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The Istanbul Convention in Practice: Holistic Care for Victims of Sexual Violence

Side event organised by the Permanent Representation of Belgium to the United Nations in Geneva and the Council of Europe

UNECE Beijing +25 Regional Review
Geneva, 29 October 2019

REPORT

The opinions expressed in this report are the responsibility of the authors and do not necessarily reflect the official policy of the Council of Europe or the co-organisers of the Conference.

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The Permanent Mission of Belgium has partnered with the Council of Europe to present some of the measures taken to further the Beijing Declaration and Platform for Action through the Council of Europe's Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention). A particular focus will be placed on how the implementation of the Istanbul Convention tackles sexual violence. Experiences from Belgium and Ukraine will be shared.



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Ambassador Geert Muylle, the Permanent Representative of Belgium to the United Nations in Geneva extended a warm welcome to all in attendance for the side event panel during the UNECE Beijing +25 Regional Review. The Ambassador noted that the Council of Europe's Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) which promotes the protection of women against violence is open for accession by non-member states of the Council of Europe, making it more than a strictly regional instrument. By accepting the Istanbul Convention, governments commit to adapt their current legislative arsenal to introduce practical measures and allocate resources in order to effectively combat sexual violence and domestic violence.

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Dr Marceline Naudi, President of the Independent Group of Experts monitoring the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (GREVIO) thanked Belgium and the Council of Europe for organising the side event at the Beijing +25 UNECE Regional Review. She stated that she would not be talking about the Istanbul Convention in general as she assumed those in attendance already had some understanding of it, but would focus instead on the Istanbul Convention in relation to holistic care for victims of sexual violence.

There are three main Istanbul Convention provisions which relate to sexual violence: Article 36 which deals with the criminalisation of non-consensual sexual acts; Article 25 which deals with support for victims of sexual violence; and Article 16 which deals with the treatment programmes for sex offenders.

Beginning with Article 36, which deals with the criminalisation of non-consensual sexual acts, i.e. rape and sexual abuse, Dr Naudi emphasised that the most important and relevant point for the current presentation was the issue of consent. In considering the holistic care of victims, the first priority should always be the respect afforded to victims and acknowledging their experience of having been violated, even if there was no use of physical force. This conveys the important message that we respect them, acknowledge their experience, and validate it. Article 36 requires states parties to criminalise all forms of non-consensual sexual acts, including between current and former partners or spouses. The central element of this article is the lack of voluntarily given consent by the victim. This means that the offender's use of force or threat, whilst it may be present, is not required to make it a criminal act, and similarly, proof of the victim's physical or verbal resistance is not required, although it may well have been present. Thus, the Istanbul Convention shifts away from the previous narrow definition of sexual violence which required active resistance on the part of the victim to be considered an offence. This change is necessary because such a narrow definition fails to protect women's rights to bodily integrity and sexual autonomy.

Article 36 also requires that the prosecution of sexual offences should be based on a context-sensitive assessment of the evidence which is established on a case-by-case basis to determine whether or not the victim had freely consented to the act. This analysis should recognise the wide range of behavioural responses to sexual violence and rape which victims may exhibit. It is known that victims of sexual violence have a number of different ways of behaving in the moment: they may freeze, or may be completely traumatised, while others may try to fight. Reliance on consent in rape and sexual offences laws allows centrality to the victim's perspective and agency, and the most important point here is that any sexual act requires freely given consent.

Article 25 requires states parties to provide appropriate support to victims of sexual assault and rape which includes setting up easily accessible rape crisis centres and/or sexual violence referral centres. The rape crisis centres should be designed to look at the longer-term needs of women who experience rape or sexual assault which might include face-to-face counselling, support groups, contact or referral to other services, help during the court proceedings, etc. In contrast, the sexual violence referral centres are specialised, short-term support centres which may be set up in hospitals for example and which offer immediate assistance, medical care, forensic examinations and crisis intervention for victims. As part of holistic care, the changing needs of survivors of sexual violence over time must be considered as it is important that appropriate support is available to them whenever they may need it, in the way that they need it and such that their needs are fully met.

