appellant's health on return and that life expectancy would be no more than one or two years at most as against a possible 10 years on her present regimen. He found that the appellant's husband lived in poverty and was unable to obtain medical treatment without production of a ZANU PF card. He lived in fear of threats of political intimidation. His brother had been killed the previous month and his house had been destroyed. He concluded that in the “peculiar circumstances” of this case the Article 3 threshold had been met and allowed the appeal. The determination was promulgated on 29 October 2004.

7. On 3 November 2004, the respondent applied for permission to appeal. It was argued that the adjudicator had failed to take into account the jurisprudence of the higher courts and that he had failed to reason how the appellant would fall into the exceptional category as outlined in N v Secretary of State for the Home Department [2003] EWCA Civ 1369, given that she had family in Zimbabwe and that medical treatment, whilst expensive, would be available. Permission to appeal was granted on 25 January 2005. When the appeal came before Senior Immigration Judge Warr on 12 July 2006, he found with the consent of the parties that following the decision of the Tribunal in JM* Liberia [2006] UKAIT 00009, the Tribunal was without jurisdiction as the appellant's removal was not imminent, this being a variation appeal.

8. Despite the agreement of the parties, the appellant's representatives sought permission to appeal to the Court of Appeal against that decision. It was submitted that JM was wrongly decided and the Tribunal had erred in concluding that on an appeal against a refusal to vary leave, the question of the compatibility with human rights of a hypothetical return was not justiciable. That application was refused by Senior Immigration Judge Jordan on 7 August 2006. A renewed application was made to the Court of Appeal on 27 August 2006. It was argued that as permission to appeal had been granted in the case of JM and was listed for hearing by the Court of Appeal, that the application in the instant

case should have been stayed until judgment was issued in JM or should have been granted pending judgment. On 29 December 2006 Laws LJ ordered that the court was satisfied that the appeal should be allowed and remitted to the AIT for reconsideration before a differently constituted Tribunal on the basis of the statement of reasons which had been agreed by the parties. The statement said that following the Court of Appeal's decision to overturn JM , the determination of the AIT in the appellant's case should no longer stand. The nature of the reconsideration was left open to the AIT.

9. Meanwhile, on 6 March 2006, the appellant claimed asylum. At her asylum interview conducted on 4 October 2006, she claimed to have been active with the MDC since its formation in 1999. She claimed that husband was also involved as were her family members. Her husband was known to the authorities as an MDC member as were his sisters. She maintained that she had attended rallies, distributed T-shirts, bandanas and leaflets and sold cards. She claimed to have been arrested three times. The first occasion was in 2000 when she had been selling T-shirts in Dema. She was taken to the police station and beaten with ropes and questioned for about two hours after which she was released. Her sister-in-law and some seven others had been arrested with her. She was told not to sell T-shirts in the future. The second arrest also took place in Dema in 2000. On that occasion she was attending a rally and she was one of many that were arrested. No further details were provided of this arrest or of the third. The appellant claimed that she had relatives here who were granted asylum in 2003 or 2004.

10. The asylum application was refused on 10 October 2006. An appeal was lodged against the decision and on 3 November 2006 the appellant prepared a statement, presumably in anticipation of her hearing. In that statement she gave the month of her birth as May, rather than June (this is corrected in the third witness statement). She also maintained that her student leave was given until the 30 November 2002 rather than 30 September 2002 which was previously claimed and which was evidenced by the copy of her passport. She also maintained that she was diagnosed as being HIV-positive in August 2002. She maintained that she made a successful application for discretionary leave. In her statements the appellant also maintained that both she and her husband remained active MDC members. Her activities were said to continue in the UK but are limited for financial reasons. She referred to three arrests in Zimbabwe all of which took place in 2000. The first detention lasted some two hours and occurred when she was taken to the police station for selling MDC T-shirts. On the second and third occasions she had been at rallies handing out MDC material. She maintained that she did not come to the UK with the intention of claiming asylum. In 2004 she was advised by her husband not to return because of the dangers she would face.

11. When the appeal came before an immigration judge at Hatton Cross on 8 December 2006 (coincidentally, it was IJ Gillespie who as an adjudicator had determined her human rights appeal), the hearing was adjourned because proceedings with regard to the human rights appeal were still outstanding. The asylum appeal was re-listed for 19 February 2007 so that the two matters could be merged. The February hearing was subsequently adjourned (it is unclear why) and the matter then came before Senior Immigration Judge Gleeson at Field House on 6 June 2007. She found that the adjudicator made a material error of law and that any difficulties the appellant may face in accessing medication did not meet the N threshold. She then proceeded to decide the substantive appeal but appears to have only decided the human rights issue. The appeal was dismissed by way of a determination promulgated on 23 July 2007. The asylum issues have never been determined.

12. On 3 August 2007 the appellant sought permission to appeal to the Court of Appeal on the basis that no material error of law had been identified. The application was refused by Senior Immigration Judge Batiste but granted on renewal by Sir Henry Brooke on 7 December 2007. The matter then

came before Pill, Arden and Longmore LJJ on 18 July 2008. The court found that Senior Immigration Judge Gleeson had correctly identified an error of law by the adjudicator but that her subsequent approach could not be justified as there was material which required analysis. The matter was therefore remitted for a fresh hearing of the Article 3 claim. In so doing Pill LJ criticised the intemperate language used by the adjudicator and advised that a more substantial factual analysis was required to justify it. He stated: “If the general conduct of government is to be condemned in this way, a cogent statement of the factual basis for condemnation is required”. Arden LJ suggested that “great care would have to be taken to determine whether the lack of medical facilities or food is due to the infliction of deliberate harm on the appellants or whether the lack of medical facilities is due to a lack of national resources for this purpose. The Tribunal will also need to determine the level of seriousness of any actual or threatened harm and the cause of such harm. It may also need to determine whether any actual or threatened harm would be a serious if it were not for the appellant's medical condition”.

13. A Case Management Review hearing was then arranged. On 19 August 2009 the respondent was directed to consider this case, along with those of the other two appellants which had been co-listed, in the light of the determination in RN (Returnees) Zimbabwe CG [2008] UKAIT 00083. This was done and the response from the respondent is dated September 2009. In this appellant's case, the Secretary of State considered that she had failed to establish the facts on which she wished to rely. It was noted that the appellant delayed making a claim for asylum by over seven years and that she had argued her case on medical grounds until the promulgation of RN . He noted that the appellant had lived with her sister-in-law who had successfully claimed asylum and that it was therefore reasonable to assume that she, herself, would have been aware of the option of claiming asylum. The Secretary of State noted the appellant had family in Zimbabwe and they were not subject to political intimidation. The appellant did not have a political profile in her own right; she was not subject to any targeted ill-treatment and would not have any profile with the authorities.

14. A third witness statement has been prepared by the appellant and is dated 19 January 2010. In it, she adopts her previous statements. She maintained that her family moved with her to Gokwe in 1992. She also maintained that she was unable to continue with her studies once they moved there. She mentioned for the first time that both she and her husband were arrested for distributing T-shirts and selling cards and leaflets. They were kept at the police station overnight and her sister-in-law, M, who had also been arrested with them, was raped by the police. The appellant claimed that she was touched by the police officers in a sexual way in front of her husband. Although she explained that she did not mention this in her 2004 statement because that application was only concerned with her ill health, she did not explain why it was omitted from her 2006 statement which was specifically prepared for her asylum appeal. She maintained that at “other times” she was arrested for a few hours when MDC meetings were broken up. Her husband was also arrested on these occasions. On two occasions she and her husband were held overnight. This was not mentioned before. On another occasion they were released in the evening after a few hours of detention.

15. The appellant said that because of her activities, she, her husband and their children were not included in food distribution. She maintained that her husband was arrested on more occasions than herself, and maintained that when her student leave was completed she saw that the situation in Zimbabwe was deteriorating and in order to find a way of remaining longer in the UK she decided to claim asylum. She maintained that her brother-in-law was killed in a house fire in August 2002 because he was an MDC supporter.

16. In her statement the appellant said that her husband, children, her husband's sister and her children survive on US $10 a month. They were denied food aid due to their MDC connections. In 2004 and 2008 during the time of the elections, ZANU PF thugs came to the house and beat them. Sometimes they had to go into hiding in order to be safe. The appellant was unsure whether her husband has been arrested since his return in 2002. In the last few months he has been bed ridden. The appellant maintained that her father died in 2004 and her mother in 2005. Her mother-in-law is supported by relatives in the USA and does not share the money with the appellant's husband. The appellant expressed concern that her husband is reaching the end of his life and hoped that her children can be reunited with her in the UK in the near future.

17. Dr Day's medical report of 4 February 2010 confirms that the appellant is on the following regimen; Tenofovir, Zidovudine and Efavirenz. She remains a low grade Hepatitis B chronic carrier at very low risk of future complications. Her latest CD4 count on 1 February 2010 was 623 and she has a fully suppressed HIV viral load of less than 50 copies/ml. Her life expectancy is said to be less than five years if medication is stopped.

EC

18. This appellant was born in Gutu; she grew up in Harare where she lived from the age of two with her parents and siblings. She attended school from 1971 until 1984 and left secondary school with seven O-levels. She then attended a secretarial college and obtained a diploma. In 1987 she commenced employment with a bank, remaining with them until December 2001. She separated from her husband in 2000 and he lived in South Africa until his death last year. Her two children remain living in Harare with her mother.

19. In September 2001 the appellant came to the UK for a short holiday to visit her mother's distant cousin, Mr M Manhuna; she refers to him as her uncle. He worked for the Zimbabwe High Commission in London. On 21 December 2001 she returned to visit him for Christmas. She maintains that she fell ill and was diagnosed with pneumonia. Tests were undertaken and she was diagnosed as being HIV positive. She maintains that she had no idea she was ill prior to this. Medical evidence dated 27 May 2002 from Southend Hospital indicates that she would, however, have had the disease for ten years or more. She then went to live with her cousins, Flo and Chipo, daughters of another uncle. She continues to live with Flo. She maintains that her mother is disabled following a stroke, her father is elderly and has limited means, her brother is deaf and cannot work and the family rely on a relative who provides them with maize. Her sister lives with her mother-in-law in a village. There are other distant relatives but they are all struggling to survive. The appellant has not felt able to tell any of her family that she is HIV positive.

20. On 5 June 2002 the appellant applied to remain in the UK in order to receive NHS treatment. Her application was accompanied by a letter from her uncle promising financial support for her studies. That application was refused on 25 June 2003. The Secretary of State considered that there were no provisions under the Immigration Rules to enable an applicant to remain to receive free medical treatment. The policy guidelines introduced on 19 December 2000 were considered. The Secretary of State considered that NHS resources were limited. He noted that the appellant had had the disease for many years, that she was fit to travel and that she had a family in Zimbabwe. He considered it was not suitable to grant exceptional leave in this case. An appeal was lodged on 2 July 2003. Articles 3 and 8 were relied on.

21. In September 2003 the appellant commenced a course of studies. On 6 October 2003 she then made an application to remain as a student. Her cousin, Chipo, undertook to finance her studies and

to support her. The Secretary of State noted that section 3C of the Immigration Act 1971 (as inserted by the Immigration and Asylum Act 1999) prevented the appellant from making a fresh application whilst an appeal was pending. However, her student application was treated as a variation of the original application and was then considered. The Secretary of State was not satisfied that the appellant met the requirements of the student rules as her college was not on the DfES register. Furthermore, there was no evidence to show satisfactory progress had been made. As the appellant had previously indicated that she wanted to remain indefinitely in the UK, the Secretary of State was also not satisfied that the appellant would leave the UK at the end of her studies. The application was therefore refused on 29 November 2006. On 6 February 2007 the Secretary of State wrote to clarify the position. He noted that as the student application had been made at a time when the appellant had no leave to be here other than under section 3C of the Immigration Act 1971, she could not seek to vary her leave during that period. As the original application had already been decided, it was no longer possible to seek to vary it and so there was no outstanding student application. In any event, the appellant has indicated in her witness statement that she does not wish to pursue this matter.

22. On 21 February 2007 the appellant's representatives informed the Tribunal that the appellant wished to rely on asylum grounds. They indicated that the appellant's previous advisers had told her she could only apply on medical grounds.

23. On 12 March 2007 the appeal came before Immigration Judge E B Grant at Hatton Cross. She heard oral evidence from the appellant but dismissed the appeal on asylum and human rights grounds in a determination promulgated on 10 May 2007. She also found that the appellant was not entitled to humanitarian protection. An application for reconsideration was sought and obtained by the appellant on 5 June 2007. The matter was heard on 7 September 2007 by Senior Immigration Judge Jarvis who found a material error of law in Judge Grant's determination and ordered a second stage reconsideration. That took place before Immigration Judges Neuberger and Dawson at Taylor House on 18 March and 20 May 2008. In a statement prepared on 18 March 2008, the appellant maintains that her former partner has died in South Africa. She maintains that her mother's cousin (Mr Manhuna) left London in 2005 and she does not know where he is. She believes he has retired. It is noted that she gave evidence to Immigration Judge Grant that his son lived in Northampton and that she had his telephone number and could contact her uncle through him. In a determination promulgated on 2 June 2008, the appeal was dismissed on all grounds.

24. On 17 June 2008 an application for permission to appeal to the Court of Appeal was made on the appellant's behalf. The application was refused by Senior Immigration Judge Freeman on 26 June 2008. The application was renewed to the Court of Appeal but refused by Laws LJ on 21 August 2008. A further application was made and on 27 October 2008 Rix and Carnwath LJJ granted permission to appeal. On 17 March 2009 Rix LJ ordered by consent that the determination be set aside and the appeal be remitted for second stage reconsideration with all matters open.

25. On 2 September 2009 the Secretary of State responded to directions set at a Case Management Review hearing that the case be looked at in the light of RN . The Secretary of State noted that the appellant had delayed making an asylum claim for five years and had relied on medical grounds until the promulgation of RN . He noted that the appellant had family in Harare and that they were not subject to political intimidation. The appellant had no political profile and had never claimed political interest. There was no evidence to show that she would attract the adverse interest of the authorities on return.

26. A medical report from Dr Day at Southend Hospital dated 12 February 2010 confirms that the appellant has been under the care of that hospital since February 2002 when she requested a sexual health screen. There is no reference to any diagnosis of pneumonia. She was tested positive for HIV with a CD4 count of only 36. She also had seborrhoeic dermatitis and oral candida. She responded well to Efavirenz and Combivir. Her last test showed an HIV viral load count of less than 50 copies/ml and a CD4 count of 597. In April 2009 her medication was simplified and she takes one tablet of Atripla daily; this does not require refrigeration. Alternative drug regimes are expected to be effective in her case and an earlier report in February 2007 from Dr Day indicated that her medication could be adjusted to alternative drugs such as the most affordable ones in Zimbabwe. The cessation of treatment would put her life expectancy at less than three years.

BR

27. This appellant is from Chitungwiza Town, an MDC stronghold. She first came to the UK on 16 February 2001 and was admitted as a visitor for six months. She returned to Zimbabwe on 9 March 2001 returning to the UK on 2 December 2001 when she was accompanied by her two grandchildren (children of her daughter S) and claimed to be visiting her other daughter, M, a student nurse. The Immigration Officer was told that S was living in Zimbabwe and had no intention of travelling to Zimbabwe as she could not get time off work. They were all admitted for six months. They all overstayed.

28. On 20 August 2002 the appellant sought to regularise her stay. It is not known what happened to the children. The appellant applied for indefinite leave to remain on compassionate grounds. An accompanying letter from her solicitor stated that she had been diagnosed with advanced HIV infection. In a later letter her solicitors notified the Home Office that the appellant was receiving £100 a fortnight in hardship money from Barnados. The appellant had two daughters in the UK, S in Leeds and M who was studying in Bristol. She had four sisters in Zimbabwe who lived with their families.

29. The application was refused on 14 April 2004. The Secretary of State considered that there were no provisions under the Immigration Rules to enable an applicant to remain to receive free medical treatment under the NHS. NHS resources were limited. The policy guidelines introduced on 19 December 2000 were considered. Overstayers would only be permitted to remain here to access free treatment in exceptional circumstances. The Secretary of State considered that the appellant was fit to travel and had a family in Zimbabwe. He considered that treatment was available in Zimbabwe. He concluded that a grant of exceptional leave was not suitable in this case.

30. As her leave had expired at the time she made her application, the appellant had no right of appeal on immigration grounds. She does not appear to have pursued her human rights claim at that stage. Nothing further was heard from her for over a year. Then on 5 July 2005 she applied for leave to remain as the dependant of a work permit holder (her daughter, M) who had permission to work here until 6 May 2009. The application was refused on 6 February 2007. The Secretary of State noted that only the spouses and children of work permit holders were allowed to remain as their dependants under the Immigration Rules. She could not remain as a dependent parent as her daughter was not settled in the UK. The other daughter was a failed asylum seeker. The appellant’s circumstances were considered under paragraph 395C but were not found to merit a grant of exceptional leave. The appellant’s application was also refused on human rights grounds. On 14 February 2007 the appellant lodged an appeal. Her appeal was heard by Immigration Judge Britton at Newport. Asylum does not appear to have been relied on and the appeal was dismissed on human rights grounds in a determination promulgated on 1 April 2007.

31. On 19 April 2007 an application for reconsideration was made on behalf of the appellant. On 1 May 2007 this was granted by Senior Immigration Judge Freeman who then sat with Senior Immigration Judge Jordan on 22 July 2007 to hear the matter. The panel decided that there was a material error of law in the determination and that the matter should be re-heard. It was conceded by the appellant's representative that there was no realistic prospect of personal risk to the appellant on the basis of her individual history "outside the lack of favour that might be shown to her in connection with AIDS treatment". It was flagged up as a possible country guidance case on the issue of the availability and distribution of medical treatment for HIV sufferers.

32. There followed the Case Management Review hearing common to all the appellants on 19 August 2009 following which the appellant's case was considered under the RN guidelines by the Secretary of State. In a letter dated 2 September 2009 the Secretary of State found that the appellant had waited seven years to claim asylum. She had relied upon her medical condition until after RN had been promulgated. He noted that the appellant could be expected to have known about asylum previously as her daughter had been an asylum seeker. The appellant's sisters in Zimbabwe did not suffer any form of political intimidation. The appellant had no political profile. It was not accepted that S's husband had been a local MDC chairman as S's asylum claim had been found to be a fabrication. The appellant would therefore be able to return safely to Zimbabwe.

33. On 17 February 2010 the appellant prepared a witness statement. She maintained that she lives with her daughter, M, who was a student. S now has indefinite leave to remain (according to the documentary evidence this was granted on 20 March 2008; the basis for this is not known). The appellant stated that she discovered that she was infected in June 2002 and that she then commenced treatment. She stated that two of her sisters in Zimbabwe had died five years earlier in an accident and she did not know whether the other two were alive or dead as they were displaced and she had lost contact with them. She maintained that M travelled to Zimbabwe in 2009 but had been unable to locate them. She stated that she is on new medication as she had developed a resistance to her previous regimen. She is currently taking Raltegravir, Atazanavir, Ritonavir and Truvada (Emtricitabine with Tenofovir). She also suffers from gastroesophageal reflux disease (GERD) and diabetes.

34. The appellant's daughter, M, also provided a written statement on 17 February 2010. She confirmed that the appellant lives with her and her family, that she (M) works as a nurse and has a work permit valid until August 2010, that she will be able to apply for indefinite leave to remain in May 2010, and that her husband is also in employment. She stated that she returned with her husband and children to Zimbabwe for two weeks in 2009 to attend her husband's grandfather's memorial service. They stayed in a hotel apart from two days spent in her husband's home village when they had to take food and water with them. She confirmed electricity blackouts and sewage problems. She stated that she went to look for her maternal aunts in Mbare but could not locate them. She maintained that she is responsible for her mother's finance and accommodation and additionally provides her with £50 a week.

35. The medical evidence submitted in respect of the appellant shows that she has been treated for tuberculosis. She is making good response to ART. Different prognoses are made of her life expectancy if treatment were to be stopped. The letter of 13 August 2002 from Dr Stanley suggests it would be less than two years; his letter of 9 October 2003 suggests 3-4 years. A report from Dr Minton of 9 October 2009 states that the appellant is on a daily tablet of Truvada with Efavirenz at night. According to his 11 January 2010 report, the appellant has a resistance to the two main classes of HIV medication commonly used, particularly Lamivudine and Efavirenz. Her regimen was therefore

changed to a complex one consisting of Raltegravir twice daily, Atazanavir once a day, Ritonavir once a day and Truvada once a day. At her last test on 29 December 2009, her HIV viral load was not detected and her CD4 count was 388. In his report of 25 February 2010 Dr Minton suggests that the only other alternative available to the appellant because of drug resistance would be Enfurvitide which is taken by injection and which he did not expect would be available in Zimbabwe.

Case Management Review Hearing

36. A further Case Management review hearing for all three appellants was held on 19 October 2009. Following that hearing directions were sent out by Senior Immigration Judge Lane. It was noted therein that both the appellant and respondent took the view that the hearings were unsuitable for giving general country guidance (if necessary, updating RN) in relation to returnees to Zimbabwe who were not HIV-positive. The hearings, originally set for 7-9 December 2009 were adjourned owing to the unavailability of expert witnesses and re-listed for 1-3 March 2010 when they came before this Tribunal.

Appeal Hearing

37. We heard oral evidence from RS and EC on the first day of the hearing. RS gave her evidence in Shona through a court interpreter and EC gave evidence in English.

Evidence of RS

38. The appellant confirmed that the contents of her three appeal statements were true and accurate and adopted them as her evidence. She was then tendered for cross-examination.

39. In response to questions put by Mr Thomann, the appellant confirmed that she had been born in Chigutu and that she had lived in Gokwe since 1990. She had a sister and four brothers all of whom lived in Gokwe. She had two uncles as well. Her parents had died. She was asked to explain the conflict in her written evidence as to which parent had died first. She stated that she had made a mistake with the dates. She clarified that she shared the same mother with her sister but that they had different fathers. She was asked to clarify the reference to stepsisters in the plural in her witness statement; she replied that she only had one. She confirmed that her husband had seven sisters and four brothers. Two of his brothers had died but the rest of his siblings were alive. Of his seven sisters, M lived in the UK and P lived in the USA. Her husband had stayed with M when he came to the UK and so had she. P used to support her financially so that she could attend college but no longer did so. She was referred to her application form in which she mentioned that her sister-in-law would assist her to obtain private treatment. The appellant stated that the lawyer who helped her with that application made a mistake when completing the form. M also assisted her with her studies but no longer provided any financial support because she had her own family and could not afford it.

40. The appellant confirmed that her husband had returned to Zimbabwe following the death of his father as he wanted to attend the funeral and pay his respects. He had family members he wanted to be with at the time. The appellant agreed that funds were sent by her sister-in-law to her mother-in-law in Zimbabwe but maintained that they were insufficient to help to support the appellant’s husband. Occasionally her mother-in-law might assist in supporting the appellant's children. She agreed that her mother-in-law had travelled abroad to visit her daughters but maintained that these were not luxury trips and she had only been abroad twice. Her daughters had funded the visits. She denied that there were people in Dema and Gokwe who were able to support her in Zimbabwe. She

maintained, in fact, that as she was in the UK she was expected to help them. She agreed that if it were possible, the community provided support generally.

41. The appellant was referred to the determination of her appeal in 2002. She was reminded that she had claimed that her husband was not politically active or targeted for persecution. Her attention was drawn to a later statement where she claimed that she and her family had always been supporters of the MDC. She was asked to explain why she had not mentioned this in the context of her earlier human rights claim. The appellant explained that she had been dealing with her medical claim the first time and that she raised asylum when she made her second claim. She stated she could not remember being asked in the context of her first appeal whether her husband had any political involvement.

42. The appellant was asked why she made no mention in her first witness statement of being detained. She replied that she had not been asked about that. The appellant was asked to explain the apparent contradiction in her written evidence as to the duration of her detention in 2000 when she claimed she was beaten with ropes. She maintained that she had been arrested three times. She said one of those detentions lasted two hours and another was overnight. She said that she may have mixed up the dates. She could not recall whether the first detention lasted two hours or all night. She denied that she was providing more detail as time went by and explained that the accounts would be different as one was based on medical reasons and the other on asylum.

43. The appellant was shown a letter dated 14 April 2001 signed by the Provincial Youth Secretary and the Secretary of the MDC for Chitungwiza province. She explained that she used to attend youth meetings with her cousin and so was able to obtain this letter. She agreed with the contents of the letter which indicated that she had been victimised, arrested, tortured, had her home and property destroyed and was being hunted by ZANU PF so that she had to leave. She stated, however, that when she arrived here her intention had been to visit. The appellant was asked why there was no mention of the destruction of her home and property in any of her other evidence. She maintained that she had mentioned that the house she had lived in was destroyed. Reference was made to her witness statement in which it is recorded that her brother-in-law's house was destroyed in 2004. She maintained that that was the incident she had been referring to and that as she also lived in the same house, she considered it as hers as well. The appellant was asked to explain why she had made no mention in her statements of being hunted by ZANU PF officials. She replied that when she had been distributing leaflets she had been told that she would be arrested if caught again. That is what was meant. It was put to her that she had only been arrested when selling T-shirts or attending rallies. She denied that, maintaining that it was not only on those occasions. It was put to the appellant that she had not left Zimbabwe because of the actions of state agents. She replied that was not true. The appellant was referred to her asylum application form and reminded that she had been requested to provide full details for her departure. She was asked to explain why she had maintained at that time that her intention had been to visit the UK and why there had been no mention of being hunted by state agents. The appellant replied that the situation had deteriorated and she realised she could not return.

44. The appellant confirmed that her husband remained in Zimbabwe. She said he was not politically active because he was ill. She stated that she would be of interest to the authorities because of her asylum claim and the length of her residence in the UK. She stated that at the moment they had no interest in him because he was ill.

45. The appellant confirmed that Dema was an MDC stronghold. She was asked why, in those circumstances, there would be any need for someone to target her. She replied that there were still people around who supported ZANU PF.

46. The appellant confirmed that there were hospitals in Dema and Chitungwiza. She agreed that her children had been born in a hospital. She stated that Chitungwiza was about 40-45 kilometres from Dema and that it took about two hours by bus.

47. The appellant maintained that her case was that she would not receive medical treatment if she returned to Zimbabwe because she could not show support for ZANU PF. It was put to her that medical aid was distributed and controlled by NGOs. She agreed that could be the case but stated that it had to go through the healthcare system and hence the government. She expressed awareness that the health minister was with the MDC but stated that they had no control. It was put to the appellant that she had a choice of hospitals to which she could go if returned to Zimbabwe. She maintained that it was not possible to travel for treatment and gave the example of being unable to travel from Southend to Scotland for treatment. She maintained that if she was unable to receive treatment from Dema Hospital, she could not expect to obtain it in Chitungwiza. She maintained that some hospitals in Harare were closed because they had no medicine. That completed cross-examination.

48. In re-examination the appellant stated that her husband was not receiving any medical treatment and was very unwell. She explained that her first witness statement was made in support of her medical claim, the second in support of her asylum application and the third was a consolidated statement for this appeal. She stated that there was nobody who would be able to provide her with financial support in Zimbabwe. She was asked about the cost of travelling from Harare to Dema. She replied that she no longer knew what it would cost as she had been away for such a long time. That completed re-examination.

49. In response to questions from the bench, the appellant confirmed that her husband had not received any treatment since returning to Zimbabwe. She was asked to explain what had prompted her asylum application in 2006. She replied that when she thought about the beatings she had experienced and saw the news she was fearful of returning. She stated that her husband had returned to Zimbabwe in 2002. He had been able to grow vegetables for the first few years as he still had “medicine in his system” . In 2006 or 2007 his sister began to help him. When he left the UK he had a student visa but it expired during the time he was in Zimbabwe. He had no problems on his return because of his visa. She explained that she had not realised that she could make a joint claim on asylum and medical grounds; additionally she had thought the situation in Zimbabwe would improve. With regard to her third detention, she stated it was during the day. She was ill treated on all three occasions.

Evidence of EC

50. This appellant gave evidence in English. She too adopted her three witness statements and was tendered for cross-examination.

51. She confirmed that she had arrived in the UK in December 2001 and that she had met the costs of the ticket herself. She had worked as a secretary. She came to visit her uncle who worked in the Zimbabwe High Commission in London. She did not know whether he had been appointed by the government. She had stayed with him when she came here and he provided her with financial support. She maintained that she had completed the application form of June 2002 herself. She said

her uncle assisted her with the student application. He had returned to Zimbabwe in 2005. They were no longer in touch. He had retired and gone to his village. She had not really tried to make contact with him but had a cousin in Harare who was his niece and whom she could contact about him.

52. The appellant stated that she had a sister in Zimbabwe who lived in Chivu with her family. Her relatives received maize from a distant cousin who was involved with farming. She stated that she had two children who were both studying and were supported by their paternal grandmother ever since their father had died. She confirmed that she attended church in the UK but there was nobody there who would be able to assist her. She stated that she used to live with a cousin but now lived with a friend from church.

