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Health, Human Rights, and Violence Against Women and Girls: Broadly Redefining Affirmative State Duties After Opuz v. Turkey

By CHERYL HANNA*

As international lawyers, I believe we are called upon to give normative content to these general statements of the ‘right to health’ by elaboration and by specification. Most of us are more accustomed to the concept of the right to access to health care, rather than the right to health.... Applying this criterion of equality in health status to the right to health, we can only conclude that there are serious failures in the provision of equal health status to all the populations of the world. We have failed to provide equal health status for various categories of persons in both developed and developing countries.... We in the developed and developing countries have to reorder our priorities on issues of health. That means that there are a great many things we can do that do not depend on cure but on prevention.

— Virginia Leary

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I. Introduction

In 1988, Professor Virginia Leary called upon lawyers to articulate that the right to health was a basic human right. She referenced the definition of World Health Organization Constitution, suggesting that everyone has the right to the highest obtainable standard of physical and mental health regardless of race, religion, political belief, economic or social condition. She then called on states to affirmatively prevent human suffering that was within their control. Nearly a quarter century later, we find ourselves still struggling to fulfill her appeal. In this article, originally presented at Health as a Human Right: The Global Option, a symposium sponsored by the Hastings International & Comparative Law Review, I humbly try to carry on Professor Leary's work by specifically elaborating on what the "right to health" means in the context of physical and sexual violence against women and girls.

To that end, this paper makes two assertions. First, while there has been tremendous progress in our understanding of how male violence against women and girls undermines gender equality and impacts their right to autonomy and full citizenship, the most fundamental and basic consequence of such violence—physical and mental injury—is often overlooked. Both legal scholarship and arguments justifying affirmative state intervention to end privately imposed violence often fail to address these injuries. Yet, gender-based violence is one of the most widespread public health problems in the world. Therefore, the right to health ought to be included

2. Id. at 122.
3. See, e.g., id. at 124 ("For example, decreasing tobacco intake, changing our food standards, wearing helmets when we are riding motorcycles are environmental changes that emphasize prevention rather than cure. And we can undertake these changes without great economic development in the country.").
4. This fact became particularly evident to me as a co-author of one of the leading American casebooks on violence against women. In the first edition, written in 2000, there was almost no discussion of the consequences of gendered violence on female health. In the second edition, in 2008, we added a chapter on the relationship between domestic violence and reproductive and sexual health. It was not until 2010, in preparation for our third edition, had there been sufficient development in the field to expand that chapter to include the relationship between gendered violence and health is general. See generally ELIZABETH M. SCHNEIDER, CHERYL HANNA, JUDITH G. GREENBERG & CLARE DALTON, DOMESTIC VIOLENCE AND THE LAW: THEORY AND PRACTICE (Foundation Press, 2nd ed. 2008).
within legal arguments justifying affirmative state duties to intervene into private relationships. By expanding our understanding of human rights and affirmative state duties to include explicit concerns about female health, we provide a more complete articulation of a rights-based approach to elimination of gendered violence, thereby honoring principles of equality within a broader human rights framework. This first assertion is hardly controversial and merely bears witness to the already extensive empirical research that documents how male violence compromises the physical, sexual, and mental health of women and girls.

In contrast to my first assertion, my second assertion is likely to provoke some debate. While few would question that states have an affirmative duty to implement policies geared at ending male violence against females, many would question whether such policies should include mandated interventions that are contrary to a woman’s choice to preference her privacy over her health or safety. It is here where two human rights – the right to health and the right to family autonomy and privacy – seemingly conflict. Of course, this conflict is hardly one of first impression, advocates for abused women have been debating where this line ought to be drawn for nearly two decades just as health advocates have struggled with the question of when mandatory public health interventions should yield to privacy concerns. To a great extent, there are no easy answers to this question.

Yet, *Opuz v. Turkey*, recently decided by the European Court of

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7. See Leary, *supra* note 1, at 130 (“The person’s right to privacy can be infringed if information about HIV test results or the fact that testing was sought or required is disclosed without the person’s authorization or without a clear public health benefit. Human rights are best respected by using the least restrictive, least intrusive measures available to accomplish specific public health objectives.”).