Article 16 states that states parties must establish and support programmes designed for sex offenders. The aim of these programmes is to minimise recidivism, but in terms of holistic care, Article 16 paragraph 3 specifically highlights that these programmes must ensure the safety and support for victims. These programmes are not only about the perpetrators but are essentially part of the continuing efforts to help and support victims. Perpetrator programmes must work closely and co-operate with specialist victim support services. This is important for survivors in terms of their safety, especially when the perpetrator is known to them, as it is a fact that many women are assaulted by people they know. Survivors should also be kept informed of what is happening if they wish to know. Although not all victims will want this, it is a very important for their holistic care that they have the choice to be kept abreast of the status of their assailant as this can help them regain a sense of control over their lives. The explanatory report of the Istanbul Convention also adds that these programmes should also co-operate with law enforcement agencies, the judiciary, probation services, and child protection or child welfare services. If the survivor has children, then the last two of these agencies are very important as the survivor will be reassured knowing that perpetrator services are also working closely with welfare and child services to protect their children.

GREVIO's monitoring of Article 36 indicates that some countries still require the use of force or threat to deem sexual violence a criminal offence. Some countries such as Austria use a two-tiered approach in which the existing legislation requiring the use of force, threat or coercion is retained, but a new legal provision is added that is based entirely on consent. The issue here is that the provision which requires the use of force will carry a harsher prison sentence compared to the consent-based standard, and this is tantamount to categorising different types of rape with some considered more worthy of punishment than others. Such an approach can be seen to be promoting the idea of 'real rape' versus something else. Furthermore, the second provision added by the Austrian government adopts a "no means no" approach which means that the use of force, threat or coercion is not required, but the state must still establish that sexual intercourse took place against the will of the victim. However, this carries the risk that criminal proceedings will focus on this as a central element of the case and hence only pay attention to the behaviour of the victim, absolving the accuser of any wrongdoing if it cannot be clearly established that the victim did not consent.

The new Swedish rape provision represents a "yes means yes" approach that is based on consent and places the onus on the perpetrator to understand that the act is consented to and not on the victim to demonstrate the lack of consent. The wording of the law reflects this difference because it criminalises intercourse as a sexual act involving a person who is not participating voluntarily as opposed to an act taking place against the will of the victim. This ensures that the criminal proceedings will focus on the behaviour of the perpetrator, asking what they did to establish consent rather than on the behaviour of the victim in terms of what they did to show a lack of consent. Lawmakers in Sweden also introduced a law on negligent rape which allows convictions for those perpetrators who did not but ought to have known that the victim did not consent. This means there is no more room for excuses and is one of the approaches that GREVIO applauds and showcases as a positive example.

Other GREVIO findings show that in the criminalisation of non-consensual sex, several states parties had modified their legislation on sexual offences to criminalise all non-consensual sexual acts as required by the article. These legal changes often depart from the previous narrower definitions which would have required the use of force, threat or coercion. So, the definition of sexual offences has changed in a positive direction. We also noted that in some countries sexual offences within marriage or intimate relationships were not previously recognised. This has now changed with more states clearly acknowledging that rape can occur within marriages and intimate relationships.

In relation to Articles 16 and 25, the findings and recommendations demonstrate the need to set up sufficient numbers of support service structures for victims of sexual violence in compliance with the numbers established by a task force before the Istanbul Convention came into being. Very few places have met the required target numbers of such services. There is also a need to ensure the adequate geographical distribution of such support services which often tend to be concentrated around the capital and urban areas, leaving rural areas without such essential services. There is a need for more psychological services for victims of sexual violence as, although such services do exist, they are often limited by the number of times the victim can use them or the (in)accessibility of their location. Psychological services must be provided to victims of rape or sexual abuse both immediately and in the longer term, and treatment programmes for sex offenders must be set up in countries which have not yet done so. These programmes must work in close collaboration with all other relevant services.