53. In re-examination the appellant stated that her sister was a widow.

Evidence of Professor Barnett

54. Professor Anthony Spencer Barnett gave his professional address as the London School of Economics on Houghton Street. He confirmed that he had prepared two reports and that he understood his duties as an expert. He confirmed that the reports were true and continued to reflect his view although he had two amendments to make. The first was with regard to the availability of antiretroviral drugs in the private sector. Although he maintained in his report that such drugs were available he had discovered by way of a telephone conversation made on 18 February 2010 that in most cases such medication was not available. The second amendment was that he was no longer certain that medical staff were on strike as funds had now been made available to them. He stated that he had first travelled to Africa as a volunteer when he was 17 years old. He had trained in social sciences to PhD level. He developed an interest in AIDS in 1986 and had continued his work in infectious diseases since that time.

55. Professor Barnett explained that the National AIDS Council was set up by President Mugabe in 2003 with a view to distributing funds obtained through an AIDS levy providing care and treatment; a detailed description was provided in the report prepared for EC. The Chair of the Board was appointed by the President and although the former could then select members, the President could impose his will in the selection process and could appoint individuals who had not been recommended by the Committee. Appointees were likely to toe the political line. Further, the situation at national level had a direct influence on what happened at village level. The structure was such that the wards charged with co-ordinating activity as regards treatment and care at ground level, were influenced by the line taken at national level.

56. Professor Barnett was asked whether there were any constraints on the co-operation of NGOs in Zimbabwe. He replied that one should not assume that international organisations had the best information. For example, the World Health Organisation (WHO) worked on the basis of reports from the field and sometimes that evidence was anecdotal. He stated that when he had contact with the Red Cross recently, he received different responses from staff in Zimbabwe as opposed to those in South Africa. His informed guess was that this was because such organisations were concerned about their own existence and constrained by the niceties of diplomacy. He said that his own information came from a variety of sources ranging from people on the street to heads of organisations.

57. Professor Barnett stated that the Global Fund, based in Switzerland, raised money to distribute throughout the world with the purpose of combating killer diseases. It found that a large amount of money allocated to Zimbabwe had been misappropriated by the government. Although the funds were repaid after international pressure, they were now channelled through the UN Development

Programme (UNDP) rather than the Bank of Zimbabwe. The Global Fund was a major donor of funds used to purchase antiretroviral drugs. It also provided drugs and trained staff. Although there was some procurement of drugs through the government program, most came from the Fund.

58. With respect to the evidence from the respondent regarding waiting lists, Professor Barnett stated that he understood waiting time to be longer than six months and indeed likely to be up to a year depending on what kind of treatment was sought. If it was first line treatment, then six to twelve months was reasonable. It depended on one's place of residence as well. If second line treatment was sought then the wait could be longer. He was asked whether people already receiving treatment were prioritised for the purpose of obtaining medication. He stated he found this question difficult to answer. He had discussed it with “someone who should know” but they did not know. He had looked at the WHO position and although they confirmed there was such priority, he was not convinced that this happened as no mechanism for that priority to operate existed.

59. Professor Barnett confirmed that he had made recent enquiries of pharmacists in the private sector in Zimbabwe about the availability of drugs taken by the appellants. He had spoken to someone called Benjamin at the Cameron Pharmacy and to someone called Tenda at Avondale Pharmacy. He had enquired as to whether the medication could be obtained within the next two or three days and he had received the following information. RS’s medication of Tenofovir was not available, Zidovudine was available, and Efavirenz was available at one pharmacy but not at the other. EC took Atripla which was a combination of three drugs: Efavirenz, Emtricitabine and Tenofovir. Efavirenz was available but the other two were not. For BR, Atazanir, Truvada and Ritonavir were not available. Raltegravir was a newly introduced drug which was extremely expensive and not available anywhere in Africa according to his enquiries. He confirmed that the cost of medication had not altered significantly since the preparation of his report.

60. Professor Barnett was asked for his view on whether political support affected the distribution of medication. He indicated that in the March 2008 elections, 52.5% had voted for the MDC and 47.5% for ZANU PF. One would therefore expect to see a 50-50 distribution. The evidence from the respondent, however, indicated that the ratio was somewhat higher in provinces that voted in favour of ZANU PF, such as Central Province, Mashonaland East and West.

61. He confirmed that he had read the report prepared by Dr Naomi Mujuru-Mvere and that he agreed with what she had said about local political control over the processes by which people get to see doctors or NGOs and about the unhealthy nature of life in Zimbabwe.

62. Professor Barnett was then asked about the oral evidence of RS with respect to the claimed destruction of her home. He stated that he had studied the anthropology of this area many years ago and that it was common for land and property to be jointly owned by a group or lineage. Therefore although the appellant described the property as being owned by her uncle (sic), it would have been owned by the entire lineage. That completed his examination in chief.

63. Professor Barnett was then cross-examined by Ms Grey. He confirmed that the Global Fund targeted remote regions of Zimbabwe. It was put to him, that in those circumstances, to suggest the imbalance between the distribution of medical treatment between MDC and ZANU PF areas was due to political allegiance was an unsophisticated method of analysis given that the criterion for funding was the remoteness of the district. Professor Barnett stood by his analysis. He maintained that there was an imbalance of aid and that he had considered voting and population density.

64. Professor Barnett agreed that his evidence was obtained from discussions with people and visits made to South Africa. He confirmed that he had not been in Zimbabwe since the year 2000. He had some important contacts, someone who spoke directly with the president but whose identity he could not reveal, and officials working in international agencies, NGOs in Zimbabwe and personal friends. He also met with Zimbabweans in South Africa, both professionals and refugees, and he met Zimbabweans in the UK.

65. He agreed that he had no medical qualifications but anyone who had worked in the AIDS field for as long as he had done, was aware that if a patient's CD4 count dropped below 250, there was a greater risk of opportunistic infections, particularly if they had been suffered in the past. When it was put to him that Dr Day did not suggest in his report that EC was at an elevated risk of ill health because she had contracted opportunistic infections in the past, he contended that Ms Grey had no understanding of an AIDS diagnosis. He explained that in many African countries people had witnessed friends and relatives dying of AIDS and had a good understanding of what conditions such as candida and dermatitis could lead to.

66. Professor Barnett agreed that at the time he prepared his report, the drugs were available. He had used the same definition of availability at that time as he did now. He did not make enquiries about any other drugs that might be available. He also made no enquiries about the availability of drugs during a different timescale. He explained, however, that his evidence showed the volatility of supply. He had no doubt that some drugs might be available today, however the point was that someone seeking treatment could not be sure that they would always be available. He confirmed he had had a single conversation with each pharmacist on 18 February 2010. The information based on his report regarding the availability of drugs was also based on a single conversation. He accepted that the respondent's evidence indicated that on 11 February 2010 Truvada was available. He confirmed that he had no disagreement with the cost analysis set out by the respondent. With respect to the new drug taken by BR, he indicated that it could not be imported to Zimbabwe as it had not been approved for importation as yet. He agreed that he had not specifically made enquiries about the drug and its licence, but he had been told it was not available in Africa. He questioned the definition of availability used by the Ministry of Health in the documentary evidence provided by the respondent. He stated he had no doubt that these drugs would be obtained but he did not know what ‘available’ meant. He agreed that by a volatile supply, he meant that drugs were available erratically. He agreed it would be reasonable to assume that whilst some drugs may not be available in some pharmacies in Harare, they could be available in others. He stated, however, that one could not be sure.

67. Professor Barnett was asked whether it was fair to say that there were some improvements in the economic situation. He agreed that there was improvement but pointed out that it was uneven. Although businesses had picked up and salaries were being paid, there was no improvement for those who were unemployed, and four or five million were dependent on food aid. He agreed that wages were now paid to public sector employees and that they had increased from $100 a month to $150 a month.

68. Professor Barnett maintained that food distribution was restricted to supporters of ZANU PF. Although he acknowledged that the food programme was under the control of international agencies and NGOs, and therefore contrasted with the situation in 2008, he stated that food had to be distributed through the local structure and that was when political influence came to bear. He stated that a document from local administration was needed to obtain a supply of food. Sometimes, party allegiances and interpersonal relationships impacted on the ability to obtain such authorisation. Professor Barnett was asked to explain how that meshed with his claim in his report that NGOs

operated effectively. He indicated that was not what he meant. He stated that there was less bias in the urban areas. It was put to him that EC would be returning to Harare and so would be unlikely to face any substantial bias regarding food aid. He agreed that was a reasonable conclusion if vouchers were to be relied on. With regard to BR's return to Chitungwiza, he replied that he had never been there and could not help. It was pointed out that Chitungwiza was an MDC seat and that there would be people willing to identify supporters of the MDC for the purposes of obtaining an authorisation document for food aid. He replied that may be the case but one could not be sure that the town hall or village council had altered its complexion and it may be that the administration or local authority was different to the political seat of the area. As to whether it was reasonable to assume that there would be an MDC MP or someone else to turn to for assistance, he was unable to say.

69. Reference was made to the comment of the Minister of Agriculture who threatened to ban NGOs. The point was made that this had not yet happened. Professor Barnett agreed but stated that it indicated the kind of environment in which NGOs were operating. By threatening their work, the minister was moderating what they had to say. He agreed that nevertheless NGOs had to show transparency and effectiveness in their work if they were to maintain international integrity. He agreed that that might justify an employee's reluctance to identify himself.

70. Ms Grey suggested that there was little reason to suppose that those operating in health centres necessarily had political allegiance to ZANU PF. Professor Barnett disagreed and stated that the further out one went in the structure, the more likely it was that one would find ZANU PF supporters, whereas those closer to the Minister were more likely to be from the MDC. He said there was no conflict between individuals supporting President Mugabe but striking because they had not been paid. When it was put to him again that there was no real evidence that health workers favoured ZANU PF supporters over the MDC when it came to access for treatment, Professor Barnett stated that people working in the Town Hall may be fossils of the old regime. He described the situation as being akin to Belfast in 1987 when the Catholics complained about discrimination. He agreed that about a third of those requiring treatment were now receiving it and that the situation was probably improving but he maintained that the estimates of the Global Fund were based on a mathematical model and one did not know the reality of the situation. He also wondered how the figures provided by the Ministry of Health had been compiled.

71. It was put to Professor Barnett that his objections to the prioritisation of patients already on ART appeared to be based on the lack of information he had about how that could operate and that he could not therefore say with any certainty that the information from the respondent was not true. Professor Barnett replied that if he was not in a position to know, neither was the Secretary of State.

72. He agreed that the funds misused by the government were returned to the Global Fund following international pressure and that the UNDP had taken over control of distribution but he maintained that the government could not be trusted and that it would not take kindly to having part of its economic system re-colonised.

73. Professor Barnett was referred to a claim in his report that supplies of available drugs may be diverted by ZANU PF personnel. He confirmed that the source of that claim was information from people in South Africa and also from Zimbabweans in the UK and some news reports. He maintained that medical personnel were stealing and selling drugs and that radio stations and the press were inflaming feelings. It was pointed out to him that he had maintained in his report that such incidents occurred in rural areas and therefore did not apply to the situation of the appellants. He disagreed. He stated that such events also happened in urban areas. When asked for evidence of that, he stated

that he had received such reports from people. It was pointed out to him that in his report he had repeatedly referred only to rural areas. He replied that that did not mean it did not happen in urban areas.

74. Professor Barnett agreed that many Zimbabweans had fled their country for economic reasons. He was asked why they should not be assumed to be economic migrants on return. He stated that the Mugabe regime thought of those who fled as traitors and opponents of the regime. He agreed he had little independent knowledge or expertise on the issue of political violence. That completed cross-examination.

75. In re-examination Professor Barnett confirmed that he had attended AIDS conferences, had written a book on the subject, had contact with leading scientists and had studied the science of HIV. He agreed that he did not have knowledge on other aspects of medicine. He confirmed that about 40% of opportunistic infections in Africa were tuberculosis cases. He explained that if medication were to be interrupted, there would be an explosion of resistant strains of the virus. This would happen if a patient missed more than two days a month. However, if a longer period of medication were to be missed, then the patient could return to the situation he was in when he first commenced treatment. He stated that Efavirenz was not suitable for those of African heritage as they became really ill and that when it was taken here, they could be supervised. He pointed out that in the information from the Ministry of Health, there was an attempt to maintain that CD4 counting machines were not needed. With regard to NGOs, Professor Barnett stated that they walked a fine line; balancing threats by ministers with the need to provide a service to the society in which they worked.

76. In reply to questions from the bench, Professor Barnett explained that it would take between four and six weeks for drugs to leave the patient's system if medication were to be stopped. He expressed surprise at the fact that RS’s husband was still alive. He agreed that it was possible that some of the informants he obtained information from may have their own agenda. He stated that he did not ask for their political allegiance and they may be critics of the government.

77. He confirmed in response to a question then put by Ms Monaghan, that the existence of an agenda on the part of his informants did not impact on his judgement. He stated that he asked questions about the sources of their information.

Evidence of Andrew Jones

78. The last witness we heard from was Andrew Jones, First Secretary for Migration at the British Embassy in Harare, called as a witness by the respondent. Mr Jones gave oral evidence via video link from Harare. He confirmed he had responsibility for policy issues in Zimbabwe and South Africa and that he had prepared two reports, both of which he relied upon. He agreed that he had no direct involvement in the health care system in Zimbabwe. He confirmed that all the interviews which had been summarised in his report were conducted in person except for one which was carried out by e-mail. He then collated the information which was agreed with his informants and prepared his report. He had selected his sources as being those whom he assessed to be able to provide the most information. He confirmed that four organisations did not want their identity or the name of the informant to be released. He confirmed that the contents of his report were true to the best of his belief. He confirmed that he had visited the Avenues Clinic in Harare. He had been taken to the store room and was shown the stock of medication. He stated that it was possible to obtain a fairly wide variety of drugs through the private system. One could take a prescription to any pharmacy. Some drugs were ordered from South Africa but he was not aware of the timescale involved.

79. Mr Jones confirmed that with respect to his second report which provided a response to Dr Kibble's report, he obtained information from other Embassy colleagues.

80. He was asked about a report that the Minister for Agriculture had banned NGOs from distributing food aid. He replied that the embassy had received no reports that food aid had been banned and there was no information forthcoming from NGOs to confirm that this had happened. He also had no information that a Food for Work Programme had been introduced.

81. Mr Jones was then cross-examined by Ms Monaghan. He explained that the terms of reference for his reports had been set in agreement with the UK Border Agency, Country of Origin Information Service and the Asylum Team. He confirmed that he had selected individuals for questioning. He had been pointed in the right direction by his colleagues. Further, some individuals he had interviewed had recommended others. If more time had been available, there would have been more interviews. He agreed that the list of questions had been attached to the report. The same questions were put to all interviewees but fewer were put to the individual interviewed by e-mail. He confirmed that his report had been prepared as a result of reliance on the responses he had received. He agreed that he had prepared notes rather than a verbatim transcript. After summarising the replies, he read them to his informants so that any amendments or additions could be made. He did not seek to filter information deliberately. He confirmed that the individual he interviewed at the WHO did not want her identity to be disclosed. He did not ask why and guessed that this might be for a variety of reasons. He could not speculate on what they might be. He agreed that one of the replies had been that not every facility had a CD4 counting machine available. He had not sought to check that information against other informants. It was pointed out to him that this information and information about long waiting lists and the politicisation of access to ART had not been mentioned in his report. He replied that he was unable to confirm this immediately but accepted that this was possible. He confirmed it would probably just have been an oversight. He stated that he had not included the identity of the individual from the Ministry of Health because he had not been given permission to use that individual's name. He had asked but had not yet received a response.

82. With respect to the interview conducted with the Ministry of Health official, he explained that questions were asked but he then realised that the full list of questions had not been put so he then contacted the individual by e-mail but had not yet received a response to the other questions. He had made two attempts to obtain the information, once was before Christmas and the second time was in January.

83. Mr Jones confirmed that where no answer was recorded in an interview, that meant that the respondee had declined to answer the question. He was asked why certain sentences had been redacted. He replied it was because they would have given an indication of the identity of the interviewee.

84. Mr Jones agreed that the only people he interviewed were in Zimbabwe. With regard to his conclusions he accepted that not all interviewees had been asked the question about withholding drugs and therefore it was not right to say that no issues about that had been raised. He agreed that the issue of stigma had not been explored. He confirmed that documents had been attached to his report and that he did not undertake extensive research. He agreed, with regard to his second report, that he was not in a position to comment on whether the observations and responses made by others to Dr Kibble and Professor Ranger's reports were valid. He confirmed that he had chosen the extracts from the DfID report that pertained to HIV. That concluded his evidence.

Submissions

The Respondent's Submissions

85. Ms Grey submitted that the appellants' claims based upon the consequences of being returned to Zimbabwe as people living with HIV and AIDS had to be seen in the context of the fact that there are about 1.1 million people living with HIV and AIDS in Zimbabwe, an estimated 13.7% of the population: Ministry of Health and Child Welfare Data for November 2009, RBA 27. The problems arising in this context had been identified by Sedley LJ in ZT v SSHD [2005] EWCA Civ 1421. He had referred to the need to set the bar for removal under both Article 3 and Article 8 cases unusually high in cases involving AIDS. She referred to the opinions given by the House of Lords in N v SSHD [2005] UKHL 31 and in particular to the comment of Lord Hope at paragraph 48 that:

"…aliens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State. For an exception to be made where expulsion is resisted on medical grounds the circumstances must be exceptional… subsequent cases have shown that D v United Kingdom is taken as the paradigm case as to what is meant by the formula."

86. Lord Brown had summarised the threshold requirement saying that it must be shown that an appellant's medical condition had reached such a critical stage that there were compelling humanitarian grounds for not removing him or her to a place which lacked medical and social services which would be needed to prevent acute suffering while he or she was dying.

87. Ms Grey submitted that the following propositions which could be derived from the ECHR's jurisprudence on the application of Article 3 as follows:

(a) The guarantees in Article 3 apply when an individual is at risk of being subjected to any of the proscribed forms of treatment as a result of intentionally inflicted acts of the public authorities in the receiving country.

(b) The jurisprudence allows sufficient flexibility to address the application of Article 3 in other contexts including the risk of proscribed treatment in the receiving country stemming from factors which would not engage either directly or indirectly the responsibility of the public authorities or which when taken alone would not infringe Article 3 standards.

(c) The types of inhuman or degrading treatment falling within Article 3 must attain a minimum level of severity and involve actual bodily injury or intense physical or mental suffering.

(d) Treatment is "degrading" when it is such as to arouse in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them. It must be considered whether this is its object and whether so far as the consequences are concerned such treatment adversely affects his or her personality in a manner incompatible with Article 3 but the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3.

88. In the case of D , described as the paradigm case for the assessment of a breach of Article 3 on the basis of lack of medical support in the receiving State, the appellant was in the advanced stages of a terminal and incurable illness and the abrupt withdrawal of facilities which permitted a limited quality of life to be enjoyed would have dramatic consequences on him and there was a serious danger that the conditions of adversity awaiting him in St Kitts would have subjected him to acute mental and physical suffering. There had been no evidence that the sole relative resident in St Kitts was willing to attend to his needs nor was there any form of moral or social support, and the lack of shelter and

proper diet would expose him to further health and sanitation problems and the UK had assumed responsibility for treating him between 1994 and 1997.

89. Ms Grey pointed out that in the twelve years between D v UK and N v UK , the ECHR had not again found that a proposed removal of an alien would give rise to a violation of Article 3 on grounds of the applicant's ill-health. The ECHR had revisited the issue of medical treatment in N v United Kingdom (Application no. 26565/05) and had held that Article 3 did not impose an obligation to alleviate disparities between the level of medical care available through the provision of free and unlimited healthcare to all aliens without a right to stay within its jurisdiction. It was insufficient to demonstrate a breach of Article 3 that an applicant's quality of life and his life expectancy would be significantly reduced on removal. Article 3 issues arose only in very exceptional cases in the context of removing an alien who was suffering from a serious mental or physical illness to a country where facilities for treatment were inferior and the high threshold set by D should be maintained although there may well be other very exceptional cases where the humanitarian considerations were equally compelling. The determination in FH (HIV/AIDS – medical facilities) Sierra Leone CG [2002] UKIAT 0390 had foreshadowed the subsequent views of the House of Lords but, even if little by way of medical care would be available to an applicant on return, the Article 3 threshold would not be crossed by returning a currently well appellant not in the terminal stages of her illness.

90. Ms Grey argued that there was no authority for the proposition that the allocation of finite resources engaged Article 3 in the absence of an intention thereby to cause harm. She accepted that intentional deprivation of resources might lead to a breach of Article 3: Cyprus v Turkey (Application no. 25781/94) [2002] 35 EHRR 30. In ZT the Court of Appeal had confirmed that in the context of health cases the rules laid down in N included a specific requirement of exceptional circumstances and did not include a special subcategory turning on the behaviour of the receiving State but it was a matter of weight for the Tribunal to assess any such behaviour in a particular case. Nothing had been put before the Tribunal to suggest that any detailed examination of the behaviour of the Zimbabwean Government was required. Dyson LJ had said in ZT that he could envisage a case where the particular treatment afforded to an AIDS sufferer on return in terms of ostracism, humiliation, or deprivation of basic rights added to existing medical difficulties could create an exceptional case in the terms of the guidance given by the House of Lords but no such circumstances were established in the present appeals.

91. Ms Grey referred to the evidence considered in RN of discriminatory exclusion and access to food aid and whether it was capable of amounting to persecution. There would need to be a careful examination of whether such deliberately discriminatory actions had had a real effect on the situation of any particular potential beneficiary and had led to a situation where a benefit was not received which otherwise would have been received. It was not enough simply to show some discrimination or skewing of what in any event were inadequate resources without also showing that the particular appellant would be adversely affected as a result.

92. In so far as it was argued that discriminatory access to food supplies or medical treatment amounted to persecution and was said to be as a result of the appellants' status as MDC supporters or their inability to demonstrate active support for ZANU-PF, lack of medical treatment or food due to insufficiency of resources would not give rise to a Convention breach. It would need to be shown that there was a deliberate withholding of food or medical treatment which would have been available absent the activities of the State authorities.

93. She referred to the respondent's IDI of March 2004 which accepted that Article 3 could be engaged in health cases: however, this guidance had been withdrawn and replaced by an IDI dated February 2007 providing simply that claims based on a medical condition should be considered in accordance with the House of Lords judgment in N . She submitted that this was accessible, clear guidance and was in accordance with the law. It carried no reasonable suggestion that applicants might be allowed to stay outside the exceptional situation meeting the D v UK criteria. There was no case law to establish a proposition that the respondent must have a policy setting out in detail how she proposed to exercise every aspect of the discretion she possessed.

94. In so far as the appellants sought to base a separate claim under Article 8, there was no basis for lowering the threshold for exceptional cases based on medical treatment. The Court of Appeal had accepted in JA (Ivory Coast) v SSHD [2009] EWCA Civ 1353 that there was a material distinction in the context of an Article 8 claim between an illegal entrant who contrived to remain and the lawful entrant whose leave had expired but there was still only limited room for an independent consideration of Article 8 in cases involving medical treatment. In JA the Court of Appeal had accepted that an appellant who was a continuously lawful entrant with a history of leave granted for compassionate reasons, did not need to demonstrate exceptional circumstances as compelling as those in D but by implication those who had never have been granted compassionate leave to remain for treatment or without any expectation of staying beyond their specific period of leave would be obliged to meet the exceptionality standard. In summary there was no basis to consider under Article 8 issues not already fully considered under Article 3 or to reach a different conclusion on the lawfulness of removal. She submitted that none of the three appellants had established an adequate factual basis to show that removal would be disproportionate.

95. The appellants were seeking to argue that the decisions violated Article 14. It was accepted in Thlimmenos v Greece [2001] 31 EHRR 14 that discrimination might arise either because analogous groups were treated differently or where States without an objective and reasonable justification failed to treat differently persons whose situations were significantly different, but the appellants failed to address the issue of the comparators. It was argued that as disabled people, HIV sufferers or as women, they should be treated differently from others who were removed or deported from the UK on the basis that they would suffer worse consequences than those others and so an adjustment was needed. Ms Grey submitted that this was an impermissibly broad comparison. It was not possible to single out one factor (e.g. access to medical treatment) to claim that this created a group which could be compared to all others subject to removal who did not face medical issues or gender disadvantage. No sensible comparisons could be drawn. Such an argument misstated the nature of the decision-making process in respect of removal. It was subject to individual consideration. For the purpose of a claim under Article 14 it had to be assumed that that process led to a lawful conclusion that removal was justified, otherwise Article 8 alone could have been relied on. In these circumstances Article 14 added nothing. If the interference was permissible or justified under Article 8 it could not be said that the State had without an objective and reasonable justification failed to give proper treatment to the appellants. This was simply an attempt to re-state an Article 8 claim which should be rejected if the threshold under Article 3 could not be met. The appellants referred to the UN Convention on the Rights of Persons with Disabilities, adopted on 13 December 2006, a Convention which had not been signed or ratified by Zimbabwe. It was not shown how or by what means the respondent might be said to have assumed a legal obligation not to remove a person to a State failing to meet such international obligations.

96. Ms Grey then turned to her submissions on the evidence relating to availability of treatment for AIDS in the public sector in Zimbabwe. The evidence showed increasing access to treatment within the public sector. The government of Zimbabwe had adopted a national AIDS policy in 1999 and ART treatment became available in the public sector at four health centres in 2004. About 6,000 people were then estimated to have access to such treatment but by the end of 2006 it was estimated that between 23,000 and 40,000 were receiving treatment. By December 2007 104,000 Zimbabweans had access to ART, a figure rising to 205,000 in January 2009. It was acknowledged that ART treatment did not currently reach all Zimbabweans who needed it and that there was a real unmet need but the evidence of the level of coverage represented a significant improvement.

97. The total number of Zimbabweans estimated to require ART varied between figures of 300,000 and 350,000 although in June 2009 the Ministry of Health and Child Welfare assessed the number at 500,000. Waiting lists for treatment in the public sector were said by Professor Barnett to span up to a year and by the WHO up to six months. These assessments were not of direct relevance to these appeals as there was evidence that returnees already on ART would be prioritised and could expect to receive treatment within two weeks and in any event in no more than a month. In these circumstances there must be a real probability that the appellants would be able to access priority treatment in the public health sector.

98. The supply of drugs appeared to be independent of economic issues in Zimbabwe as 90% of the drugs used for ART were supplied and imported by NGOs and international aid sources. A number of NGOs and other organisations assisted the government in distribution to clinics and treatment centres. There was evidence that most people treated privately were reported to have opted to move to the public sector by the end of 2008 as a result of private treatment costs but also as public care had become a more viable option. The evidence did not bear out Professor Barnett's conclusion that public treatment would not be available for the appellants EC and RS. Treatment would be available for BR even if Raltegravir was not available. Ms Grey also argued that support would be available for the appellants from family members. This again made it unlikely that the D threshold would be crossed. The evidence did not establish that there was a shortage of drugs in private pharmacies. The availability of private treatment therefore provided an additional safeguard for returnees able to access overseas remittances or who received resettlement funding. If Raltegravir was not available it still did not mean that Article 3 would be engaged. There was no general entitlement to continue to benefit from a particular form of treatment where an applicant had been able to have access to sophisticated treatment available within this country.

99. She argued that there was no adequate evidence to show that there were distortions in access to treatment which would affect the appellants. There had been a misuse of donor funds but the funds diverted by the Government of Zimbabwe were returned following threats by the Global Fund to withhold future funding. In 2009 the Global Fund decided to bypass the National AIDS Council in Zimbabwe as the principal recipient of existing and future grants choosing instead to channel money through the UN Development Programme. This paved the way for the country to receive a grant of $37.9 million in August 2009. Even if this constituted a re-colonisation of a part of the Zimbabwean economy as Professor Barnett suggested, it did not have any bearing on the appellants' claims. There was anecdotal evidence of political corruption, government officials being provided with priority access to ARVs and there was a further allegation in 2007 that senior government and ZANU-PF officials sold ARV drugs from government hospitals on the black market. However, this would not support a finding of widespread political corruption.

100. The evidence showed that ARVs were procured by NGOs and international organisations with no control being exercised by ZANU-PF. The current Health Minister was an MDC member and there were no allegations of corruption against him. There was no intrinsic evidence to show that medical staff who handled the distribution of ARVs were intrinsically loyal to ZANU-PF. As regards political control allegedly exercised over treatment by local aid action committees, the evidence from those interviewed by the respondent was there was no systematic problem of access being determined by political affiliation, although there was some limited anecdotal evidence to suggest that in some areas this might be the case. Professor Barnett had accepted that in central areas such as Harare and its surroundings, there would be much closer contact between NGOs and medical staff and there would therefore not be any substantial issues in respect of distribution. He had specifically included Dema as being within the periphery of Harare. As far as Chitungweza was concerned, this was no more remote from Harare and Dema. It was clear from Professor Ranger's report that Chitungweza had elected a mayor and councillors made up of MDC members.

101. The appellants were not facing return to a rural area but to Harare and its vicinity. These were locations where the NGOs or the international community would be able to monitor closely the unbiased distribution of aid. It was submitted that the evidence did not support a finding that there was any problem of significant diversion of medical resources away from those requiring treatment let alone the withholding of treatment as part of a policy deliberately to inflict harm.