Human Rights, articulates a clear and simple standard to guide state actors in deciding whether mandatory interventions into specific relationships promote or compromise human rights. When assessing whether a nation has violated its duties under the European Convention for the Protection of Human Rights and Fundamental Freedoms ("European Convention"), the Court required states to intervene if authorities knew or should have known there was a risk to the life of an individual by a third party. The Court created a list of factors to use when assessing the State’s actions that uniquely apply to private violence perpetrated by intimate partners, including the nature of the victim’s injuries and the continuing threat to her health and safety. Here, the Court specifically articulates how the preservation of health requires positive state intervention, even if it arguably comprises another human rights principle. This articulation shows the Court’s willingness to err on the side of ensuring physical and mental integrity rather than the more conceptually amorphous concept of privacy.

It is my assertion that states, including the United States and state and local officials, should adopt the standard set forth in Opuz when resolving the conflict between the right to health and the right to privacy in the context of intimate violence. Thus, as a practical matter, in individual cases the State must proceed with positive intervention regardless of whether the victim implicitly or explicitly requests otherwise. This approach, which is hardly radical, leaves significant discretion to state decision-makers over the appropriateness of positive state intervention in individual cases and thereby requires a case-by-case analysis that takes into account the victim’s health, along with other concerns.

This is precisely the kind of specific articulation of the right to health that Professor Leary urged a quarter of a century ago. By adopting the Opuz approach, states give life to the right to health by implementing affirmative policies that consider an individual’s physical and mental state while delicately balancing other concerns. The Opuz approach also incorporates the principle of equality within the right to health that Professor Leary urges by recognizing that women and girls have physically and mentally suffered because of state indifference, if not state perpetuation, of gendered violence.

9. Id.
10. Id. ¶ 138.
Finally, by requiring positive state intervention when there is a serious future risk to health, the Opuz approach is one of prevention. We may never be able to cure those men who perpetuate physical and sexual violence against women, but we can prevent them from doing future harm by limiting access to their victims. The only way to do that in many cases is for the State to intervene by assuming control over the offender. While that may make many uncomfortable in light of concerns over privacy and autonomy, such an approach is necessary if we are to take the right to health for women and girls seriously.

II. Bearing Witness to the Consequences of Male Violence on Female Health

In bearing witness to the impact of intimate partner abuse on women’s health, I begin with two thoughts. First, there is rich and extensive data describing how intimate partner violence results in ill-health, but little discussion on how ill-health affects a woman’s legal status and participation in legal processes. Thus, legal scholars have an enormous opportunity, as well as a responsibility, to more accurately understand the relationship between ill-health, social and economic conditions, and the law. Second, and perhaps more importantly, all of the available data suggests that intimate partner violence is among the greatest preventable health risks that women and girls face. State indifference or inaction to curb such abuse is therefore unconscionable. This is precisely the kind of failure in the equal provisions for health status that Professor Leary cautioned against. Yet, rather than interpret a lack of progress cynically, we should view it optimistically by recognizing the potential that exists for improving the health of women and girls by implementing policies aimed at ending gendered violence.

There have been numerous reports, both domestic and international, documenting the health consequences of male violence against females. Among the most comprehensive is the 2005 World Health Organization’s (WHO) Multi-country Study on Women’s Health and Domestic Violence Against Women.11 The study analyzed data collected from over 24,000 women, representing diverse cultural, geographical and urban/rural settings in ten

countries: Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro (at the time a unified state), Thailand, and the United Republic of Tanzania. The emphasis of the study was on violence perpetrated by intimate partners. Below are its key findings:

Physical health:

In the majority of settings, women who had ever experienced partner violence were significantly more likely to report poor or very poor health than women who had never experienced partner violence. Ever-abused women were also more likely to have had problems walking and carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge in the four weeks prior to the interview. An association between recent ill-health and lifetime experience of violence suggests that the physical effects of violence may last a long time after the actual violence has ended, or that violence over time may have a cumulative effect.

Mental health and suicide:

In all settings, women who had ever experienced physical or sexual violence, or both, by an intimate partner reported significantly higher levels of emotional distress and were more likely to have thought of suicide, and to have attempted suicide, than women who had never experienced partner violence.