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Marijke Weewauters, Head of the Federal Unit on Gender-Based Violence, Institute for the Equality of Women and Men, Brussels, Belgium, thanked the Ambassador for the invitation to speak at the event. She stated that her presentation would cover Belgium's successful experience of introducing multi-disciplinary holistic care services for victims of sexual violence.

It is widely evident today that no single agency can stop violence, and this was acknowledged in the Belgian 2006 national circular concerning the criminal policy on intimate partner violence (COL4/2006). This directive stated that police, aid services and justice departments should work together to improve intersectoral co-operation when dealing with Intimate Partner Violence (IPV). Comparing the statistics before and after 2006 show that prior to 2006 victims were not reporting violence to the police and police were not dealing with IPV. After this circular, women had greater trust in reporting because they knew that the police would work together with aid services.

Belgium's National Action Plan which is based on the Istanbul Convention has several key elements including a "focus on a victim-oriented, multidisciplinary and integral, holistic approach (focus attention on the victim and their environment, including the children who have witnessed violence)". The National Action plan uses a victim-centred approach based on survivors' needs and considers all the problems they face, but it also includes helping any children involved and the perpetrators of sexual violence. This involves familial, social, cultural and economic issues as well as other forms of violence which may have occurred. During this process, priority is given to victims' safety while taking a long-term approach to ensure appropriate responses for the victim as well as children and perpetrators. A key element is a collaborative approach with everyone working together.

Since 2015, Belgium has worked on three key projects: Family Justice Centres (FJCs), a new stalking app and the Sexual Assault Referral Centres (SARCs). This presentation focuses only on the Family Justice Centres but a colleague would later cover the sexual assault centres.

FJCs were introduced in light of the knowledge that 87% of cases of Intimate Partner Violence (IPV) were not reported. Moreover, victims only reported after, on average, 35 incidents of violence, a figure which has now been reduced to 7 incidents. Victims also only tended to report when their own life or that of their children is in grave danger. In 45% of cases of IPV, children witnessed the violence. This is a concern as it is known that children confronted with violence are at a higher risk of becoming perpetrators or victims.

As a society, we felt that our response to help survivors was too late. It was envisaged that FJCs would allow interventions to be made earlier to help victims, perpetrators and children. There is a need to solve the many causal factors which contribute to IPV as well as to increase protection for those at risk as it is known that violence does not just end upon separation.

Another reason for introducing the FJCs was that previously victims had to visit several different centres to obtain the information they needed. There were on average ten centres dealing with the family, but they were not working in a collaborative manner, meaning that a victim had to visit many different centres to get help. In such a difficult time in their lives, many victims of IPV are not capable of doing this. In addition, in some cases the support offered by the centres was counter-productive, fragmented or not working. This is not how society should be responding to IPV.

Therefore, FJCs were introduced as a one-stop shop where all the services for IPV could be located in one building, and with outreach to other existing centres; all the family centres are now collaborating. The FJCs are victim-focused and are open to all victims regardless of whether they have been referred by other institutions, for example, the police or they present directly.

The goals of the FJC are to stop violence and recidivism, deal with all the causal factors of IPV (inequality, housing, stress, drugs, finance, migration, culture, divorce, etc.) as well as providing resilience training to increase protective factors. The aim is to reduce the number of times the victim has to tell their story and increase victim security. Information between all partners is shared to improve the quality of the interventions and potentially provide earlier interventions. The aim is to deal with the whole family: victim, perpetrator and children who witness IPV. The FJCs have to be victim-centred, and it is clear that both victims and perpetrators want this type of holistic care. The FJCs seek to help perpetrators while recognising that they are accountable for their actions.

How is this achieved? The mainstay in the Belgian National Action Plan is the multisectoral and holistic approach to gender-based violence which centres around the victim. Any intervention must be tailored to the victim's needs, taking into account the individual, familial, social, cultural and economic aspects of her/his situation. There is also a protocol for information sharing to improve the effectiveness of the FJCs.