102. The general consensus in the evidence was that the general medical position had improved in Zimbabwe with the restoration of funds flowing to towards medical staff. Hospitals were described as functioning. There had been evidence that medical facilities were stretched to breaking point in late 2008 but the consensus of the expert evidence was that there had since been a steady improvement. Similarly, the food security outlook for January to June 2010 appeared better than in previous years and the focus had shifted from the availability of food to the availability of resources to buy food. Allegations of persistent abuses were made in April 2009 and there were very recent reports of villagers complaining that ZANU-PF officials were taking control of food aid and distributing it to party members. However, the Health and Finance portfolios were held by MDC members and Mr Tsvangirai chaired the Council of Ministers responsible for the implementation of government policies and NGOs were now able to operate freely and effectively.

103. Ms Grey argued that the situation prevailing at the time when RN was decided no longer applied. There was evidence of violence but it was generally a targeted form of retributive violence between ZANU-PF and MDC activists. Recent incidents had not been on the scale of April to June 2008. The risk to the appellants should be assessed on a case-by-case basis; the background information now showed no ongoing violence directed at non-activists and a change in the political situation since the power sharing agreement. There had been an abatement of the indiscriminate violence associated with the election and it should now be found that a returnee with a low profile would not be at real risk of persecution or serious harm.

104. In summary, none of the appellants reached the threshold required for a breach of Article 3. Some treatment, both in the public and private spheres, was available in Zimbabwe. There was no evidence to support a finding that the Unity Government of Zimbabwe or non-State agents were deliberately withholding medical treatment. The guidance in domestic jurisprudence and by the Strasbourg Court on Article 3 was sufficiently certain to fulfil the requirement, and interference with Article 8 would be in accordance with the law during the period when the policy was being updated. An Article 8 claim could in principle be advanced alongside an Article 3 claim and the sole issue relied on was one of access to medical treatment, but the argument would not avoid the need to satisfy the

exceptionality requirements in N . There was no real risk that any of the appellants would suffer treatment contrary to Article 3 or persecution on return.

The Appellants' Submissions

105. Ms Monaghan submitted that each individual appellant in the light of the facts relating to their appeal should succeed on both asylum and Article 3 grounds. The withdrawal of medical treatment being received in this country would have a drastic impact on the lives and life expectancy of the appellants such as to engage Article 8. She argued that an arbitrary or deliberate denial of access to food or medical treatment on political grounds could amount to persecution and that discriminatory measures could constitute persecution if the consequences were sufficiently severe. The position was now confirmed by the provisions of the Qualification Directive and acts of persecution could take the form of administrative measures which were discriminatory or implemented in a discriminatory manner. If the appellants were able to show that there was a real risk that they would be denied medical treatment or food aid because they were not government supporters and that their suffering would be exacerbated for this reason then they would be entitled to refugee status.

106. When considering Article 3, although it was accepted that there may be very exceptional cases where there could be a breach of Article 3, those cases did not cover intentional acts or omissions of public authorities or non-State bodies. There was clear evidence given by Professor Barnett of discriminatory treatment in Zimbabwe against those seen as not being loyal to the regime. This was confirmed in the report from Dr Mujuru-Mvere. The background evidence also confirmed that the political situation described in RN had not significantly changed. There was evidence that the receipt of medical treatment had been politicised. As far as the evidence obtained by the respondent was concerned, the level of response by some agencies in that evidence was more significant than the responses. The evidence of Professor Barnett confirmed that although some drugs were available, there was no regularity of the drug supply and there were significant waiting lists. There were not enough CD4 testing machines to enable treatment to start in any reasonable period of time. There was no evidence that the appellants would be able to afford drugs even if they were available. It was fanciful to argue that drugs could be purchased by remittances received from this country. There was significant evidence of discrimination and disadvantage arising both from being a woman and being in an older age bracket. The position under Article 3 was that the threshold was reached because there was the important aggravating factor that the real harm the appellants would suffer would derive in part from positive acts of the State arising from discrimination and poor governance.

107. Article 8 provided a broader protection and a lower threshold for engagement but any interference could be justified. She submitted that the interference with the appellants' right to family and private life was not in accordance with the law in the absence of an existing policy which had now been taken from the website. Secondly, that would be a violation of the provisions of the Disability Discrimination Act 1995 (DDA).

108. Ms Monaghan submitted that removal would be contrary to the provisions of Article 14. Considering the questions set out in Wandsworth LBC v Michalak [2003] 1WLR 617:

(1) The decision to deport the appellant plainly fell within the ambit of Articles 8 and 3.

(2) The meaning of discrimination for Article 14 purposes included a duty to make reasonable adjustments. The decision in Thlimmenos held that discrimination occurred not just when there had been a difference in treatment but also where persons, including disabled and non-disabled persons, were treated in the same way but in circumstances where that treatment was especially

disadvantageous to one group. This imposed a duty to make adjustments or to treat more favourably such disadvantaged groups so as to obviate or mitigate that disadvantage.

(3) The grounds of discrimination protected by Article 14 precludes discrimination on grounds of political opinion and discrimination on disability grounds would be covered by “other status” which had been applied in a wide variety of cases including claims based on personal characteristics and social categorisations or qualities.

(4) Article 14 would be violated if there was no reasonable and objective justification for the discrimination. The existence for justification must be assessed in relation to the aims and effects of the measure under consideration and where the discrimination was connected to a “suspect class”. “The notion of objective and reasonable objection must be interpreted as strictly as possible.” “Disability” should be regarded as a suspect class for these purposes given its highly protected status domestically, regionally and internationally.

109. As it appeared to be the case that in all cases, absent a violation of Article 3 or 8, the respondent would remove an individual irrespective of disability, the respondent would inevitably fail to discharge the burden of establishing justification. This would make any decision to remove the appellants a violation of Article 14.

110. Ms Monaghan also argued that the respondent failed to comply with her duty to make reasonable adjustments under section 21D(2) of the Disability Discrimination Act 1995 (DDA) having adopted a practice or policy which made it impossible or unreasonably difficult for disable persons to receive any benefit which was or might be conferred and made it unreasonably adverse for a disabled person to experience being subjected to any detriment to which a person might be subjected.

111. The DDA regulated discrimination against disabled persons and the DDA 2005 specifically extended the definition of disability so as to treat people with HIV infection as disabled from the point of diagnosis, whether asymptomatic or not. The appellants were therefore disabled within the meaning of the DDA.

112. The appellants relied on the duties set out in section 21D(2) to make reasonable adjustments. The provisions of section 21D provide that:

“(ii) For the purposes of section 21D1, a public authority also discriminates against a disabled person if –

(a) it fails to comply with the duty imposed on it by s.21E in circumstances in which the effect of that failure is to make it

(i) impossible or unreasonably difficult for the disabled person to receive any benefit that is or may be conferred, or

(ii) unreasonably adverse for the disabled person to experience being subject to any detriment to which a person is or may be subjected,

by the carrying out of a function by the authority; and

(b) it cannot show that its failure to comply with that duty is justified under subsection (3), (5) or (7)(c).

The duty referred to in section 21D(2) under section 21E is the duty to make reasonable adjustments. Section 21 E provides that:

“(i) Subsection 2 applies where a public authority has a practice, policy or procedure which makes it -

(a) impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred, or

(b) unreasonably adverse for disabled persons to experience being subject to any detriment to which a person is or may be subjected, by the carrying out of a function by the authority.

(ii) It is the duty of the authorities to take such steps as is reasonable in all the circumstances of the case, the authorities would have to take in order to change that practice, policy or procedure so that it no longer has that effect.”

113. The practice of removing the appellants as failed asylum seekers would be a practice or policy which made it impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred or be unreasonably adverse for disabled persons to experience being subject to any detriment to which a person is or may be subjected. This would then trigger the duty to make reasonable adjustments which may require a public authority to exercise its functions in a different way for a disabled person. The duty to make reasonable adjustments imposes a duty to take such steps as is reasonable in all the circumstances for it to have to take in order to make reasonable adjustments. In the light of the code of practice as to what amounts to a reasonable step, a decision not to remove would plainly constitute such a reasonable step as it would mitigate completely the adverse consequences otherwise resulting to the appellants. It would be plainly practicable for that step to be taken as had been proved by the care provided to the appellants to-date, the cost would not be prohibitive and no disruption would be caused as there were no concerns about any risk of offending or the need to protect the public from criminal activities.

114. In these circumstances it could not, she argued, be said by the respondent that removal was necessary for the protection of the rights and freedoms of others. Ms Monaghan accepted that the code of practice made it clear that the principle of proportionality was an accepted principle of administrative law but was designed to deal with a public authority having to choose between a number of courses of action, and that in order to demonstrate that an act was a proportionate means of achieving a legitimate aim the public authority must show that there was a pressing policy need supporting the aim the treatment was designed to achieve, its actions were related to achieving that aim and there was no other way to achieve the aim that had a less detrimental impact on the rights of disabled people.

115. The legitimate aim here could be said to be the preservation of available NHS services for HIV sufferers who have leave to remain in the UK independently of their HIV status but the mere identification of a legitimate aim was not sufficient by itself. The means chosen to achieve the aim must be proportionate and require consideration of the alternative means of achieving that aim. Given the impact of removal on the appellants the respondent could not discharge that burden. It followed, so she argued, that removal in the present cases would constitute unlawful discrimination contrary to section 21B in light of section 21D, E of the DDA.

116. Ms Monaghan also relied on the general and specific equality duties set out in s.49 of the DDA requiring institutional frameworks necessary to ensure that “due regard is had to the equality objectives in section 49”. This involved an assessment process of the impact or likely impact of policies and practices on equality for disabled people. The general disability equality duty and its requirement to conduct an impact assessment operated as a restriction on a public authority’s decision-making function. It was not clear from the UKBA website whether that agency had

undertaken any form of DDA assessment in relation to its removal policy for failed asylum seekers. If there was no such impact assessment this in itself rendered the decision to remove unlawful and would require the decision to be taken again. Even if the respondent might lawfully have exercised his discretion in precisely the same way after giving proportionate weight to the matters set out in section 49A, it could not be assumed that they would, and undertaking a public impact assessment meant keeping an open mind on that issue. Ms Monaghan also referred to the UN Convention on the Rights of Persons with Disabilities arguing that this Convention should inform the respondent's decision and in any event the evidence as to discrimination and of the lack of availability of ARVs would violate fundamental principles of the Convention.

117. In summary, she submitted that the appellants were entitled to recognition as refugees. The appellants could not show allegiance to ZANU-PF and there was no proper basis from departing from the guidance in RN . The appellants would be subjected to ill-treatment breaching the Article 3 threshold on the basis of a discriminatory exclusion from access to medical treatment and food aid. The discriminatory deprivation of food and other medical services arose from deliberate policy decisions made by the State acting through its chosen agents. The ability to access medication in the appellants' circumstances distinguished their position from that in N by reason of the deliberate policy of denying access to MDC supporters, a wide-scale government corruption and diversion of funds, the fact the health system was in disarray and that the ARVs available to the private sector were far beyond the means of the appellants. Their situation fell into a different category from the position of the appellant in N as the situation in Zimbabwe was of a wholly different magnitude. The appellants also relied on Articles 8 and 14. The discrimination they would be subjected to went to the very heart of fundamental human rights, their right to physical integrity and access to food and medical treatment. The decisions were in breach of the respondent's obligations under the DDA and the respondent's decisions were not lawful as there was no policy in place in respect of individuals with HIV.

The Legal Framework

Article 3

118. Article 3 of the European Convention on Human Rights provides as follows:

"No-one shall be subjected to torture or to inhuman or degrading treatment or punishment."

This is an unqualified right. It was established in Pretty v United Kingdom (Application N º 2346/02 ECHR 2002 at paragraph 52) that the types of inhuman or degrading treatment falling within the scope of Article 3 must attain a minimum level of severity and involve actually bodily injury or intense physical or mental suffering. It is clear from the decision of the House of Lords in R v Secretary of State for the Home Department ex parte Adam Limbuela and Tesema [2005] UKHL 66 that, though the threshold is a high one in cases such as, in that case, not involving the deliberate infliction of pain or suffering, the threshold could be crossed if an appellant with no means and no alternative sources of support and unable to support himself was, by the deliberate action of the state, denied shelter, food or the most basic necessities of life. Treatment may be described as being "degrading" where it is such as to arouse in the victims of that treatment feelings of fear, anguish and inferiority capable of humiliating and debasing them (Garabayev v Russia (Application no. 38411/02), paragraph 75).

119. A number of ECHR authorities have addressed the issue of Article 3 and illness. In D v The United Kingdom , the applicant was a national of St Kitts, who had been convicted and sentenced in the United Kingdom in connection with a drugs offence. The United Kingdom authorities sought to

deport him on completion of his sentence but by that time he was in the advanced stages of AIDS. The Court found that he was in the advanced stages of a terminal and incurable illness and that the abrupt withdrawal of facilities permitting a limited quality of life to be enjoyed would have dramatic consequences for him. The United Kingdom had assumed responsibility for treating him since August 1994 and he had become reliant on the medical and palliative care which he was at present receiving and was no doubt psychologically prepared for death and in an environment which was both familiar and compassionate. It could not be said that the conditions which would confront him in the receiving country were themselves a breach of the standards of Article 3, but his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment. There was a serious danger that the conditions and adversity awaiting him in St Kitts would subject him to acute mental and physical suffering and there was no evidence that the sole relative resident in St Kitts, a cousin, was willing to attend to his needs or to any other form of moral or social support. Lack of shelter and of proper diet would expose him to further health and sanitation problems. The Court concluded that given the very exceptional circumstances of the case and the compelling humanitarian considerations, implementation of the decision to remove the applicant would be a violation of Article 3.

120. Subsequent to D and before the next case which we must consider in detail, that of N , no cases were found to show a violation of Article 3 on grounds of an applicant's ill health where it was proposed to remove him. The Commission found a breach to be established in BB v France but a friendly settlement was reached before the case came to be considered by the Court. In Karara v Finland No. 40900/98, Commission decision of 29 May 1998 and Henao v The Netherlands (dec) No. 13669/03, 24 June 2003, applications were held inadmissible which sought to rely upon Article 3 where the applicant's illness had not yet reached an advanced or terminal stage. Also found to be inadmissible was a claim to entitlement to remain in the territory of a contracting state in order to continue to benefit from medical, social or other forms of assistance provided by the expelling state (SCC v Sweden [2000] 28 EHRR CD 245, paragraph 1). In that case, however, it was emphasised that all the circumstances of the case, and especially the applicant's personal situation, had to be scrutinised rigorously.

121. In N v United Kingdom , the Grand Chamber considered a case involving a Ugandan who had claimed asylum in the United Kingdom, and reviewed the case law relating to illness and Article 3. At paragraph 42 the Court said the following:

"42. In summary, the Court observes that since D v the United Kingdom it has constantly applied the following principle.

Aliens who are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance and services provided by the expelling State. The fact that the applicant's circumstances, including his life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3. The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the contracting state may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling. In the D case the very exceptional circumstances were that the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support."

122. The Court went on to say that it did not exclude that there might be other very exceptional cases where the humanitarian considerations were equally compelling but considered that it should maintain the high threshold set in D and applied in subsequent case law, which it regarded as correct in principle given that in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-state bodies but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country.

123. In ZT , the appellant was a citizen of Zimbabwe who fairly shortly after her arrival in the United Kingdom in July 2000 was diagnosed as being HIV Positive. She sought leave to remain in the United Kingdom on the basis that to return her to Zimbabwe, where treatment for her very serious illness would be difficult or impossible to obtain, would infringe her human rights.

124. It was said on behalf of the appellant that a point of distinction between that case and previous jurisprudence was that whereas in N the receiving country, Uganda, was making proper efforts to counter an impossibly difficult situation, in the present case the difficulties in Zimbabwe had been significantly contributed to by the policy of the government itself, in particular in its malevolent attitude, discriminatory practices in the application of healthcare, and systematic violations of humanitarian and human rights laws. It was argued by analogy with the decision of the Court of Human Rights in Soering 11 EHRR 439, that a separate category of liability under Article 3 arose where the lack of healthcare of which the applicant complained was directly the fault of the receiving state.

125. The Court considered this argument to be misconceived as a point of law. It was said that Soering came nowhere near to laying down any special rule about the behaviour of the receiving state, and that in the particular factual category of health cases, N laid down the rules as to how Article 3 should be applied. Those rules included a specific requirement of exceptional circumstances and did not include a special sub-category turning on the behaviour of the receiving state. It was said that if, as was plain, there was no special rule of law relating to the behaviour of the receiving state, then the weight that the Tribunal gave to that behaviour must be a matter for the judgment of the Tribunal applying the guidance in N .

126. Buxton LJ went on to say at paragraph 18 that, that said, he could envisage a case in which the particular treatment afforded to an AIDS sufferer on return, in terms of ostracism, humiliation or deprivation of basic rights that was added to her existing medical difficulties, could create an exceptional case in terms of the guidance given by Baroness Hale of Richmond in N [2005] 2 AC 296 where she had said that the test in that sort of case was whether the applicant’s illness had reached such a critical stage (i.e. he was dying) that it would be inhuman treatment to deprive him of the care he was currently receiving and send him home to an early death unless there was care available there to enable him to meet that fate with dignity. She also noted that there might of course be other exceptional cases with other extreme facts where the humanitarian considerations were equally compelling.

127. Nor did the Court of Appeal see any merit to the suggested distinction between the facts of ZT and N , in that ZT had only contracted or at least only presented with HIV after she arrived in this country and was given temporary leave to enter as a visitor in contrast to N who was already HIV Positive on arrival in the United Kingdom. The Court of Appeal concluded that ZT and N were in the same position as never having had any right to be in the United Kingdom and in the absence of the present proceedings any permissive presence in the United Kingdom would have been terminated

nearly five years ago. Lord Nicholls at paragraph 16 of N had made no distinction, nor could he have done, based on the respective circumstances of the original arrival in the United Kingdom.

The Refugee Convention

128. It can be seen from paragraph 53 of the UNHCR Handbook that discriminatory measures combined with other adverse factors may, if taken together, amount to persecution. The Qualification Directive provides guidance on the meaning of "acts of persecution" within Article 1A of the Refugee Convention. This provides as follows:

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

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

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

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

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

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

(c) prosecution or punishment, which is disproportionate or discriminatory…"

129. In Ullah v Special Adjudicator [2004] UKHL 26, Lord Steyn endorsed the human rights approach dictated by the preamble to the Refugee Convention as propounded by Professor Hathaway in The Law of Refugee Status where he defined persecution as "The sustained or systematic failure of state protection in relation to one of the core entitlements which has been recognised by the international community". Though lack of medical treatment or food which is attributable to insufficiency of resources does not give rise to any arguable breach of the Convention regardless of the degree of suffering involved, (whether or not it is a consequence of mismanagement of the economy), the arbitrary or deliberate denial of access to food on political grounds may amount to persecution. In RN (Returnees) Zimbabwe CG [2008] UKAIT 00083, the Tribunal gave very thorough and careful consideration to the issue of risk on return to Zimbabwe. At paragraph 249 the Tribunal accepted that discriminatory exclusion from access to food aid was capable itself of constituting persecution for a reason recognised by the Refugee Convention. At paragraph 250 the Tribunal noted that the evidence now established that the government of Zimbabwe had used its control of the distribution of food aid as a political tool to the disadvantage of those thought to be potential supporters of the MDC, and that this discriminatory deprivation of food from perceived political opponents, taken together with the disruption of the efforts of NGOs to distribute food by means of the ban introduced in June 2008, amounted to persecution of those deprived of access to this essential support.

130. It can be seen from paragraph 53 of the UNHCR Handbook that discriminatory measures combined with other factors may, if taken together, amount to persecution.

Article 8 of the Human Rights Convention

131. It is well established that the private life aspect of Article 8 may be engaged in a case which involves physical or mental health. Thus, for example, in Bensaid v United Kingdom [2001] 33 EHRR

10, it was said that mental health must be regarded as a crucial part of private life associated with the aspect of moral integrity, and there is no reason why this would not extend to physical health also.

132. In R v Secretary of State for the Home Department ex parte Razgar [2004] UKHL 27, Lord Bingham said (at paragraph 10):

"…the rights protected by article 8 can be engaged by the foreseeable consequences for health of removal from the United Kingdom pursuant to an immigration decision, even where such removal does not violate article 3, if the facts relied on by the applicant are sufficiently strong… It would seem plain that, as with medical treatment so with welfare, an applicant could never hope to resist an expulsion decision without showing something very much more extreme than relative disadvantage as compared with the expelling state."

133. In N the European Court of Human Rights engaged briefly with the applicant's argument that the circumstances facing her on return to Uganda would engage her right to respect for her private life, but did not consider that any separate issue arose under Article 8.

134. It is relevant however to note JA . The appellants had entered the United Kingdom lawfully and they were thereafter diagnosed for the first time as being HIV Positive and treated with anti-retroviral drugs which stabilised their conditions and kept them stable. Both had been granted leave to remain in 2002 specifically to continue with treatment for HIV pursuant to the then existing Home Office policy. The Court of Appeal considered that, though the argument for a formal assumption of responsibility went too high, the real question was how far in each case the proportionality of removal was affected by the history of the compassionate grant and renewal of leave to remain for treatment, having regard to the impact both of that history and of the proposed discontinuance of treatment on the individual's life. This, it was considered, placed the appellants in a significantly different position from the appellants in D and N . It was considered that in the case of JA , as a continuously lawful entrant, she was in a different legal class from N so she was not called upon to demonstrate exceptional circumstances as compelling as those in D . Their appeal was remitted back to the Tribunal to make findings on all issues arising under Article 8(2), the Court of Appeal noting that there had been no finding by the Tribunal that she had much hope, if any, of securing treatment if returned to the Ivory Coast and therefore as to the severity and consequences of removal.

Article 14 of the European Convention on Human Rights

135. Article 14 states as follows:

"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

136. In Wandsworth LBC v Michalak [2003] 1 WLR 617, it was said by the Court of Appeal that in considering the issues arising under Article 14 the Court is required generally to approach its task in a structured way, considering the following four questions:

(1) Do the facts fall within the ambit of one or more of the substantive Convention provisions?

(2) If so, was there different treatment as respects that right between the claimant on the one hand and the chosen comparators on the other?

(3) Were the chosen comparators in an analogous situation to the claimant's situation?

(4) If so, did the difference in treatment have an objective and reasonable justification?

137. The point was made that this was only a framework and there were potential overlaps between considerations relevant in the determination of at least the last two and possibly the last three questions, and it was necessary to be cautious about treating the questions as a series of hurdles to be surmounted in turn. In Thlimmenos v Greece [2001] 31 EHRR 14, it was established that the discrimination might arise either because analogous groups were treated differently or when states without an objective and reasonable justification failed to treat differently persons whose situations were significantly different.

Disability Discrimination Act 1995

Relevant Provisions

" **Part I**

Disability

1 Meaning of 'disability' and 'disabled person'

(1) Subject to the provisions of Schedule 1, a person has a disability for the purposes of this Act [and Part III of the 2005 Order] if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.

(2) In this Act [and Part iii of the 2005 Order] 'disabled person' means a person who has a disability."

" **[18B Reasonable adjustments: supplementary]**

[(1) In determining whether it is reasonable for a person to have to take a particular step in order to comply with a duty to make reasonable adjustments, regard shall be had, in particular, to—

(a) the extent to which taking the step would prevent the effect in relation to which the duty is imposed;

(b) the extent to which it is practicable for him to take the step;

(c) the financial and other costs which would be incurred by him in taking the step and the extent to which taking it would disrupt any of his activities;

(d) the extent of his financial and other resources;

(e) the availability to him of financial or other assistance with respect to taking the step;

(f) the nature of his activities and the size of his undertaking;

(g) where the step would be taken in relation to a private household, the extent to which taking it would—

(i) disrupt that household, or

(ii) disturb any person residing there.

(2) The following are examples of steps which a person may need to take in relation to a disabled person in order to comply with a duty to make reasonable adjustments—

(a) making adjustments to premises;

(b) allocating some of the disabled person's duties to another person;

(c) transferring him to fill an existing vacancy;

(d) altering his hours of working or training;

(e) assigning him to a different place of work or training;

(f) allowing him to be absent during working or training hours for rehabilitation, assessment or treatment;

(g) giving, or arranging for, training or mentoring (whether for the disabled person or any other person);

(h) acquiring or modifying equipment;

(i) modifying instructions or reference manuals;

(j) modifying procedures for testing or assessment;

(k) providing a reader or interpreter;

(l) providing supervision or other support.

(3) For the purposes of a duty to make reasonable adjustments, where under any binding obligation a person is required to obtain the consent of another person to any alteration of the premises occupied by him—

(a) it is always reasonable for him to have to take steps to obtain that consent; and

(b) it is never reasonable for him to have to make that alteration before that consent is obtained.

(4) The steps referred to in subsection (3)(a) shall not be taken to include an application to a court or tribunal.

(5) In subsection (3), 'binding obligation' means a legally binding obligation (not contained in a lease (within the meaning of section 18A(3)) in relation to the premises, whether arising from an agreement or otherwise.

(6) A provision of this Part imposing a duty to make reasonable adjustments applies only for the purpose of determining whether a person has discriminated against a disabled person; and accordingly a breach of any such duty is not actionable as such.]"

" **[18D Interpretation of Part 2]**

[(1) Subject to any duty to make reasonable adjustments, nothing in this Part is to be taken to require a person to treat a disabled person more favourably than he treats or would treat others.

(2) In this Part—

'benefits'[, except in sections 4G to 4K,] includes facilities and services;

'detriment', except in section 16C(2)(b), does not include conduct of the nature referred to in section 3B (harassment);

‘discriminate’, ‘discrimination’ and other related expressions are to be construed in accordance with section 3A;

‘duty to make reasonable adjustments’ means a duty imposed by or under section 4A, 4B(5) or (6), 4E, [4H,] 6B, 7B, 7D, 14, 14B, 14D[, 15C] or 16A(5);

‘employer’ includes a person who has no employees but is seeking to employ another person;

‘harassment’ is to be construed in accordance with section 3B;

‘physical feature’, in relation to any premises, includes [(subject to any provision under section 15C(4)(e))] any of the following (whether permanent or temporary)—

(a) any feature arising from the design or construction of a building on the premises,

(b) any feature on the premises of any approach to, exit from or access to such a building,

(c) any fixtures, fittings, furnishings, furniture, equipment or material in or on the premises,

(d) any other physical element or quality of any land comprised in the premises;

‘provision, criterion or practice’ includes any arrangements.]”

“ **[21B Discrimination by public authorities]**

[(1) It is unlawful for a public authority to discriminate against a disabled person in carrying out its functions.

(2) In this section, and sections 21D and 21E, ‘public authority’—

(a) includes any person certain of whose functions are functions of a public nature; but

(b) does not include any person mentioned in subsection (3).

(3) The persons are—

(a) either House of Parliament;

(b) a person exercising functions in connection with proceedings in Parliament;

(c) the Security Service;

(d) the Secret Intelligence Service;

(e) the Government Communications Headquarters; and

(f) a unit, or part of a unit, of any of the naval, military or air forces of the Crown which is for the time being required by the Secretary of State to assist the Government Communications Headquarters in carrying out its functions.

(4) In relation to a particular act, a person is not a public authority by virtue only of subsection (2)(a) if the nature of the act is private.

(5) Regulations may provide for a person of a prescribed description to be treated as not being a public authority for purposes of this section and sections 21D and 21E.

(6) In the case of an act which constitutes discrimination by virtue of section 55, subsection (1) of this section also applies to discrimination against a person who is not disabled.

(7) Subsection (1)—

(a) does not apply to anything which is unlawful under any provision of this Act other than subsection (1); and

(b) does not, subject to subsections (8) and (9), apply to anything which would be unlawful under any such provision but for the operation of any provision in or made under this Act.

(8) Subsection (1) does apply in relation to a public authority's function of appointing a person to, and in relation to a public authority's functions with respect to a person as holder of, an office or post if—

(a) none of the conditions specified in section 4C(3) is satisfied in relation to the office or post; and

(b) sections 4D and 4E would apply in relation to an appointment to the office or post if any of those conditions was satisfied.

(9) Subsection (1) does apply in relation to a public authority's functions with respect to a person as candidate or prospective candidate for election to, and in relation to a public authority's functions with respect to a person as elected holder of, an office or post if—

(a) the office or post is not membership of a House of Parliament, the Scottish Parliament, the National Assembly for Wales or an authority mentioned in section 15A(1);

(b) none of the conditions specified in section 4C(3) is satisfied in relation to the office or post; and

(c) sections 4D and 4E would apply in relation to an appointment to the office or post if—

(i) any of those conditions was satisfied, and

(ii) section 4F(1) (but not section 4C(5)) was omitted.

(10) Subsections (8) and (9)—

(a) shall not be taken to prejudice the generality of subsection (1); but

(b) are subject to section 21C(5).]"