Reproductive health and violence during pregnancy:

In the majority of settings, ever-pregnant women who had experienced partner physical or sexual violence, or both were significantly more likely to report having had at least one induced abortion than women who had never experienced partner violence. Similar patterns were found for miscarriage, but the strength of the association was less. . . . Between one quarter and one half of women physically abused in pregnancy were kicked or punched in the abdomen. In all sites, over 90% were abused by the biological father of the child the woman was carrying. The majority of those beaten during pregnancy had experienced physical violence before. . . .

This study confirms what other studies found: victims of intimate

13. Id. at xv.
14. Id.
15. Id.
partner abuse suffer ill-health effects at a greater rate than non-victims.16

The World Bank estimates that one to five years of life are lost in women ages fifteen to forty-four through death or disability resulting from domestic violence.17 That is “more than [are lost] to breast cancer, cervical cancer, obstructed labor, heart disease, AIDS, respiratory infections, motor vehicle accidents or war.”18 Women and girls suffer a range of injuries at the hands of violent men: bruises, cuts, scrapes, sprains, burns, broken teeth and bones, dislocations,
internal injuries, wounds from knives or guns, loss of sight, hearing, smell, taste, and touch, and permanent disfigurement or brain damage.\textsuperscript{19} They also suffer from higher rates of drug and alcohol addiction.\textsuperscript{20} In addition, reproductive health consequences as a result of sexual abuse include HIV and other sexually transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain, and urinary tract infections.\textsuperscript{21} Unintended pregnancies, miscarriages, and induced abortions are also experienced at higher rates for abused females when compared to non-abused females.\textsuperscript{22}

While the WHO study examines physical, mental, and reproductive health consequences of intimate partner violence, the legal literature in the U.S. on the effects of abuse has tended to emphasize the mental health consequences of violence. This is in part because a victim's mental state is often a central question in various legal contexts, such as the concept of "self-defense," when women kill their abusers. Further, the public is obsessed with the question of why women do not leave abusive relationships; ill mental health is an easy, albeit grossly inadequate and usually patently wrong answer.

I do not mean to suggest that women and girls do not suffer significant mental injury when they are abused. Indeed, as one woman from Serbia and Montenegro said in the WHO study, "[e]motional abuse is worse. You can become insane when you are constantly humiliated and told that you are worthless, that you are nothing."\textsuperscript{23} Yet, the unintended consequence of the focus on mental health has been to over-pathologize women and girls by attributing their otherwise rational behavior to things like "battered women syndrome" and to under-appreciate the relevance of poor physical


\textsuperscript{20} See Evan Stark, \textit{Nicholson v. Williams Revisited: When Good People Do Bad Things}, 82 DENV. U. L. REV. 691, 711 (2005) (indicating that battered women are more likely to abuse drugs and alcohol, have a psychotic break, report depression or attempt suicide); see also Kelsey S. Barnes, \textit{The Economics of Violence: Why Freedom from Domestic Violence Must Be Treated as a Developmental Right in International Law}, 6 U. MIAMI Y.B. INT'L L. 97, 120 (1997) (revealing that victims of domestic abuse are fifteen and nine times more likely to abuse alcohol and drugs, respectively, than women who are not abused).

\textsuperscript{21} GARCÍA-MORENO ET AL., \textit{supra} note 11, at 101-02.

\textsuperscript{22} Id.

\textsuperscript{23} WHO, \textit{supra} note 16, at 9.
and reproductive health to the choices and behaviors of victims.

To the extent that the law does focus on physical health, its tendency is to locate a specific injury as the basis for legal intervention. It is the black eye or the broken arm that serves as the basis for granting a restraining order or initiating prosecution. Yet, according to the WHO’s Report on Health and Violence, for example, “[i]njury . . . is not the most common physical outcome of partner abuse. More common are ‘functional disorders’ – a host of ailments that frequently have no identifiable medical cause, such as irritable bowel syndrome, fibromyalgia, gastrointestinal disorders and various chronic pain syndromes. Studies consistently link such disorders with a history of physical or sexual abuse.”

We know very little as to how ailments such as chronic pain or digestive disorders can hinder a victim’s ability to meaningfully participate in legal processes, including her ability to attend court, communicate effectively with legal counsel, and request appropriate remedies. We fail to fully appreciate how to compensate victims for these long-term ailments, or how such conditions may affect a woman’s ability to parent or work.

