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CASE COMMENTARY

SHROUDED GENDER AND REPRODUCTIVE ISSUES IN CHILD WELFARE AND PROTECTION PROCEEDINGS

A re-appraisal of *The Haringey London Borough Council v C (A Child), E and Another*

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INTRODUCTION

This commentary examines the case of *Haringey London Borough Council v C (a child), E and another*[1] (referred subsequently in this article as the Haringey LBC case). The case focused on child protection issues under the Children Act 1989 (the 1989 Act) arising from a UK charity's claims that it could provide infertile couples with miracle babies through supernatural means.

While the case focused on child protection issues, the High Court also found that that Mrs E had been seriously assaulted during a stage-managed childbirth in Kenya. Despite this finding, no further judicial or other state action was taken to address these issues whereas the High Court's concurrent findings on child trafficking led to trans-boundary state action against the perpetrators of this offence.

This commentary considers why the court's finding on the serious assault against Mrs E was not given the same attention as its finding on child trafficking. It explores whether the assault against Mrs E could have been characterised in the finding by the High Court as gender based violence (GBV) and what difference such findings would have made to the protection of involuntarily childless women like Mrs E Accordingly, the commentary deliberates on whether states have a responsibility to investigate and punish such acts under the international human rights instruments that safeguard the rights of women. The article also considers against the backdrop of the

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[1] [2004] EWHC 2580 (Fam); [2005] 2FLR 47; [2005] Fam Law 351; *The Times*, November 27, 2004; Official Transcript; Fam Div. References to this decision are obtained from the official transcript.

libertarian harm principle as enunciated by Mill, the question on whether there should be state intervention in cases where alleged acts of gender based violence and reproductive harm arise from a woman's autonomous decision to seek treatment that puts her in harm's way.

CASE BACKGROUND

Infertility is a very traumatic experience for involuntary childless couples regardless of their race, nationality or social status. However, it is even more of an ordeal when social identity and recognition is tied up with the ability to procreate.[2] This applies particularly to pro-natal regions such as sub-Saharan Africa.[3]

The social consequences of infertility in Sub-Saharan Africa, particularly for infertile women, have been examined in academic literature[4] and they include marital instability, domestic violence, loss of property and inheritance rights, victimisation and abuse from extended family members, social exclusion, denial of cultural rites (such as proper burial rights) and the loss of social security and support.[5] These all affect the quality of life of infertile women and may also adversely affect their mental health.[6] The deleterious social consequences of infertility have led many infertile women to explore diverse forms of treatment or methods to achieve pregnancy. Some of these methods are outside the realm of conventional medical health care and include complementary medicine[7] and faith based solutions.[8]

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[2] G Pennings "Ethical issues of Infertility Treatment in Developing Countries" (2008) 1 *Human Reproduction* 15 at 16.

[3] See generally M Hollos "Motherhood in Sub-Saharan Africa: The Social Consequences of Infertility in an Urban Population in Northern Tanzania" (2008) 10(2) *Culture, Health and Sexuality* 159; M Hollos, U Larsen, O Obono, B Whitehouse "When Reproduction is not a Choice: Infertility in Sub- Saharan Africa" (2007) *Union for African Population Studies* Arusha, Tanzania.

[4] Above n 2, at 16. See also A Daar, Z Merali "Infertility and Social Suffering: the Case of ART in Developing Countries" in E Vayena, P Rowe, P Griffin (eds) *Current Practices and Controversies in Assisted Reproduction* (Geneva, Switzerland: 2002 WHO) 15-21.

[5] Ibid.

[6] S Dyer, N Abrahams, N Mokoena "Psychological Distress among Women Suffering from Couple Infertility in South Africa: a Quantitative Assessment" (2005) 20 *Human Reproduction* 1938-1943.

[7] E Mariano et al "Healers, Nurses, Obstetrics-Gynaecologists Dealing with Women in the Quest to become Pregnant in Southern Mozambique" (2010) F, V & V in Ob Gyn, Monograph 43 at 44 and 45.

[8] In one study, it was shown that the treatment outlet for 41.4% of the respondents was faith based treatment. See T Ola, F Aladekomo, B Oludare "Determinants of the

The events leading to the facts that formed the basis of the *Haringey LBC* case supports the view that infertility may also be an agonizing experience for women in African Diasporas in the West. Some of these women may also seek the recourse of non-conventional medical methods in an attempt to achieve pregnancy.[9] Fascinatingly, while the social consequences of infertility could be argued as a primary catalyst that triggered the events that created the factual situation in the *Haringey LBC* decision, little attention if at all was given to this point despite the court's acknowledgement that in arriving at its decision that it needed to take due cognisance of "the wide context of social, emotional, ethical and moral factors surrounding the case".[10]

As stated above, events preceding the judicial decision in *Haringey LBC* case were extensively reported in the media.[11] They relate to the claims of the Gilbert Deya ministry (a UK based charity) that it could help infertile couples to achieve miraculous pregnancies and live births through divinely inspired power. While it is clear that other faith groups also subscribe to the reality of miraculous events,[12] the difficulty with the claims of this specific group and its adherents had to do with the fact that the 'miraculous pregnancies' did not fall within the normal gestation period or conform to other recognised indicators of pregnancy.[13] Further, it was asserted that since the pregnancies

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choice of treatment outlets for infertility in South West Nigeria" (2008) 33(2) *Rawal Medical Journal* (Periodical of the Pakistan Medical Association) 193-196.

[9] V Yebei "Unmet Needs, Beliefs and Treatment-seeking for Infertility Among Migrant Ghanaian Women in the Netherlands" (2000) 8(16) *Reproductive Health Matters* 134-141 also documents similar experiences of women of African descent in the Netherlands.

[10] Above n 1, court judgment at paragraph 10.

[11] J Waite "Gilbert Deya: Miracle Babies" BBC Radio 4: *Face the Facts* Transcript August 13 2004; BBC UK "Pregnant by Jesus?" BBC August 13 2004; S Bogan "Miracle Worker or Baby Thief?" *The Times* September 3, 2004; J Este "The Preacher, the 'miracle' births and the lost children" *The Independent* September 1, 2004; S Left "The Kenyan Connection" *The Guardian* November 12, 2004; S Boggan "Gilbert Deya & Missing Babies: God Knows" *The Guardian* June 6, 2006. A detailed account of media coverage of the Gilbert Deya ministry can be obtained from Religion News Blogs Archive at http://www.religionnewsblog.com/ (last accessed August 1, 2011).

[12] For a critique discussing the historical basis for belief in miracles, see J Pawlikowski "The History of Thinking About Miracles in the West" (2007) 100 (2) *Southern Medical Journal* 1229-1235.