" **[21C Exceptions from section 21B(1)]**

[(1) Section 21B(1) does not apply to—

(a) a judicial act (whether done by a court, tribunal or other person); or

(b) an act done on the instructions, or on behalf, of a person acting in a judicial capacity.

(2) Section 21B(1) does not apply to any act of, or relating to, making, confirming or approving—

(a) an Act, an Act of the Scottish Parliament[, a Measure or Act of the National Assembly for Wales] or an Order in Council; or

(b) an instrument made under an Act, or under an Act of the Scottish Parliament, [or under a Measure or Act of the National Assembly for Wales,] by—

(i) a Minister of the Crown;

(ii) a member of the Scottish Executive; or

(iii) the [Welsh Ministers, the First Minister for Wales or the Counsel General to the Welsh Assembly Government].

(3) Section 21B(1) does not apply to any act of, or relating to, imposing conditions or requirements of a kind falling within section 59(1)(c).

(4) Section 21B(1) does not apply to—

(a) a decision not to institute criminal proceedings;

(b) where such a decision is made, an act done for the purpose of enabling the decision to be made;

(c) a decision not to continue criminal proceedings; or

(d) where such a decision is made—

(i) an act done for the purpose of enabling the decision to be made; or

(ii) an act done for the purpose of securing that the proceedings are not continued.

(5) Section 21B does not apply to an act of a prescribed description.]”

“ **[21D Meaning of ‘discrimination’ in section 21B]**

[(1) For the purposes of section 21B(1), a public authority discriminates against a disabled person if—

(2) For the purposes of section 21B(1), a public authority also discriminates against a disabled person if—

(a) it fails to comply with a duty imposed on it by section 21E in circumstances in which the effect of that failure is to make it—

(i) impossible or unreasonably difficult for the disabled person to receive any benefit that is or may be conferred, or

(ii) unreasonably adverse for the disabled person to experience being subjected to any detriment to which a person is or may be subjected,

by the carrying-out of a function by the authority; and

(b) it cannot show that its failure to comply with that duty is justified under subsection (3), (5) or (7)(c).

(3) Treatment, or a failure to comply with a duty, is justified under this subsection if—

(a) in the opinion of the public authority, one or more of the conditions specified in subsection (4) are satisfied; and

(b) it is reasonable, in all the circumstances of the case, for it to hold that opinion.

(4) The conditions are—

(a) that the treatment, or non-compliance with the duty, is necessary in order not to endanger the health or safety of any person (which may include that of the disabled person);

(b) that the disabled person is incapable of entering into an enforceable agreement, or of giving an informed consent, and for that reason the treatment, or non-compliance with the duty, is reasonable in the particular case;

(c) that, in the case of treatment mentioned in subsection (1), treating the disabled person equally favourably would in the particular case involve substantial extra costs and, having regard to resources, the extra costs in that particular case would be too great;

(d) that the treatment, or non-compliance with the duty, is necessary for the protection of rights and freedoms of other persons.

(5) Treatment, or a failure to comply with a duty, is justified under this subsection if the acts of the public authority which give rise to the treatment or failure are a proportionate means of achieving a legitimate aim.

(6) Regulations may make provision, for purposes of this section, as to circumstances in which it is, or as to circumstances in which it is not, reasonable for a public authority to hold the opinion mentioned in subsection (3)(a).

(7) Regulations may—

(a) amend or omit a condition specified in subsection (4) or make provision for it not to apply in prescribed circumstances;

(b) amend or omit subsection (5) or make provision for it not to apply in prescribed circumstances;

(c) make provision for purposes of this section (in addition to any provision for the time being made by subsections (3) to (5)) as to circumstances in which treatment, or a failure to comply with a duty, is to be taken to be justified.]"

" **[21E Duties for purposes of section 21D(2) to make adjustments]**

[(1) Subsection (2) applies where a public authority has a practice, policy or procedure which makes it —

(a) impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred, or

(b) unreasonably adverse for disabled persons to experience being subjected to any detriment to which a person is or may be subjected,

by the carrying-out of a function by the authority.

(2) It is the duty of the authority to take such steps as it is reasonable, in all the circumstances of the case, for the authority to have to take in order to change that practice, policy or procedure so that it no longer has that effect.

(3) Subsection (4) applies where a physical feature makes it—

(a) impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred or,

(b) unreasonably adverse for disabled persons to experience being subjected to any detriment to which a person is or may be subjected,

by the carrying-out of a function by a public authority.

(4) It is the duty of the authority to take such steps as it is reasonable, in all the circumstances of the case, for the authority to have to take in order to—

(a) remove the feature;

(b) alter it so that it no longer has that effect;

(c) provide a reasonable means of avoiding the feature; or

(d) adopt a reasonable alternative method of carrying out the function.

(5) Regulations may prescribe—

(a) matters which are to be taken into account in determining whether any provision of a kind mentioned in subsection (4)(c) or (d) is reasonable;

(b) categories of public authorities to whom subsection (4) does not apply.

(6) Subsection (7) applies where an auxiliary aid or service would—

(a) enable disabled persons to receive, or facilitate the receiving by disabled persons of, any benefit that is or may be conferred, or

(b) reduce the extent to which it is adverse for disabled persons to experience being subjected to any detriment to which a person is or may be subjected,

by the carrying-out of a function by a public authority.

(7) It is the duty of the authority to take such steps as it is reasonable, in all the circumstances of the case, for the authority to have to take in order to provide that auxiliary aid or service.

(8) Regulations may make provision, for purposes of this section—

(a) as to circumstances in which it is, or as to circumstances in which it is not, reasonable for a public authority to have to take steps of a prescribed description;

(b) as to steps which it is always, or as to steps which it is never, reasonable for a public authority to have to take;

(c) as to what is, or as to what is not, to be included within the meaning of ‘practice, policy or procedure’;

(d) as to things which are, or as to things which are not, to be treated as physical features;

(e) as to things which are, or as to things which are not, to be treated as auxiliary aids or services.

(9) Nothing in this section requires a public authority to take any steps which, apart from this section, it has no power to take.

(10) This section imposes duties only for the purposes of determining whether a public authority has, for the purposes of section 21B(1), discriminated against a disabled person; and accordingly a breach of any such duty is not actionable as such.]”

“ **[49A General Duty]**

[(1) Every public authority shall in carrying out its functions have due regard to—

(a) the need to eliminate discrimination that is unlawful under this Act;

(b) the need to eliminate harassment of disabled persons that is related to their disabilities;

(c) the need to promote equality of opportunity between disabled persons and other persons;

(d) the need to take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons;

(e) the need to promote positive attitudes towards disabled persons; and

(f) the need to encourage participation by disabled persons in public life.

(2) Subsection (1) is without prejudice to any obligation of a public authority to comply with any other provision of this Act.]"

"[**49B Meaning of 'public authority' in Part 5A]**

[(1) In this Part 'public authority'—

(a) includes any person certain of whose functions are functions of a public nature; but

(b) does not include—

(i) any person mentioned in section 21B(3);

(ii) the Scottish Parliament;…

(iii) a person, other than the Scottish Parliamentary Corporate Body, exercising functions in connection with proceedings in the Scottish Parliament;

[(iv) the National Assembly for Wales; or

(v) a person, other than the National Assembly for Wales Commission, exercising functions in connection with proceedings in the National Assembly for Wales].

(2) In relation to a particular act, a person is not a public authority by virtue only of subsection (1)(a) if the nature of the act is private.

(3) Regulations may provide for a person of a prescribed description to be treated as not being a public authority for the purposes of this Part.]"

Country Background Evidence

138. For the appellants expert reports were produced from Professor Anthony Barnett, Dr Steve Kibble, Dr Naomi Mujuru-Mvere, Professor Terence Ranger, Dr Rachel Baggaley, and medical reports from Dr John Day and Dr Jane Minton. From the respondent we have a report from the British Embassy in Harare entitled "Availability of treatment for HIV/AIDS in Zimbabwe". We also have a number of other pieces of background evidence comprising in the main reports from a number of bodies and news items.

Professor Barnett

139. Professor Anthony Barnett has provided a report dated 27 January 2010 which was supplemented in his oral evidence. Professor Barnett is presently Professorial Research Fellow at the London School of Economics and Political Science and Honorary Professor at the London School of Hygiene and Tropical Medicine. Since 1987 his main research focus has been the implication of the HIV/AIDS epidemic in Africa for social and economic life, and he has published extensively in this area. Though he is not a medical doctor, he has acquired extensive knowledge of the science of HIV and the clinical treatment of AIDS.

140. In his report Professor Barnett at pages 5 to 6 quotes from three other reports, the first from IRIN, a news gathering facility supported by the UN Office for Coordination of Humanitarian Affairs, a report from Africanpress.wordpress.com, and a report from the Organisation for Physicians for Human Rights. The first of these, dated 7 July 2009, reports on difficulties in Bulawayo for municipal health officials who are said to be struggling to cope with growing waiting lists of people in need of HIV treatment and a lack of doctors to prescribe the drugs. It is feared that it might take up to a year before a person is put on ARV drug therapy. The second report, also from July 2009, refers to concerns on the part of government officials in Zimbabwe at a decision by the Global Fund to Fight AIDS, tuberculosis and malaria ("the Global Fund"), to ditch the National AIDS Council (NAC) as the principal recipient of its existing and future grants and instead to channel funds to the United Nations Development Programme (UNDP). There is reference to the fact that seven months ago the Reserve Bank of Zimbabwe (RBZ) admitted diverting over US$7 million from the Global Fund's Round 5 Grant earmarked for scaling up the national anti-retroviral programme. The third report, from January 2009, says among other things that for HIV/AIDS the most severe threat has been the interruption of regular supplies of anti-retroviral drugs. It is said that the organisation had been told by multiple key informants, patients and providers that supplies had become irregular due to breakdowns in drug delivery, distribution, provision and theft of ARV drugs by ZANU-PF operatives. There is reference to a current collapse of the system and that HIV programmes are currently being capped. There is also reference to troubling reports that physicians were switching patients on established ARV regimens to other regimens based not on clinical need but on drug availability.

141. Professor Barnett expresses concerns for the appellant RS in respect of whom specifically his report was prepared, that she would not survive having to wait a year before being put on ARV drug therapy, comments on the lack of hesitation on the part of the Zimbabwean government in diverting funds specifically earmarked for ARVs to other purposes, and expresses concerns that the appellant would be very unlikely to access treatment and if able to do so it would be irregular and inappropriate to her needs. Professor Barnett refers to a conversation he has had with a person who has spoken directly to Mr Mugabe who on one occasion said that as Zimbabwe is subject to sanctions by the UK and others it was quite reasonable and rational for the Zimbabwean government to ensure that any ARVs were preferentially available to ZANU-PF cadres if the state was to remain viable. Professor Barnett also says that in many cases local officials and local state employees have not changed since the recent power sharing agreement and that this is certainly the case with the lowest levels of organisation, the village councils, and it is at this level that in rural areas AIDS committees have the potential to facilitate or block an individual's access to medication. He goes on to refer to the fact that in around 2005 the government of Zimbabwe established a structure of AIDS committees, the intention being to create AIDS action committees, provincial AIDS action committees in all provinces, and district AIDS action committees in districts, ward AIDS action committees at sub-district level and village AIDS action committees in all villages. He describes the nature and powers of the various committees and says that the entire structure has always been under tight political control. He says that in practical terms it has been known for some years that when very limited supplies of

medications were available at a few public facilities, people seeking treatment were required to produce a ZANU-PF membership card before receiving available medications. He refers to the report of Dr Baggaley in this regard. He goes on to say that he believes it still to be the case that party membership cards may be demanded by people controlling access to goods and services including access to medical services and that his understanding is that in rural areas a person seeking treatment is expected to approach the local AIDS committee for a letter to take to the public medical facility. These processes are described in great detail in Dr Mujuru-Mvere's doctoral thesis of March 2004. Professor Barnett says it is inevitable that the makeup of local committees reflects the local political balance and that evidently a committee member who is a ZANU-PF supporter is unlikely to certify or support someone whom he or she knows to be a supporter of the MDC. He provides a diagram which shows the process whereby funds flow from the top of the system to the village level and where and how political influence can be exercised. He goes on to say with respect to the availability of RS's medications, that the evidence shows that they will not be available through the state system as the government has no money to pay for their import and they are not manufactured locally.

142. Professor Barnett goes on to characterise medical treatment in the public sector as extremely unpredictable, and poorly resourced. He refers to the practical difficulties for RS of seeking treatment in Harare some 30 kilometres away from her home. As regards private sector medication, he has spoken within the last two months of the time of that report, and, as we have seen, more recently again, to pharmacists at Avondale Shops and Cameron Pharmacy in Harare concerning availability of specific ARVs. Thus it would appear that, at least at the time of the report, RS's drug regimen could be purchased for approximately USD$100 per month, though his more recent researches were more pessimistic. He considers it to be very unlikely indeed that supplies of her medications would be securely available in Dema through the private sector, let alone via the public sector. He notes that though Dema has a small public rural hospital, it does not have a pharmacy, and therefore considers it doubtful whether there is any public medical provision for ARV treatment in Dema. He understands that Dema is a strongly ZANU-PF area to the south west of Harare. He also considers it to be unlikely that the appellant would be able to gain employment, bearing in mind the very high level of unemployment, being above 94% of the population.

143. Professor Barnett goes on to note medical evidence from Dr Day, showing that RS's virus had developed insensitivity to some ARVs and the fact that she would require good clinical laboratory support in addition to her medications if she were to maintain her current health status. He considers that the necessary support in the public sector is unpredictable and often unavailable.

144. Professor Barnett goes on to comment on the current situation in Zimbabwe. There are progressive difficulties in gathering dependable information. It is known from the United Nations World Food Programme (WFP) and from news reports that food has been and remains in short supply and he says that at times food supplies have been restricted by administrative action to those who can show that they are supporters of ZANU-PF. He mentions the fact that major NGOs such as the IFRC/RC are now able to operate relatively freely and effectively within Zimbabwe, and also that these organisations have been able to distribute food vouchers to some people, notably in urban areas. Allegiance to ZANU-PF is a significant entrance qualification to employment, particularly in the public sector, and it may also be the case with some private sector employers, and employment opportunities of any kind are very small indeed in rural areas. In effect he considers there has been little if any change with the accession of Mr Tsvangirai to office. As well as the NGOs beginning to work in the country with regard to food aid, it seems that some other NGOs, typically missions, are re-establishing

themselves and are able to provide some limited ARVs to people in their local areas, but that even so accessing such limited services can be hard or impossible for poor people. He is not aware of any NGO or mission providing ARVs in or around Dema. In effect he endorses what is to be found in the Country of Origin Information Report (COIR) of July 2009 and the views at paragraph 4 in the country guidance case of RN .

145. Professor Barnett refers to the situation concerning ZANU-PF and ARVs as being complex. He says that it does not fit into simple generalised explanations where a visit to a health facility may inevitably result in a request for a ZANU-PF card or some other form of authorisation but what is to be seen from the objective evidence he summarises is a variety of mechanisms whereby government policy results in supplies of ARVs being directed favourably to those who are likely to be ZANU-PF members. In regard to this he refers to reports of ZANU-PF diverting medications, the report which he cites speaks of “theft”, and there are also reports of people being required to present membership cards at public medical facilities, and he refers also to the diverting by the Reserve Bank of Zimbabwe of over USD$7 million from the Global Fund’s Round 5. He refers to the issue of the collapse of medical services, quoting from the July 2009 COIR. He considers that if RS were returned to Zimbabwe she would have to receive treatment in the private sector and that if she missed her medication for more than one or two occasions per month her viral population would soon increase dramatically and would evolve to be resistant to the medications with which she is currently being treated. She would be very vulnerable to a wide range of waterborne infections such as cholera, and also to widespread tuberculosis. His conclusion is that she has little or no chance of obtaining the medications and clinical care she requires for treatment of her HIV disease.

146. Professor Barnett also considers the issue of stigma on return from the United Kingdom and in this regard again quotes from Dr Mujuru-Mvere’s thesis of 2004. He considers that there is no identifiable reason why women’s circumstances should have altered dramatically since she did her research. There she notes matters such as a lack of rural women’s voice in their own families and households and a lack of effective representation in decision-making bodies, gender discrimination at all levels of society and fear of discrimination on grounds of the stigma of HIV. It would be assumed that RS had been infected by HIV in the United Kingdom and she would be seen as an assumed MDC member or sympathiser, given the amount of time she has been in the United Kingdom. She would, as a person returning from abroad, have to join the end of the long queues for what treatments might be available in the public sector.

Dr Kibble

147. Dr Steve Kibble works for Progressio, an international development charity working for justice. His report is dated 22 February 2010. He has worked on Zimbabwean and Southern African issues for this institute (formerly the Catholic Institute for International Relations) since 1990, and has been to Zimbabwe on a number of occasions, most recently in October/November 2009. Dr Kibble comments on the political and human rights situation in Zimbabwe. He notes weaknesses in the Global Political Agreement (GPA) and refers to recent arrests of members of civil society, journalists, human rights activists, independent newspaper distributors, lawyers and MDC officials. In spite of an undertaking in the GPA to deal with violence and its perpetrators and the overwhelming amount of empirical evidence in this regard, impunity continues to characterise the situation. Levels of violence and intimidation initially reduced but a recent survey suggests that requisite levels of fear and related immobilisation are being maintained. He refers to the fact that half the new government ministers are from ZANU-PF, which party retains, with the exception of the finance ministry, the most important portfolios in terms of reflecting “power”. He says that there is no evidence that the ZANU-PF-aligned

civil servants, military or police are obeying any new MDC minister and that there is plenty of evidence that they are being obstructive and considers that it is even less likely that the youth militia and war veterans would be any different. He refers to polls reporting that support for ZANU-PF has dropped below 10% even in areas that had been no-go areas for the MDC and that the majority of the population appear to credit the MDC with turning round the economy. There are conflicts between the ZANU-PF factions, for example divisions inside the Harare party and over the vice-presidential succession. He says that the economy has shrunk by over 80% since 1999, a record for a country not at war, and has seen disastrous land reform policies, draconian measures for curbing civil and political liberties, the plundering of the economy by the government, a devastating HIV and AIDS epidemic, cholera and widespread hunger and dependency on outside food aid. He says that Zimbabwe's once admired social services have collapsed in the face of the economic crisis and the HIV and AIDS epidemic. Zimbabwe has one of the highest HIV and AIDS prevalence rates in the world, recorded at 15.3% in 2007, and that in 2006 life expectancy had dropped from 61 years in 1990 to 34 for women and 37 for men. EU special measures ("sanctions") against the ZANU-PF elite were renewed in February 2010 and Zimbabwe stands as the 151 st poorest country out of the world's 177 ranked countries three years ago, and indications were that it had now declined further. The rural poor are said to be more or less out of the mainstream economy and are dependent upon harvesting, trading and survival. Although the harvest looked to be marginally better this year, the need for aid was acute with 80% of the population having been in need of food aid and half of the maize requirements having to be imported. Initial estimates made by the UN Food and Agriculture Organisation (FAO) and World Food programme (WFP) were that about 2.8 million people would need food assistance until April 2010. Major hospitals had almost closed down due to staff exodus and unavailability of drugs, although public sector workers went on strike again in February 2010.

148. There had been a failure to overcome institutionalised violence and though there had been some initial scaling down of the violence directed against civic and opposition members from the extreme oppression of 2008, despite the signing of the GPA little progress had been made in the protection and promotion of human rights in Zimbabwe, as seen by the sustained levels of violence from month to month. Some reports received by the Human Rights Forum indicated that ZANU-PF bases which were used as places to torture and maim supporters and purported supporters of the MDC during the electoral violence were still operational or reactivated. Zimbabwe has a high level of violence and patriarchal attitudes are extremely harsh on women. According to the Girl Child Network, 40,000 girls are raped annually before they turn 17. Rape is also reported to be used as a political weapon. An estimated 25,000 people had been the victims of human rights abuses, along with 200,000 displaced. There was endemic torture, beatings and murders. Reports of human rights monitors in rural areas suggested that they were scared and witnessing escalating human rights abuses.

149. Dr Kibble confirms the report of Professor Barnett as a correct assessment of the situation in Zimbabwe. Zimbabwe Doctors for Human Rights apparently said that there was now only one doctor for every 12,000 people (outside the private and NGO sectors). Around 1 in 7 adults living with HIV and an estimated 565 adults and children were becoming infected every day. He was told by a Zimbabwean social activist that those who qualified for it were enrolled in the state health protection for HIV and related conditions (which were assisted by international organisations and NGOs) and there was reasonably adequate care at little cost but that for those not within this scheme and provision the costs of private medication and treatment were astronomical. It was currently estimated that about half of those who qualified on the basis of their medical condition to receive anti-retrovirals or another medication actually did so, therefore 200,000 out of an estimated 400,000. Though this was a considerable improvement on the 15% or so who were receiving attention twelve months

previously, it still left a very large backlog. He considered it was very unlikely and difficult whether someone newly arriving back in the country would immediately be able to benefit from the international agencies' assisted state processes and considered that at least for a time recourse would have to be made to private medicine with its very high costs. Although medication would be available, unlike a year ago, for almost any conditions, the costs would be likely to be very prohibitive. He did not think that returnees would have priority in getting onto the register of eligible people for state provided medication.

150. Dr Kibble goes on to say that there is a plethora of organisations and networks working on support, advocacy and training around HIV, medication provision, care and destigmatisation. He considers that despite this, the coverage of service delivery is likely to improve only slowly because of the very slow recovery of the national economy and the fact that donor funds were extremely stretched at present. He also considers that stigma and ostracisation due to HIV is still very problematic and debilitating, especially for people lacking extensive family support. He considers social services support is likely to be entirely lacking and that there would be no likelihood of finding professional care except at great expense and likewise hospitalisation or institutionalisation for care though now available would be again prohibitively expensive.

151. Dr Kibble goes on to note that Zimbabwe receives international aid in this sector with the main donors being the UK and the US Department for International Development (DfID and USAID) and the European Commission. He considers that access, particularly to anti-retroviral drugs, is still a major problem and that there has been a shortage of ARVs for some years. He refers to a report in October 2005 that government officials who are HIV Positive are being given priority access to ARVs and intercepting drugs for their own use that were actually meant for public hospitals. Women who live in rural areas purportedly find it very difficult to obtain ARVs and would have to travel long distances to health centres to receive ARVs. A severe national shortage of healthcare workers had led to long waiting lists and administration problems. He goes on to refer to the difficulties experienced by people whose HIV mutates at speed and the different lines of treatment which become necessary as a consequence and the increasingly complicated nature of the regime. He says that it is impossible in Zimbabwe under current circumstances to access the required drugs except for those who can get help from the most sophisticated forms of private medicine. He considers that the health sector in Zimbabwe had almost entirely collapsed, and that it is still on life support.

Dr Mujuru-Mvere

152. Dr Naomi Mujuru-Mvere was a doctoral student of Professor Barnett at the University of East Anglia and has subsequently been part of a consultancy team contracted by the United Nations Children's Fund (UNICEF) and the Minister of Education of Zimbabwe on a field study to establish the unit cost and co-financing modalities of basic education in Zimbabwe, with special reference to those afflicted and affected by HIV and AIDS. She was in Zimbabwe between April and June 2007, when she visited a number of hospitals, clinics and pharmacies, and again visited Zimbabwe between 20 November and 17 December 2008 and most recently was in Zimbabwe between 18 November and 25 December 2009 when she again visited a number of hospitals, shops and clinics and consulted the Zimbabwe Medical Research Council (ZMRC) and the University of Zimbabwe Clinical Research Centre (UZCRC). Her report is dated 25 January 2010.

153. Dr Mujuru-Mvere considered that the health issues of BR, in respect of whom she was specifically asked to provide a report, were worse than her socioeconomic position in Zimbabwe. She would be seen as being irresponsible, since her HIV was diagnosed after she entered the United

Kingdom. She says that the care system for chronically ill patients in Zimbabwe is still poor and worse for single old women, as she describes BR, who was born in 1957. She will be isolated and stigmatised since in Zimbabwe nobody wants to be near a person who is known to be chronically ill, especially from AIDS and that the Shona tribal groupings to which she belongs are patrilineal and patrilocal, hence entailing that women occupy a subordinate role and that this could mean that her nursing and care could be challenging.

154. She says that bribery is now definitely required to succeed in acquiring many commodities or services, and that healthcare workers, particularly those in the HIV/AIDS sector are being singled out as being among groups of workers that are greatly profiteering from corrupt practices. Because of the difficulty in obtaining foreign currency, BR will find it hard to buy food, and as a sick single woman she will confront great difficulty in accessing food, electricity, clean water and sanitation. She says that the situation on food is problematic in urban areas including Chitungwiza, BR's home town. She says that there is another looming food shortage. She will experience endless queuing for food and other commodities and may experience the need to pay fees for privileged positions or favours within a queue. The current problematic water situation and food issues will have a serious impact on her health as a sick, diabetic, single woman.

155. Dr Mujuru-Mvere says that it is still also a standard requirement at health centres for sick people on treatment to have a partner within their household, someone who will be in a position to assist them with, for example, being a companion, encouraging them to take tablets and help with other personal needs. She notes that BR has no such person in Zimbabwe. She says that she knows for certain that the majority of people are unable to meet costs for any treatment which requires cash payment up front in foreign currency including the costs of tests and fees for consultation. She said that, in any event, new patients such as BR are not being accepted in the public sector, whilst for those already on the government scheme, supplies are still intermittent and subject to substitution. She says that on her most recent visit she observed that many public health institutions had reopened including the main hospital in Harare, but they were still not operating normally and there were still shortages and waiting lists and queues for ARVs. She made enquiries from the Avenues Clinic pharmacy in Harare as to the availability of ARVs, and found that it had exactly the same type and number of ARVs as the other ordinary private pharmacies. She says that a range of ARVs is sometimes available from some private institutions, but they are not manufactured in Zimbabwe and the cost of importing them is high. She concludes that if the appellant is returned to Zimbabwe, there is no hope that she will get the help she needs and that also her complex specialist combination HIV treatment is unavailable. Dr Mujuru-Mvere notes the medical evidence concerning BR and the fact that in Dr Minton's report of 11 January 2010 it had been found necessary to change her anti-retroviral regimen in November 2009 to a more complex one. She had acquired resistance to certain ARVs. She notes the specific ARVs that BR is now on, and says in respect of these that Raltegravir is not available from government institutions or private pharmacies, and nor are Atazanvir and Ritonavir. The other ARV in the combination of therapy she receives is Truvada which she says is not available in government hospitals. She concludes that the appellant's combination ARV treatment is now more complex and is unavailable in Zimbabwe. In particular Raltegravir is a very new form of treatment known as an integrase inhibitor which has only recently come into widespread use in the UK NHS and is certainly not available in either the public or private sectors in Zimbabwe. This chimes with Professor Barnett's evidence respecting Raltegravir.

156. Dr Mujuru-Mvere goes on to say that it will not be possible for BR simply to slot into the programme of treatment on arrival. It has been reported that there are plans to expand the

government's ARV programme. With regard to the impact of government policies and political considerations, Dr Mujuru-Mvere says that the public administrative structures have always been and still are to date embedded with powerful ZANU-PF politicians who tend to be militant and corrupt. She says that these cadres are still there despite the formation of the "Unity" government. She says that corruption has now also widely spread to all levels and sectors of the economy, including both senior and junior civil servants. The issue of political affiliation is still a significant issue in Zimbabwe and it is still a priority for protection and for survival, and an insurmountable hurdle for those outside the structures with health issues. She refers to it being a problem as long ago as July 2001 of political discrimination in relation to the composition of the boards of the National AIDS Council in Zimbabwe (NAC) and in relation to its distribution of funds/scarce resources. She had also come across this during her fieldwork. She says that it has always been policy that for someone to access free government treatment or other free handouts from government, there has to be means testing at a local level and a letter of support written. To get this letter of support could be very subjective and discriminatory on political lines, increasing the vulnerability of HIV sufferers compounded by the high levels of corruption. She says that the Unity government's efforts to revive the economy have not been successful and that the Unity government is broke. She considers that the power sharing agreement does not seem to be making any immediate impact. She concludes that the appellant's removal from the United Kingdom would include a real risk of deterioration in her health as there is no realistic prospect whatsoever of her accessing the combination ARV treatment that she needs in Zimbabwe.

Dr Baggaley

157. Dr Rachel Baggaley has written a report dated 27 February 2007 specific to the appellant EC. She is a medical doctor and currently a Head of the HIV Unit at Christian Aid. She is also an Honorary Research Fellow at the London School of Hygiene and Tropical Medicine. For the previous four years she had worked in London for Christian Aid, having previously lived and worked in Africa, specialising in HIV and counselling issues, and as part of her current work she continued to travel to Africa to review projects and programmes having most recently been in Zimbabwe in May 2006.