We do know that there is a direct relationship between ill-health and the ability of women and girls to support themselves and their families. According to the WHO, “[w]omen who have been abused also experience reduced physical functioning, more physical symptoms and a greater number of days in bed than non-abused women.” This observation is consistent with other studies that document that ill-health suffered by abused women and girls reduce their ability to participate in the economy and realize economic independence.

24. Id. at 102.
25. Id.
26. See John E. Matejkovic, Which Suit Would You Like? The Employer’s Dilemma in Dealing with Domestic Violence, 33 CAP. U.L. REV. 309, 311 (2004) (asserting that one-quarter to one-half of female victims lose their jobs due to domestic violence); Jennifer M. Gaines, Comment, Employer Liability for Domestic Violence in the Workplace: Are Employers Walking a Tightrope Without a Safety Net?, 31 TEX. TECH L. REV. 139, 143 (2000) (noting that domestic violence decreases productivity in the workplace and increases costs to employers); Sushma Kapoor, Domestic Violence Against Women and Girls, INNOCENTI DIG. NO. 6, 13 (June 2000), available at http://unicef-icdc.org/publications/pdf/digest6e.pdf (illustrating that domestic violence has caused a reported thirty percent of abused women to lose their jobs in the U.S. and that in Chile, abused women earn less than one-half in average wages compared to those women who do not suffer from violence at home).
Thus, in looking at the issue of violence and health, I am struck with the sense that we legal scholars have been missing something. While our medical colleagues have done tremendous work in documenting the health effects of partner violence, to a large extent, legal scholars have been unsure exactly how physical and reproductive health, in particular, ought to factor into law. But, if we start with the premise that the right to health, as defined in Professor Leary’s remarks, is a basic human right, then we can begin to understand how including health in our arguments about affirmative state duties to end gendered violence can provide another perspective and another tool to persuade the powers that be to prioritize eliminating gendered violence.

III. Opuz v. Turkey: Giving Meaning to the Right to Health

I start with the premise that states should have an affirmative obligation to implement policies, procedures, and programs that address gendered violence. Every major international human rights instrument, beginning with the United Nations Charter, prohibits discrimination on the basis of sex, and every major human rights instrument ratified after the Charter guarantees the right to equality before the law.27 The International Covenant on Civil and Political Rights,28 the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),29 the U.N. Declaration on the Elimination of Violence Against Women,30 and the Convention Against Torture and Other Cruel, Inhuman or Degrading


28. See International Covenant on Civil and Political Rights, Dec. 16, 1966, 1057 U.N.T.S. 407 (for reiteration of the U.N.’s goal of achieving equal rights without distinctions of race, sex, religion, etc.).


Treatment or Punishment are among the many human rights documents that support affirmative state duties to end gendered violence.

In addition, many of these documents also include the right to health. For example, the Universal Declaration of Human Rights includes “the right to a standard of living adequate for ... health and well-being.” The International Covenant on Economic, Social and Cultural Rights requires states to uphold “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The Constitution of the WHO says that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction as to race, religion, political belief, economic or social condition.

While some countries, including the U.S., have not formally ratified documents like CEDAW and have refused to recognize affirmative state obligations to intervene to protect women and children from private violence, there is no disagreement among legal scholars that states should undertake positive action, even if not bound to do so by domestic or international law. No informed legal scholar or advocate of good will would deny that all states should, as the WHO recommends, “[e]stablish, implement and monitor action plans to address violence against women, including violence by intimate partners.” In other words, there is no legitimate argument to be made that violence against women perpetrated in private settings like the home, is immune from public responses. Furthermore, there is little disagreement that at the policy level, states at the very least should have policies and programs geared at prevention, that they should monitor violence against women, and that they should provide individual redress of private violence through the judicial system. While there are policy questions over


35. GARCÍA-MORENO ET AL., supra note 11, at xvii.
which exact policies and procedures may be most effective in various contexts, international norms firmly dictate against state inaction. Furthermore, there is little disagreement among scholars and advocates that when a victim requests assistance from the State to preserve her health, safety, and welfare from a violent partner, that there ought to be some reasonable response. Exactly what that intervention should actually be is subject to reasonable debate, such as whether arrest policies should be mandatory or discretionary.