[13] In two instances of the alleged miracle pregnancy, the gestation period for one was over 12 months while the other was not more than 27 days. See court judgment n 1 above at paragraphs 17 and 56.

were miracles, they could not be detected by conventional medical techniques.[14]

There were further press reports that the women who had allegedly conceived through this process travelled to Kenya (the birth place of Gilbert Deya) to 'give birth' to miraculous children when the hospitals in the UK did not support their claims that they were pregnant.[15] This fact was also adduced in evidence in the *Haringey LBC* case.[16] Press media[17] also focused on the issue of whether the alleged 'miracle children' were actually victims of child trafficking. The High Court in the *Haringey LBC* case found this to be the position in its consequential finding[18] and this triggered criminal law proceedings in Kenya[19] as well an extradition process in the UK to enable the key protagonist, Gilbert Deya face charges of child trafficking and abduction in Kenya.

THE HIGH COURT'S TREATMENT OF THE CASE

Facts and Judgment

The specific set of facts that formed the basis of the decision in *Haringey LBC* had to with child "C" who had purportedly been conceived by Mrs E (a member of the Gilbert Deya ministry). She claimed that she had given birth to C (a miracle child) in Kenya and had brought him back to the United Kingdom to live with her and her husband (Mr E). Based on her claim, child protection referrals were made to the local authority which attended the couple's home with the police on October 28, 2003 and questioned them about C. It was resolved that C could not be removed from the couple's home until his DNA results were received. These results were received in writing on November 13, 2003 and the local authority applied to the courts without notice to Mr and Mrs E for an emergency protection order and for permission to refuse further contact between the couple and C. The court granted both orders which led to the forced removal of C on November 15, 2003. Upon

[14] Above n 1 court judgment at paragraph 36.

[15] Above n 11. See also D Okwatch "Plot Now Thickens as 'Miracle' Saga Points at Scandal" *The East African Standard* August 2, 2004.

[16] Above n 1, court judgment at Paragraphs 33 to 40.

[17] Above n 11.

[18] Above n 1, court judgment at paragraph 93.

[19] See the case of *Rep v Miriam Nyeko & 2 others* 3110/04. Convictions were obtained against Mary Deya (wife of Gilbert Deya), Rose Keserem, a church worker and Miriam Nyeko. Mary Deya was re-arraigned on further charges of child theft and is currently serving a fresh custodial sentence in Kenya. See "Deya's Wife Gets 3 Years for Baby Theft" *Kenya Broadcasting Corporation* January 28, 2011.

further application to the court, the couple were given permission by the court under the 1989 Act to apply for a residence order.[20]

The *Haringey LBC* case primarily focused on the legal point on whether there were sufficient findings of fact to establish that the threshold under section 31[21] of the 1989 Act had been satisfied to warrant state intervention by way of a care order as opposed to Mr and Mrs E's application for a residence order under the same Act.

The High Court, with regard to the facts before it, held that the threshold under section 31 had been fully satisfied. Based on the strength of the evidence, it refused to grant the residence order sought for by Mr and Mrs E and issued an interim care order under the 1989 Act and gave directions in private to ensure that C's best interests were safeguarded whilst a permanent family, preferably his birth family could be found.[22] It did this on the basis of the DNA evidence that showed that the child shared no biological links with either Mr E or Mrs E[23] The refusal to grant the residence order sought by Mr and Mrs E was also based on the ground of securing and protecting the child's identity. As Mr and Mrs E were both not prepared to admit that C was not a miracle child and that he had been fraudulently removed from his real parents. The court held that C may experience difficulties in the future if he continued to live under the "false impression that he was a miracle child (with carers of the same view) when in fact this was not the case".[24]

Although the High Court reached a decision that denied Mr and Mrs E's application for a residence order for C on the strength of the factual findings, it did find as a matter of law that it was not only C's rights that should be protected but that the couple also enjoyed Convention rights under the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR).[25] These rights included the right of a fair trial under Article 6, the right to respect for a family life under Article 8 together with the enjoyment of these rights without discrimination inter alia of their religion.[26] The court criticised the child protection process and the early stages of the decision making of the case for not demonstrating adequate consideration of these rights. [27]

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[20] Above n 1, see court judgment for full facts.

[21] This section deals with care orders sought by local authorities in relation to children suffering from harm or at risk of significant harm.

[22] Above n 1, paragraphs 83 to 92 of the court judgment.

[23] Ibid at paragraphs 25, 41, 73 and 86 of the court judgment.

[24] Ibid at paragraph 83 of the court judgment.

[25] Rome 4 XI 1950 given legal effect in the United Kingdom by the Human Rights Act 1998 Cap 42.

[26] Above n 1, court judgment at paragraph 30.

[27] Ibid paragraphs 25-26.

The High Court stated that in securing these rights that it had taken steps to treat Mr and Mrs E "as significant adults in C's life who for a short time enjoyed with C the existence of de facto family life".[28] In reaching its decision that the threshold under section 31 had been satisfied and its refusal to grant the residence order, the High Court held that it had taken into account the sensitive ethical issues involved in the case and applied the reasoning in several decisions[29] which held that best interests are not only defined by medical or scientific evidence alone, but by the wider context of social, emotional, ethical and moral factors.[30]

One of the ways that the court addressed the wider social context of the case was to direct that a "culturally appropriate assessment of the context of the case"[31] be undertaken. This assessment was undertaken by a consultant child and adolescent psychiatrist and played a key role in the court's denial.[32] Notwithstanding that Mrs E declined to be assessed by an adult psychiatrist,[33] there is nothing to show that this "culturally appropriate assessment" (which was undertaken not only to safeguard "C" rights but also to promote the Convention rights of Mr and Mrs E) took into account the socio-cultural consequences of involuntarily childlessness upon women like Mrs E There is also no evidence to show that it considered the impact that the social consequences of infertility may have on the treatment seeking behaviour of Mrs E and why this had led her to the Gilbert Deya's ministry and where she had been cruelly deceived into believing that she had given birth to a "miracle child."[34]

Whereas it may be argued that the primary issue that the court had to deal was the s 31 threshold requirement for a care order to be issued, it is important to note that the court also had to take into account the Convention rights of Mr and Mrs E in deciding whether to grant their application for a residence order. Surely in considering these rights, which included the right to family life as set out in article 8, the court could have done more through its directions for "a culturally appropriate assessment of the wider context of the case" to

[28] Ibid, paragraph 29.

[29] *Re A* (Male Sterilisation) [2000], 1 FLR 549 at page 555; *Re B* [2004] 2 FLR 263 at paragraph 26 and *Re U* (Serious Injury: Burden of Proof. See n 1 above, paragraph 10 of the court judgment.

[30] Ibid.

[31] Ibid at paragraph 28.

[32] Ibid.

[33] While there is nothing in the court decision to explain why Mrs E declined to be assessed, this may relate to the reservations that people from ethnic minority backgrounds have toward mental health providers. This point will be explored in more detail in the subsequent sections of this article.