The process starts with the risk assessment. Many issues have to be dealt with, but each collaborating agency involved in the process remains within their own responsibilities and objectives because the police and justice departments, for example, do not have the same goals as the aid services. Only need-to-know information is shared.

During this process, adequate consideration must be given to the victim's safety and well-being. It is also important to offer the victims and their children long-term care and to ensure that they are able to reintegrate into society and avoid repeated victimisation.

On the question as to whether Ms Weewauters would recommend other countries introduce FJCs, she said that they should be, but that it will take time, and success will depend on collaboration and trust between the police, justice department and service providers which can be challenging.

Since the introduction of FJCs, results show a reduction of over 30% in recidivism in complex cases, but in order to solve such complex cases, adequate time is required. Many IPV cases cannot be solved in only a short time frame, and the average length of a case is 15 months.

While FJC's are expensive, the cost of one FJC case is less than the cost of one murder case.

As all stakeholders are now collaborating effectively together in the pilot centres, the aim now is to create a legal instrument to introduce FJCs everywhere in Belgium. This new legal instrument and several others have been put in place to facilitate collaboration between the stakeholders.

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Professor Dr Ines Keygnaert, Assistant Professor in Sexual and Reproductive Health, International Centre for Reproductive Health, Public Health and Primary Care, Ghent University, Belgium, thanked the moderator for the invitation and said she would be speaking about setting up sexual assault referral centres (SARCs) in Belgium.

It is well known that sexual violence can induce a broad range of negative consequences not only for the victims but also for their peers, children and communities. These can be psychological (shock, ASR, PTSD, depression, anxiety, low self-esteem, phobia, aggression), physical (bruises, genital lacerations, death), sexual and reproductive (STIs, sexual dysfunction, unwanted pregnancy, infertility), and socio-economic (school drop-out, stigma, expulsion), and once someone has experienced sexual violence, they are at a higher risk for revictimization and perpetration.

International guidelines such as those established by the World Health Organization (WHO) suggest that optimal care for victims of sexual violence means providing holistic care in the form of multidisciplinary forensic, medical and psychosocial services. Research suggests that this care must be of higher quality to facilitate faster and better chances of sustainable recovery and less risk of revictimisation.

The WHO 2003 guidelines state that when providing services for victims, the health and welfare of victims should be a priority and if forensic examinations are to be carried out, then the number of invasive examinations must be kept minimal.

Such a holistic approach was not used in Belgium for a long time. Instead, Belgium used a forensic approach, called the Sexual Aggression Set (SAS) in which the victim's body was viewed as a crime scene which had the potential to provide the DNA of the assailant. The SAS system previously used in Belgium involved seven steps: anamneses, or the patient's account of events; clothes collection; physical examination; biological sampling; anogenital examination; toxicologic examination and treatment and administration. Only at the last step would victims receive any treatment.

Victims found the SAS system invasive and re-traumatising, and it prevented victims from undergoing any forensic examination before filing an official police report. This system was not patient-centred nor did it provide holistic care. Moreover, doctors in Belgium were not trained to perform such forensic examinations and hospitals often lacked protocols for this.

The International Centre for Reproductive Health (ICRH) has conducted research on sexual violence prevention globally since 1994, and it later became a WHO Collaborating Centre on Sexual and Gender Based Violence (SGBV) and developed protocols which were implemented in 2004 at Ghent University Hospitals and shared in training sessions with other hospitals. The ICRH staff worked with the Institute for the Equality of Women and Men and the Belgium government.

In 2016, Belgium ratified the Istanbul Convention which states that governments must provide adequate and accessible SGBV crisis and referral centres with medical, trauma and psychosocial aid and medical and forensic research (Article 25).

The ICRH was asked to conduct a feasibility study of Belgian SARCs with the aim of developing a SARC model that was evidence-based, met international guidelines, offered holistic and high-quality care and was patient-centred at every stage.

A mixed-method approach was used involving four groups of experts (judicial, forensic, medical and psychosocial) in close collaboration with the government. An interdisciplinary evaluation workshop was also held and finally piloting was authorised in December 2016.

