IFMSA Policy Proposal
Domestic Violence

Proposed by SfGH U.K and MSAI India
Presented to the 69th IFMSA General Assembly August Meeting 2020

Students for Global Health U.K

Name of National Member Organization 1

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Draft Policy Proposals have to be sent to all National Member Organizations (nmos@ifmsa.org) by the proposer to request for feedback by June 10 2020 23.59 GMT. Policy Proposals to be discuss at 69th August Meeting General Assembly 2020 have to be sent to gs@ifmsa.org by July 1, 2020 @ 23.59 GMT (please put the code [POLICY] in the beginning of the subject of your email).
Policy Statement

Introduction:

The World Bank describes domestic abuse as the “most pervasive, common, under-recognized, underestimated and under-reported type of violence against women”. The World Health Organisation (WHO) estimate that 30% of all women and girls aged 15-49 have reported physical and/or sexual violence from an intimate partner in their lifetime. Although domestic abuse is undoubtedly a gendered issue, there are multiple vulnerable groups affected by it, for example; LGBTQIA+ and ethnic minorities, men and children. This harrowing abuse has wide reaching societal consequences and is associated with lifetime costs of $3.6 trillion. There are not, as of yet, any successful international interventions to tackle domestic abuse. However, research has shown that education rebuking traditional patriarchal gender roles, that is male authority and female obedience, could lead to a cultural shift and the eventual eradication of domestic abuse.

IFMSA position:
The International Federation of Medical Students’ Associations strongly condemns all forms of domestic abuse and reaffirms that domestic abuse is a human rights violation that is severely detrimental to the short and long term physical, psychological, social and economic well being of the victim. It is a universal issue that disproportionately affects the most vulnerable in society. As future health professionals, IFMSA acknowledges its responsibility in upholding the human rights of survivors, and is committed to fight against domestic abuse.

Call to Action:
Therefore, IFMSA Calls on:

Governments to:
- To sign and ratify international conventions aiming to eradicate domestic violence;
- Develop an intersectional approach to help-seeking for the survivors of intimate partner violence;
- Set up a legal framework and implement laws and policies that aim to prevent violence, protect the victims and prosecute the perpetrators of domestic violence;
- Incentivise the education sector to incorporate teaching and training on identifying and reporting domestic violence from an early stage;
- Incentivise the police to invest more resources towards training that helps staff identify and decisively act against reports of DV;
- Facilitate collaboration between the health, police and judiciary to collate reliable data about incidences of DV in community;
- Work with the public health sector to implement effective public awareness campaigns and evidence based prevention and management interventions to support the survivors of domestic violence;
- Ensure there are contingency protocols and guidelines in place to deal with increased domestic violence in times of national and global emergencies such as pandemics, natural disasters etc.
- Set and accomplish national employment targets as unemployment is a strong predictive factor for DV;

Inter-governmental Organisations to:
- Collect and compile data on the incidence and impact of Domestic Violence in all members of the community especially those that are currently underrepresented e.g the LGBTQIA+;
- Ensure their work doesn’t just focus on the urban community but also considers the rural and remote communities;
- Work with public health services to design evidence based interventions that are well suited to individual communities;
Health Sector to:
- Implement a domestic violence sensitive medical practice by training staff to recognise potential domestic abuse in their patients and conduct the consultation in a sensitive manner;
- Provide specific, targeted support for vulnerable groups who are at an increased risk of domestic abuse e.g. couples where one or both partners are abusing alcohol and illicit drugs;
- Regularly screen for the development of psychological disorders including conduct disorder in children regularly witnessing domestic abuse;
- Ensure all primary and secondary care staff are well trained at identifying, reporting and escalating cases of domestic violence;
- Ensure that domestic violence related support services are available to the rural as well as the urban community;
- Coordinate with the police and the judiciary to create dedicated medico-legal services which can be accessed by survivors of domestic abuse and to ensure confidentiality of the same;