[34] Above n 1, court judgment at paragraphs 2 and 75.

ascertain why an involuntarily childless couple like Mr and Mrs E would resort to the steps they took in their quest to have a child? This article queries whether the cultural assessment made by the child psychiatrist would have been adequate to fully decipher this issue. To his credit, Dr O, the child psychiatrist, did identify some positives beneficial to Mr and Mrs E's application for a residence order,[35] but his assessment of these issues would have been better supported by an independent assessment undertaken not necessarily by an adult psychiatrist which appears to have been what the court considered as the next step of further assessment,[36] but by an expert competent and knowledgeable in matters relating to the socio-cultural impact of infertility on people of African descent and how this might affect their treatment seeking behaviour.[37]

Before proceeding further on this point and the other issues to be explored in this article, it is necessary to provide some perspective on why the *Haringey LBC* case is being re-appraised seven years after it was decided by the High Court. Admittedly, this is a High Court case, and while it has been described as one of "the longest child custody cases in British legal history,"[38] it is worth noting that the judgment[39] is yet to be the subject of further appeal. Further since the focus of the judgment centred primarily on the s 31 threshold issue, it is understandable that its contextual discourse of other issues may not be as engaged as an appellate decision (on the same facts) from either the Court of Appeal or Supreme Court. However, this commentary argues that the gender and reproductive issues contained in this case are of such significant public interest which deserves not only academic investigation, but appropriate consideration by the state and other stakeholders concerned with the protection and safeguard of the rights of women.

[35] Above n 1, court judgment at paragraph 87.

[36] Above n 1, court judgment at paragraphs 63 and 87.

[37] See generally works that explore the relevance of considering cultural implications in judicial hearings. See for example, A Rentein *The Cultural Defence* (New York: Oxford University Press, 2004) pp 416. See also D Deas-Nesmith and S Mcleod-Bryant "Psychiatric Deinstitutionalisation and its Cultural Insensitivity: Consequences and Recommendations for the Future" (1992) 84(12) *Journal of the National Medical Association*, at 1036, which emphasises the need for cultural awareness of patients' needs in "programme planning and implementation" on mental health issues.

[38] D Taylor, H Muir "Couple Make a New Attempt to Win Back 'Miracle' Boy" *The Guardian* September 15, 2007.

[39] To the best of this writer's knowledge.

COMMENTARY

Why Re-appraise The LBC Haringey Decision Seven Years On?

While as identified above, the Haringey LBC case dealt with the s 31 threshold requirement for a care order under the 1989 Act, there are several reasons why this case can be considered as a significant one. First it has been cited in a spectrum of cases dealing with child protection issues.[40] Second, it also made a significant consequential finding on state responsibility relating to child trafficking. [41] Third, it has been showcased in the fourth report of session of the House of Commons Constitutional Affairs Committee[42] as playing a fundamental role in the promotion of "a greater public understanding of the work of the family courts while at the same time maintaining the protection of the private lives of litigants." [43]

Beyond these key considerations, this article argues that the *Haringey LBC* case encapsulates other important, but ignored issues relating to reproductive harm and gender based violence suffered by Mrs E as an involuntarily childless woman. Of particular interest to this article is the issue on whether the case could have served as a catalyst to expedite state action on gender violence just as it did through its consequential finding on child trafficking.

This is important considering that the High Court in the *Haringey LBC* case had held that Mrs E had been seriously assaulted at the point of child birth, after having been deceived into thinking that she had achieved a live birth in the clinic in Kenya.[44] However, unlike the response given to its finding on child trafficking, there is very limited evidence to show that appropriate state action was taken to address the finding of the serious assault

[40] See *Haringey LBC v C* (A child) [2006] EWHC 1620 (Fam); 2007 1 FLR 1035; [2006] Fam Law 1016; [2006] 103 (34) LSG 32. This is the follow up case to the LBC Haringey case under review in this article. The follow up case considered whether adoption was the best way to secure the security and identity of C, a child abducted from his parents through international child trafficking. The case was also cited in *Northumberland CC v Z* [2009] EWHC 498 (Fam); [2009] 2 FLR 696; [2010] 1 FCR 494 and in A (Local Authority: Religious Upbringing), Re [2010] EWHC 2503 (Fam); [2011] PTSR 6032; [2011] 1 FLR, 615; [2011] Fam Law 9; Fam Div.

[41] Above n 1, court judgment at paragraph 93.

[42] Fourth Report of Session 2004-05 1 HC-116-1 at 39.

[43] Ibid at 39.

[44] Above n 1, court judgment at paragraph 75.

suffered by Mrs E and other women that had been deceived into believing that they had given birth to "miraculous babies." [45]

While this article subscribes wholeheartedly to the continuing state effort to prevent and punish the acts of child trafficking identified by the High Court's consequential findings and press coverage, it questions why relevant state organs both in the United Kingdom and Kenya failed to investigate and punish acts of serious assault and harm suffered by Mrs E and other women[46] in this debacle? The article therefore considers the extent to which a state has responsibility to prevent and punish gender based violence and other harm against women. Related to this, the paper also considers whether there is a duty to protect vulnerable infertile women like Mrs E whose reproductive treatment seeking behaviour exposes them to gender violence or other reproductive harm as factually described in the *Haringey LBC* proceedings.

This paper argues that it is time to give some recognition to these significant but shrouded issues contained in the *Haringey LBC* case. This is important when one considers that seven years after the court's decision, the wider events that led to that case are still have a reverberating effect in the United Kingdom and Kenya. For example, fresh convictions on child trafficking were recently obtained this year against Mary Deya in Kenya[47] and there have also been recent calls in the United Kingdom that Gilbert Deya should be extradited to Kenya as quickly as possible to ensure that "justice is delivered for these young children who should not have been taken from their natural parents".[48] Yet the on-going state effort to combat illegal activity relating to child trafficking appears not to have taken into cognisance the other illegal activity relating to gender based violence and other harm to women. The re-appraisal of the case therefore seeks to highlight the failure of the state to act on behalf of involuntarily childless women like Mrs E and to identify the steps that can be taken to right this wrong.

[45] Primary and secondary infertility are both considered since unlike Mrs E in the London Borough case, Miriam Nyeko could be said to be suffering from secondary infertility having been reported to have given birth to children before.

[46] See n 19 above.

[47] Ibid.

[48] See remarks accredited to the Tottenham MP David Lammy in J Douglas "'Miracle babies' Pastor still in UK despite extradition" BBC News Thursday, 1 April 2010 See also recent press coverage on the current status of the extradition process. J Douglas "'Miracle babies' pastor to be extradited to Kenya" You and Yours BBC Radio 4 September 21, 2011.

Missed Opportunities to Address Gender Violence and other Harm Against Involuntarily Childless Women

It is not in dispute that the *Haringey LBC* case did acknowledge that Mrs E had suffered some serious assault at the point of delivery,[49] however as highlighted above, no further state action appears to have been taken in this regard. This may be to do with the fact that the cause of action before the court had nothing to do with gender violence and therefore it was right for the court to confine itself to the issues in dispute.