The Sexual Assault Care Centres (SACCs) that have been established under the new model are accessible 24 hours a day, every day, for victims of all ages who present within one month of sexual victimisation. In the acute phase, a forensic nurse provides initial psychological aid, medical care, forensic examination (if the victim presents in under one week), a forensic roadmap and the possibility of speaking to a police vice inspector if they want to file a complaint.

Victim follow-up care is co-ordinated by the SACC case manager in collaboration with existing medical, psychosocial and legal services. Psychological support is provided by a trauma psychologist. After appropriate assessment, psychosocial counselling is available for up to 20 sessions.

The forensic roadmap bridges the interests of victims and the healthcare system, police and justice department and was developed in co-ordination with Belgian DNA laboratories, forensics experts, doctors, geneticists and gynaecologists. Swabs of different types are now used in forensic examinations depending on the nature of the physical contact, and specula are no longer used unless victims present more than six to seven days after the incident. The forensic examination also looks for saliva and other traces of contact in addition to sperm.

The time frame during which victims can undergo forensic examination has been increased from 72 hours to up to a week. The same procedure is followed whether a complaint is filed immediately or if the victim wants to file it later or not at all. Any forensic evidence collected is stored for six months which allows the victim the possibility of pressing charges later.

Having completed the feasibility study, pilot and evaluation phases, work is currently underway to adapt and finalise the SACC model to be rolled out across Belgium.

There are three pilot SACC sites in Flanders, Ghent and Liege. The pilot study results show that in the first year of the pilot (25 October 2017-31 October 2018), 930 victims were admitted to SACCs, which is an average of 78 new victims per month. This was with little or no promotion of the SACC facilities. By 31 July 2019, over 1,700 victims had been admitted, averaging around 88 new victims per month. People of all ages are seen at the SACCs from babies of a few months to people in their 80s. Just under one third (27%) are children, but most are young adults with an average age of 24.8 years. About 90% of victims who present are female, and 10% are male with some transgender victims also seen in each SACC.

Analysis of the type of sexual violence victims presented for shows that 69% of reported cases are for rape or attempted rape and in 58% of rape cases the victim knew the assailant. This suggests 39% of victims were raped by people they did not know which is high compared to other countries. Most victims present within one week which is important as it allows for the possibility of forensic examination.

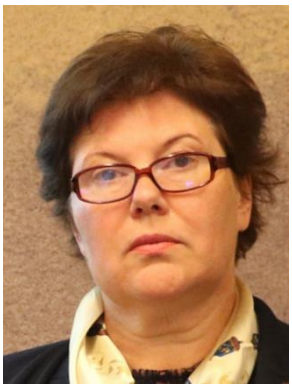
People come to the SACCs through different routes with the largest segment (39%) being referred by police. This is not surprising given that previously there was a requirement for victims to have filed a complaint with the police before they could be seen at a sexual assault centre. It is hoped that the percentage of victims coming to the centres via the police will decrease over time and that more people will come directly to the SACCs. There is a high uptake of holistic care, although not all victims need trauma therapy. 68% of victims who are admitted at SACCs file complaints, of which 37% were facilitated by SACC interventions, meaning that the victims decided to file a complaint after talking to the forensic nurse or others at the SACCs.

In conclusion, Belgian SACCs effectively respond to the needs of victims of sexual violence and bring together the interests of all stakeholders. A high number of victims reach the SACC services despite minimal promotion, and most victims make use of the comprehensive package of SACC services. There is a high percentage of reporting to the police. This new model allows for improved questioning, investigation and outcomes as victims have already received appropriate treatment and care by the time they talk to the police. The DNA laboratories and the Justice Department also note improved DNA analysis outcomes. Further research is ongoing to explore the accessibility of SACCs as well as their effects on judicial outcomes.

Care is free regardless of the victim's immigration status, but there is still a problem if a victim wants to file a complaint and they are undocumented, as SACCs cannot guarantee that victims will not be deported.