Educational Sector to:
- Provide training to staff and encourage them to actively identify domestic abuse in students and colleagues;
- Assign a safe-guarding officer that can help escalate and manage all issues related to DV in school;
- Develop curricula to include education about domestic abuse, including different types, warning signs and how to report and seek help if they witness it;

Researchers:
- Carry out research to measure the impact of DV in under-represented groups including LGBTQIA+ groups;
- Carry out field research to highlight the key community specific causative factors of DV in different vulnerable groups and how these can be used as intervention targets;
- Carry out research to understand the factors that contribute to higher incidences of DV within certain ethnic groups e.g. Indian American and African American

NMOs to:
- Promote and ensure education and awareness of the health impacts of domestic abuse at an individual, local and national level;
- Promote engagement in research regarding domestic abuse and share data and findings of the same with NGO’s and NMOs;
- Help develop modules on training of medical students to aid their skills when addressing any case of domestic abuse

Medical Schools to:
- Include teaching on all aspects of DV as part of comprehensive sexuality education in the core medical curricula, ensuring students are competent at: identifying different types of abuse in various groups; sensitively screening for DV in vulnerable groups; escalating reported cases; having a structured management approach and handling DV related consultations in a non-judgmental, confidential and sensitive manner;
- Set up OSCE stations that examine competence in initiating difficult conversations;
- Enforce Zero tolerance in cases where medical students are perpetrators.
Position Paper

Background information:
The United Nations (UN) defines domestic abuse, which is also referred to as domestic violence or intimate partner violence (IPV), as "a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner" (1). This pattern of behaviour is multifaceted and encompasses, but isn't limited to, psychological, physical, sexual, financial and emotional abuse (2). It is important to note that domestic abuse is not just defined as the abuse itself but also the threat of abuse, (2).

Although domestic abuse often falls under the umbrella term of gender-based violence (3) which is defined by the UN as "violence that is directed against a woman because she is a woman or that affects women disproportionately" (4), domestic abuse can affect people of all genders and ages.

Nonetheless, it is important to state that domestic violence is a gendered issue, with the World Health Organisation (WHO) stating that IPV is "one of the most common forms of violence against women" (5). Furthermore, the WHO estimate that 35% of women worldwide have experienced physical and/or sexual violence from an intimate partner in their lifetime (6). Globally, 243 million women and girls (18%) aged 15-49 have reported either physical and/or sexual violence from an intimate partner in the previous 12-months (7). This abuse can often have horrific consequences, as over 1/3 of women who are intentionally killed are killed by either a current or previous partner (8).

Domestic abuse not only affects cisgendered women but the transgender community, too. A 2018 Stonewall report found that 21% of trans men and 19% of trans women had faced domestic abuse in the past year (9). Cisgendered men also face domestic abuse, although there is little international data available. In the US, 1 in 4 men have experienced some form of physical violence from an intimate partner in their lifetime (10). In the UK, 2.2 million men (13.2%) aged 16 to 59 have experienced some form of domestic abuse since the age of 16 (11). Furthermore, in the UK 1/3 of domestic abuse victims are male and 1 in 6 men will suffer from domestic abuse in their lifetime (11). Domestic abuse is not just faced by heterosexual couples, however, as men who have sex with men are particularly vulnerable too. Numerous studies and systematic reviews have found the prevalence of domestic violence amongst same-sex couples to be equal to, or in some cases greater than, the prevalence of domestic violence amongst women in opposite-sex relationships (12).

Children are vulnerable to detrimental psychological impact from witnessing domestic abuse. It is important to note that the witnessing of domestic abuse would fall under the umbrella term of child abuse. The witnessing of domestic abuse can directly affect a child's health, leading to severe depression or anxiety and difficulty learning in later years (13). Furthermore, evidence shows that children witnessing domestic abuse are more likely to be affected by domestic abuse as adults - either as victims or perpetrators (14,15,16,17). UNICEF estimates as many as 275 million children worldwide are exposed to violence in their homes (18).