However, having found that it (the High Court) had a duty to secure the Convention rights of not only the child but Mrs E, could it not be argued that there was some scope for the court to consider whether the assault committed against Mrs E at the point of birth could be addressed by way of her Convention rights? Perhaps on this point, the High Court would have faced considerable jurisdictional constraints had it adopted this approach since the act of assault in question, having been committed in Kenya, would be deemed to have fallen outside the remit of the framework of the Convention rights.[50] This would suggest that the High Court was faced with a situation that left it very little room to manoeuvre or to provide further remedy for Mrs E (particularly with regard to the gender based violence (GBV) question) other than what it did by recognising her and Mr E as significant adults in C's life.[51]

Yet this does not mean that there has not been a missed opportunity for state action on the court's findings on a serious assault having been committed against Mrs E at the point of the supposed child birth delivery. If as highlighted in earlier sections, the High Court's consequential finding on international child trafficking helped to facilitate "national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form"[52] under the United Nations Convention on the Rights of the Child 1989,[53] this commentary repeatedly asks the question, why similar measures were not adopted to address the harm of gender violence under relevant international human rights instruments to which the UK and Kenya are state parties or have endorsed in the case of non-binding UN resolutions relating to Gender Violence enumerated herewith.

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[49] Above n 1, at paragraph 75 of the court judgment.

[50] The relevant regional Human Rights instrument that would apply in Africa is not the ECHR but the African (Banjul) Charter on Human And Peoples' Rights 1981.

[51] Within the context of the proceedings of determining the section 31 threshold, the court in paragraph 32 of its judgment seemed to suggest that in relation to Mr and Mrs E's rights, it could do no more than rectify the earlier "defaults... and arbitrary interference" as identified in paragraphs 25 and 26 of the court judgment.

[52] Above n 1, the court judgment at paragraph 93.

[53] United Nations, Treaty Series, vol 1577, p 3.

These instruments include the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 1979[54] and its optional protocol 1999,[55] Declaration on the Elimination of Violence against Women (DEVAW) 1993[56] and the UN General Assembly Resolutions on the Intensification of Efforts to Eliminate all Forms of Violence against Women 2009[57] and 2010 respectively.[58] Discussions on the relevance of these instruments would be further developed in subsequent sections of this commentary.

An examination of the judicial proceedings[59] relating to the Gilbert Deya ministry would suggest that far from taking steps to address this specie of harm, state action particularly in relation to the child abduction and theft cases in Kenya has adopted a rather unsympathetic attitude to the female victims in this case. Take for example, the case of *Rep v Miriam Nyeko*[60] and others where the court held that the claims of miraculous births made by Miriam Nyeko and her co-accused[61] *deserve no mercy.*[62]

While it is not the intention of this commentary to condone heinous crimes as child trafficking, child abduction and theft, it does question whether the custodial sentence given to Nyeko in particular was an appropriate sanction. This is in light of evidence that suggests that she had been similarly deceived like Mrs E in the *Haringey LBC* case into believing that she had achieved a live pregnancy and had also been subjected to a similar type of assault in a sham clinic in Kenya where her alleged child birth delivery took place.[63] Although this commentary does not dispute that there may be some basis to argue that Nyeko was rightly tried for child theft since the court did

[54] CEDAW was adopted by the General Assembly of the United Nations on 18 December 1979 and came into force in September 1981. The UK ratified this treaty in April 1986 while Kenya ratified same in March 1984. While Kenya ratified this instrument several years ago, it has not been fully implemented into its domestic legislative framework. However see the *Concluding observations of the Committee on the Elimination of Discrimination against Women*, CEDAW/C/KEN/CO/7 (CEDAW, 2011 which highlights the current efforts under the new constitution to domesticate CEDAW as well as to provide for a bill of rights for women.

[55] Adopted October 6 1999 and came into force on 22 December 2000.

[56] Resolution 48/104 of 20 December 1993.

[57] Resolution 63/1555 adopted by the United Nations on January 30, 2009.

[58] Resolution A/RES/65/187 adopted by the General Assembly of the United Nations on December 21, 2010.

[59] This includes the proceedings in Kenya, see n 19 above.

[60] Cited above n 19.

[61] Mary Deya and Rose Kiserem

[62] Statement accredited to the presiding magistrate Teresia Ngugi. See BBC report, Kenya "Miracle Baby Wife Jailed" BBC News, 31 May 2007.

[63] See Bogan "Miracle Worker or Thief", above n 11.

find that she had harboured a stolen child, it is doubtful whether she had the requisite criminal intent or motive required in law to convict her of having knowingly and actively participated in child abduction or child trafficking. For instance there is video evidence purporting to show Nyeko in child birth recorded scenes. In these scenes, she had been "heavily sedated with what appears to be pethidine, a form of synthetic morphine used in child deliveries."[64]

Fundamental questions can therefore be raised as to whether she was aware that she had not experienced a child birth, but had been cruelly deceived into thinking she had. Further, Nyeko just like Mrs E in the *Haringey LBC* case experienced what she assumed to be pregnancy symptoms, including distended abdomens and amenorrhea.[65] It was suggested in the *Haringey LBC* case that this was symptomatic of pseudocyesis (phantom pregnancy).[66] This commentary queries why these critical facts were not taken into consideration in deciding whether Nyeko had the necessary mens rea to commit the offences that she had been accused of. Further, it questions why these issues were not considered as mitigating factors in the sentencing process and why the court did not consider imposing other sanctions on her instead of a custodial sentence.

It is therefore puzzling why there has been very limited effort by the states concerned to address the significant harm suffered by Nyeko, Mrs E and other women in the 'miracle babies' debacle? In particular, it will appear that the Kenyan State, as the applicable jurisdiction where the acts of assault occurred, failed to consider in past and present criminal proceedings relating to the miracle babies whether these acts could be characterised as gender based violence and whether it has a responsibility to punish them. The following section of this commentary will therefore reflect on whether state failure or unwillingness to act could be explained on the basis of the argument that unlike child trafficking that there is no binding obligation under international law requiring states to combat gender based violence (GBV). This is particularly relevant when the violence has arisen from a woman's autonomous choice to seek treatment that puts her in harm's way as seen in both the cases of Mrs E and Miriam Nyeko.

[64] Ibid.

[65] See the account of her husband reported in Bogan, ibid. He explained that "Miriam said she thought she was pregnant — her legs and ankles swelled, she was getting back pains and her stomach began to grow." Mrs E and other women also experienced similar occurrences.

[66] See above n 1 court judgment at para 63.

Articulating State Responsibility for Righting Gender Based Violence under International Human Rights Law

The focus of this section is to consider whether there is state responsibility under international human rights law to prevent and punish acts of gender based violence (GBV).