The much harder question is what to do when the State has knowledge that a woman's right to health and right to equality are being compromised but the woman herself does not want state intervention — perhaps because she is fearful of the abuser or fearful of the consequences, or because she simply distrusts the State. Nevertheless, the woman either implicitly or explicitly expresses that she does not welcome the state intervention that is available to her. It is this question that is most difficult for both theorists and practitioners to answer. That is especially true in the context of criminal intervention, but is central to other issues such as mandatory reporting by medical professionals and issuing of mandatory stay-away orders. Therefore, the simple question is this: Under what conditions should the State preference the right to health and equality over the right of privacy and autonomy?

This was precisely the question presented in the case of Opuz v. Turkey, recently decided by the European Court of Human Rights (ECHR). In Opuz, the ECHR found Turkey to be in violation of its obligations to protect women from domestic violence, and for the first time held that gender-based violence is a form of discrimination under the European Convention. This is the first time this particular court has elaborated on the nature of state obligations with respect to violence in the family and held domestic violence to be an issue of public interest that demands effective state action. Thus, while the case has only precedential application to those countries that are signatories to the European Convention, it has enormous intellectual value to any local, state, or national jurisdiction that has inevitably struggled with the question of when state intervention ought to be mandatory.

The applicant, Nahide Opuz, claimed that Turkey had failed to

protect her and her mother from Nahide’s husband. At least seven times, Nahide and her mother filed assault and death threat reports with the authorities, citing grievous injuries that included severe beatings and even stabbings. In a particularly horrifying incident, Nahide’s husband hit both her and her mother with a car while they were walking on the sidewalk. These injuries rendered Nahide and her mother unable to work for weeks at a time. The violence perpetrated by Nahide’s husband was significant, severe, and unyielding.

However, while Nahide and her mother often withdrew their complaints after reporting the violence to the authorities, on other occasions, the court dismissed cases for lack of evidence. Thus, Turkey did little to gain control over Nahide’s husband. Finally, while in the process of moving her daughter away, Nahide’s husband shot her mother who died instantly. Although convicted of murder, his sentence was reduced to fifteen years. The court reasoned that Nahide’s mother had provoked Nahide’s husband by leading Nahide into an immoral life, and he shot her trying to defend his honor and children.

Nahide alleged that Turkey’s actions and inactions violated three articles of the European Convention: the Right to Life under Article 2; the Right to be Free from Torture under Article 3; and the Right to be Free from Gender Discrimination under Article 14. The basis of her argument was “that domestic violence was tolerated by the authorities and society and that the perpetrators of domestic violence enjoyed impunity.”

The government of Turkey denied these claims, and instead submitted that Nahide and her mother had contributed to the immunity enjoyed by Nahide’s husband because they had withdrawn the complaints. Because “the criminal acts in question had not resulted in sickness or unfitness for work for ten days or more,” under Turkey’s criminal code, Turkey was dependent on the complaining

37. Id. ¶ 23.
38. Id. ¶ 25.
39. Id. ¶ 12.
40. Id. ¶ 54.
41. Id. ¶¶ 56-57.
42. Id. ¶ 119.
43. Id. ¶¶ 122-23.
witness to proceed.\textsuperscript{44} Turkey claimed that there was no evidence that Nahide’s husband had exerted pressure on Nahide or her mother to withdraw the complaints.\textsuperscript{45} And, perhaps most importantly, Turkey claimed that “the authorities could not be expected to separate the applicant and her husband and convict the latter while they were living together as a family, as this would amount to a breach of their rights under Article 8 of the European Convention.”\textsuperscript{46} Article 8 of the European Convention states that

1. everyone has the right to respect for his private and family life, his home and his correspondence;

2. there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.\textsuperscript{47}

Thus, Turkey’s defense was based on two concepts: privacy, as explicitly articulated in Article 8, and, implicitly, on Nahide’s autonomy, which she asserted freely when she no longer cooperated with the State. The Court rejected Turkey’s defense and instead found that it had violated the three articles of the European Convention.