Discussion:
The impact of domestic violence on vulnerable groups:

Women:

Domestic violence affects a wide range of the population, with some groups being particularly vulnerable. Women are mainly affected, with approximately 243 million females worldwide subjected to domestic violence in the past 12 months (19). In addition, those in their 20s and 30s are more at risk (20).
Women who are pregnant are more vulnerable to domestic violence (21). This may, therefore, affect not only the mother, who is more likely to use smoking, alcohol and illicit drugs as a coping mechanism but also the unborn baby, who is impacted by the increased adrenaline released by the mother due to the additional stress (22). The mother is more likely to suffer from pre-eclampsia, with the baby at an increased risk of a low birth weight or infection of the amniotic membrane. The child is also at an increased risk of severe psychological problems and emotional and behavioural disorders later in life (22).

There is evidence suggesting that there are other factors which increase susceptibility to domestic violence such as low income, mental health problems and disabilities due to increased vulnerability through a power imbalance (23).

**LGBTQIA+:**

There are specific communities who are at a higher risk of domestic violence but are more neglected in prevention strategies. For example, the rates of domestic violence within LGBTQIA+ and ethnic minority groups are equal to or greater than in non-minority groups (24). In particular, in a study of transgender people, 80% of respondents had experienced a form of domestic violence (25). Research suggests that increased incidence of violence is due to the ‘minority stress model’, whereby minority groups are under additional stress, which can be particularly damaging in the long term (26) by rendering them to a greater risk of perpetuating violence. There is less specific-support available for these minority groups and as a result, the extent of the domestic abuse is often worse.

**Children and Young adults:**

Domestic violence has a disproportionate impact on children and young people, with it being the most frequently reported form of trauma in young adults (27). The profound impact of experiencing or witnessing domestic violence on children ranges from short- and long-term cognitive effects to physical manifestations. They are also more likely to be a participant, either as a perpetrator or victim, in domestic violence later in life (28). There is an additional impact on the community, as children witnessing domestic violence will grow up without learning about positive and respectful relationships.

**The Elderly:**

Domestic violence also affects older adults, with more than 250,000 people aged 66 and older reporting experiencing some form of maltreatment in 2006-2007 in the UK. (29). Of those experiencing maltreatment, 51% experienced it from a partner. Furthermore, certain perpetrator characteristics were associated with particular types of maltreatment for example neglect was mainly perpetrated by partners and other family members where as a significant proportion (31%) of victims reported having suffered through financial abuse perpetrated by care workers. These types of abuse have severe consequences on the health of the elderly, with the most widely reported impact being emotional (invoking feelings of anger and distrust) and social (feeling cut off from family and friends). The issue is further complicated by the fact that 70% of victims in 2006, reported seeking help from their partners and family members when facing abuse. Naturally, if the perpetrator is so often the individual they usually seek support from, the consequences are dire. (29)

**Refugees:**

Conflicts and natural disasters around the world have forced millions of people to flee their homes in search for a safer sanctuary. It has been difficult to understand the true impact of domestic violence in refugee populations due to lack of proper reporting mechanisms in place. Our current understanding of the impact is based on national and area specific data. Data from refugee women in Rwanda indicates that half of the refugee women there experience some form of sexual or gender based violence. Unsurprisingly, women living in precarious settings such as those living in the Democratic Republic of Congo during times of armed conflict extensively reported incidences of intimate partner
violence. Furthermore, the closing of European borders to refugees coincided with an increase in the reported incidences of intimate partner violence as women were forced to cover smuggling costs with transactional sex. (30)

Indigenous Populations:

As with some of the other vulnerable groups, it is difficult to estimate the exact extent of the impact of DV on the indigenous population due to insufficient data from around the world. One of the reasons for this is that in countries like Nepal the indigenous people are spatially scattered making it difficult to obtain significant sample size and another that a lot of the data collected is qualitative which can be patchy and hence fails to provide a comprehensive and cohesive account of the situation in indigenous groups. (31)

Looking at nation specific data shows that in Australia, in 2006-7 indigenous women were 35 times more likely to be hospitalised due to acts of domestic violence than non-indigenous women. (32) Several factors are contribute to the higher rates of DV in indigenous population including: customary and statutory standards on the minimum age of marriage; poverty, exclusion and limited access to services; the impact of stigma and discrimination on access to services and the quality of these services; dispossession of ancestral land. (31)