Acknowledgements were given to all SACC personnel who have rigorously collected the data and are assisting victims of sexual violence on a daily basis, victims and their confidants who were willing to participate in the study and the government agencies and donors that made the pilot and its evaluation possible.

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Kateryna Levchenko, Government Commissioner on Gender Equality Policy, Ukraine, thanked the organisers for the opportunity to speak about gender-based violence which is an important topic due to its damaging consequences for physical and mental health and numerous long-term effects. This violence is rooted in gender inequality and linked to patriarchal cultures, gender stereotypes and gender-based discrimination.

Ms Levchenko felt that the development of a holistic approach to assist victims of sexual violence seemed only logical from the perspective of strengthening women's rights and gender equality.

Separating the prevention of violence from combating discrimination against women means ignoring the main reason *for* violence against women, including sexual violence. It also leads to the lack of effective prevention and assistance strategies**.**

Hence gender-based violence, including sexual violence, is a key focus of organisations in Ukraine which are looking for comprehensive solutions such as improving national legislation, proper training for specialists, developing infrastructure to provide adequate support and assistance to survivors of sexual violence, raising awareness of the problem and collaborating with civil society organisations and women's groups.

In explaining what had been done so far in Ukraine, Ms Levchenko said that the Istanbul Convention had not yet been ratified due to significant resistance from some politicians from right-wing groups and religious groups and organisations.

The Ukrainian Parliament had nonetheless made some significant amendments to Ukrainian law including adopting a law on domestic violence and including a definition of sexual violence. There is now a separate chapter on sexual violence in the criminal court procedure and a separate article, Article 153, on sexual violence which criminalises sexual violence as sexual acts without consent. Ukrainian law also now acknowledges marital rape.

Ukraine has come a long way in adopting a meaningful definition of rape which is consistent with international standards, and it is encouraging to know that such a definition now exists in Ukrainian legislation. It must be emphasised that these new laws represent an immense change in Ukrainian law and for Ukrainian society. But they continue to face resistance from some politicians and political parties and from parts of society which still support traditional patriarchal structures.

Despite this, efforts have continued and succeeded in increasing assistance for survivors of sexual crimes in Ukraine. Ms Levchenko shared the following concrete examples of these positive changes:

- Ukraine has now developed free legal aid centres which offer medical assistance and support from social workers and government organisations. Victims can speak to trained professionals without having to report a crime to the police, and all staff are trained on how to communicate with victims of sexual violence and provide assistance to them.

- The National School of Judges of Ukraine and the National Academy of Prosecutors of Ukraine in co-operation with STRADA Ukraine and the Geneva Centre for the Democratic Control of Armed Forces are looking to provide training courses for judges and prosecutors on gender-based crimes.

- Ukraine has only just begun to train specialists to deal with sexual violence and can learn much from best practices from other European countries with greater experience. There is a real need to train forensic medical specialists on how to assist victims of sexual violence, so she appreciated hearing about the Belgian centres which are client-orientated and client-friendly.

It is important for Ukraine to create a range of services for survivors, including medical assistance, free legal aid and shelters for victims of sexual violence. However, no separate shelters exist for victims of sexual violence in Ukraine; they are placed in shelters with victims of domestic violence, human trafficking and other forms of violence. Today there are nine shelters in Ukraine for domestic violence and GBV including sexual violence. These were created through co-operation with professional organisations, UNFPA and local authorities and are a result of the updated law. Many of the shelters are funded by local partners which is important for a large country like Ukraine.

There is a free national hotline counselling service which operates 24/7. This is an important tool for providing services, information and monitoring of incidents. The hotline meets international standards and guarantees anonymity and confidentiality to callers. La Strada estimated that between 2016-2018, over 1,000 consultations related to sexual violence were carried out through the hotline.

Furthermore, there is a need to fight gender stereotypes using national and international initiatives. One such example is in 2016 when Ukrainian activists organised a national flash mob after a women's rights activist sharing her personal experience of sexual violence on her Facebook page went viral. In sharing her story, the activist called on other women and men to do the same, and soon public figures and the media joined the initiative. During this campaign, many individuals shared personal stories about different forms of violence including sexual abuse.