1. Right to Life

Article 2 of the European Convention states that, “[e]veryone’s right to life shall be protected by law.”\textsuperscript{48} The Court determined that under this article nations are “not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction[,]” thus establishing an affirmative duty to protect its citizens.\textsuperscript{49} When assessing whether a

\begin{itemize}
\item \textsuperscript{44} Id. \S 123.
\item \textsuperscript{45} Id.
\item \textsuperscript{46} Id.
\item \textsuperscript{48} Id. at art. II.
nation has violated this duty to a citizen, the Court asks whether the
authorities under the State "knew or ought to have known at the time
of the existence of a real and immediate risk to the life of an
identified individual or individuals from the criminal acts of a third
party" and, further, whether the State "failed to take measures within
the scope of [its] powers which, judged reasonably, might have been
expected to avoid that risk."\textsuperscript{50} Importantly, the Court framed this
discussion in the context of domestic violence, recognizing that it
often includes psychological as well as physical abuse, and takes place
in homes often hidden from the public sector. The Court also
recognized that domestic violence is a problem facing all nations, and,
therefore, the right to life in a domestic violence context carries
greater weight than in other contexts.\textsuperscript{51} The Court concluded that
Turkey failed to adequately protect Nahide's mother based both on
laws that could not deter unlawful behavior, as well as the authorities'
failure to use existing laws to prevent the harm.\textsuperscript{52} It is important to
note that this article applied only to Nahide's mother, and not to
Nahide herself, because she had survived Nahide's husband's abuse.

2. Right to Be Free from Torture

Article 3 of the European Convention states that, "[n]o one shall
be subjected to torture or to inhuman or degrading treatment or
punishment." In order for Article 3 to apply, the harm to the victim
must reach a minimum level of severity.\textsuperscript{53} The Court did not quantify
the level of severity; rather, it examined the specific circumstances of
the case to decide if the violence against Nahide and her mother had
reached the level of torture.\textsuperscript{54} The European Convention requires
member states to "ensure that individuals within their jurisdiction are
not subjected to torture or inhuman or degrading treatment or
punishment, including such ill-treatment administered by private
individuals."\textsuperscript{55} Also, the Court emphasized that Article 3 will carry
more weight, or will more likely apply, if the victims are of a
vulnerable class of persons.\textsuperscript{56}

\textsuperscript{50} Id. \textsuperscript{\textsection} 129.
\textsuperscript{51} Id. \textsuperscript{\textsection} 130.
\textsuperscript{52} Id. \textsuperscript{\textsection} 149.
\textsuperscript{53} Id. \textsuperscript{\textsection} 149.
\textsuperscript{54} Id. \textsuperscript{\textsection} 158.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
Nahide fell into the category of a "vulnerable individual" as a repeat victim of domestic violence who felt helpless because of the inadequate protection the State offered. Thus, she was vulnerable not because of some inherent psychological condition, but because her sense of helplessness was rationally based on the State's inaction. The State violated Article 3 not only because it should have recognized Nahide as a vulnerable person given the nature of the crimes, but also because it blamed her for not cooperating or withdrawing her complaints. The Court concluded that Turkey violated Article 3 by failing to protect women from extreme domestic violence, thereby abdicating its duty to its citizens and condoning "torture or inhuman or degrading treatment or punishment."

3. Right to Be Free from Gender Discrimination

Article 14 of the European Convention states that, "[t]he enjoyment of the rights and freedoms set forth in [the] 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." In deciding whether Turkey violated this article of the European Convention, the Court used a similar balancing test as used by the U.S. Supreme Court, allowing discriminating practices only if the State can justify the reason for treating classes differently. Once the party contesting the State's discriminatory action makes a prima facie case, the burden shifts to the government to justify its policy, law, or actions in furtherance of that law or policy. In gender discrimination cases, statistical evidence that women are impacted to a greater degree is generally sufficient to shift the burden to the government.