Domestic violence during times of crisis:

The number and severity of cases of domestic violence increases during times of crisis, such as natural disasters, wars and pandemics (e.g. Ebola and COVID-19, which has seen a worldwide 25-50% increase in cases, (33) (34). This is as many victims are isolated with their abuser and therefore lack the mobility to seek help. There is also increased stress during these times, alongside potential economic hardship, which has been linked to increased cases of domestic violence (35).

Causes of domestic violence:

It is paramount to understand the complex causality of DV in order to produce an effective recognition and prevention strategy that transforms gender-power inequalities and helps victims of DV (36). DV has shown to have links to:

- Demographic factors (age, gender, socioeconomic status, race/ethnicity, acculturations, stress, employment opportunities, education)
- Community factors (school, neighbourhood)
- Developmental factors (family history of DV, experiences of child abuse, parenting styles and support)
- Peer factors and support (peer association with deviant peers, social/emotional support)
- Interpersonal factors (religion, conduct disorder/antisocial personality, anger, hostility, personality disorders, depression, suicidal tendencies, substance abuse)
- Cognitive factors (hostile attributions, attitudes, beliefs)
- Relationship influences (marital/relationship status, relationship issues, satisfaction within the relationship, attachment, jealousy)
- Influences of broader interactional patterns of the society and of the culture. (37)(38)

A large systematic study on intimate partner violence (IPV) found that the most strongly associated factors which were found to be predictive of DV were: younger age, deprivation, including unemployment and low income, and minority group. (37) (38).

Stress (resulting from work-related, financial, acculturation) was found to be a significant predictor of abuse. For men and women, high acculturation stress was directly related to IPV. (38). There was insufficient, mixed evidence for community and school factors influencing DV. (37)
Addressing links between race and ethnicity with IPV perpetration showed that the American Indian community had higher rates of DV against them than other communities. This information was based on the National Violence Against Women Survey on a probability sample of US telephones. However, there were limitations with this data as: ‘According to the National Crime Victimization Surveys, only about half of IPV is reported to police, and African American women are more likely to report IPV than are White women.’(39) and thus introduce sampling bias.

There have been many studies that have looked into theories based on social learning and intergenerational transmission as a risk factor for IPV in subsequent intimate relationships. Exposure to violence in the family and experiences of childhood physical abuse, sexual abuse, and witnessing IPV were predictive of IPV victimisation.(40)(41)

In contrast, protective factors such as supportive parenting and significant involvement in the child’s life, encouragement of good behaviour and good social support were all shown to be protective of victimisation.(37)

An individual involved with aggressive peer groups was found to be a significant social and behavioural risk factor for DV (42), whereas a higher friendship quality at 16 years was shown to be protective, irrespective of gender. (41)

In regard to psychology, conduct disorder or antisocial behaviour was a substantial risk factor for perpetrators of DV in both men and women (43)(44). A study carried out within a Chinese community found frequent exposure to altercations between guardians negatively impacts children and can damage their psychological health, leading to a multitude of short and long term psychological problems such as depression and anxiety. It also found similar results to children who had witnessed DV had similar outcomes to those who had experienced abuse themselves (45).

However, depression had insufficient evidence to draw conclusions but may show a stronger risk factor for IPV perpetration for women than men. (38)

The risk of intimate partner violence is 4.5 fold higher with heavy drinking when compared to mild and moderate drinking. Violence is much more likely to occur on days of drinking and the episodes are much more severe with heavy drinking. (46)

Married women reported significantly lower rates of DV than separated women. However it is important to note that the lower reporting rate in the former might be due to several factors including the wife being financially dependent on the husband; the husband being controlling and preventing the wife from reporting incidences of abuse and lack of legislation protecting married women e.g marital rape being legal etc. A volatile relationship with low satisfaction within the relationship was a predictor for DV. (38)

Both men and women find it difficult to disclose experience of IPV, (47) whether from the stigma that is attached, fear of the consequences of disclosing information and ending the aggressive relationship (financial support, childcare, housing and other social problems).