One of the main challenges for Ukraine is the lack of effective investigation mechanisms to deal with cases involving sexual crime. There is also a lack of understanding of these kinds of crimes, especially among representatives of law enforcement and even victims themselves who often lacked the skills to identify themselves as victims of violence.

One important step towards solving these problems in Ukraine would be the ratification of the Istanbul Convention, but in the meantime, it is important to continue efforts to implement the provisions of the convention which have already been adopted by the legislative reforms of two years ago. It is also vital to learn from the experiences of other countries, both from governmental and non-governmental organisations, in order to develop and implement a holistic approach to assisting victims of sexual violence.



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In the discussion which took place after the presentations, **Professor Dr Ines Keygnaert** commented that the SACCs in Belgium combined the functions of both the rape crisis centres and the sexual violence referral centres mentioned in Article 25 of the Istanbul Convention, thereby providing both the short-term immediate care for victims as well as longer term care.

Kateryna Levchenko asked if any economic estimation had been made of the cost of sexual violence by the Family Justice Centres in Belgium. **Marijke Weewauters** replied that they did not have any cost estimates for sexual violence in Belgium, but the cost of domestic violence to employers was seven million euros per year. The intention of the FJCs was to build partnerships with employers since returning survivors and perpetrators to work formed an important part of their holistic care.

A participant from Switzerland asked how data sharing between the different stakeholders on domestic violence had been achieved in Belgium, as in Switzerland there were many barriers to data sharing due to doctor-patient confidentiality and data protection laws. **Ms Weewauters** said that this had not been easy and had taken a long time to achieve. This was helped by establishing protocols for information sharing which distinguished between information which other stakeholders needed to know and information which would be nice to know. Only information that other stakeholders needed to know related to the violence was shared. In addition, in Belgium, a new law was introduced to allow professionals the possibility of sharing confidential patient information.

A participant wanted to know if the FJCs were working on family mediation, and if so, how this works. **Ms Weewauters** said while FJCs do not carry out family mediation, they do work together and share information on perpetrators and victims. Everything is based on risk assessment tools because when information is shared, there is always a risk, so risk assessments are vital.

A representative from the International Labour Organization (ILO) mentioned the new ILO Convention 190 on violence and harassment in the world of work adopted in June 2019 which complements existing treaties such as the Istanbul Convention and asked how FJCs and the victim centres could include the employment perspective to ensure holistic economic support to victims and perpetrators.

Professor Dr Ines Keygnaert said that in relation to employment, the Belgium SACCs can now issue a certificate to victims for one week's leave from their employment following sexual victimisation. Also, because the SACCs provide access to all the information and services that victims need in one centralised location, most can return to their employment in one to two weeks with ongoing and comprehensive care.

The SACC in Ghent is based in the university hospital, and there is an agreement now with the university for people who were victimised at the university either as a student or a professional person working in the university. So, SACCs provide professional support as well as holistic care.

Dr Marceline Naudi gave an example from Malta where they had recently launched an online course for human resources personnel specifically on domestic violence and GBV to highlight the importance of these issues and to make them aware of how they can help these individuals.

She also mentioned that the high incidence of sexual violence in which the victims did not know their assailant, could be explained by low reporting levels for this category. The figure of 58% of rapes by someone known to the victim could indeed be higher

Professor Dr Keygnaert was asked why the SACCs were only accessible to victims within one month of experiencing sexual violence since it was still possible to file a complaint after that time period and victims may still need psychosocial support. Were survivors who presented after one month just sent away?

In reply, she said that the one-month limit for presenting at SACCs had been set by the Belgian government for financial reasons. However, if someone presents beyond that timeframe, staff consider what medical care can still be provided, whether it is still possible to do some forensic examination (although this is unlikely to include DNA testing) and if there are any lesions which can still be documented. Two to three psychosocial counselling sessions may be offered, but then victims are referred to external trauma psychologists with whom they already work. The ideal long-term aim from Ghent University's perspective is for SACCs to be open to all victims of sexual violence regardless of how long ago the violence took place.