Several international human rights instruments address gender based violence (GBV), but as identified above the instruments most closely connected to the type of harmful acts examined in this article are CEDAW[67] and DEVAW[68] and recent UN resolutions on the Intensification of Efforts to Eliminate all Forms of Violence against Women 2009[69] and 2010 respectively.[70]

Violence against women is not specifically mentioned in the text of CEDAW neither is a definition provided in this Convention. However, the expert body which monitors the compliance of the CEDAW states in its general recommendation 19 that:

> "…discrimination includes gender-based violence, that is violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence."[71]

Article 1 of DEVAW also defines violence against women as:

> "For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[72]

[67] See above n 54.
[68] See above n 56.
[69] See above n57.
[70] See above n 58.
[71] See paragraph 6 of General Recommendation number 19 (1992) (Eleventh Session, 1992).
[72] See above n 56.

Likewise, the 2009 UN Resolution on the Intensification of Efforts to Eliminate all Forms of Violence against Women defines violence against women[73] in the same way as the DEVAW definition.

The facts leading to the *Haringey LBC* decision and other criminal cases in Kenya, including the case of *Rep v Miriam Nyeko* establish that it was women (and not their male partners) that were subjected to the acts of assault which occurred during the staged managed child birth deliveries. It therefore can be argued that the assaults that occurred are acts of gender based violence (GBV) as they were directed at the women on the basis of their gender. It can further be argued that unlike their spouses, Mrs E and Miriam Nyeko were more disproportionately affected by the assaults committed to them during the so call child birth deliveries.[74]

While CEDAW does not expressly create a basis for state responsibility on gender related violence, the General Recommendation 19 does state that the *full implementation of the Convention required states to take positive measures to eliminate all forms of violence against women.*[75]

Likewise, Article 4 of DEVAW[76] requires states to *pursue by all appropriate means and without delay a policy of eliminating violence against women.* Article 4 (c) goes further to require that State policy on eliminating violence against women must be based on the principle of due diligence. It requires states to:

> Exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons.[77]

State responsibility on the basis of due diligence is also emphasised in the 2009 and 2010 UN Resolutions cited above.[78]

There is of course a debate[79] on whether these international instruments which can be characterised as soft law instruments[80] can be said to impose

[73] See Article 1, above n 57.

[74] Again it is women like Miriam Nyeko who have been convicted of child abduction and not their spouses. Miriam Nyeko's husband claims that he was powerless to help his wife out of her predicament. See Bogan's report, see above n 11. Likewise in paragraph 41 of the court judgment, above n 1, Mr E stated that he had remained at all times in the United Kingdom when his wife travelled to Kenya to "give birth to the miracle babies."

[75] See Article 4 of the General Recommendation, above n 71.

[76] Above n 56.

[77] Ibid.

[78] See Articles 10 and 11 of Res/63/155 of 2009, above n 57 above, and Article 9 of Res/65/187 of 2010, above n 58.

responsibility upon states to eliminate all forms of violence against women? This continuing debate may shed further light on why, unlike the findings on child trafficking, not much appears to have been done by the United Kingdom and Kenya to address the findings that Mrs E[81] had experienced some form of gender violence during her alleged child birth delivery.

The academic literature[82] focuses on the potential that the concept of due diligence has in providing the basis for state action in combating gender violence against women. It is argued that the role of due diligence in creating state responsibility to prevent and punish acts of gender violence is premised on leading cases such as *Velasquez Rodriguez v Honduras*[83] which held that state responsibility "could arise not because of the act itself, but because of the lack of due diligence to prevent the violation or to respond to it."[84]

Authoritative reports from the United Nations, including those issued by the special rapporteurs on violence against women have also been touted as another ground for arguing that positive state obligations based on due diligence to prevent and punish gender based violence have emerged under international law.[85] It is argued that states should be held accountable if they

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[79] See generally works like C Romany "State Responsibility Goes Private: A Feminist Critique of the Public/Private Distinction in International Human Rights Law" in R Cook (ed) *Human Rights of Women: National and International Perspectives* (Philadelphia: University of Pennsylvania Press, 1994) 634; D Shelton "Private Violence, Public Wrongs, and the Responsibility of States" (1989-90) 13(1) *Fordham International Law Journal* 21; R Copelon "International Human Rights Dimensions of Intimate Violence: Another Strand in the Dialectic of Feminist Lawmaking" (2003) 11 *American University Journal Gender, Social. Policy & Law* 865, and C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence* (Leiden, Martinus Nijhoff, 2008).

[80] See generally Feminist theories on International Law and Human Rights In A Edwards "Violence Against Women Under International Human Rights Law" (Cambridge: Cambridge University Press, 2011) Chapter 2.

[81] See also the case of Miriam Nyeko, above n 19.

[82] See Shelton n 79 above at pp 21-23; see also Y Erturk "The Due Diligence Standard: What Does it Entail for Women's Rights?" in C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence*, above n 79; see also L Hasselbacher "State Obligations Regarding Domestic Violence: The European Court of Human Rights, Due Diligence, And International Legal Minimums of Protection" (2010) 8(2) *North Western Journal of International Human Rights* 190 at 194.

[83] 1988 Inter-Am CtHR (ser C) No 4, (July 29, 1988) para 172.

[84] Ibid, at p 172.

[85] See for example C Bettinger-Lopez "Jessica Gonzales v United States: An Emerging Model for Domestic Violence and Human Rights Advocacy in The United States" (2008) 21 *Harvard Human Rights Journal* at 183, where reference is made to the Report of the Secretary General on the In-depth Study on All Forms of Violence

do not exercise due diligence in enforcing laws against crimes of violence against women. For example, one of the special rapporteurs, Yakin Erturk asserts that there is "a rule of customary international law that obliges states to prevent and respond to acts of violence against women with due diligence." [86]

Some commentators[87] have expressed reservation on whether a rule of customary international law has crystallised on state responsibility for gender based violence, especially in relation to systemic intimate violence (or domestic violence) as Erturk and some academic commentators have led us to believe.[88] Notwithstanding the academic debate on whether there is a clear rule of customary international law on state responsibility for gender based violence (GBV), it is significant that recent case law from the European Court of Human Rights (ECHR)[89] and as well as the Inter-American Commission on Human Rights [90] have affirmed the due diligence standard as a ground to impose responsibility upon states to address gender based violence (GBV) when it occurs.

This had led some to arguments that even if there is no clear crystallisation of a customary rule of international law on state responsibility

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Against Women, delivered to the General Assembly, UN Doc A/16/122/Add 1 (July 6, 2006). See also Hasselbacher's commentary on this, above n 82 at 194.