Translating the right to equal treatment to the context in this case, the Court held that a "[s]tate's failure to protect women against domestic violence breaches their right to equal protection of the law

57. *Id.* ¶ 160.
58. *Id.* ¶ 171.
59. *Id.* ¶ 159.
60. *Id.* ¶ 177.
61. *Id.* ¶¶ 183-91.
62. *Id.* ¶ 183.
63. *Id.*
and that this failure does not need to be intentional." The Court could not point to specific instances where women were classified differently under the law, but rather focused on the general treatment and disposition of the authorities towards women. Turkey could not passively allow domestic violence to occur based on archaic norms that such violence is "a family matter" or needed to express a man's honor. The Court held Turkey violated Article 14 because its laws were inadequate to treat women and men equally, and, more importantly, the special context of domestic violence did not require a woman to exhaust all remedies on her own before the State could take action.

While Opuz has been hailed by international legal scholars as one of the most important decisions to date regarding affirmative duties to end gendered violence, the decision is fairly measured and pragmatic. It draws on prior precedent that had already established that a government is responsible for intervening in cases of private abuse, and is one in a number of cases that has rejected the argument that privacy considerations should override those of bodily harm in private relationships. The decision does not establish any absolutist position, but rather takes a far more measured approach, giving a great deal of discretion to state officials to decide when intervention is warranted by holding that "the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities."

64. Id. ¶ 191.
65. Id. ¶¶ 192-98.
66. Id. ¶ 195.
67. Id. ¶¶ 114-17.
69. In particular, the Court relied upon Kontrova v. Slovakia, App. No. 7510/04, Eur. Ct. H.R. ¶ 49 (2007) (holding that right to life also "extends in appropriate circumstances to a positive obligation on the authorities to take preventative operational measures to protect an individual whose life is at risk from the criminal acts of another individual").
question of whether the authorities did all that could be reasonably expected once they knew or should have known of the real and immediate threat to life "can only be answered in the light of all the circumstances of any particular case." The Court thereby prefers a pragmatic approach to any political or theoretical concerns about victim privacy or autonomy.

Of particular usefulness, the Court set forth a list of factors that authorities should consider in deciding to pursue a prosecution when faced with a victim’s withdrawn complaint:

- The seriousness of the offense
- Whether the victim’s injuries are physical or psychological
- If the defendant used a weapon
- If the defendant has made any threats since the attack
- If the defendant planned the attack
- The effect (including psychological) on any children living in the household
- The chances of the defendant offending again
- The continuing threat to the health and safety of the victim or anyone else who was, or could become, involved
- The current state of the victim’s relationship with the defendant
- The effect on that relationship of continuing with the prosecution against the victim’s wishes
- The history of the relationship, particularly if there had been any other violence in the past and
- The defendant’s criminal history, particularly any previous violence

The Court concluded: "It can be inferred from this practice that the more serious the offence or the greater the risk of further offences, the more likely that the prosecution should continue in the public interest, even if victims withdraw their complaints." This list provides an excellent starting point for training decision-makers on the dynamics of abuse and how to access risks on a case-by-case basis.

One criticism of Opuz is that the decision does not go far enough in setting forth more objective criteria by which to assess whether

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72. *Id.* ¶130.
73. *Id.* ¶138.
74. *Id.* ¶139.
state intervention is mandated. One of the problems with the "Opuz test," as it were, is that it does not include other risk factors for intimate partner homicide such as forced sex, extreme jealousy, and the use of drugs and alcohol.\(^75\) The National Institute of Justice, for example, has developed an assessment tool based on a review of women who were killed by their intimate partners.\(^6\) It lists fifteen factors, and found that women who score eight or higher have a very grave risk of being murdered.\(^77\) Yet, it also notes that the assessment is only a guide, not a predictive tool.\(^78\) It also found that almost half of the women studied did not recognize their high level of risk.\(^79\)

Thus, while Opuz provides a useful starting point for framing the affirmative duty to undertake a risk assessment in all cases made known to state authorities, as a practical matter state authorities should seek out richer and more sophisticated data on how to evaluate cases.

Finally, the facts of Opuz are "bad" facts in that the violence was extreme, ongoing, and well-known to the authorities. It involved two women who suffered severe and documented physical injury, and one of them was killed. Because these facts are so bad, it would have been almost unthinkable for the Court to have found that state authorities were innocent actors. But many domestic violence cases that end in serious injury or death have not had such a "bad" history. To that extent, one concern is that state authorities will only undertake intervention in the most extreme cases using the bad facts of Opuz as a guide, and may continue policies of nonintervention in cases that are distinguishable.