158. At the time of her report there were an estimated 1.7 million people living with HIV in Zimbabwe. Generic ARVs though licensed in Zimbabwe were not currently widely available. There was a very limited drug supply through government health services. ARVs had recently started to become available through some government clinics, but as yet the programme was very small and very few people had access. Though it was available, she says that people receiving ART had to have a letter from social welfare recommending free treatment. According to colleagues in Harare, she said it is unlikely that anyone would be able to obtain this letter of support unless they were a card-carrying member of ZANU-PF. If they had other political affiliations or were known previously to have been members of the opposition party, it would be highly unlikely that they would be supplied with the necessary paperwork needed for them to get free ART. A recent report from Human Rights Watch also stated that access to ART through government schemes was "subjective and arbitrary" with "unnecessary obstacles for vulnerable and poor people living with HIV who urgently need access to healthcare, leaving them at risk of fatal deterioration in their health. She deals also with the availability of ARVs from private pharmacies which she says are sometimes available, the fact that CD4 counts are sometimes available in Harare, costing in the region of £40 and that viral load measurements were only available in some private health clinics, at a cost of approximately £100. She says that unless the appellant EC had access to foreign currency (a minimum of £949 per month) she would not be able to access ART and would deteriorate quickly and die. She says that this is the cost of the drugs alone and does not cover the monitoring and clinical care costs which would double the

overall costs. She would die prematurely due to HIV but it was not possible to estimate the timescale of this, though it would be compounded by the lack of basic healthcare now available in Zimbabwe. She says that HIV is still a hugely stigmatising condition in Zimbabwe, with very few people feeling able to be open about their positive HIV status. She says that counselling services are available in Harare but women are often reluctant to attend because of worries about confidentiality. The appellant said that she had not been able to disclose her situation to relatives and she might therefore experience feelings of isolation and this would be exacerbated if her clinical condition deteriorated.

Professor Ranger

159. Professor Ranger's report is dated 24 February 2010. He is an Emeritus Professor of the University of Oxford who also gave evidence in RN . He was asked to provide a report in respect of the appellant RS. He makes no comment on the question of her HIV status or of the availability of treatment in Zimbabwe as he says that he is not an expert on AIDS and in any case it does not seem to him that her case depends on the matter. His report is therefore essentially addressed at the issue of risk on return for her if she is unable to demonstrate support for ZANU-PF. In effect he does not consider there to be any material difference in the human rights situation in Zimbabwe since he made his report to the AIT in RN 's case. He notes initial optimism after the signing of the global political agreement but emphasises the fact that subsequent human rights reports and political violence reports have become more pessimistic thereafter. He notes for example the Zimbabwe Human Rights NGO Forum Political Violence Report for May 2009, which states that the month of June saw the levels of organised violence sustained with little indication that the government of national unity was committed to ending human rights violations in the country. Student leaders had been arrested and groups of ZANU-PF youths had been harassing MDC supporters. He quotes Human Rights Watch as stating on 12 February 2010 that no real progress had been made in ending human rights abuses a year after the formation of the Unity government. The African Director of Human Rights Watch is quoted as saying that the government of national unity is a sham and that from a human rights perspective nothing has changed for the better. Amnesty International on 11 February 2010 said through its Africa Director that the Attorney General's office, the police and the army had been left free to violate human rights. There was renewed violence on the ground and the situation could deteriorate if no urgent measures were taken to stop state security agents from carrying out violent political campaigns. On 23 February the European Union announced that it would not lift sanctions on Zimbabwe, finding "insufficient progress with regard to the rule of law, respect for human rights, national reconciliation, security sector reform". Professor Ranger concludes by saying that in his view the caution expressed in RN has proved abundantly justified and should continue to be taken as the statement of the legal position.

Mr Jones

160. Mr Jones, the First Secretary (Migration) of the British Embassy in Harare has provided a report entitled "The availability of publicly funded anti-retroviral treatment (ART) and drugs in Zimbabwe". The terms of reference of this fact-finding mission are set out at the start of his report. It addresses such matters as the availability of publicly funded anti-retroviral treatment/drugs in Zimbabwe, the criteria for access to such treatment/drugs, evidence of waiting lists and average waiting times, the cost of private anti-retroviral treatment in Zimbabwe and access to it, the prospects of remittances from the United Kingdom feeding through, developing a view as to whether any shortages in medicines or limitations in healthcare were the result of deliberate and malign government "targeting", whether there was evidence of preferential access to public or private treatment and the

criteria for such preferential treatment. Mr Jones consulted a number of organisations and individuals.

161. After receiving the responses of the individuals Mr Jones wrote up the responses given and checked these back with the individuals and organisations in question, thus enabling him to provide his overall report. Several organisations or individuals were not willing for their names or identities to be provided and therefore these were redacted. However, there are specific responses from the National AIDS Council, the World Health Organisation, the Zimbabwe Red Cross Society, the Zimbabwe Association of Doctors for Human Rights, and the Ministry of Health and Child Welfare. He also relied on various published sources including uncorrected written evidence submitted by the Department for International Development (DfID) to the House of Commons International Development Committee and the September 2009 Guidelines for Anti-Retroviral Therapy in Zimbabwe. It is said that the individuals and organisations were chosen in order to give the best representation of the current situation in Zimbabwe due to their level of involvement in and knowledge of the issues.

162. There is set out a list of common anti-retroviral drugs available in Zimbabwe. There were also some drugs that were not available in Zimbabwe though it was said that some ARVs not found in the public sector could be found in the private sector. This was part of the response from the World Health Organisation. One anonymous aid organisation reported that there was at least one ART clinic in each of the 62 districts in Zimbabwe, but that patients often had trouble in finding the money to pay for transport to the nearest clinic. This was a more common issue for those living in more rural areas, though it was said by the National AIDS Council that the government had a number of outreach teams to address this issue. The National AIDS Council said that in the past, although there was better access to treatment in urban areas, there was also a longer waiting time. The Global Fund targeted support to more remote regions. There is a table setting out various districts in Zimbabwe which received additional ART support. This also includes an indication of representation in terms of Parliamentary seats after the 2008 elections designed to give more clarity to the issue of whether access to treatment is dependent on political motivation. Mr Jones says that a total of 40 MDC districts and 57 ZANU-PF districts benefited from additional support in Round 5 from the Global Fund.

163. As regards the criteria for access to treatment/drugs in the public sector, these are set out in the “Guidelines for Anti-Retroviral Therapy in Zimbabwe”. It is said by the World Health Organisation (WHO) in its response that new arrivals in Zimbabwe who are already on treatment will be prioritised. The National AIDS Council said that if someone had already been initiated on treatment in another country they would not have to wait more than a month for treatment. An anonymous international organisation said that those who had already been tested “should be able to access treatment with two weeks in government hospitals and a few days in private institutions”. The WHO said that priority for treatment was currently given to children, pregnant women, health workers and their immediate families and all patients who meet the criteria set out in the National ART Guidelines, including those already on ARV treatment (in order to avoid development of HIV drug resistance). The WHO had said that some members of the diaspora had already contacted them with enquiries about treatment on return, and some had since returned.

164. As regards stigma on return, it is said in the report that a large number of people in Zimbabwe are affected by AIDS or HIV and that the majority who are not directly affected have friends or family who are. It is said, given the level of infection over the years and the sensitisation campaigns run by

aid organisations and governments in Zimbabwe, that it is difficult to see how a returnee from overseas would face any higher risk of stigma simply because they had lived in the United Kingdom.

165. It is said in Mr Jones' report that by the end of November 2009 a total of 215,123 people was receiving ART in the public and private sectors. This figure, it is said, has gradually increased since 2004, and a chart is provided. It is said that estimates for waiting times vary in part due to the fact that there are so many organisations involved in the process. For example, Médecins Sans Frontières provide treatment exclusively in the Buhera district, and also have AIDS/HIV programmes in other places, supporting free healthcare for 40,000 people. It is said that there are numerous clinics and treatment centres run independently by various organisations. The World Health Organisation stated that of the estimated 300 clinics in Zimbabwe, 100 were involved in initialising treatment, with 200 concentrating on follow-up treatment. Current guidance stated that whilst a person could only be initiated on anti-retroviral treatment by a doctor, follow up treatment in terms of supplies of drugs need only be carried out by a nurse or other clinician. The waiting time for access to public treatment for those not deemed to be priority cases could typically be up to six months, according to the WHO.

166. There is then set out a list of available ARTs in Zimbabwe and their costs. Mr Jones had visited a pharmacy in Harare on 11 February 2010 which commonly supplied drugs to private patients on ARV which gave him a list of the drugs that they had in stock and their prices.

167. On the question of whether there was political motivation affecting shortages and availability, most respondents said that they had seen no evidence of the availability or otherwise of anti-retroviral treatment being dependent on political affiliation. All of those interviewed said they were not aware of any issues around the withholding of drugs by the government in MDC areas, and some said that it was difficult to see how ZANU-PF would be able to orchestrate the withholding of drugs to particular areas, as they would not have access to the relevant mechanisms, for example, as was said in an anonymous response, they had "no control over procurement, which is handled by NGOs and international organisations etc". The World Health Organisation simply replied "No" when asked whether the availability of ARVs was in any way dictated by political affiliation and whether someone would have to demonstrate loyalty to a political party to obtain ARVs. On this issue the Zimbabwe Red Cross Society said that there was a defined referral system which did not discriminate against race, gender, political affiliation, religion etc. The Zimbabwe Association of Doctors for Human Rights said that there had been some limited anecdotal evidence to suggest that the availability of ARVs might be dictated by political affiliation in some areas but insufficient to support this view and there was no suggestion that it was systematic or policy-driven. The Department for International Development had said with reference to its involvement in the Expanded Support Programme for HIV and AIDS in Zimbabwe (the ESP) that "the ESP demonstrated it was possible to support national policy and public services without passing money through the government and without becoming entangled in political debate". There was reference also to one NGO stating that they had heard of food aid being withheld during the 2008 elections.

168. Some of the interviewees stated that in terms of supply, economic conditions were not necessarily an issue. This, according to the National AIDS Council, was because the majority of drugs (90%) used for ART in Zimbabwe were supplied by NGOs and international organisations and were therefore imported, bypassing any economic issues within Zimbabwe itself. It is said in the report that a number of international organisations, governments and NGOs provide transport within the country to ensure drugs reach regional clinics and treatment centres. Officially a patient can only be initiated on ARV treatment by a qualified doctor. It is said by the WHO that drugs are delivered to the regions every other month and that from the end of 2007 to the date of interview there had been no reported

shortages of ARVs from the national stores, although there were some in 2006 to 2007. Where there were shortages, patients were provided with a shorter supply so more patients could be treated. It was said by the National AIDS Council that drug shortages in regional clinics had sometimes also been caused by a lack of a qualified person to order the drugs.

169. As regards preferential access to public or private treatment, the WHO said that it had only heard limited anecdotal evidence that people had attempted to use bribery to move up waiting lists and these were apparently discovered by the authorities. The National AIDS Council said that there was no evidence of access to treatment being dependent on political affiliation or corruption. It is said that local AIDS committees would not have access to the initiating or treatment system in any way that would enable them to interfere with that process, especially where the treatment in some areas is controlled by NGOs such as Médecins Sans Frontières.

170. It is said that according to the 2009 HIV estimates, about 343,000 people were in need of ART. As at the end of 2009, there were an estimated 1.1 million people living with HIV and AIDS in Zimbabwe. According to the Ministry of Health and Child Welfare in August 2009, approximately 128,000 eligible PLHIV (people living with HIV) were currently waiting to be started on ART (across all public health facilities in Zimbabwe). This figure would increase, however, if the government adopted the WHO Guidelines recommendation that patients start treatment at a CD4 count of 350 (the current threshold appears to be 200).

171. It is noted that there is a significant shortage of health workers across Zimbabwe. DfID has led on a process to ensure the return and retention of health workers and they stated that:

“By October 2008, health services were close to closure, with many hospitals physically closed. A retention scheme enabled these facilities to reopen in January, and by February 2009 they were almost fully functional.”

This is to be found in the uncorrected written evidence submitted by the Department for International Development of the House of Commons International Development Committee set out at Annex K to the report. Government figures show an estimated (AIDS related) mortality rate for both adults and children combined of 92,379 in 2007, 79,572 in 2008, and 66,073 in 2009. This is said to be a consequence of upscaled ART programmes.

172. As regards treatment guidelines and CD4 count testing, it seems that most people started on treatment in Zimbabwe had CD4 counts of less than 200. As noted above, Zimbabwe has not yet adopted the new WHO treatment guidelines, though it is currently reviewing the new guidance and considering options. There are currently pharmaceutical companies in Zimbabwe which have the capacity and potential to manufacture ARVs, according to the WHO.

173. As regards food security, harvests and malnutrition, hyper-inflation and acute shortages of basic supplies and a series of very poor harvests led to serious food shortages and acute insecurity in recent years. This has necessitated large-scale humanitarian food assistance operations in Zimbabwe. The country faces a cereal shortfall of around 677,000 tonnes during the current consumption year which ends in March 2010, despite a significantly improved harvest of maize in the previous year. It is estimated that around 2.8 million people might need humanitarian assistance before the harvest in April 2010, with the majority in rural areas. The World Food programme is aiming to assist almost 1.5 million Zimbabweans per month during the first quarter of 2010 through Vulnerable Group Feeding (VGF) and other social safety net programmes and has identified with its cooperating partners a three tier strategy to prioritise food assistance interventions.

Dr Day

174. There are two medical reports from Dr John Day respecting the appellant EC. The first of these is dated 16 February 2007. She had been under the care of his department since February 2002 when she presented with recurrent genital herpes and a routine test for HIV was found to be positive. She was commenced on anti-retroviral therapy on 4 March 2002 and had made an excellent response. Her most recent CD4 count on 3 January 2007 was 470 and her HIV viral load had been fully suppressed since June 2003, indicating her excellent adherence to the medication. Dr Day has had eleven years' experience of working in HIV medicine in the UK, Zimbabwe and South Africa. He noted that both of the drugs the appellant was on at that time, Efavirenz and Combivir were available in the private sector at high cost in Zimbabwe and that availability of anti-retroviral therapy was very limited in the public sector and primarily reserved for those who were symptomatic. There were cheaper alternatives to Efavirenz and Combivir which would be suitable for the appellant but would be more likely to produce side effects. The supply was prone to interruptions. HIV remained a highly stigmatised condition in Zimbabwe and patients with HIV were subject to persecution and prejudice. With no or limited access to medication, she would inevitably become ill, lose weight and die.

175. In his recent report of 12 February 2010, Dr Day refers to the fact that the appellant has remained on Efavirenz and Combivir and her last test on 9 October 2009 showed a CD4 count of 597. On 27 April her regime was simplified from Efavirenz and Combivir to Atripla. Her future health was dependent on her continuing to be able to receive an uninterrupted supply of anti-retrovirals. She had not had a viral load resistance test carried out before commencing treatment as it was not part of the clinic routine at the time, but it was likely that she had no resistance mutations and therefore alternative drug regimes would be expected to be effective. If she were to receive an erratic supply, she would be at risk of developing resistant strains which would necessitate change of treatment to a more complex, more expensive and hence less available combination. If she was unable to receive a supply that fully controlled her virus then her life expectancy would be limited to less than three years as a consequence of a deterioration in her immune function predisposing her to opportunistic infections. That risk would be exacerbated by inadequate nutrition, particularly with respect to tuberculosis which remained the commonest opportunistic infection for people living with HIV infection in Southern Africa, Dr Day said that he does not have recent first hand experience of the availability of anti-retroviral therapy in Zimbabwe.

Dr Minton

176. As regards the appellant BR, there are a number of medical reports dating back to 13 August 2002, the most recent being 11 January 2010. That is a report from Dr Minton. He says that the appellant, despite being on HIV treatment, had a persistently raised HIV viral load in September and October 2009 and they therefore carried out resistance studies. This showed that she had unfortunately acquired resistance to the two main classes of HIV medication commonly used, i.e. reverse transcriptase inhibitors including Lamivudine and non-nucleotide reverse transcriptase inhibitors, particularly Efavirenz. Her anti-retroviral regimen was therefore changed in November 2009 to a more complex one consisting of Raltegravir, Atazanavir, Ritonavir and Truvada. He says that she has tolerated this regimen well and is pleased to say that her HIV viral load was not detected when last checked on 29 December 2009. Her CD4 count was reasonable at 388. His understanding was that these second line anti-retroviral medicines would be very hard to obtain in Zimbabwe.

Dr Day

177. In respect of the appellant RS there are two reports, again from Dr Day. The first of these is dated 7 August 2008. RS was commenced on Combivir and Nelfinavir on 30 August 2001. Nelfinavir was withdrawn as a result of safety concerns on 2 June 2007 and she was switched to other drugs. Unfortunately blood tests showed a suboptimal control of her HIV on this combination, and an HIV resistance test confirmed the resistant strains necessitating another change on 9 July 2008 to Tenofivir and Zidovudine and Efavirenz. He says that her prognosis, provided she continued to receive medication, was excellent but if she was unable to receive an uninterrupted supply of treatment he would expect her life expectancy to be less than five years. He says that the development of resistant strains also restricts the repertoire of HIV medication she may require in the future. The combination she currently takes is also active against hepatitis B of which she is an asymptomatic carrier and there is a small risk that she may develop complications due to reactivation of the hepatitis B virus.

178. Dr Day's most recent report is dated 4 February 2010. RS continues to receive treatment for HIV on the basis of the three drugs to which she changed on 9 July 2008. On this she has maintained a fully suppressed HIV viral load of less than 50 copies/ML and a stable healthy CD4 count of over 500. Her latest CD4 count on 1 February 2010 was 623. When she was last reviewed by the hepatologist on 26 March 2009, he confirmed that she remains a low grade hepatitis B chronic carrier at very low risk of future complications. Dr Day considers that, provided she is able to continue to receive an uninterrupted supply of anti-retroviral therapy, he would anticipate a near normal life expectancy and good health. If she experienced treatment interruptions, her risk of developing further viral resistant mutations would limit treatment options necessitating more medication with likely greater side effects and escalating cost. If medication was stopped completely he would expect her life expectancy to be less than five years.

Overview of the Other Background Evidence

179. There is a good deal of other background evidence provided on behalf of the appellants relating to the issues in this case. We cannot set it all out in detail, so an overview must suffice. Thus, in the context of evidence concerning the collapse of the public health sector, the appellants rely on a report from Physicians for Human Rights of January 2009. This states among other things that the health and nutritional status of Zimbabwe's people has acutely worsened in the past year due to a raging cholera epidemic, high maternal mortality, malnutrition, HIV/AIDS, tuberculosis and now anthrax. It is said that the health and healthcare crisis in Zimbabwe is a direct outcome of the abrogation of a number of human rights, including the right to participate in government and in free elections and the right to a standard of living adequate for one's health and wellbeing, including food, medical care and necessary social services. The report says that the collapse of Zimbabwe's health system in 2008 is unprecedented in scale and scope. The current status of healthcare in Zimbabwe is best understood, it is said, as an overall health system collapse. The public sector's hospitals have been shut since November 2008. As of December 2008 there were no functioning critical care beds in the public sector in Zimbabwe. Transport costs, even within Harare proper, had made the simple act of getting to work impossible for many healthcare employees. There were similar problems for would-be patients.

180. This state of affairs is effectively confirmed in a report from Médecins Sans Frontières of February 2009. They refer also to a widespread shortage of basic medical material such as syringes and gloves, and also drugs. It is said that there are few doctors left in Zimbabwe and nurses are not allowed to initiate treatment.

181. In a further report of June 2009 of Médecins Sans Frontières it is said that 7 million out of the remaining population of 9 million are presently food insecure. It is said that, though some speculated that the establishment of a government of national unity in February 2009 had “normalised” the situation in Zimbabwe, the political and economic situation was far from stable and the health system continued to exist in a state of near collapse and as a consequence Zimbabweans would continue to flee to South Africa in desperation. Further similar concerns are expressed in a Zimonline report of 23 September 2009 and The Zimbabwean of October 2009.

182. The Lancet on 13 October 2009 also referred to the ongoing problems in the healthcare system and otherwise in Zimbabwe. The report said that many believe that tangible universal health and social improvements would only follow radical change to the current political dispensation. It was said that recent South African humanitarian assistance worth USD$30 million which was meant for agriculture imports went mainly to areas loyal to ZANU-PF.

183. On the FCO website on 9 February 2010 there is reference to a shortage of drugs and trained medical staff in hospitals making it difficult for hospitals to treat certain illnesses including accidents and trauma cases. It is said that the state healthcare system was gradually improving, but it could not always be relied upon to provide basic treatment, and standards of nursing care, even in private hospitals, varied. If payment was available, some of the best hospitals were often too full to admit patients.

184. With regard to access to treatment for HIV/AIDS, the Physicians for Human Rights report of January 2009 referred to food insecurity experienced by a focus group of fifteen HIV Positive urban women. A former Ministry of Health official and current mission hospital administrator reported that some HIV/AIDS patients were selling their ARV medications to receive money to buy food. Patients living with HIV/AIDS were especially vulnerable as a result of food insecurity. The most severe threat for HIV/AIDS was the interruption of supplies of anti-retroviral drugs. This had occurred due to a breakdown in delivery, distribution and theft of ARV drugs by ZANU-PF operatives. Most troubling were reports that some physicians were switching patients on established ARV regimens to other regimens based not on clinical need, but on drug availability. This clearly increased the risk of HIV drug resistance and drug complications and side effects and constituted a significant threat to public health.

185. A further report, AVERT, HIV and AIDS in Zimbabwe, 2009, also refers to the shortage of anti-retroviral drugs and also in October 2005 to a quadrupling in the cost of anti-retroviral drugs in the previous three months. An article published in 2006 had reported that government officials who were HIV Positive had been given priority access to the drugs, and while doing so they had intercepted drugs for their own use which were actually meant for public hospitals. A Voice of America report of 14 August 2009 refers to the inaccessibility of healthcare in Zimbabwe for the majority of the population due to the official introduction of the use of foreign currency and the death of the Zimbabwe dollar. The Lancet report of 13 October 2009 states that anti-retroviral treatment coverage at 17% is the lowest of any country in Southern Africa, and external funding contributes some 21% of total health spending, a low proportion compared with that in most African countries.

186. With regard to the politicisation of treatment and discrimination against HIV sufferers, a report of the Zimbabwe Daily of 2 May 2007 states that cabinet ministers and ZANU-PF bigwigs are now topping the list of beneficiaries of the government ARV therapy scheme. There is reference in the AVERT report to high stigmatisation of HIV and AIDS sufferers, despite a high level of awareness. The Physicians for Human Rights report refers to the plundering by ZANU-PF government officials of

USD$7.3 million in humanitarian aid for HIV/AIDS treatment, part of USD$12.3 million provided by the Global Fund which was returned to the Global Fund following public outrage. There is reference to an article by the Chawapiwa Youth Organisation that government officials who are HIV Positive had been given (by the National AIDS Council) priority access to ARVs and while doing so they intercepted generic AIDS drugs for their own use which were actually meant for public hospitals. This may be a further reference to the incident referred to in the AVERT article in 2006. An article in The Zimbabwe Metro of 23 August 2009 states that most of the beneficiaries of the AIDS levy are top government officials, mostly ministers and their relatives. An IRIN article of 14 September 2009 refers to the Zimbabwe National AIDS Council (the NAC) purchasing USD$890,000 worth of ARV drugs following allegations that it was abusing funds generated by a 3% tax on income known as the AIDS levy. The NAC had constantly come under fire for failing to use the fund to improve the welfare of people living with HIV, and several recent reports in the local media allege that most of the money was being spent on salaries and perks.

187. As regards the issue of politicisation of food, the Physicians for Human Rights' report of January 2009 says that the Mugabe regime has been accused of using donor food aid as a tool to manipulate elections by providing food to communities that supported ZANU-PF and denying food aid to communities that did not. It says that this policy became severe in around 2000 and was still used during the recent 2008 elections. It is said that this restriction of food became most blatant in June to August 2008 when the Mugabe government banned all charitable organisations from distributing food. A Zimonline report of 5 October 2009 states that hundreds of hungry Zimbabwean villagers are being denied food handouts and forced to denounce their own parties in return for assistance as marauding ZANU-PF militants continue to wage a war of attrition against perceived political enemies. A Zimbabwe Peace Project (ZPP) report of September 2008 stated that of the 1,335 incidents of political violations recorded during the month of July, some 37% were of people harassed, intimidated or physically assaulted while trying to access food assistance. The report says that incidents of harassment, discrimination and violence continue to halt the distribution of humanitarian and food assistance. It is said that about 42% of the cases involve discrimination in areas relating to food relief, government subsidised food, tillage support, input distribution and medical treatment, while 42% were harassments involving incidents in which people were forced to chant slogans, denounce their parties, attend political meetings and produce party cards.

188. A report entitled Zimbabwe Democracy Now, New Year 2010, dated 16 January 2010, says that gangs of ZANU-PF activists move from ward to ward stating that for people to receive food aid they will be required to produce ZANU-PF membership cards. A Zimbabwe Telegraph report of 14 February 2010 states that the Minister of Agriculture has announced that the government has banned food handouts by non-governmental organisations. It says that if the past programmes of ZANU-PF are the barometer a ZANU-PF card and voter registration card are prerequisites for food aid. A ZimDaily report of 16 February 2010 refers to Prime Minister Tsvangirai having been told of how ZANU-PF officials have taken control of food aid from local NGOs and distributed it only to ZANU-PF members.

189. As regards the current political climate, a report in the Zimbabwean of 26 February 2010 refers to militant supporters of President Mugabe having set up torture camps in some parts of Zimbabwe and stepped up a campaign to intimidate villages to back a controversial draft constitution. Amnesty International were reported on 24 February 2010 as having called on the government of Zimbabwe to end the harassment and intimidation of a union activist who was in hiding. Amnesty International had documented consistent politicised and partisan policing by members of the Zimbabwe Republic Police,

in particular the law and order section, aimed at silencing the voices of human rights defenders. There is an uncorrected transcript of oral evidence before the House of Commons International Development Committee of 23 February 2010 at which Mr Gareth Thomas MP, Minister of State at the Department of International Development was quoted as saying that there had been an improvement in the delivery of basic services, but having said that, there were huge challenges still in terms of the delivery of those services. The crisis in terms of access to healthcare had not gone away, albeit that there were more health workers in place. It was difficult to see how free and fair elections could take place in the short term, and the government view was that what was included in the global political agreement in terms of changes that were going to be needed had not happened as yet.

190. A report in the Economist of 18 February 2010 states that after the relative optimism of last year, the situation in Zimbabwe was deteriorating badly. The one year old “government of national unity” was described as being as good as dead. Schools, hospitals, courts and other state services have been brought to a halt by striking civil servants. Though there had been an improvement in the economic situation and the reopening of schools and hospitals, it was considered that this had more to do with the replacement of Zimbabwe’s worthless currency by the dollar, which happened before the Unity government was set up. Apart from the economy, the situation on the ground had hardly changed at all. According to Amnesty International, in a report of 10 February 2010, the abuse of human rights in Zimbabwe continued under the unity government. Villagers in parts of Zimbabwe had suffered ceaseless intimidation by supporters of ZANU-PF. The Human Rights Watch Report of 12 February 2010 confirms the pessimism expressed in the Amnesty International Report about lack of progress in implementing political reforms and in respect of human rights abuses in Zimbabwe. Recent research by Human Rights Watch in Zimbabwe suggested that there had been no meaningful political transition, and ZANU-PF continued to engage in political violence against perceived opponents. In written evidence submitted by the Department for International Development to a House of Commons International Development Committee, in January 2010, it was said that in theory the Zimbabwean national constitution guaranteed many basic human rights, but the state had consistently failed to protect citizens. Widespread repression and human rights abuses seen at the time of the 2008 elections had decreased under the inclusive government, but arrests of trade unionists and civil society activists, land invasions and politically motivated legal action against parliamentarians had continued, with weak and inconsistent responses from the judiciary. It was said that the political situation remained volatile and unpredictable and the tipping point had not yet been reached.

191. As regards the issue of government corruption, there is of course the example we have quoted above of the misuse by the Zimbabwe government of USD$7.3 million of its USD$12.3 million grant from the Global Fund, which had to be repaid. The US State Department Report of 25 January 2009 states that the government did not implement the law which provides criminal penalties for official corruption effectively and impartially, and officials frequently engaged in corrupt practices with impunity. The same report, dealing with the issue of the operation of NGOs, noted that a number of domestic and international human rights groups operating in Zimbabwe were subject to government restrictions, interference, monitoring and harassment. The government continued to obstruct the activities of organisations involved in humanitarian activities, particularly in rural areas. The government restricted feeding programmes and blocked efforts by local and international NGOs to provide humanitarian relief to those affected by Operation Murambatsvina. Following the March 29 election, NGOs and humanitarian organisations were increasingly denied access by a variety of official and unofficial personnel acting on behalf of the government. There was harassment of representatives of international NGOs. There was a suspension of NGO “field operations” on June 5, and this lasted

until August 29, when organisations were allowed to renew their activities but were compelled to adhere to new reporting requirements to maintain valid NGO registrations with the Ministry.