[86] UN Econ & Soc Council, Comm'n on Human Rights, Special Rapporteur on Violence Against Women, its Causes and Consequences, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women: The Due Diligence Standard as a Tool for the Elimination of Violence Against Women* 29 (Jan 20, 2006) (prepared by Yakin Ertürk in accordance with Commission on Human Rights Resolution 2005/41) [hereinafter 2006 Due Diligence Report]; see also her academic work based on this report in Y Erturk Erturk "The Due Diligence Standard: What does it Entail for Women's Rights?" in C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence*, above n 79.

[87] B Meyerfield, G Gulik, S Sonya "The Principles of State Responsibility and Systemic Intimate Violence" Summary of the International Law Discussion Group meeting (Chatham House, September 2010) 1-11.

[88] The debate on whether there is positive state obligation to combat gender violence on the basis of the principle of due diligence has been focused quite predominantly on domestic violence which is seen as an area where state action has been lacking potentially on the grounds of whether there is a public/private divide. See Shelton n 79 above and Y Erturk "The Due Diligence Standard: What does it Entail for Women's Rights?" in C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence*, above n 79 at pp 32-3.

[89] See for example *Osman v United Kingdom* 1998 VIII Eur CtHR 3124, *Bevacqua v Bulgaria*, App No 71127/01, *Opus v Turkey* App No 33401/02, Eur CtHR (2009). For academic commentary on these cases, see Hasselbacher, n 82 above.

[90] *Jessica Gonzales v United States* Petition No 1490-05, Inter-Am CHR, Report No. 52/07, OEA/Ser L/V/II 128, doc 19 (2007). For academic commentary of the case, see Bettinger Lopez, n 85 above.

for gender based violence (GBV) due to the lack of the requisite state practice (opinio juris), there is enough evidence to show that the rule is emerging in international law and that states, particularly in the European Union must take cognisance of the position set out in the authoritative UN reports as well as decisions that have emerged from the ECHR.[91]

This appears to be the position adopted by the recent Council of Europe Convention[92] on preventing and combating violence against women and domestic violence which in its preamble takes into cognisance the jurisprudence of the ECHR. It also affirms in Article 5 positive state obligations to act against gender based violence (GBV) on the principle of due diligence. Article 5(2) of the Convention states that:

> Parties shall take the necessary legislative and other measures to exercise due diligence to prevent, investigate, punish and provide reparation for acts of violence covered by the scope of this Convention that are perpetrated by non-State actors.

It would appear that the recent Council of Europe Convention albeit at the regional level does lend some support for the emerging crystallisation of state obligation to prevent, combat and punish gender based violence (GBV). [93] Likewise, article 4 of the Protocol to the African Charter on Human and Peoples' Rights of Women in Africa[94] also sets out state duties to prohibit, prevent, punish and eradicate all forms of violence against women. These regional European and African instruments are significant to this discussion since Kenya and the United Kingdom which are the two states arguably that have state responsibility for any gender based violence (GBV) arising from the miracle baby saga, are situated within these regions.

But even if the situation remains inconclusive on whether there is a universally accepted customary international law principle that imposes state responsibility for gender based violence (GBV), some have argued that the wrongs relating to gender based violence (GBV) are intertwined with other binding human rights obligations such as the prohibition of torture, inhumane and degrading treatment and violations against the right of life. [95] It is

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[91] See Hasselbacher, above n 85 at 198 , 201 and 202..

[92] [Instabul 11 V 2011] adopted on April 7, 2011.

[93] See B Meyerfield, G Gulik, S Sonya, above n 87 at 8, 10 and 11.

[94] Adopted by the Second Ordinary Session of the Assembly of the Union, Maputo, 11 July 2003.

[95] See Integration of the Human Rights of Women and the Gender Perspective: Violence against Women. Report of the Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, in accordance with the Commission on Human Rights Resolution 1997/44, E/CN 4/1999/68/Add 4,

therefore argued that state responsibility on these issues can be used in certain cases to impose on states the duty to prevent and to punish gender violence. [96] Arguably, the threshold to equate an act of gender based violence to being synonymous with these established rights will be high and will be judged on the measure of its severity and the context in which it occurred.[97]

Further, in arguing for state responsibility for gender based violence (GBV) there is also academic debate on whether the public/private dichotomy discourse is still tenable?[98] While not dwelling too much on this argument for state responsibility, it is noteworthy that even if there is a ground to maintain the public/private dichotomy argument in relation to domestic violence, this argument would not apply to the cases under review in this article. This is because the gender based violence (GBV) experienced by both Mrs E and Miriam Nyeko did not take place in a home, but in a hospital (albeit a sham clinic) and therefore cannot be considered as being private conduct or within a private sphere that is outside the jurisdiction of public policy or state intervention. While is it true that the relevant authorities in Kenya did close down the clinics where the alleged miracle births were supposed to have taken place, the grounds for the closure had more to do with the fact that the clinics had not been registered with the Ministry of Health[99] rather than regarding any clear concerns about the acts of gender based violence (GBV) or other potential reproductive harm perpetrated against female patients.

This again is illustrative of state inaction or the failure to protect women from activities that could result in violence or harm against them. Moreover, it will also appear that the closure of these clinics did not arise from the state's recognition that violence against women could result within the context of poor provisioning of reproductive health care services and the need to enforce its core obligations to provide safe health facilities for women.[100] Some reflection on this issue shall be taken up in the next section of this commentary which considers the extent to which the state should protect involuntarily childless women such as Mrs E in the Haringey LBC case from

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21 January 1999, paragraph 8. See also A Vesa "International and Regional Standards for Protecting Victims of Domestic Violence" (2004) 12:2 *Journal of Gender, Social Policy and the Law* 338.

[96] Ibid.

[97] See B Meyerfield , G Gulik , S Sonya, n 87 above at 5.

[98] Y Erturk Erturk "The Due Diligence Standard: What does it Entail for Women's Rights?" in C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence*, above n 79 at pp 32 to 33.

[99] See n 1 above, court judgment at paragraph 40. see also Blair D "'Miracle parents' Face Abduction Case" *The Telegraph* September 6, 2004.

[100] See Coomaraswamy, above n 95 at paragraphs 66 to 72 and 76 to 78.

gender violence or other reproductive harm that arises from autonomous reproductive treatment choices.

Protection of Infertile Women from Gender Based Violence and other Harm arising from Reproductive Treatment Choices

This section of the commentary explores whether vulnerable infertile women should be protected from gender based violence or other harm arising from autonomous reproductive treatment decisions exercised in favour of cross border health care[101] combined with non-conventional medical methods as was the situation in the *Haringey LBC* case.[102] It does this against the backdrop of a consideration of the libertarian harm principle as enunciated in the seminal work of Mill.[103] The discourse in this section begins by considering the important point that in *Haringey LBC* as well as the *Rep v Miriam Nyeko's* cases, what took place is a reverse of conventional medical tourism where a patient travels from a developing country to a developed country in search of medical care. In the Haringey LBC case for example, Mrs E[104] travelled from United Kingdom to Kenya to obtain gynaecological and obstetrics care that she felt was more closely suited with her cultural and religious sensitivities.[105] It concludes by considering whether there is a basis for state intervention to protect involuntary childless women who embark on such medical tourism expeditions that could potentially expose them to significant harm as depicted in the Haringey LBC case.