A participant said that a lot had been mentioned about online violence at the opening session and they were interested to hear how online crimes such as online stalking and violence would fit within the Istanbul Convention.

Dr Naudi replied that the various types of violence which occur online also occur offline, so they fall under the same rules. For example, when talking about stalking online and stalking in the street, it is still talking about stalking; emotional bullying is still emotional abuse whether it occurs online or in person, so most types of violence which are encountered online already exist offline. The online environment is just another tool which is being used to abuse, but the abuses remain the same and are therefore covered by the Istanbul Convention.

In answer to a question about the role of the family doctor in the prevention of family violence, **Ms Weewauters** replied that GPs are key personnel in the prevention of violence as when people talk about violence, they often talk to their family doctor first. Belgium is now working to create a code of conduct for doctors to address sexual violence, including FGM and domestic violence.

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Ambassador Muylle thanked the panellists and audience. He said it was clear that victims of sexual violence and domestic violence require a specific but also integrated approach which means involving a wide range of professionals from various backgrounds. It also requires that all practitioners approach victims in a consistent manner. The Istanbul Convention provides a useful tool for legislators to provide this beneficial environment and can be adopted by non-European states. More should perhaps be done to advocate for the importance of the Istanbul Convention in the rest of the world, and this could be an avenue of future action as we prepare to celebrate the Beijing Declaration and Platform for Action.



The flyer for the side-event is attached at Appendix I to this report.

Appendix I

The Permanent Representation of Belgium to the United Nations in Geneva
and the Council of Europe have the honour to invite you to the side event

The Istanbul Convention in practice
Holistic care for victims of sexual violence

TUESDAY, 29 OCTOBER 2019 FROM 13.30 TO 14.45

Room XXIV, Palais des Nations, Geneva

Many initiatives have been taken to eliminate sexual and gender-based violence against women and girls following the Beijing Declaration and Platform for Action, also at a regional level. Since the 1990s, the Council of Europe has undertaken a series of initiatives to promote the protection of women against violence, which culminated, in 2011, in the adoption of the Convention on Preventing and Combating Violence against Women and Domestic Violence, also known as the Istanbul Convention. This convention is open for accession by non-member States of the Council of Europe. By accepting the Istanbul Convention, governments are obliged to change laws, introduce practical measures and allocate resources to effectively prevent and combat violence against women and domestic violence.

Five years after entering into force in August 2014, 34 states have ratified the Istanbul Convention and taken concrete actions. They have amended laws, strengthened the criminal justice system, established or strengthened multi-agency collaboration, and adopted National Action Plans. Among these efforts we can mention the setting up of appropriate, easily accessible rape crisis or sexual violence referral centres for victims (Istanbul Convention, Article 25).

This side-event will allow experts, governments and civil society organisations to share experiences, good practices and challenges in the implementation of the Istanbul Convention as a framework for action at national level in providing support to victims of sexual violence. Particular focus will be placed on sexual violence referral centres and Belgium's recent experience. Ukrainian efforts towards holistic care for victims of sexual violence will also be presented.

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> Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The long-standing failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all states and should be addressed."
>
> Beijing Platform for Action

PROGRAMME

Moderator

- **Geert Muylle,**
  Ambassador, Permanent Representative of Belgium to the UN in Geneva

Panellists

- **Marceline Naudi,**
  President of GREVIO, independent group of experts monitoring the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence
- **Marijke Weewauters,**
  Head of the federal unit on gender-based violence, Institute for the equality of women and men, Belgium
- **Ines Keygnaert,**
  Assistant Professor in Sexual and Reproductive Health, International Centre for Reproductive Health, Ghent University, Belgium
- **Kateryna Levchenko,**
  Government Commissioner on Gender Equality Policy, Ukraine

Sandwiches and refreshments will be available prior to the event