192. There is reference in the Zimbabwean of 26 February 2010 to HIV/AIDS activists accusing government health officials of looting anti-retroviral drugs supplied by international donor groups for sale on the black market. It is also said by several activists that some politicians, especially from remote areas, were demanding HIV Positive people to support them or their political parties in exchange for letters confirming they were in need of ARVs. It is said that in some remote rural communities, parliamentarians and councillors are required to write letters confirming that a sick person is too poor to afford ARVs in order that they can get free drugs supplied by donors, but in many cases the politicians demand that the HIV Positive person and their family promise to vote for them in future elections in exchange for the letter. It has also been said that aid agencies operating in Zimbabwe have been urged to take ARVs directly to people with HIV/AIDS amid allegations that some state officials involved in the distribution system were corrupt. The Zimbabwe Peace Project is quoted as saying that party affiliation continues to determine one's chances of accessing both government subsidised food and humanitarian assistance. It is said that the procedure is that HIV/AIDS and TB patients who want to be registered for NGO relief assistance have to register first with village health workers who are required to sign the form which they submit to NGO relief officers. It is said that these well laid out procedures have been politicised by ordering intending beneficiaries to go and register first with the ZANU-PF district chairpersons who would in turn authorise the village health workers to register the patient for relief assistance. Examples of this are given for a number of areas of Zimbabwe. It is said that most volunteers, healthcare givers, and ward coordinators in these districts allegedly report directly to ZANU-PF officials. It is said that those targeted are systematically denied access by government officials, who are mostly ZANU-PF functionaries refusing to sign letters authorising victims medical and other forms of assistance.

193. On behalf of the Secretary of State again a good deal of material is provided and we can do no more than summarise that material. Paragraph 2.13 of the OGN for Zimbabwe of 24 March 2009 refers to reports of political violence continuing, if not on the scale of April to June 2008, and that suppression of peaceful protests is still the normal pattern. The Human Rights Watch Report of August 2009 states that to its credit, the power-sharing government has managed, with the assistance of international donors and aid agencies, to bring Zimbabwe's serious humanitarian crisis under control and somewhat stabilise the country's economic situation through a range of new policies. The report disclosed no ongoing violence directed at non-activists.

194. In the December 2009 COIR, account was taken of the Solidarity Peace Trust and IRIN's conclusions, which reported that the levels of violence against members of the MDC had reduced since 2008, but that there had been a sharp increase within days of the party disengaging from the Unity government in October 2009. Cooperation with the government of national unity was resumed on 27 November 2009. It is noted that while there had been an increase in violence during the last few months of 2009, the levels of violence recorded for the first half of that year were much reduced in comparison to the same period in 2008 and 2007, and it is suggested that there is no basis for the argument that violence has reached the scale witnessed during 2008. A Ministry of Healing has been established. Very few indications of political violence were found in the two provinces monitored by the Solidarity Peace Trust in its report of June 2009.

195. There is a response, dated 25 February 2010, from the First Secretary (Migration) of the British Embassy Harare to Dr Kibble's report. It is said that Zimbabwe in 2010 is markedly better off economically and politically than it was in 2008 for example. The symbolic importance of the fact that

Mr Mugabe has been forced to share power and ZANU-PF no longer has a majority in the House of Assembly is emphasised. It is also noted that there is enough optimism among MDC-T and its supporters for them to want to carry on in government. Issue is taken with specific points in Dr Kibble's report, with reference to such matters as the low, almost non-existent inflation, and rising GDP, the fact that most vegetables are local and serious efforts are being made to improve economic management. As regards Professor Ranger's report, it is said that there is little doubt that as far as human rights abuses are concerned, the situation on the ground in Zimbabwe in February 2010 is better than at any time during 2008, where election related violence was well catalogued. While there had been cases of abuse, these had not been at the high level seen previously. It is said that the political situation is positive in the sense that former opponents are still together in the inclusive government.

Discussion

196. We must now assess the evidence that we have set out above in the context of the relevant legal principles, in relation to the issue of risk on return to Zimbabwe for persons who are HIV Positive. Thereafter we will apply our findings to the specific circumstances of the three appellants.

The Current Country Guidance in RN

197. It was agreed prior to the hearing of these appeals that they would be concerned with risk to the appellants on return to Zimbabwe on account of their HIV/AIDS diagnoses, and it was not understood that the country guidance decision in RN would be revisited. Nevertheless it was argued on behalf of the Secretary of State that it was appropriate to revisit RN , and reference is made in the Secretary of State's skeleton argument and elsewhere to background evidence postdating RN in this regard.

198. The suggestion that RN should be revisited was vigorously resisted on behalf of the appellants, in light of the pre-hearing agreement, but nevertheless some evidence was put in and submissions made regarding the status of RN as country guidance and emphasising the point that RN remains in effect binding country guidance unless very clear and cogent reasons are given for departing from it. The point is made that if the appeals had been listed as general country guidance then a good deal of evidence would have been provided on behalf of the appellants.

199. We do not propose to dwell on this issue. The status of RN as the relevant country guidance is not a substantive issue before us, and we understand that it is likely that later this year RN will be revisited. In any event such evidence as we have before us to the extent that we have considered it appropriate to give consideration to it, indicates sufficiently clearly to our view, and bearing in mind that it is limited evidence only, that there is no reason to depart from RN as the country guidance that should lie behind our decision insofar as it is relevant to do so. Matters such as the State Department Report of 11 March 2010, and the report of Professor Ranger, indicate to us sufficiently clearly, that bearing in mind the terms of Practice Statement 12, we have not been provided with the kind of clear and cogent reasons which seem to us to be required in cases involving issues relating to aspects of country conditions as a whole for departing from RN as country guidance. It remains therefore very much of significance in this case as background (and in some cases as foreground) to the issues that we must consider.

Article 3 of the Human Rights Convention

200. As can be seen from the case law we have summarised above, a high threshold is set in cases where it is contended that a person should not be removed from the host state to their country of

nationality on the basis of their state of health where it is alleged that removal would amount to a breach of Article 3. The European Court of Human Rights in D emphasised the very exceptional circumstances of the case and the compelling humanitarian considerations at stake. The applicant in that case was in the advanced stages of a terminal and incurable illness, and the limited quality of life he enjoyed resulted from the availability of sophisticated treatment and medication in the United Kingdom and the care and kindness administered by a charitable organisation. He had formed bonds with his carers. There was no evidence to show that he would benefit from any moral or social support when returned to St Kitts and nor had it been shown that he would be guaranteed a bed in either of the hospitals on the island. It was also noted that the United Kingdom had assumed responsibility for treating his condition. It could not be said that the conditions which would confront him in St Kitts would themselves cause a breach of Article 3 but his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment.

201. It is relevant to note that in the years between D and N , the decision to which we shall come shortly, no further cases were found where proposed removal of an alien was found to give rise to a violation of Article 3 on grounds of the applicant's ill health. BB v France , as we have noted, was resolved on the basis of a friendly settlement. In the meantime there are other decisions in Karara and Henao , to which we have referred above, where applications relating to people whose illness had not yet reached an advanced or terminal stage were held to be inadmissible.

202. In N , at paragraph 42, the Court reminded itself of the very exceptional circumstances that existed in the case of D . It did not exclude that there might be other very exceptional cases where the humanitarian considerations were equally compelling but considered it should maintain the high threshold set in D and applied in subsequent case law. The applicant in N , as noted at paragraph 47, had been diagnosed in 1998 as having two AIDS defining illnesses and a high level of immunosuppression. Her condition was now stable as a result of the treatment she had received in the United Kingdom. She was fit to travel and would remain fit as long as she continued to receive the basic treatment she needed. The evidence before the United Kingdom courts was that if she were to be deprived of her present medication her condition would rapidly deteriorate and she would suffer ill health, discomfort, pain and death within a few years. It was noted that anti-retroviral medication was available in Uganda although through lack of resources it was received by only half of those in need. The applicant claimed that she would be unable to afford the treatment and it would not be available to her in the rural area from which she came. It appeared that she had family members in Uganda, though she said they would not be willing or able to care for her if she were seriously ill. She had been provided with medical and social assistance at public expense during the nine year period it had taken for her asylum application and the human rights claim to be determined by the domestic courts and the Court of Human Rights. It was said however at paragraph 49 that this did not in itself entail a duty on the part of the respondent state to continue so to provide for her. The Court accepted that the quality of her life and her life expectancy would be affected if she were returned to Uganda. She was not however at the present time critically ill. The rapidity of the deterioration which she would suffer and the extent to which she would be able to obtain access to medical treatment, support and care, including help from relatives, had to involve a certain degree of speculation, particularly in view of the constantly evolving situation as regards the treatment of HIV and AIDS worldwide. The Court's conclusion was that the applicant's case could not be distinguished from cases it had cited earlier such as Karara and Henao and Bensaid . It did not disclose the very exceptional circumstances required to be shown as had existed, for example, in D .

203. We have set out the medical evidence concerning the three appellants above. To summarise it, the current situation of RS is that she continues to receive treatment for HIV with Tenofovir, Zidovudine and Efavirenz. Her most recent CD4 count was 623. She is a low grade hepatitis B chronic carrier at very low risk of future complications. She is able to continue to receive an uninterrupted supply of anti-retroviral therapy and nearly normal life expectancy and good health are expected. If there are treatment interruptions then there is a risk of developing further viral resistant mutations which would limit treatment options necessitating more medication with likely greater side effects and escalating cost. If medication were stopped completely her life expectancy would be less than five years. BR has had to be placed on a complex regimen of treatment consisting of Raltegravir, Atazanavir, Ritonavir and Truvada. Her CD4 count is reasonable at 388. There is no projected life expectancy without such treatment in the most recent report of Dr Minton of 11 January 2010, but in his previous report of 9 October 2009, in respect of her previous anti-retroviral therapy, he considered that if she were no longer able to obtain her medication her CD4 count and general health would rapidly decline and she would become susceptible to severe infection and cancers. EC is treated with Atripla. The most recent CD4 count was 597. Her future health is dependent on continuing to be able to receive an uninterrupted supply of anti-retrovirals. If she were to receive an erratic supply, she would be at risk of developing resistant strains which would necessitate a change of treatment to a more complex, more expensive and hence less available combination. If she were unable to receive a supply that fully controlled her virus, her life expectancy would be limited to less than three years, the risk being exacerbated by inadequate nutrition, particularly with respect to tuberculosis.

204. As regards availability of medication for HIV/AIDS in Zimbabwe, Professor Barnett's evidence was that medical treatment in the public sector was extremely unpredictable, poorly resourced and the facilities would not be appropriate for RS, in respect of whom he provided a report, to be able to access her medication or the clinical or laboratory support she requires. His recent researches at pharmacies had revealed that her drug regimen could be purchased for approximately US$100 per month. He thought it very unlikely indeed that supplies of her medication would be securely available in her home town of Dema through the private sector, let alone via the public sector. He considered that in the public sector, were the medications available, the medical staff would in all probability be unavailable to prescribe them and carry out the necessary medical checks as they have been on strike frequently since 2009. He considered that with regard to availability of her medications, they would not be available through the state system as the government had no money to pay to import them and they were not manufactured locally.

205. Dr Mujuru-Mvere in her report prepared in BR's case emphasised the issue of scarcity of essential goods and services including life saving drugs such as ARVs to the extent that they are not affordable for the bulk of the population. In her visit in late 2009 she made enquiries from a pharmacy in Harare which revealed that ARVs were to an extent available in the private sector but supplies were inadequate and their cost was high. With regard to the situation in the public sector, she used the example of the situation of the drug store she visited which had run out of Efavirenz, making arrangements to go to the University of Zimbabwe outlet to borrow supplies for their patients. She said that this was a significant improvement on what she had previously observed, as in the past patients on the government scheme had to augment their combination ARV treatment shortfalls themselves. She concluded that there was no hope that BR would get the help she needs on return. Of the ARVs currently prescribed to BR, Dr Mujuru-Mvere's research revealed that Raltegravir is not available from either government institutions or private pharmacies, Atazanavir and Ritonavir are likewise not available from government institutions or private pharmacies and Truvada is not available in government hospitals. To an extent, however, this contrasts with what was said by the

World Health Organisation responding to Mr Jones' questionnaire indicating that Ritonavir can be purchased privately at a cost of USD$55 per month as of August 2009. But we accept the situation is one which is fairly fluid and we attach no significance to that apparent distinction.

206. It is relevant however to note the table set out by Mr Jones, in his report of 11 February 2010. He referred to the reports on the availability of ART drugs from those interviewed and that the Ministry of Health and Child Welfare had reported that the drugs available in the public system were as set out in Annex J to his report. He set out in his report a comprehensive list of those drugs and also indicated which of them were stated to be available by the Avenues Clinic in Harare during a visit on 11 February 2010. They include Atazanavir, Truvada and Ritonavir, all of which are said to be available in the public system according to the Ministry of Health and Child Welfare, though none of them is recorded as having been stated as available by the Avenues Clinic. There is no mention of the availability of Raltegravir as regards the drugs from which RS benefits. According to this list Tenofovir is available, and also Zidovudine and Efavirenz, the latter two both available in the Avenues Clinic on 11 February 2010. There is no mention in this list of Atripla which is the medication currently being taken by EC.

207. There is therefore something of a conflict in the evidence as to the availability of various ART drugs, both as within the public sector and the private sector. We do not think that it is being argued on the one hand that all ARTs are available in Zimbabwe or that none of them are. It is apparently the case that Raltegravir is not available in Zimbabwe or indeed in Africa, and clearly that poses particular problems for BR.

208. As regards the question of who provides ARVs, the WHO response to Mr Jones' questionnaire was that ARVs are provided from a number of sources, including the government of Zimbabwe, the US government through USAID, the Global Fund, NGOs and UN agencies. The Zimbabwe Red Cross Society said that the government of Zimbabwe provides the greater percentage of the drugs through centres across the country and these efforts are complemented by NGOs in collaboration with the Zimbabwe Ministry of Health. The Zimbabwe Association of Doctors for Human Rights said that only a small fraction of those needing treatment use private facilities and out of a total of 180,000 receiving treatment in Zimbabwe, around 140,000 are being treated under the public system. They say that 40,000 are under other treatment from NGOs, international organisations and private treatment.

209. According to data provided by the Ministry of Health and Child Welfare, by the end of November 2009 a total of 215,123 people were receiving ART in the public and private sectors. It was said that this figure had gradually increased since 2004. Physicians for Human Rights in their report of January 2009 reported that some 205,000 people were thought to be taking anti-retrovirals. Dr Kibble echoes that figure of about 200,000, though he refers to an estimated 400,000 who would plausibly benefit from such treatment, whereas Physicians for Human Rights considered that some 800,000 Zimbabweans were thought to require therapy or would require it in the coming months/years. The Ministry of Health and Child Welfare figures therefore appear to be broadly credible. As regards where treatment takes place, Mr Jones' report says that estimates for waiting times vary in part due to the fact that there are so many organisations involved in the process. For example, Médecins Sans Frontières provide treatment exclusively in the Buhera district, and also have HIV programmes in other locations in Manicaland Province supporting free healthcare for 40,000 people. There are said to be numerous clinics and treatment centres run independently by various organisations. The WHO in its response to Mr Jones' questionnaire said that of the estimated 300 clinics in Zimbabwe, 100 are involved in initialising treatment, with 200 concentrating on follow up treatment. It also said that waiting times for those not deemed to be priority cases could typically be up to six months.

210. From the evidence as a whole we conclude that there are a significant number of people receiving treatment for HIV/AIDS in Zimbabwe, and we do not consider that waiting times, as set out in the previous paragraph, are excessive. It is relevant in this regard also to note the document in the respondent's bundle entitled "Guidelines for anti-retroviral therapy in Zimbabwe" dated September 2009 and provided by the National Drug and Therapeutics Policy Advisory Committee (NDTPAC) and AIDS and TB Unit of the Ministry of Health and Child Welfare in Zimbabwe which sets out detailed guidelines to assist those involved in the management of HIV and AIDS in Zimbabwe.

211. We turn next to the question of whether there is discrimination and politicisation of access to AIDS treatment and therapy in Zimbabwe. Professor Barnett referred to a variety of mechanisms whereby government policy results in supplies of ARVs being directed favourably to those who are likely to be ZANU-PF members. He referred to reports of ZANU-PF diverting medications and to a report speaking of "theft", but we do not see that as necessarily entailing political discrimination but rather opportunism. He also referred to reports of people being required to present membership cards at public medical facilities, though it is not clear what his source for this remark is. He said that in rural areas AIDS committees have the potential to facilitate or block an individual's access to medication. He also referred to the diversion by the Reserve Bank of Zimbabwe of the USD$7 million from the Global Fund's Round 5 grant earmarked for scaling up the national anti-retroviral programme which, after public protest, was returned to the Global Fund. He appeared to be critical of the WHO for working on the basis of reports from the field, but that seems to us to be entirely proper and, indeed, almost inevitable. He thought that local committee members who were ZANU-PF supporters would be unlikely to certify or support someone whom he or she knew to be a supporter of the MDC, but that would not be the case for any of these appellants. Contrary to what was said by Dr Baggaley, he did not say that only a card-carrying ZANU-PF member would be likely to obtain a letter from social welfare recommending free treatment. Dr Baggaley said in February 2007 that if available people receiving ART had to have a letter from social welfare recommending free treatment and according to colleagues in Harare it was unlikely that anyone would be able to obtain this letter of support unless they were a card carrying member of ZANU-PF. If they had other political affiliations or were known previously to have been members of the opposition party it would be highly unlikely that they would be supplied with the necessary paperwork needed for them to get free ART. She also quoted a (then) recent report from Human Rights Watch that access to ART through government schemes is "subjective and arbitrary". It is relevant to note in passing that this evidence is some three years old and also is made available from one source only.

212. Dr Mujuru-Mvere considers that the local aid structures either aid or hinder someone's progress leading to a real risk of deterioration in health and subsequent death. She said that it has always been government policy that for someone to access free government treatment or other free handouts from government there has to be means testing at local level and a letter of support written. She says that to get this letter of support can be very subjective and discriminatory on political lines, increasing the vulnerability of HIV sufferers now compounded with the high levels of corruption. There is some support for what she says in this regard from Professor Barnett. There is also the evidence to which we have referred above from the Zimbabwe Peace Project of 1 December 2009 concerning the registration process for HIV/AIDS and TB patients who want to be registered for NGO relief assistance, who have to go through village health workers, claiming that these well laid out procedures have been politicised in that intending beneficiaries have to register first with the ZANU-PF District Chairpersons who would then authorise the village health workers to register the patient for relief assistance.

213. One sees little if any of this reflected in the responses to Mr Jones' questionnaire. For example, the WHO denied that the availability of ARVs was in any way dictated by political affiliation and nor would someone have to demonstrate loyalty to a political party to obtain ARVs. They simply say that priority for treatment is given to children, health workers and their immediate families and all patients who meet the criteria set in the National ART Guidelines. Perhaps not surprisingly, the National ART Guidelines do not indicate any political or other bias in access to treatment. The Zimbabwe Red Cross refer to a defined referral system which does not discriminate on grounds of race, gender, political affiliation or religion. The Zimbabwe Association of Doctors for Human Rights states that there has been some limited anecdotal evidence to suggest that the availability of ARVs is dictated by political affiliation and loyalty for political party might have to be demonstrated, but says it is insufficient to support this view and says that there is no suggestion that it is systematic or policy driven. These conclusions are also borne out by the anonymous respondees at Annex C and Annex D of Mr Jones' report.

214. The evidence overall therefore presents something of a mixed picture on this important point. We bear in mind that the legal test is that of showing a reasonable degree of likelihood. On the evidence considered as a whole, we are not satisfied that it has been shown that there is a reasonable degree of likelihood that any of these appellants would be confronted with the need to display political affiliation or political loyalty in order to obtain ARVs. It is clearly something that happens, but not generally, and we consider that ultimately the comment that the evidence is anecdotal is one that is borne out by an overall assessment of the evidence as a whole. There is a risk that, perhaps particularly in rural areas, difficulty might be confronted, but we do not consider that that amounts to a real risk and accordingly our assessment of the evidence is that it has not been shown that access to ARVs is dictated by political affiliation or that the appellants would experience any real problems in that regard. Specifically, it has not been shown that any of them would face discriminatory access in their home areas, to which they would return.

215. We consider next the issue of access to food and any politicisation in that regard. Again we consider the evidence of this to be essentially anecdotal. It is clear that food has been and remains in short supply in Zimbabwe. Professor Barnett quotes from the Guardian, itself quoting the International Red Cross/Red Crescent/Zimbabwe Red Cross as stating that life for large sectors of the population who have no access to cash remains very difficult in rural and urban areas. It is reported that 56% of Zimbabweans live below USD$1 per day and 80% live below USD$2 per day. Though availability of food has increased, access remains a limiting factor. Problems were magnified in vulnerable households including those badly impacted by HIV and AIDS. This report is dated 2 December 2009. Professor Barnett says that "at times" food supplies have been restricted by administrative action to those who can show that they are supporters of ZANU-PF and that those who could not prove this to be the case were sometimes deprived of food. He does not however state this as being the current situation. Professor Barnett also makes it clear that major NGOs such as the International Red Cross and the Red Cross are able to operate relatively freely and effectively within Zimbabwe and also some people are in receipt of food aid in the form of food vouchers from those organisations, notably in urban areas. He did not disagree when it was put to him that in a MDC seat such as Chitungwiza, to which BR would return, there would be people willing to identify MDC supporters in order to obtain authorisation documents for food aid. He made the point that one could not be sure that the town hall or village council had not altered its political complexion, though this, we suppose, could equally be said of an area previously thought to be a ZANU-PF stronghold. He agreed that there was less bias in respect of food distribution in urban areas, and it was reasonable to

conclude that EC, on return to Harare, would be unlikely to face any substantial bias regarding food aid if vouchers were to be relied on.

216. In her report, Dr Mujuru-Mvere refers to the need for bribery in order to acquire many commodities or services. There would be problems in queuing and problems of ability to buy food because most supplies of commodities have substantially increased and are being sold in US dollars or South African rand. During her 2008 visit she had observed people queuing all the time for scarce provisions and though there was less queuing when she arrived in November 2009 that was because of the availability of goods albeit sold in foreign currencies, but just before she left queuing resurfaced just as in 2008, indicating the fragility of some of the apparent improvements. Dr Kibble refers to the politicisation of food and that this continues to favour government supporters and those who have obtained a ZANU-PF membership card. He says that those without are left to starve especially when the ban on humanitarian agencies was only lifted in September 2008, but with severe restrictions on what NGOs can do. He confirms what Dr Mujuru-Mvere says about the impact on the availability of commodities except for those with dollars, leaving only the black market as a source of goods and food and says that it is difficult for anyone unemployed and without a support network or remittances from the diaspora to survive.

217. It has to be borne in mind in this regard however that the ban on humanitarian agencies was lifted in September 2008, albeit with restrictions on what they can do. Nevertheless we see that as a positive sign. It is relevant also however to mention the evidence from the Zimbabwe Peace Project that public access to food and humanitarian assistance is being denied through well coordinated webs of partisan structures such as ward coordinators, volunteers, village heads, councillors and chairpersons. The Project said that it recorded 133 violations relating to food and humanitarian assistance in the month of August (it seems likely that this is 2009) with cases of discrimination constituting 87% of the incidents. It is alleged that in certain provinces supporters of the MDC had their names removed from food registers or donors were misinformed that targeted people were no longer in need of food relief. It is also said that in Mashonaland East, a ZANU-PF stronghold, beneficiaries are required to produce party membership cards and to attend political meetings regularly. There is an uncorroborated report at page 9 of the country material bundle of the appellants from Eyewitness News that the government had taken the radical move of banning all food handouts by NGOs. This is said to be dated 13 February 2010. It was said to be done on the basis that the government was reintroducing food for work programmes and the main motivation was to ensure the rehabilitation of farmland. Professor Barnett made no reference to this. Mr Jones said that the Embassy had received no reports that food aid had been banned, and there was no information from NGOs to confirm that this had happened. In the USAID Zimbabwe Food Security Outlook to June 2010 report in the appellants' country bundle, there is reference to a significant improvement in the availability of staple cereals at the sub-national level and to a relatively stable current food security situation at page 36. It is thought that the importance of livestock and remittances, particularly in the southern half and eastern parts of the country is expected to ameliorate the projected food insecurity levels to moderately food insecure between April and July 2010. It is also thought likely that food aid programmes will kick in earlier than usual in those areas, further reducing the food insecurity severity.

218. The Country of Origin Information Report of 22 December 2009 on Zimbabwe has a section on the politicisation of food. It is noted that reports of political bias in the distribution of food continued through 2008 and into 2009, with reference to food distributions being run by the army, the Central Intelligence Organisation, the police and district administrators. There were reports from 2005 and

2007 concerning the political manipulation of food aid and a report by the International Crisis Group on 20 April 2009 that ZANU-PF was believed still to divert food and distribute it on a partisan rather than a strict need basis. There is further reference in the Solidarity Peace Trust Report to all districts within Matabeleland reporting problems with political manipulation of access to maize, saying that only ZANU-PF card holders were able to buy maize from the Grain Marketing Board (GMB) and another report of October 2009 concerning high numbers of villagers being denied food by ZANU-PF if they do not renounce the MDC. There is reference to a Zimbabwe Peace Project Report on 1 December 2009 reporting that ZANU-PF continue to use food aid as a political weapon, denying known opponents assistance from government relief agencies. It is of course the case that there was evidence of the politicisation of access to food and medicines before the Tribunal in RN , for example at paragraph 104 where it was noted that the evidence indicated that the government continued to deny food and medicines to perceived supporters of the MDC, and evidence that the European Commission discussed at paragraph 203 that returnees would be likely to find it harder than others to get access to food and services.

219. It is relevant however to note that there are no confirmed cases of politicisation of international food aid through NGOs who, as is argued in the Secretary of State's written submissions, operate a zero tolerance role respecting bias in the selection of those needing assistance, and who also make the final selection of recipients. It is also not without significance that the Minister of Health (and also the Minister of Finance) in the National Government of Unity is an MDC member, and Mr Tsvangirai chairs the Council of Ministers responsible for implementation of government policies.

220. Bringing all this evidence together, we do not consider it has been shown that there is a real risk that any of the appellants would be denied food aid on grounds of political opinion. Certainly there is evidence of discriminatory denial of access to food, but we see that as being no more than sporadic and certainly not endemic. Nor do we consider that there is a real risk of harm to any of the appellants on the cumulative basis of access to medication and access to food.

Refugee Convention

221. There is little that we need to add in respect of the Refugee Convention given what we have said about Article 3. As we have said elsewhere, we consider the country guidance in RN continues to be binding and to set out the appropriate criteria for the analysis of risk on return under the Refugee Convention as would be the case in respect of these three appellants of actual or imputed political opinion. Given the conclusions that we have come to about claimed politicisation of access to AIDS medication, associated medication and access to food, we do not consider that any difficulties the appellants may experience in accessing medication and/or food can be said to arise as a consequence of there being a real risk of this being motivated by considerations of imputed political belief. Insofar as there is evidence of differential access, we consider that it is, as we have explained above, random and not systemic. Accordingly we do not consider that any of these appeals can succeed under the Refugee Convention.

Article 8

222. It is clear that in a case such as this involving physical health, the private life aspect of Article 8 may be engaged. As much can be seen from Bensaid v United Kingdom [2001] 33 EHRR 10 where, at paragraph 47, the Court of Human Rights made it clear that mental health had to be regarded as a crucial part of private life associated with the aspect of moral integrity, and clearly it must follow from that that physical health must be regarded likewise.

223. A particular submission in respect of Article 8 is made in the case of EC. This is, as summarised in the skeleton argument for EC at paragraph 55, that the Secretary of State has been operating a policy, which has been varied from time to time, on the proper approach to applications for leave to remain by persons with HIV/AIDS; that any interference with an individual's Article 8 rights requires to be in accordance with the law, which includes a requirement to adhere to relevant policies; such law and policy require to be clear and accessible; however, the Secretary of State withdrew his HIV/AIDS policy in February 2007 "for updating" but has failed to publish any such updated policy since then; and it follows therefore that the Secretary of State does not have a clear or accessible policy on the point and/or has failed to apply that policy to the individual case, and therefore the interference with EC's Article 8 rights is not in accordance with the law. These points are elaborated on at paragraphs 56 to 94 of the skeleton.

224. The present version of the Secretary of State's policy on people with HIV/AIDS is contained in Chapter 1, section 8 of the Immigration Directorate Instructions (IDIs) which we shall refer to as "the medical IDIs". There appear to have been earlier versions in 1998 and 2000, but the particular version we have concentrated on in connection with EC's argument in this regard is the March 2004 version ("the 2004 policy"). This contains full guidance on the matter and includes references to D v United Kingdom and N in the Court of Appeal, and states in summary that such cases will have to be ones that are truly exceptional and involve extreme circumstances. Examples of this are given.

225. This was replaced by the 2007 policy which states as follows:

"3.4 Human Rights Act

This paragraph has been withdrawn for updating. Claims that removal from the United Kingdom would breach Articles 3 and/or 8 of the European Convention on Human Rights because of the claimant's medical condition should be considered in accordance with the House of Lords judgment in the case of N v SSHD [2005] UKHL 31 and other relevant case law."