III. Opuz and Health as a Human Right

There are three notable aspects of the Opuz decision relative to the conversation about health as a human right. First, and most glaringly, the European Convention itself does not include any right to health, in contrast to the other human rights documents discussed above. The Court relied on Article 2's Right to Life and Article 3's

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76. Id.
77. Id. at 16.
78. Id.
79. Id.
Right to be Free from Torture or Humane or Degrading Treatment as providing the context for the injuries both of the women suffered. But, because there was no specific claim to the right to health, the physical harms suffered by both victims, while detailed in the Court's opinion, serve as a weak basis for finding that Turkey should have done more to prevent their physical and psychological harms. Thus, because of the lack of language in the European Convention as to health, the Court was hampered in addressing a state's positive obligation to ensure not just the life of its citizens, but their health as well. In some respects, it is almost absurd that the Court had to look to Article 3's ban on torture to find that Turkey had violated Nahide's human rights. Because she survived the attacks Nahide had no specific claim under Article 2's Right to Life. Thus, Opuz highlights why an explicit right to health ought to be a necessary inclusion in all human rights documents in order to address the real harms suffered by citizens at the hands of intimate partners. The inclusion of the right to health may not have changed the outcome of the decision, but it would have provided the Court with a far more honest and accurate assessment of the harms that were suffered by both women.

Second, despite any explicit discussion of the right to health, the Court nevertheless incorporates an affirmative state obligation to at least consider a victim's health and threats to a victim's health and safety when deciding whether it should proceed against as abuser. What is critical about this is that the Court articulates that health is a critical consideration even if the European Convention does not specifically provide for such. Therefore, even if states have no specific obligation to ensure a citizen's health, in the context of domestic violence, a victim's health, broadly defined as both physical and psychological, should be a central concern.

Opuz implicitly requires states to train authorities to better assess domestic violence cases. As part of that training, state authorities need to understand and account for the broad range of health consequences discussed in Part I of this article. While bruises and broken bones are easy to identify and document, reproductive health issues, chronic ailments, and certain mental consequences are far harder to detect. In providing guidance on how to identify the range of health issues and their relevance to state intervention, the medical profession can be of enormous help to the law.

Finally, and particularly important relative to the question of the conflict between privacy/autonomy and positive state intervention, the Opuz Court firmly and unequivocally preferences the latter when
there is a risk of serious injury or a long-term threat to health and safety. The Court held that “national authorities’ interference with the private or family life of the individuals might be necessary in order to protect the health and rights of others or to prevent commission of criminal acts.” The seriousness of the risk to the applicant’s mother rendered such intervention by the authorities necessary. Here, the Court rejects any absolutist position and instead requires the state to undertake an affirmative assessment of risks. To that end, doing nothing is never an option for the state once it knows or has reason to know of a serious risk to the physical or mental health of its citizen. It must assess the situation in every case that comes to its attention, and that assessment must be meaningful and include health concerns.

Therefore, while Opuz does not directly create an explicit right to health in the context of gendered violence, it does give life to such a concept by articulating a clear standard of positive state intervention. It also rejects any absolutist position on mandatory intervention by requiring a case-by-case analysis that accounts for a victim’s health as part of an overall assessment as to whether privacy concerns must yield to the state’s obligations to equally and affirmatively protect the lives of its citizens from private violence. Therefore, the importance of Opuz is not just its holding, but its sophisticated and balanced approach to the complicated dynamics of state intervention into otherwise private relationships.

IV. Conclusion

I am confident that Professor Leary would view Opuz as a positive step towards the right to health even though no such specific language is used the opinion. What is most important are the general principles of both bodily integrity and equality embodied in the decision. To that end, Opuz provides a far clearer articulation of a right to health in the context of gendered violence than any case to date. Even if states, like the U.S., refuse to recognize such affirmative state duties, individual jurisdictions can certainly adopt policies that reflect the principles in Opuz when balancing health and privacy.

81. Id. ¶138.
concerns. By recognizing health concerns as part of a broader agenda of ending gendered violence, we come closer to alleviating the human suffering that Professor Leary devoted her life to ending.