ESHRE[106] states that among the key reasons why patients seek reproductive treatment in other countries are:

> (1) unavailability of treatment in the home country due to costs (2) national regulations that prohibit treatment because of religious, ethical or legal reasons (3) unavailability of a service because of unknown risks and the adoption of precautionary measures adopted by

[101] ESHRE researchers have chosen to replace the terminology reproductive tourism with a neutral descriptor "cross border reproductive care." See F Shenfield et al *ESHRE Taskforce on Cross Border Reproductive Care: Cross Border Reproductive Care in Six European Countries* (2010) 25 Human Reproduction 1361-68.

[102] Above n 1, paragraphs 35 to 37 and 44.

[103] J S Mill *On Liberty* (Indianapolis: Hackett Pub Co 1978, Original 1859).

[104] The same applies to Miriam Nyeko in *Rep v Miriam Nyeko* and others, see above n 19.

[105] See her evidence before the High Court in paragraph 35 of the court's judgment, n 1 above.

[106] G Pennings et al "ESHRE Taskforce on Ethics and Law 15: Cross-border Reproductive Care" (2008) 23 *Human Reproduction* at 2182.

> the state in this regard (4) prohibition of services to a group of people because of marital status, age or sexual orientation (5)Poor quality medical care and low ART success rates in the home state (6) Lack of medical privacy or confidentiality in the home state (7) lack of expertise and equipment and (8) unavailability due to supply shortages.[107]

Costs and law restrictions are the most cited reasons out of those identified above for patients' decisions to seek cross border reproductive care.[108] Yet for some patients as we see in the *Haringey LBC case*, the main reason for seeking cross border reproductive care is based on what has been described as 'religious resistance'.[109] The treatment seeking behaviour of Mrs E and other female members of the Gilbert Deya ministry supports this point that cost and law restrictions may not always be the primary causes for seeking cross border reproductive care. Rather patients may undertake cross border reproductive health care activity to seek health care that is provided to them in a religious and culturally sensitive manner. However, it is important to point out that women like Mrs E in the Haringey LBC case were not involved in the pure form of religious resistance as envisaged above,[110] since they were not so much resisting religious restrictions that prohibited them from realising their reproductive plan, but rather that they were seeking for health care services that took into account their religious or cultural values.

For instance, Mrs E in her evidence in the *Haringey LBC* case explained that she travelled to Kenya to obtain confirmation of her 'miraculous pregnancy' when UK health care facilities failed to provide her with the diagnosis that she was seeking for.[111] As stated elsewhere, the evidence before the court pointed to the fact that what she had probably experienced was an episode of pseudocyesis.[112] Evidently, a medical analysis of pseudocyesis is outside the remit of this article, but the starting point to demonstrate to a patient that she may be experiencing an episode of pseudocyesis is to have her

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[107] Ibid, Penning's; See also above n 101, F Shenfield et al (2010) at 1367.

[108] Ibid, Shenfield at 1367. The study flags law restrictions as the patients' key reason for seeking cross border care; see also Marcia Irhorn " Globalization and Gametes: Reproductive 'Tourism,' Islamic Bioethics, and Middle Eastern Modernity" 2011 transitions to modern colloquium, Department of Sociology, Yale University, unpublished paper at p 11. This paper has been recently published as M Irhorn "Globalization and Gametes: Reproductive 'Tourism,' Islamic Bioethics, and Middle Eastern Modernity" (2011) 18(1) *Anthropology and Medicine* 87-103.

[109] Ibid, Irhorn at p 12 unpublished paper.

[110] Ibid.

[111] Above see n 1, paragraphs 33 to 35 of the court judgment.

[112] Ibid at paragraph 63.

undergo ultra-scanning as well as other medical tests. Mrs E obviously went through this process but refused to accept the medical diagnosis performed in the UK. This resulted in her choosing to seek medical treatment in another country which she believed would cater for her religious and cultural values. Even when she was asked to undergo psychiatric assessment during the course of the judicial proceedings, Mrs E declined to submit to this assessment.[113]

While this commentary does not argue for health care providers to provide patients with false hopes of a desired pregnancy, it does query whether the cultural or religious factors that guide the treatment seeking behaviour of infertile patients of ethnic minority descent is fully or properly understood. [114] This is explored in the light of the High Court's recommendation which was based on expert testimony that the culturally appropriate assessment of the wider context of the case should include a psychiatric assessment of Mrs E Understandably, to be able to effectively treat pseudocyesis, some form of psychiatric evaluation[115] may be necessary and it may therefore be argued that the High Court was right to recommend that Mrs E undergo psychiatric assessment. But this commentary will suggest that a recommendation for such evaluation should have been contextualised within the proper understanding of how some people from religious-cultural backgrounds may respond to mental health care services.[116]

Further, as expounded in earlier parts of this commentary, any proposal for a psychiatric evaluation to determine whether women like Mrs E are suffering from episodes of pseudocyesis must seek to understand the social stigmatisation of involuntary childlessness in certain communities and how

[113] Ibid.

[114] See generally works like S Dyer et al "Men Leave Me Alone as I Cannot have Children: Women's Experiences with Involuntarily Childlessness" (2002) 17(6) *Human Reproduction* at 1663 and 1667, which states that "central to the delivery of effective infertility care is an understanding of the experiences and implications of involuntary childlessness and of the religious and cultural context in which these experiences occur."

[115] However, it has been note that in developing Asian and African countries, that this condition is also handled by obstetricians and gynaecologists. See S Upadhyay "Pseudocyesis: Case report" (2008) 47(151) *Journal of Nepal Medical Association* at 147 and 149; See also P Ibekwe, J Achor (2008) 50(2) "Psychosocial and Cultural Aspects of Pseudocyesis" 50(2) *Indian Journal of Psychiatry* at 114 and 115.

[116] See M Cinnirella, K Loewenthal "Religious and Ethnic Group Influences on Beliefs about Mental Illness: A Qualitative Interview Study" (1999) 72 *British Journal of Medical Psychology* at 505 and 513 which highlights some beliefs that some religious-cultural communities may have about health professionals and that ethnic and religious matching of patients with therapist is a central part in the "formulation of culturally sensitive mental health service provision."

this may trigger off episodes of pseudocyesis.[117] Without this proper socio-cultural understanding, women such as Mrs E may not be offered the appropriate *culturally sensitive care*[118] and the treatment they require to help them rise above this traumatic medical condition. Where this level of health care is not provided, it is inevitable that women like Mrs E would exercise their reproductive treatment autonomy in favour of cross border health care services that take into cognisance the socio-cultural significance of their involuntary childlessness and their desperate quest to experience biological motherhood at any cost. While reproductive autonomy and choice would permit them to embark on such cross border reproductive care expeditions, there is the real and potential danger that they may face attendant risks of gender related violence and harm arising from unsafe or poor health care services as was the situation in the *Haringey LBC* case.