226. It is argued in EC's skeleton that, bearing in mind the terms of the earlier policies which were referred to and discussed by Baroness Hale in N v SSHD , in the 2004 policy the Secretary of State envisaged the prospect of a grant of leave to remain on medical/human rights grounds in circumstances which, though narrow, were wider than those envisaged in D or in N . The policy remained in place, unaltered, however, for almost two years after N was decided. For example, D is referred to in the 2004 policy as "an example" rather than constituting the only circumstances in which Article 3 might be breached. We interpose at this point that that must be right. The European Court of Human Rights did not limit the application of Article 3 or Article 8 to the specific circumstances in D and clearly other examples of extreme circumstances may exist. A further part of the 2004 policy, whether "the removal of the patient would both significantly shorten his or her life expectancy and result in acute mental or physical suffering" is, it is argued in the skeleton, significantly more generous than the test in N v SSHD , and a further criterion, whether:

"the claimant has been receiving treatment for the relevant condition in the UK for a long time (i.e. more than five years) and has become dependent on the treatment he or she is receiving to sustain life even for a short period"

does not appear to play any part in the judgments in N .

227. It is argued at paragraph 68 of the skeleton argument in EC's case that it is not clear whether the 2004 policy remains the Secretary of State's policy, since the Secretary of State has "withdrawn"

that part of the IDI and has not published the updated policy for some three years, without giving any indication of when the updated version will be ready. It is argued on behalf of EC that, as the European Court of Human Rights has frequently reiterated, it is vital that the law should be accessible and clear. Reference is made to the Court's elaboration of this principle in Sunday Times v UK [1979] 2 EHRR 245 at paragraph 49, and Malone v UK [1984] 7 EHRR 14. It is further argued that if the Secretary of State does not currently have a policy on the point, it is very difficult to see how she might have any lawful basis for interfering with EC's Convention rights in the absence of any clear or adequate guidance to her officials on when it might or might not be appropriate to remove people in her position. The fact that it is said that the policy is being updated indicates that something else is in mind other than refusal in cases not analogous to N and D . It is said therefore that there is no published policy on whether and in what circumstances the Secretary of State will allow people with HIV/AIDS to remain in the United Kingdom, beyond the obvious statement that she will not act contrary to the judgments of the courts. The requirement to have a clear and accessible policy is said to be all the greater in the light of the Secretary of State's duties under the DDA. It is argued that merely instructing her caseworkers to have regard to "relevant case law" does not constitute a policy but a statement of the obvious. It is also said that the policy is out of date because it fails to refer to the decision in N v United Kingdom and it cannot be said that the answer lies simply in the case law. The Secretary of State has discretion to act more generously than her obligations require, and her policies in the past have reflected that fact. It is said therefore that until the updated policy is published, it cannot be known whether it is more generous than Article 3 requires and, if so, whether it would be a breach of Article 8 not to apply it and that, in any event, it is a breach of Article 8 not to ensure it is sufficiently publicised and accessible and therefore the interference with EC's Article 8(1) rights cannot be in accordance with the law.

228. The Secretary of State's submission in response is that the 2007 guidance, which mandates the application of the consistent ECHR and domestic jurisprudence on Article 3 and medical treatment, is both sufficiently certain to qualify for the description of being "in accordance with the law" and publicly accessible. It is argued that a statement by the Secretary of State that she will act in accordance with the applicable legal principles is sufficient and clearly enables individuals to regulate their conduct and provides no reasonable suggestion that they be allowed to stay outside an "exceptional" situation which meets the D v United Kingdom criteria. It is argued, with respect to paragraph 76 of EC's skeleton, that the complex regulatory situation regarding telephone tapping, as in Malone , is in no way comparable to the exercise of the Secretary of State's discretion to allow a "more generous" claim than would be permitted under Article 3. Unlike the examples of R (Salih & Rahmani) v Secretary of State for the Home Department [2003] EWHC 2273 (Admin), and Abdi and Ors v Secretary of State for the Home Department [2008] EWHC 3166 (Admin), referred to at paragraph 77 of EC's skeleton, it is not a case involving a "secret" unpublished policy and needing to be distinguished from such cases. It is argued that there is no case law to establish the proposition that the Secretary of State must have a policy setting out in detail how she proposes to exercise every aspect of a discretion which she possesses.

229. We agree with the submissions made on behalf of the Secretary of State in this regard. There is no obligation on the Secretary of State to have a policy indicating how she will exercise every part of the discretions she has at any given time. In any event, there is a policy which is the 2007 guidance. There is nothing inconsistent in the Secretary of State having a policy that effectively coincides with the existing law. The decision of the House of Lords in N was, broadly speaking, endorsed by the European Court of Human Rights. The fact that the earlier policy may have been broader in some respects than the relevant legal principles as set out by the courts at that time, in no sense entails

that a subsequent policy is required to maintain that breadth. No doubt the “other relevant case law” to be taken into account by caseworkers under the 2007 guidance must be taken to include what was said by the European Court of Human Rights in N subsequent to the decision of the House of Lords. We do not consider it can be said that pointing caseworkers and others to the decision of the House of Lords and other relevant case law breaches the requirements of clarity or accessibility. It must, we think, be clear to anybody looking at this guidance that there is no discretion propounded by the Secretary of State for the assessment of cases such as EC’s outside the existing legal principles. That is a policy which it is perfectly open to the Secretary of State to have, and we do not consider that the nature and status of that policy are such as to indicate that it is not in accordance with the law.

230. With regard to the reference at paragraphs 90 to 92 of EC’s skeleton to the IDIs dealing with leave outside the Rules, which say that leave may be granted outside the Rules in “particular compelling circumstances” but

“only for genuinely compassionate and circumstantial reasons or where it is deemed absolutely necessary to allow someone to enter/remain in the United Kingdom, when there is no other available option.”

Again this does not appear to us to be either lacking in clarity or couched in such terms that it is at all likely that if it had been considered and applied in this case it would have been decided in the appellant’s favour. It is clear that compassionate circumstances were taken into account in the case of EC in the Secretary of State’s letter of 25 June 2003, albeit not specifically from the perspective of the IDI on leave outside the Rules, but we do not think that any specific consideration of the case in that context could have led to a positive outcome for the appellant, in particular given the light of the latter part of the instruction which is clearly indicative of an entirely exceptional case having to be shown.

231. Otherwise, as regards Article 8, the position of all three appellants contrasts with the situation in JA (Ivory Coast) , where the appellants had been granted leave to remain specifically to continue with treatment for HIV in accordance with a Home Office policy. It was said that it would not be necessary for such a person to show exceptional circumstances as compelling as those required by D v United Kingdom . However, none of the appellants in the instant appeals has been granted leave on this basis, and they must therefore, in our view, meet the exceptionality test set out in D . In Razgar [2004] 2 AC 368, Lord Bingham said (at 380):

“…I have no doubt that the court would adopt the same approach to an application based on Article 8. It would indeed frustrate the proper and necessary object of immigration control in the more advanced member states of the Council of Europe if illegal entrants requiring medical treatment could not, save in exceptional cases, be removed to the less developed countries of the world where comparable medical facilities were not available.”

We conclude therefore that the appellants do not succeed under Article 8 in respect of their health problems.

Article 14

232. Article 14 of the European Human Rights Convention states as follows:

“Prohibition of Discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

As we understand the appellants' arguments, it is contended that the discrimination which it is said that the appellants would experience on removal to Zimbabwe on account of their health problems amounts to discrimination on the basis of their "other status", or possibly also on grounds of political opinion.

233. In Wandsworth LBC v Michalak [2003] 1 WLR 617, the Court of Appeal set out the governing principles relevant to the resolution of an Article 14 issue, developed initially by the Court of Human Rights in the Belgian Linguistic Case (Number 2) [1968] 1 EHRR 252. These are as follows:

(i) Do the facts fall within the ambit of one or more of the substantive Convention provisions?

(ii) If so, was there a different treatment as respects that right between the complainant on the one hand and the chosen comparators on the other?

(iii) Were the chosen comparators in an analogous situation to the complainant's situation?

(iv) If so, did the difference in treatment have an objective and reasonable justification?

234. In the skeleton argument the appellants add a further requirement, "Was that difference in treatment based on one or more of the grounds proscribed by Article 14?" (which follows from what was said at paragraph 40 of the decision of the Court of Human Rights in Thlimmenos v Greece [2001] 31 EHRR 14). It is clear, as is pointed out in the appellants' skeleton argument, citing Thlimmenos , that the right not to be discriminated against in the enjoyment of rights guaranteed under the Convention is violated when states without an objective reasonable justification fail to treat differently persons whose situations are significantly different. That case also makes it clear that discrimination occurs where there has been a difference in treatment but also where persons are treated in the same way but in circumstances where that treatment is especially disadvantageous to one group. It is argued as a consequence that this imposes a duty to make adjustments or treat more favourably such disadvantaged groups so as to obviate or mitigate that disadvantage.

235. On behalf of the respondent it is argued that the appellants are apparently unable to point to any case law in which a claim of this nature has been put forward or accepted and that also the arguments fail to address the issue of the relevant "comparators". It is suggested that if the argument is that as "disabled people" or alternatively as women the appellants should be treated "differently" from those others removed or deported from the United Kingdom on the basis they will suffer worse consequences than those others, and so "adjustment" is needed, then this is an impermissibly broad comparison.

236. Firstly, as to the issue of the "ambit", it is common ground that the claims clearly fall within the ambit of Article 8 and Article 3, and accordingly Article 14 is appropriate for consideration.

237. It can be seen from the decision of the European Court of Human Rights in Thlimmenos v Greece [2001] 31 EHRR 14, that discrimination may arise because analogous groups are treated differently where people, including disabled and non-disabled people, are treated in the same way but in circumstances where that treatment is especially disadvantageous to one group. Like the Secretary of State, we have some difficulty in understanding who the proper "comparators" are. The suggestion is that it may be that either as disabled people or HIV sufferers or as women, the appellants should be

treated differently from others who are removed or deported from the United Kingdom on the basis of the consequences they will face on return and that therefore some form of adjustment is required. As is pointed out by the Secretary of State, however, the categories of those subject to removal are many and varied, and the range of consequences they may face on return may also vary considerably. It may be that in the end this comes down to an argument about justification, to which we will come shortly, but we agree that it does seem unmanageably broad to single out the factor of access to medical treatment, for example, and claim that this creates a group which should be compared to all people who do not face medical issues or gender disadvantage and does not permit the making of sensible comparisons. We are not aware of any authority which suggests that unlawful discrimination under Article 14 occurs in circumstances where removal may be especially disadvantageous to one particular group.

238. The third issue is whether the difference in treatment was based on one or more of the grounds proscribed by Article 14. Again there is, we think, no issue as to this, as discrimination on grounds of political opinion is explicitly prohibited and, as pointed out in the appellants' skeleton, disability is covered by "other status" in Article 14. The final and perhaps crucial point is that of justification. Here, as is emphasised in the Belgian Linguistic Case (Number 2) [1968] 1 EHRR 252, there will be a violation of Article 14 if there is no reasonable and objective justification for the discrimination. In that case it was said that "the existence of such justification must be assessed in relation to the "aims and effects of the measure under consideration, regard being had to the principles which normally prevail in democratic societies". In DH v Czech Republic [2008] 47 EHRR 3 it was said that the notion of objective and reasonable justification must be interpreted as strictly as possible where the discrimination is connected to a "suspect class", and it is argued on behalf of the appellants that disability should be regarded as a "suspect class". Thereafter it is argued that unless there is shown to be a violation of Article 3 or Article 8, the Secretary of State will remove an individual in respect of a disability in all cases, and it is contended that such a rule is impossible to justify, especially when, as it is contended, it is in breach of the DDA. It is argued that as a consequence the Secretary of State cannot discharge the burden of establishing justification in this case.

239. We see considerable force however in the argument put forward on behalf of the Secretary of State, that clearly nothing is added in this case by a claim under Article 14. If, as we have found, the interference is permissible or justified under Article 8, then it cannot be said that the state has, without any objective or reasonable justification, failed to afford proper treatment to the appellants by failing to give proper recognition to any aspect of the disadvantages which they may face on return. As it is put in the alternative, if the removal is justified under Article 8 on full consideration of the case then the fact that others removed might suffer consequences not so adverse cannot render the decision to remove unlawful. In addition, it seems to us that the issue in these appeals involves a matter of general social policy, rather than the right to respect for the individuality of human beings, as identified by the House of Lords in R (Carson) v Secretary of State for Work and Pensions [2005] UKHL 37, at paragraphs 15-17 per Lord Hoffman, and decisions about the general public interest which underpin differences in treatment in that category of case are very much a matter for the democratically elected branches of government. Accordingly we consider that the Secretary of State can discharge and has discharged the burden of establishing justification in this case and we find that there is no breach of Article 14.

Disability Discrimination Act

240. In the skeleton argument the appellants assert that the Tribunal has jurisdiction to deal with issues under the DDA, referring to a decision of the Tribunal in NM (Disability discrimination) Iraq

[2008] UKAIT 00026, where the Tribunal considered arguments based on the Act. The point is made that the Tribunal plainly regarded itself as having jurisdiction to deal with those arguments, albeit that they were unsuccessful on the facts.

241. At that stage the appellants said no more about the issue of jurisdiction, but in light of detailed points made on behalf of the Secretary of State, which we set out below, there was subsequently a detailed response on this matter on behalf of the appellants, which again of course we shall go into in some detail.

242. As regards the point made at paragraph 68 of the skeleton to which we have referred above, we say no more at this stage than that NM was in our view but slender authority for the Tribunal having jurisdiction to deal with the issue since an assumption of jurisdiction cannot amount to a reality of jurisdiction. As is pointed out on behalf of the Secretary of State at paragraph 25 of the written submissions on the DDA, it is clear that the issue of jurisdiction was not argued before the Tribunal in NM , and the Tribunal appears to have had some doubts as to its jurisdiction, albeit that it was considering it in the context of whether the Act had extraterritorial effect.

243. Before going on to consider in detail the respective submissions, it is relevant to note that the Secretary of State's submissions are amended submissions following the considered position taken subsequent to earlier submissions having been filed, that the Secretary of State did not wish to argue that the phrase "in accordance with the law" as set out in sections 84 and 86 of the Nationality, Immigration and Asylum Act 2002 is limited in the manner in which it was argued to be in the original submissions filed on 23 March 2010. The letter from the Treasury Solicitor goes on to say that for policy and legal reasons the Secretary of State is content to accept that, subject to the statutory limitations contained in the DDA itself, sections 84 and 86 of the 2002 Act would be wide enough to cover an argument that the decision was unlawful under the DDA.

244. In her submissions, the Secretary of State makes the point that section 25 of the Act, which is headed "Enforcement, Remedies and Procedure", makes it clear that any proceedings under Part III of the Act, which would include the first head of the appellant's DDA claim, can only be brought in a County Court (or by judicial review). Reference is also made to Schedule 3 Part 2 of the Act at paragraph 5 and also the point is made that unlike the Race Relations Act 1976, which at section 53 specifically includes the provisions of Part 5 of the Nationality, Immigration and Asylum Act 2002 in respect of the proceedings which may lie against any person in respect of an act which is made unlawful by virtue of a provision of the Race Relations Act, the DDA is silent on the point. The point is also made that section 57A of the Race Relations Act makes specific exclusionary provisions for "immigration cases", and therefore in effect broadly the Act envisages that alleged acts of racial discrimination under section 19B are to be litigated in the County Court as breaches of statutory duty save that in relation to immigration decisions, there is specific provision to ensure that those issues are instead tested in the AIT where there are rights of appeal under the 2002 Act, and that this clearly contrasts with the provisions in the DDA. There is no provision made to allocate a role to the AIT.

245. The point is further made at paragraph 14 of the written submissions that by virtue of the DDA's specific enforcement scheme it is only where there is a claim under the Human Rights Act 1988 that there is jurisdiction for consideration within an immigration appeal of disability discrimination arguments. It is noted that the Race Relations Act is specifically listed in section 84(1)(b) of the 2002 Act, whereas the DDA is not listed and by reason of a specific jurisdictional scheme it is said that it falls outwith section 84(1)(e).

246. As regards the second head of the appellants' DDA claim, which arises under sections 49A and 49D of the DDA, it is argued that there is a breach of the Secretary of State's duties by reason of failure to publish a Disability Equality Scheme (DES) and, more specifically, to carry out an impact assessment prior to removal in these cases. It is argued on behalf of the Secretary of State that the only body with the power to enforce the duty of public authorities to have regard to the need to make positive efforts to promote the cause of disabled persons and eliminate discrimination in carrying out their functions is now the Equality and Human Rights Commission (EHRC). Under section 31(1) of the Equality Act (EA) the Commission may assess the extent to which or the manner in which a person has complied with a duty by virtue of "…(a) section 48A or 49D of the DDA". Section 32(2) of the EA provides that if the Commission has completed an assessment under section 31 and thinks that a person has failed to comply with a section 49A duty, it can give that person notice requiring him to comply with the said duty and give the Commission written information, within 28 days, of the steps it has taken or proposes for the purposes of complying with the duty. Under section 32(8) the Commission is empowered to apply to the court for an order requiring a person to comply if it thinks they have failed to comply with the requirement of the notice. The relevant court by subsection 32(9) in relation to section 49A of the DDA is the High Court or in any other case a county court. Also it is provided by section 32(11) that enforcement action in relation to duties under section 49D can only be brought by the Commission in the court specified in section 32(8) and may not be brought in any other way. It is argued therefore that enforcement of the duties created under section 49D is a matter for the EHRC and not the Tribunal.

247. As regards the argument advanced on behalf of the appellants that the decision of the Secretary of State is otherwise not in accordance with the law, it is argued that it is impermissible to rely upon Part III of the DDA in an appeal before the Tribunal. Reference is made to the arguments set out above concerning the means by which the relevant part of the Act can be enforced. It is also argued that the specific provisions of the DDA cannot be said to have been impliedly repealed or modified by the general provisions of the 2002 Act.

248. In addition, with regard to any attempt to invoke sections 49A and D of the DDA, it is argued that the case law upon which the appellants rely relates to the duty to make assessments before new policies etc. are introduced whereas in this case it is not established that there has been any relevant change of practice on the part of the Secretary of State. Further, it is argued that even if there had been any such failure, the issue of its impact upon the individual immigration decisions in question in the appeals would clearly be a disputed one. Reference is made to the decision of the Court of Appeal in R(C) v Secretary of State for Justice [2008] EWCA Civ 882, which is said to show the ability of the High Court to tailor the discretionary remedies of, for example, quashing orders to the particular circumstances of the case, and also says nothing about whether or not individual decisions that might have been taken under relevant subordinate legislation (the Secure Training Centre (Amendment) Rules 2007) would also have been quashed. It is said that this is a situation which the Tribunal would need to address, concerned as it is with individual immigration decisions, and that its jurisdiction to consider whether decisions are "in accordance with the law" does not extend so far as to consider both whether a failure to conduct an impact assessment regarding the effect of a policy would be unlawful, and then to consider the application of any such general holding to the individual facts. It is said that as a minimum the "policy" issue of the impact assessment should have been litigated in the High Court by way of an application for judicial review.

249. Thereafter the Secretary of State's submissions go on to make points concerning case law cited on behalf of the appellants including R (Chavda) v Harrow LBC [2007] EWHC 3604 and R (Elias) v

Secretary of State for Defence [2005] IRLR 788 which, together with the other authorities relied on by the appellants are said not to support the proposition that the DDA accords adjudicative responsibility to the Tribunal. Comment is further made that the Tribunal is a creature of statute and unlike the High Court does not enjoy any inherent jurisdiction.

250. In the appellants' response dated 15 April 2010, the point is made firstly that it is acknowledged on behalf of the Secretary of State that judicial review is not precluded by section 25 of the DDA, and breach of the statutory tort created by that section is of necessity an unlawful act. This is of relevance to the argument that the decision is not in accordance with the law. The simple argument is that the grounds of appeal are justiciable in this case because in deciding to remove the appellants the Secretary of State would be in breach of the DDA and would thus not be acting "in accordance with the law". There is no claim for compensation or injunctive relief but simply it is argued that the breach of the DDA founds a ground of appeal under sections 84(1)(e) and section 86(3) of the Nationality, Immigration and Asylum Act 2002.

251. It is further argued that the Race Relations Act (RRA) is not a helpful analogue in this context. It is noted that the DDA contains numerous exemptions to the unlawful acts created by section 21B, but that none concerns immigration decision making. It is said that such decisions and ancillary functions therefore fall within section 21B of the DDA but by contrast the RRA creates a quite different regime. It is said that necessarily almost all immigration decision making and functions would be unlawful under the RRA given the definition of "racial grounds" in that Act, but for the fact that, unlike in the DDA, almost all immigration decision making is excluded from the RRA.

252. The point is further made that it would be unsatisfactory, wasteful and contrary to Parliament's intention for the appellants to be required to pursue judicial review proceedings in parallel with the instant proceedings and also would result in duplication of cost and process and create a risk of inconsistency or incoherence. Disagreement is also reiterated with the Secretary of State's argument that Article 14 adds nothing to Article 3. This reinforces previous points made on behalf of the appellants.

253. With regard to the points made on behalf of the Secretary of State concerning section 49A and the specific statutory duties under section 49D of the DDA, the submissions made above are repeated, and in addition it is argued that, though it is clearly the case that the EHRC has special powers to take enforcement action in respect of a breach of the statutory equality duties, it is very important to note that section 32(11) does not preclude action by others including the invocation of the duties by individuals, and a number of authorities including Elias , referred to above, are relied on. The point is further made that the Secretary of State is wrong to argue that it can be deduced from the fact that powers under sections 31 to 32 came into force on 1 October 2007 that earlier case law can be explained on the basis that the powers were not then in force. It is said that prior to that date a materially identical enforcement scheme was in place, save that the Disability Rights Commission (DRC) carried out the material functions now carried out by the EHRC. Sections 31 to 32 replicate, it is said, the existing statutory scheme but take account of the fact that the DRC, together with other bodies such as the Commission for Racial Equality and the Equal Opportunities Commission been dissolved and replaced by the EHRC which has in all material respects assumed their powers.

254. It is further argued that the suggestion that there is a distinction between the assessment of a new policy and an existing policy is a distinction without a legal or principled basis. The point is made that the duty to impact assess policies arises in respect of all policies, under regulation 2(3)(b) of the Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005 (SI 2005/2966). It is

clear that an assessment of the relevant policy has not been undertaken, and it is also emphasised that the general disability duty under section 49A of the DDA applies to the carrying out all of a public authority's functions. It is said in relation to the decision in Elias that this was a case under the equality duties under the RRA whose enforcement mechanism is materially identical to those in the DDA and now the Equality Act 2006. The fact that jurisdictional points have not been taken so far in the various Divisional Court and Court of Appeal cases to which reference is made by the Secretary of State and including cases where the EHRC was itself a party, is said to be for the simple reason that this would be a very bad point in law and that it is wholly improbable to suggest that the point had not been taken by the claimants in those cases the EHRC and the government departments and other public authorities who were the subject of the duties of the proceedings, in error. The point is made that section 30 of the Equality Act 2006 gives the EHRC a specific legal power "to intervene in legal proceedings" which emphasises the fact that it clearly has power to intervene in judicial review cases and has regularly done so. The point is emphasised that the law requires the Secretary of State to have due regard to the equality objectives in section 49A of the DDA and that this is achieved by carrying out an equality impact assessment and that, although the EHRC has exclusive enforcement powers over the duty to create and publish a disability equality scheme, the same is not so of the general equality duty under section 49A of the DDA which is generally enforceable as, it is said, the case law amply demonstrates and which has been violated in the instant case by the failure to have due regard as required.

Discussion

Jurisdiction

255. On the first issue, as we have said, we derive little assistance from NM given the fact that the issue of jurisdiction was not argued there and, though we note the point made in the appellants' response that the doubts expressed by the Tribunal rather concerned the extraterritorial effect of the DDA, which does not arise in the instant appeals, the absence of argument and detailed analysis means that we can derive but limited assistance from that case.

256. We turn to section 25 of the Disability Discrimination Act. That, as has been argued on behalf of the appellants, creates a statutory tort under which damages can be awarded for discrimination and proceedings in England and Wales should be brought only in a County Court. It is clear from Schedule 3, Part II, paragraph 5(2) that the making of an application for judicial review is not precluded.

257. We read the word "proceedings" in section 25(3) as referring back to the civil proceedings which are referred to in section 25(1) in respect of the process for breach of statutory duty that the section envisages. But we do not read it as ruling out other forms of relief, and we do not read those other forms of relief as limited to the reference to judicial review in the Schedule to which we have just referred. It is clear from the Treasury Solicitor's letter to the Tribunal of 26 March 2010 that it is accepted on behalf of the Secretary of State that, subject to the statutory limitations contained in the DDA itself, sections 84 and 86 of the 2002 Act are wide enough to cover an argument that the decision was unlawful under the DDA. We do not read section 25 as precluding proceedings of the kind that are argued for before us on the basis that the decisions of the Secretary of State in these cases are "not in accordance with the law". Clearly it is right that the Tribunal is a creature of statute and has no inherent jurisdiction, but equally clearly an appeal to the Tribunal under section 82(1) of the 2002 Act can be brought under subsection (1)(e) on the basis that the decision is otherwise not in accordance with the law. It has not been suggested that the decisions in respect of the three

appellants in this case do not fall within section 82 of the 2002 Act. Clearly, by dint of section 86(2)(a) we must determine any matter raised as a ground of appeal and therefore are required to consider whether or not unless otherwise precluded, the decisions of the Secretary of State in this case are not in accordance with the law.

258. With regard to the point made on behalf of the Secretary of State that a meaningful contrast can be made between DDA and the RRA, we agree with the submissions made at paragraph 13 of the appellants' response of 15 April 2010. There is force, we think, to the point made that the DDA sets out a number of exceptions to the unlawful acts created by section 21B and none of those concerns immigration decision making. We agree that the regime created by the RRA is significantly different, in that, given the definition of "racial grounds" in that Act, of necessity almost all immigration decision-making and functions would be unlawful under the RRA but for the exclusion from the RRA of almost all immigration decision making, leaving residual acts falling within the RRA to be litigated in the Tribunal if a claim under the RRA for damages is pursued, and any decision by the Tribunal is to be binding. Though it is not a knock-out point, we consider there is also relevance to the argument that it would be unsatisfactory for parallel judicial review proceedings to be pursued at the same time as these proceedings. It is not a point of interpretation but a matter of common sense which we think adds something to the arguments made on behalf of the appellants in this regard. Accordingly we conclude that on the first point on jurisdiction the argument made on behalf of the Secretary of State fails.

259. We turn to the argument arising in respect of sections 49A and 49D of the DDA. Part of the argument made on behalf of the Secretary of State is that it is only the EHRC that has the power to enforce the duties of public authorities to have regard to the need to make positive efforts to promote the cause of disabled people and eliminate discrimination in carrying out their functions. There is also the point concerning section 32(11) that we have set out above.

260. The point is made in the appellants' written submissions that section 32(11) does not preclude action by others including individuals and the examples of Elias and also Brown v Secretary of State for Work and Pensions [2008] EWHC 3158 are given. Brown , in particular, shows that an individual is not precluded from challenging by way of judicial review under sections 49A and 49D of the DDA a decision of a public authority, in that case the Secretary of State for Work and Pensions, in respect, in that case, of the closure of a Post Office and its impact on Mrs Brown who is disabled. This litigation took place after October 2007, when sections 31 and 32 of the Equality Act 2006 came into force, but in any event, we accept the point made at paragraph 17.1 of the appellants' skeleton submissions that the previous enforcement scheme was essentially identical, save that the Disability Rights Commission carried out the functions now carried out by the EHRC. As a consequence we conclude that, though enforcement action in relation to section 49D duties can only be brought by the Commission and Court specified in section 32(8) of the Equality Act, it seems clear that other types of proceedings can be brought by individuals and presumably in the appropriate case other bodies. Again we consider that the argument that the decision is not otherwise in accordance with the law is a matter that is within the jurisdiction of this Tribunal to determine.

261. Accordingly on both points we consider that the Tribunal has jurisdiction to deal with this type of claim arising in respect of the Disability Discrimination Act.

Substantive Issues

262. Under section 21B of the DDA it is unlawful for a public authority to discriminate against a disabled person in carrying out its functions. Though there are a number of exceptions to the unlawful

act created by section 21B, as set out at paragraph 21C, immigration functions are not excluded. Indeed they are specifically referred to as within the ambit of the legislation in the Code of Practice, Rights of Access: Services to the Public, Public Authority Functions, Private Clubs and Premises (2006, DRC), which was issued under section 53(1)(a) of the DDA and is admissible in legal proceedings. Although these provisions have been repealed, they have been replaced by comparable provisions under the Equality Act 2006, and in any event transitional arrangements apply and the Code remains effective.

263. The concept of "discrimination" is defined at section 21D of the DDA, and section 21E sets out in detail the duties that exist for the purposes of section 21D(2) to make adjustments.

264. On behalf of the appellants it is argued that the practice of removing the appellants as failed asylum seekers would be a practice or policy triggering the duty to make reasonable adjustments if it makes it:

"impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred, or unreasonably adverse for disabled persons to experience being subject to any detriment to which a person is or may be subjected".

It is also argued that the duty to make adjustments is a compelling duty as set out in the Code of Practice, and it imposes a duty to take such steps as are reasonable in all the circumstances of the case for it to have to take in order to make reasonable adjustments. The Code of Practice gives guidance as to what will constitute a reasonable step, stating that it will:

"vary according to:

- the type of service being provided;
- the nature of the service provided and its size and resources; and
- the effect of the disability on the individual disabled person."

265. The Code of Practice also identifies certain factors which may be taken into account in considering what is reasonable, and these include:

- whether taking any particular steps would be effective in overcoming the difficulty the disabled people face in accessing the service in question;
- the extent to which it is practicable for the service provider to take steps;
- the financial and other costs of making adjustment;
- the extent of any disruption which taking the steps would cause;
- the extent of the service provider's financial and other resources;
- the amounts of any resources already spent on making adjustments; and
- the availability of financial or other assistance.

It is said that a decision not to remove in the instant cases would clearly constitute a reasonable step.

266. As regards a possible justification for a failure to comply with the duty to make reasonable adjustments, it is suggested that the most relevant prima facie basis for this is to be found in section 21D(4)(d), but again with reference to the Code of Practice, it is argued that the public authority can

only justify treating a disabled person less favourably, or failing to comply with a duty to make reasonable adjustments, where this is necessary for the protection of the rights and freedoms of other people. It is argued that it cannot be said by the Secretary of State that removal is necessary for the protection of rights and freedoms of other persons.

267. As to any potential argument in respect of section 21D(5), the proportionality argument, here, again with reference to the Code of Practice, it is argued on behalf of the appellants that, in the words of the Code of Practice:

" • there is a pressing policy need that supports the aim which the treatment is designed to achieve, and it is therefore a "legitimate" aim; and

- the authority's action is causally related to achieving that aim; and

- there was no other way to achieve the aim that had less detrimental impact on the rights of disabled people."

268. It is suggested that though the legitimate aim here may be said to be the preservation of the available NHS services for HIV sufferers who have leave to remain in the UK independent of their HIV status, the mere identification of a legitimate aim will not be sufficient in itself, as is made clear in the Code of Practice and with reference also to the decision in Alan and Others v GMB [2008] IRLR 690. The means chosen to achieve that aim must be proportionate and it is said that this requires consideration of whether there are alternative means of achieving that aim, and it requires a balancing between the impact on the appellants and the interests of the Secretary of State. It is argued that, since the impact of removal on the appellants would be very severe and life-threatening and in the circumstances will involve a real risk of violation of their rights under the Human Rights Convention, the Secretary of State cannot discharge the burden of establishing justification.

269. On behalf of the Secretary of State four points are made on this issue. Firstly it is argued that the public authority providing any "benefit" to a disabled person is a different authority from that which is carrying out the function in question, referring to what is said at section 21E(1) of the Act. It is argued that the Secretary of State and a primary care trust could not be considered as "one public authority" on an ordinary construction given their different functions and also the fact that they are listed separately under the list of "public authorities" who are made subject to the duty under section 49D of the Act to publish an equality scheme.

270. Secondly it is argued that there is not a sufficient causal connection between the Secretary of State's functions or actions and the detriment that may or will be suffered following removal to Zimbabwe. It is argued that there must be a real causal connection between the source of the detriment and the functions of the public authority which is said to lead to exposure to the detriment.

271. Thirdly it is argued that the incorporation of the concept of reasonableness in section 21D and section 21E has to take into account the substantial body of ECHR and domestic case law defining the scope of the state's obligations towards non-nationals without leave to remain in medical treatment in similar cases. It is argued that if that were not the case the rulings of the European Court would be bypassed and those who were disabled could rely upon the DDA to provide a lower hurdle than the exceptional case test applicable in Article 3 cases. The point is also made in this regard that it is relevant to have regard to the cost implications of the "adjustments" said to be required, quoting from what was said by the Court of Human Rights in N . Reference is made to the arguments made in respect of the submissions on the issues on Article 3 and Article 8 considered above. It is also noted

that the Tribunal in NM (Disability discrimination) Iraq [2008] UKAIT 00026 had serious doubts as to the extraterritorial effect of the DDA and it is contended that the situation in Zimbabwe is not a matter for which the United Kingdom is responsible and so similar concerns about the de facto extraterritorial reach of the statutory duties as arose in Soering in the context of Article 3 are also relevant in this regard. Hence the extraterritorial nature of the "detriment" to which the appellants say they will be subject if removed is a highly material factor.

272. Fourthly reference is made to the justification provisions at section 21D(3) and section 21D(5). It is argued that both of these justifications apply because for the United Kingdom government to allow disabled persons who did not possess leave to remain, to remain in the United Kingdom so they did not suffer a significant decline in the standard of medical and related care on return to their country of origin would impose a disproportionate cost and burden upon the finite funds of the UK government and this draining of resources would further inevitably impact upon the rights and freedoms of UK citizens and those with leave who would otherwise have access to the medical facilities and trained staff available for medical treatment. The point is also made that the process of removal only occurs once the person in question has exhausted all their appeal rights and it would entail therefore that they had not succeeded in respect of Article 3 and Article 8. As regards the latter, the point is made that issues of proportionality would already have been considered and that factor may be regarded as part of the DDA assessment. It is argued in conclusion that the legitimate objectives of a fair system of immigration control require the consistent application of the Secretary of State's current policy, which incorporates the Strasbourg jurisprudence threshold.

273. In their response to these submissions, the appellants say with regard to the first point that this misunderstands the trigger for the duty and the point is made that section 21E(1) of the DDA only sets the threshold for triggering the duty and so sets a low threshold. There is no requirement that it should be:

"impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred by that public authority or (b) unreasonably adverse for disabled persons to experience being subject to a detriment to which a person is or may be subjected by that public authority , by the carrying out of a function by the authority"

as, it is contended, Parliament would have said if it intended section 21E(1) to bear the meaning contended for by the Secretary of State. The reason for this is, it is said, because this is a duty designed to secure that the acts of public authorities do not unduly disadvantage disabled people and is adjusted where appropriate, even though the disadvantage experienced by removal or the conferring of status such as ILR will usually arise not from the decision itself, but from the consequences for which other authorities and indeed sometimes other states will be responsible.

274. As regards the second point made by the Secretary of State, it is argued that section 21E of the Act anticipates a causal link between the acts of the respondent and the disadvantage and the disability. The duty is directed at disabled persons. The act of removal will be causally linked, though it will not be the only cause, to the particular disadvantage and disability which is self-evidently causally connected to the disadvantage.

275. With regard to the third issue this is said to lack any merit at all. Section 21E, it is said, sets a low threshold, as opposed to the high threshold in Article 3 cases and in the case of Article 8 only where the treatment alleged is not justified. It is argued that the low threshold set by section 21E is set only for the purposes of triggering the reasonable adjustments duty, and to set an Article 3/8 threshold for the mere triggering of the duty would make the requirement of reasonableness otiose. It

is argued that the Code of Practice makes it quite clear that the duty is triggered simply where "disabled people" would otherwise "have a worse experience in relation to the exercise of these functions than other people".

276. With regard to the Secretary of State's last point, it is argued that the Secretary of State faces a real struggle in this regard because as is now admitted she has not undertaken an equality impact assessment to determine whether the decisions in these cases and similar cases are necessary and proportionate or indeed had regard to the equality objectives in section 49A of the Act with which the defence of justification must be read. It is not submitted on behalf of the Secretary of State that she has complied with the duty to make reasonable adjustments by making such adjustments. Hence, if the Tribunal were to conclude that the duty was triggered, having regard to the other submissions made on behalf of the appellants, then unless justified the failure would mean that the Secretary of State had acted unlawfully. For the failure to be legally justified, the discrimination must be justified under section 21D(3) and (4), and there is no evidence that the conditions for establishing justification are met in this case and no evidence has been adduced on the issue. Quite apart from the absence of an equality impact assessment, it appeared that there had been no consideration or any thought given to whether the discrimination was justified at all prior to the hearing of the case. This would mean that the discrimination was, if not impossible, extremely difficult to justify and in this case impossible given the absence of any evidence at all. Reference is made to what was said by the Supreme Court in R (E) v Governing Body of JFS and Another (United Synagogue and Others intervening) [2009] UKSC 15.

Discussion

277. The duty to make reasonable adjustments as set out at section 21E of the DDA does, in our view, link the practice, policy or procedure of a public authority to the impact on disabled persons of the carrying out of a function by the authority. It is true, as is argued on behalf of the appellants, that it does not say "by that public authority", but equally nor does it say "by any public authority". By use of the definite article we see the link here required to exist as contended for on behalf of the Secretary of State. Again, we consider that the words "any benefit" in section 21E(1)(a) and "any detriment" in (b) are properly to be regarded as referring to any benefit or detriment arising as a consequence of the carrying out of a function of the particular authority which has the practice, policy or procedure in question. As is argued on behalf of the Secretary of State, the function of a primary healthcare trust is a very different matter from the obligations of a government department such as the Home Office, and it is not without relevance that the two are listed separately in Schedule 1 of the 2005 Regulations. It would have been easy for the legislation to make it clear that there was a potential division between the authority which has the practice, policy or procedure in question and the one the carrying out of whose function adversely impacts on disabled persons, but that was not done and we consider that therefore the argument of the Secretary of State in this regard is made out.

278. With regard to the second issue, since we consider it is necessary to go and consider all four of these points, we see force in the point made on behalf of the appellants. If it were the case, which clearly from the previous paragraph we do not accept, that the Secretary of State's practice policy or procedure could give rise to a breach of the Act and therefore arguably would not be in accordance with the law, then there would be a causal connection between that and the impact on the particular person on removal. As is said at paragraph 21.2 of the appellants' further submissions, the practice of the respondent would be causally linked, though not the only cause. We do not read the legislation as requiring it to be the only or the dominant cause but simply to be causally linked and we think the point made on behalf of the appellants in this regard is made out.

279. As regards the third issue, again we see force in the points made on behalf of the appellants. The concept of reasonableness arising under section 21D(2)(a), essentially replicated at section 21E(1) in our view involves the need to assess that reasonableness on the basis of the circumstances of the case rather than of necessity linking it to ECHR case law on Article 3 and Article 8. However, it is not irrelevant to take account of the point made at paragraph 47 of the Secretary of State's submissions concerning such matters as the costs implications of the "adjustments" said to be required. The reasoning behind some of the arguments put forward in respect of Article 3 and Article 8 is not without relevance in this regard, but the case law comes from a somewhat different context. It is concerned with removal rather than the triggering of an obligation under section 21E. Again, however, it is not irrelevant to take account of the further point made by the Secretary of State at paragraph 50 of the further submissions that the Secretary of State is being asked to react to and thus to assume a measure of responsibility for, conditions in a third country. In particular, it may be said that nothing in the Act suggests that Parliament intended it to have extraterritorial effect. If a person who comes within the scope of the legislation while she is in the United Kingdom leaves the country, including the situation where she is removed compatibly with the immigration laws and the United Kingdom's international treaty obligations, that may properly be said to be the end of the government's responsibilities under the Act. Further, we see force to the argument in effect that the practice of the Secretary of State does not make it unreasonably difficult for the appellants to receive any benefit that is or may be conferred. Factors such as the extraterritoriality point and the costs point are of relevance to the issue of reasonableness in this context. We also see force to the submission that it would not be reasonable to require the Secretary of State to adjust his policies on removal to avoid the anticipated effect by ceasing removal action.

280. On the fourth and final point, it is necessary to consider the justification provision in particular as set out at section 21D(4)(d) and also section 21D(5).

281. We do not agree with the submission made on behalf of the appellants that the absence of an equality impact assessment makes it extremely difficult for the Secretary of State to argue justification successfully. It seems to us that it is open to the Secretary of State to argue, as she has done, that the treatment or non-compliance with the duty is necessary for the protection of rights and freedoms of other persons, as argued at paragraph 56 of the Secretary of State's further submissions. There is force to the argument that if disabled people without leave to remain are permitted to stay in the United Kingdom so they do not suffer a significant decline in the standard of medical related care upon return to their country of origin this would impose a disproportionate cost and burden upon the limited funds of the United Kingdom government. Again there is force to the point that there would be an inevitable further impact upon the rights and freedoms of UK citizens and persons with leave who would otherwise have access to the medical facilities and trained staff available for medical treatment. Likewise, we consider it is open to the Secretary of State to argue that her acts giving rise allegedly to the treatment or failure are a proportionate means of achieving a legitimate aim. In this regard also we see some force to the point made on behalf of the Secretary of State that if it has been decided, as we have concluded, that there would be no breach of the appellants' Article 8 rights in removing them, then this is clearly relevant to the proportionality aspect of section 21D(5). We do not see the need for evidence in this regard. It is a matter essentially of legal argument; the arguments have been made and we prefer the argument of the Secretary of State. The circumstances that we have set out above and the arguments made above seem to us to provide ample justification of the point. Accordingly we agree with the Secretary of State's submissions in this regard, and therefore in sum for the reasons set out we conclude that there is no failure to act in accordance with the law on the part of the Secretary of State in respect of duties arising under section 21 of the DDA.

UN Convention on the Rights of Persons with Disabilities

282. It is argued that the international law obligations created by the UN Convention on the Rights of Persons with Disabilities ("the Convention") are relevant both in their own right and also to issues of proportionality under the DDA. Article 5 of the Convention states:

"1. States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention."

Article 25 recognises "that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability", and requires States Parties to "take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation".

283. The United Kingdom ratified the Convention on 8 June 2009, and its Optional Protocol on 7 August 2009. However, it has entered a number of reservations in respect of the Convention, including the following:

"The United Kingdom reserves the right to apply such legislation, insofar as it relates to the entry into, stay in and departure from the United Kingdom of those who do not have the right under the law of the United Kingdom to enter and remain in the United Kingdom, as it may deem necessary from time to time."

284. The point is made on behalf of the appellants that a similar reservation with respect to immigration, initially made by the UK to Article 22 of the UN Convention on the Rights of the Child ("UNCRC") was withdrawn in September 2008, following criticism by a number of bodies, including the Joint Committee on Human Rights (JCHR), and the JCHR has said that the reservation is very similar to that initially made in respect of the UNCRC, nevertheless it is the case that the reservations in respect of the Convention have not been withdrawn.

285. The point is also made on behalf of the appellants that Zimbabwe has neither signed nor ratified the Convention and it is argued that the evidence of discrimination concerning the availability of ARVs would clearly violate the fundamental principles of the Convention and a decision not to remove the appellants would make sure that the Secretary of State complies with her international law obligations as contained in the Convention.

286. This does not however in our view give rise to a legal obligation justiciable per se before this Tribunal. It is entirely unclear on what basis the Secretary of State might be said to have assumed a legal obligation not to remove the appellants to a state failing to meet such international obligations, especially in light of the reservation. As is pointed out at paragraph 125 of the Secretary of State's written submissions, the nature and extent of the obligations not to remove a person to a place where the "recipient" state may breach international obligations or tenets are set out in Soering and arise under Article 3 of the European Human Rights Convention. Accordingly we conclude that there is no

issue justiciable per se before this Tribunal arising from any breach of the terms of the Convention. Nor do we consider that the UK's obligations, reserved in this context as they currently are, materially impact on the issues of proportionality under the DDA.

Decisions on the Individual Appellants

RS

287. We have set out RS's evidence above.

288. We remind ourselves that, though the appellant first came to the country in February 2001, it was not until 2004, at the time of her appeal against the decision refusing leave to remain to undergo private medical treatment, that she claimed that she and her family had always been MDC supporters. She claimed asylum in March 2006 and claimed to have been active for the MDC since its formation in 1999, and claimed that her husband was also involved, as were her family members, and that her husband and her sisters were known to the authorities as MDC members. She claimed to have attended rallies and distributed T-shirts and other items, to have sold cards, and to have been arrested three times, at each time in the year 2000. Only the human rights issues were considered at the subsequent appeal and the asylum issues have never been determined.

289. In her statement of January 2010 she claimed for the first time that she and her husband were arrested for distributing T-shirts and selling cards and leaflets. Initially she had only referred to herself as having been arrested on that occasion. She said that her sister-in-law was also arrested with them and was raped by the police, and she herself was touched inappropriately. She said she did not mention this in her 2004 statement because the application was only concerned with her ill health but in the January 2010 statement did not explain why it was omitted from the 2006 statement which was specifically prepared for her asylum appeal. She referred to two other occasions when she and her husband were held overnight. She said that her brother-in-law was killed in a house fire in 2002 because he was an MDC supporter. Previously she had said that this occurred in 2004.

290. The appellant said in her statement that her husband, her children, her husband's sister and her children survive on US$10 a month and are denied food aid due to their MDC connections. They had been beaten by ZANU-PF thugs in 2004 and 2008 during the time of the elections and sometimes had to go into hiding in order to be safe. She was unsure whether her husband had been arrested since returning in 2002. In the last few months he had been bedridden. Like her he had been diagnosed as HIV positive in August 2001. He went back to Zimbabwe in 2002. The appellant said that her father died in 2004 and her mother in 2005. She said her mother-in-law was supported by relatives in the USA and did not share the money with the appellant's husband.

291. In oral evidence the appellant adopted the three appeal statements as true and accurate. She was reminded that she had at one stage said that her husband was not politically active or targeted for persecution, in contrast to her later evidence that she and her family had always been supporters of the MDC. She was asked why she had not mentioned this in the context of the earlier human rights claim and said she had been dealing with the medical claim first time and raised asylum when she made her second claim. She said she could not remember being asked in the context of her first appeal whether her husband had any political involvement. When asked why she made no mention in her first witness statement of being detained, she said she had not been asked about it. As regards discrepancies in her written evidence as to the duration of the detention in 2000, she said that she might have mixed up the dates and that one of the detentions lasted two hours and another was overnight.

292. As regards evidence that her home and property had been destroyed, in a letter signed by the Provincial Youth Secretary and the Secretary of the MDC for Chitungwiza Province, whereas she had not mentioned this in any of her other evidence, she said that she had mentioned that the house she lived in was destroyed and this was a reference to her brother-in-law's house being destroyed in 2004. As regards the reference in the letter to her being hunted by ZANU-PF officials which she had not mentioned in her statements, she said that when she had been distributing leaflets she had been told she would be arrested if caught again and that was what she had meant. She confirmed that Dema, where her home is, is an MDC stronghold and that there were no hospitals there nor in Chitungwiza. Her husband was ill and not politically active. He was not receiving any medical treatment. He had not received any treatment since returning to Zimbabwe.

293. We find the appellant's claim of MDC involvement of herself and her family to lack credibility. We do not find credible the explanation she gives for not having mentioned the fact that she and her family had always been MDC supporters at the time of her human rights claim. If she had experienced the problems she claims to have experienced in 2000 it lacks credibility that she would not have referred to these incidents at the time of her initial application for leave to remain. It also lacks credibility that her husband would have returned to Zimbabwe in 2002, even though it was after the death of his father, if he had experienced the arrests and ill-treatment that she now claims that he had experienced. Accordingly, as we say, we do not accept the appellant's claim that she and her family have had any involvement with the MDC. She would therefore return to Zimbabwe as a failed asylum seeker with no adverse history with the authorities. We remind ourselves that in RN it was said at paragraph 230 that a person returning to their home area from the United Kingdom as a failed asylum seeker will not generally be at risk on that account alone, although in some cases that may in fact be sufficient to give rise to a real risk. Each case will turn on its own facts and the particular circumstances of the individual are to be assessed as a whole. It is relevant in this regard to bear in mind the appellant's evidence that Dema, where her family live, is an MDC stronghold. In line with the guidance in RN we consider that the appellant has not shown she faces a real risk on return to Zimbabwe either at the airport or in her home area on account of actual or suspected political beliefs. We also find lacking in credibility the family's claim not to have been included in food distribution and her husband in medication distribution when he has been back in Zimbabwe now for some eight years, having been diagnosed as HIV positive in 2001. We do not find it credible that the family can have existed for such a lengthy period without food aid and, in the case of the appellant's husband, medication. We do not find it credible that the appellant's mother-in-law, who is said to be supported by relatives in the United States of America, does not share the money with the appellant's husband.

294. We have set out above our findings on risk on account of a diagnosis of being HIV positive which all these appellants have. We have set out above the medical evidence concerning RS. Dr Day considered, putting the position at its starkest, that if medication stopped completely he would expect her life expectancy to be less than five years. In accordance in particular with the guidance in N , we conclude that the appellant has not shown a real risk of breach of her Article 3 or Article 8 rights by reason of return to Zimbabwe and thus being denied the access to medication that she is presently receiving. We have noted that there is a significant number of people receiving treatment for HIV/ AIDS in Zimbabwe. Quite apart from the case on its facts not crossing the N threshold, we consider there is a good chance of the appellant obtaining access to the necessary medication.

295. We have also set out our views above concerning discrimination and politicisation of access to AIDS treatment and therapy in Zimbabwe. Particularly in an area which is an MDC stronghold, such as Dema, we do not consider that the claim in this regard is made out either. We maintain our view

that in general there is not such a level of discrimination and politicisation in this regard as to give rise to a real risk in general in Zimbabwe. Likewise, given our conclusions above on access to food aid, we do not consider that the appellant's claim in this regard is made out either.

296. As regards other aspects of Article 8, the appellant has been in the United Kingdom for over nine years now and has clearly therefore developed a private life, although little evidence has been provided other than the fact of having been in the United Kingdom during this period. It does not seem to us that either her removal would be disproportionate as regards private life, and as regards her family, her husband and children are in Zimbabwe as also are her husband's sister and her children. Clearly therefore the heart of her family is in Zimbabwe and our conclusion is that her removal would not be disproportionate as a consequence, in respect of her family life, for her to be removed to Zimbabwe. Her claim is dismissed on all grounds.

EC

297. As we have set out in EC's history above, she was born in Gutu and grew up in Harare. Her husband died last year and her two children live in Harare with her mother. She has not claimed to be involved with the MDC or any other opposition parties either while in Zimbabwe or since she came to the United Kingdom. She was diagnosed as being HIV positive in late 2001 or early 2002. She lives with a cousin in the United Kingdom. Her parents and brother are in Zimbabwe and the family, she says, rely on a relative who provides them with maize. She also has a sister who lives with her mother-in-law. Dr Day has reported on the appellant, stating in his most recent report that if she were unable to receive a supply of drugs that controlled her virus then her life expectancy would be limited to less than three years. She had originally come to London to stay with an uncle who worked in the Zimbabwe High Commission here. She said that he returned to Zimbabwe in 2005 and though she had not really tried to make contact with him she had a cousin in Harare who was his niece and whom she could contact about him. By the time of the hearing she was not living with her cousin but living with a friend from church.

298. EC would return as a failed asylum seeker who has been in the United Kingdom since September 2001 and has no record of political involvement either while in Zimbabwe or while in the United Kingdom. On the basis of the guidance in RN , we consider that her claim is not made out. Whether or not she is able to renew contact with the cousin she initially came to visit, we consider, taking the evidence as a whole, that she would not face a real risk on return. Harare is an area of strong MDC support, and it is to Harare that the appellant would return. We conclude that she does not face a real risk of persecution or breach of her Article 3 rights on return. The findings we have set out above concerning risk on account of politicised access to medication and food aid apply equally to EC as to the other appellants. As regards the issue of her life expectancy if denied medication, we rely on what we have said above about the application of the decision of the Court of Appeal in N , but in any event remind ourselves of the significant numbers of people in Zimbabwe who are in receipt of HIV/AIDS medication.

299. As regards other aspects of Article 8, the appellant has, as we say, been in the United Kingdom for nearly nine years. That must give rise to private life and it seems clear that she has friends in the United Kingdom and cousins also. However we do not consider her removal would be disproportionate in respect of her private life, nor, bearing in mind that her two children live in Harare with her mother, do we consider that the appellant's family life would be disproportionately interfered with by her removal. Her appeal is dismissed on all grounds.

BR

300. BR is from Chitungwiza Town which is described as an MDC stronghold. She has been in the United Kingdom since December 2001 (having previously visited for some three weeks earlier in that year), and lives with her daughter M. She has another daughter, S, also living in the United Kingdom. It is unclear where S's two children, who accompanied the appellant to the United Kingdom in December 2001, are.

301. BR discovered that she was suffering from HIV in June 2002. Like EC she does not claim a history of political engagement or political action. The particular complication in her case as regards her health is that due to a resistance she has to the two main classes of HIV medication commonly used, she is on a complex regimen including Raltegravir, which is extremely expensive and, according to Dr Barnett, not available anywhere in Africa. The most recent report on BR is from Dr Minton. In an earlier report of 9 October 2009 Dr Minton said that if BR were no longer able to obtain her current medication her CD4 count and general health would rapidly decline and she would become susceptible to severe infection and cancers. He does not appear to have stated how long her life expectancy would be if denied her current medication.

302. Taking the evidence in the round as concerns BR, we consider that she has not shown a real risk of persecution on grounds of actual or suspected political opinion. She would return to Zimbabwe as a failed asylum seeker who had been in the United Kingdom for over nine years but without any political history. She would be returning to Chitungwiza, an MDC stronghold, and she has four sisters in Zimbabwe who live with their families. Applying the guidance in RN , we consider that her circumstances do not show any real risk of persecution or Article 3 ill-treatment on ground of perceived political opinion.

303. We reiterate what we have said above about risk on account of limited access or no access to medication in Zimbabwe. We remind ourselves that a significant number of people in Zimbabwe do have access to AIDS medication. There is the particular difficulty we have noted above in BR's case of her need for Raltegravir which we accept she would not be able to receive in Zimbabwe. However, bearing in mind the guidance of the Court of Appeal in N , we consider that, though this must significantly impact on the health and life expectancy of BR, that it does not cross the Article 3 threshold.

304. As regards the Refugee Convention and Article 3 claims in respect of claimed politicisation of access to medication and food, we rely on what we have set out above about these matters in general terms. It is of relevance in BR's case again that she comes from an MDC stronghold and therefore any risk that might exist on account of politicisation is on our view of the background evidence not of a level such as to give rise to a real risk of breach of her rights.

305. As regards other aspects of Article 8 and the health and access to food issues, it is clearly the case that BR enjoys family and private life in the United Kingdom. She lives with one of her daughters and her other daughter also lives in the United Kingdom. The evidence of her daughter M is that she looked for her maternal aunts in Zimbabwe when she returned there in 2009 but was unable to find them. We accept therefore that BR would return to Zimbabwe without family support. In the current circumstances, it is clear that she would not be joined in Zimbabwe by either of her daughters and therefore the family life she enjoys with them would be adversely affected as a consequence. However she is an adult and they are adults, and the evidence does not show a degree of dependency by her on them beyond what is normally expected in the case of a mother and her adult daughters. Accordingly we conclude her removal would not be disproportionate, and her appeal is dismissed on all grounds.

Signed Date

Senior Immigration Judge Allen

(Judge of the Upper Tribunal)

APPENDIX: LIST OF DOCUMENTATION CONSIDERED

Item	**Document**	**Date**
1	First Report of Dr Day (concerning EC)	16 February 2007
2	Report of Dr Baggaley	27 February 2007
3	Zimbabwe Daily	2 May 2007
4	First Report of Dr Day (concerning RS)	7 August 2008
5	Zimbabwe Peace Project	September 2008
6	Physicians for Human Rights Report	January 2009
7	US State Department Report	25 January 2009
8	Médecins Sans Frontières Report (1)	February 2009
9	Operational Guidance Note for Zimbabwe	24 March 2009
10	Médecins Sans Frontières Report (2)	June 2009
11	Human Rights Watch Report	August 2009
12	Voice of America Report	14 August 2009
13	The Zimbabwe Metro	23 August 2009
14	IRIN article	14 September 2009
15	Zimonline Report	23 September 2009
16	The Zimbabwean	October 2009
17	Zimonline Report	5 October 2009
18	The Lancet	13 October 2009
19	Country of Origin Information Report: Zimbabwe	December 2009
20	Report of Dr Minton (concerning BR)	11 January 2010
21	AVERT, HIV and AIDS in Zimbabwe	2009 (last updated 14 January 2010)
22	Zimbabwe Democracy Now, New Year 2010 Report	16 January 2010
23	Report of Dr Mujuru-Mvere	25 January 2010
24	Report of Professor Barnett	27 January 2010
25	Second Report of Dr Day (concerning RS)	4 February 2010
26	FCO Website	9 February 2010
27	Amnesty International Report	10 February 2010
28	British Embassy Harare Report	11 February 2010
29	Second Report of Dr Day (concerning EC)	12 February 2010
30	Human Rights Watch Report	12 February 2010
31	Zimbabwe Telegraph	14 February 2010
32	ZimDaily Report	16 February 2010
33	The Economist	18 February 2010

34	Report of Dr Kibble	22 February 2010
35	Uncorrected transcript of oral evidence before the House of Commons International Development Committee	23 February 2010
36	Report of Professor Ranger	24 February 2010
37	Response to Dr Kibble and Professor Ranger’s Reports: First Secretary, Migration, British Embassy, Harare	25 February 2010
38	The Zimbabwean	26 February 2010