This leads to the final argument on whether the State (without risking charges of paternalism)[119] can and should intervene to protect women like Mrs E from harm that has arisen out of their autonomous treatment seeking decisions?[120] If as Mill[121] and more recent works[122] have argued that *limiting liberty can only be justified to prevent harm to other people and not to prevent self-harm*[123] then why should the state intervene to prevent and punish gender based violence arising from an adult's decision to exercise autonomy and choice in her treatment seeking behaviour?

If it is accepted that the strict application of the harm principle as enunciated by Mill plays a role in limiting[124] paternalistic state intervention, then it is arguable whether there is a basis for seeking state intervention in cases where women such as Mrs E in the *Haringey LBC* case have chosen to subject themselves to treatment that put them in harm's way. As such it could

[117] See Upadhyay and P Ibekwe and J Achor respectively, above n 115.
[118] See S Dyer, n 114 above and M Cinnirella, n 116 above.
[119] P Suber, Essay on Paternalism available from: http://www.earlham.edu/~peters/writing/paternal.htm (accessed August 15, 2011). Original essay published as P Suber, *Paternalism* in C Bray (ed) Philosophy of Law: An Enclycopedia (New York: Garland Pub. Co, 1999) II, 632-635
[120] J S Mill, n 103 above .
[121] Ibid.
[122] P Suber, at 1, above n 119; see also generally J Fienberg *The Moral Limits of the Criminal Law* (Oxford: Oxford University Press, 1984-1988) Volumes 1-IV.
[123] Ibid.
[124] See P. Suber at 1, above n 119.

be argued that the harm principle would allow for "unrestricted self- regarding autonomous behaviour irrespective of personal consequences".[125]

However, there is strong argument that the harm principle will permit a role for paternalistic regulation where the decision that creates self-harm is "compromised by ignorance, deception, duress or clouded faculties."[126] In this regard, the High Court's findings that Mrs E had been a victim of deception[127] may justify some basis to argue for regulatory intervention even where the harm has arisen due to individual autonomy. This is because it is doubtful from the evidence[128] available if Mrs E exhibited the necessary self- regarding autonomous behaviour or granted valid voluntary consent to the sham clinic that subjected her to the specie of harm (the assault) so vividly described in the High Court decision. Likewise, it can be argued that the possibility that Mrs E had experienced episodes of pseudocyesis[129] could have further clouded her decision making process to seek treatment in the Kenyan clinic. This is because the symptoms of pseudocyesis which mimicked pregnancy symptoms provided her with some proof and false hope that she was pregnant and had experienced a live child birth at the Kenyan clinic.

While there would always be valid concerns on how far we should allow paternalism in the guise of justified regulatory intervention[130] to get in the way of hard fought liberties like reproductive autonomy and choice, it is hard to dismiss the role of regulatory intervention in safeguarding the protection of infertile women from gender based harm as depicted in the *Haringey LBC* decision.

Further, there is a benefit for such regulatory intervention to strengthen the reproductive health care rights of infertile women, particularly those whose reproductive treatment seeking behaviour is influenced not only by health considerations, but by a desperate need to overcome the deleterious socio-cultural consequences of infertility. To do this will give some support to the argument that there is some positive value of paternalistic intervention if it fosters the "process of speaking for others in the course of defining needs." [131]

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[125] R Hull "Involuntary Commitment and Treatment of Persons Diagnosed as Mentally Ill" in J Humber and R Almeder (eds) *Biomedical Ethics Review* 1983 (New Jersey: Humana Press, 1983) 131 at 138.

[126] P Suber, above n 115, at 2.

[127] See above n 1, paragraph 75 of the court judgment.

[128] See above n 1 above, paragraphs 47 and 48 of the court judgment. The court found that she had been injected with a substance and could not see or feel all of what was happening to her.

[129] Above n 1 at paragraph 63.

[130] P Suber, above n 119.

[131] J White *Democracy, Justice, and the Welfare State: Reconstructing Public Care* (Pennsylvania State University Press, 2000) at 123.

Construed this way, regulatory intervention can be seen not as limiting the rights and freedoms of patients but rather as requiring states to comply with the international legal framework[132] on providing safe health care services for involuntarily childless women particularly in the developing world. The call for regulatory intervention would also require that states proactively redress, where detected, any acts of gender based violence that arise when infertile women embark on cross border reproductive health expeditions akin to that undertaken by Mrs E in the *Haringey LBC* case discussed above. It is argued that the positive benefits of such state intervention far outweighs any libertarian concerns on the potential stifling of individual autonomy since the regulatory object is to protect vulnerable involuntary childless women who due to their socio-cultural circumstances are desperate to achieve pregnancy at any cost.

CONCLUSION

This article has provided a discussion on the gender and reproductive health care rights issues embedded in the *Haringey LBC* High Court decision. The key focus has been to consider whether there is binding state obligation to prevent and redress gender based violence under relevant international human rights instruments. While this article acknowledges that there is some measure of uncertainty on whether there is a clear customary obligation requiring binding state responsibility for gender based violence under international law, it reaffirms the position that there is sufficient basis to support the fact that there is an emerging crystallisation of the rule particularly in the European region where the *Haringey LBC* case was adjudicated. It therefore recommends for more proactive state action in combating gender violence and other harm suffered by women.

It recommends that states (and their relevant organs such as health care providers and the courts that adjudicate on matters relating to family life) should develop a greater appreciation of the socio-cultural consequences of involuntary childlessness particularly when it affects women of African descent. This would help them to develop appropriate regulatory responses that protect and safeguard the rights of women like Mrs E who through their treatment seeking choices are exposed to harmful activities including gender based violence. It is argued that notwithstanding the libertarian harm principle which censures state intervention for consequences arising from self regarding autonomous behaviour, there is a justifiable case to seek state intervention to protect women like Mrs E affected by deleterious socio-cultural consequences of involuntary childlessness. This is necessary when regard is given to the

[132] See R Coomaraswamy at paragraphs 77 and 78, above n 95.

peculiar nature of facts presented in the *Haringey LBC* case which creates some reservations on whether the treatment seeking choices of women like Mrs E can ever be considered as truly self regarding and autonomous.

Beyond an academic appraisal of the *Haringey LBC* decision, this article has a policy reformatory goal as its primary objective. It seeks to highlight the missed opportunities to redress acts of gender based violence and other harm arising from the facts that led to the *Haringey LBC* case and other related judicial proceedings. The article is written in the hope that the continuing state action on child trafficking issues arising from the Gilbert Deya judicial proceedings would finally take into cognisance the need for equivalent state action in tackling the shrouded but extremely important gender and reproductive issues that are embedded in these proceedings.