Another problem we face is access to help for victims affected by IPV. Disclosure of IPV to mental health services is rare. Instead women favour help-seeking from primary care which is more comfortable, whilst gay men prefer to seek GUM (Genitourinary Medicine) clinics for help rather than a GP. These findings may suggest that an intersectional approach for IPV is needed (47).

**Widespread Impact of DV on Society:**

The impact of domestic violence is within various thematics of the society and is multi-dimensional including social, economic and healthcare. Violence against women is found in all countries to varying degrees and the impact is also witnessed in varying degrees.
Familial impact:

The long-term effects of domestic violence are far-reaching and often devastating for victims – most often women and children. Women and children, who live in an environment where domestic violence commonly occurs, face increased risks because of the strenuous and pressurised atmosphere in their lives. Women may develop an impaired ability to nurture their children and contribute to their positive development. Children witnessing domestic violence may withdraw from their parental relationship, suffer seriously delayed or distorted development, and emotional problems. (48)

Psychosocial Impact on women and children:

The effects of domestic violence on women go beyond the immediate physical injuries they suffer at the hands of their abusers. Frequently, domestic violence survivors suffer from an array of psychosomatic illnesses, eating disorders, insomnia, gastrointestinal disturbances, generalized chronic pain, and devastating mental health problems like posttraumatic stress disorder (PTSD). Due to the long term stress experienced, it might also lead to women being at a higher risk of hypertension, diabetes etc. (49)

Many abused women find it difficult to function in their daily lives because of the effects of domestic violence. Absences from work, due to injuries or visits to the doctor, often cause them to lose their jobs, making them less able to leave their abusive situations. They may feel ashamed that their partners abuse them, see themselves as unworthy of love, and suffer from a significantly diminished self-perception. Because of their feelings of low self-worth, these women become isolated from friends and family and do not participate in social activities common to others in their demographic. (50)

There is a common link between domestic violence and child abuse. Among victims of child abuse, 40% report domestic violence in the home. One study in North America found that children who were exposed to violence in the home were 15 times more likely to be physically and/or sexually assaulted than the national average. This link has been confirmed around the world, with supporting studies from a range of countries including China, South Africa, Colombia, India, Egypt, the Philippines, and Mexico. (51)

There are varying degrees to which children are affected in various age groups. Primary school children may have more trouble with school work, and hence show poor concentration and focus which leads to them not performing well in school.

In one study, forty per cent had lower reading abilities than children from non-violent homes.(25) Personality and behavioural problems among children exposed to violence in the home can take the forms of psychosomatic illnesses, depression, suicidal tendencies, and bed-wetting. Later in life, these children are at greater risk for substance abuse, juvenile pregnancy and criminal behaviour than those raised in homes without violence.(51) (48)

Economic Impact:

The toll of domestic violence is not only physical and psychological, but it is also economical. According to the Center for Disease Control and Prevention (CDC), the financial impact of domestic violence ranges from individual to societal. Victims of intimate partner violence lost almost 8 million days of paid work because of the violence perpetrated against them. This loss is the equivalent of more than 32,000 full-time jobs and almost 5.6 million days of household productivity as a result of violence. (52) The economic impact also refers to the economic violence faced by the victims of sexual violence. Economic violence is difficult to define and can vary significantly according to the cultural context and country circumstances. Economic violence can involve denying access to property, durable goods or the labour market; deliberately not complying with economic
responsibilities, thereby exposing a woman to poverty and hardship; or denying participation in economic decision-making. (50)

Sixty-four percent (64%) of victims of domestic violence indicated that their ability to work was affected by the violence. Decline in productivity, victims noted "distraction" (57%); "fear of discovery" (45%); "harassment by intimate partner at work (either by phone or in person)" (40%); fear of intimate partner's unexpected visits" (34%); "inability to complete assignments on time" (24%); and "job loss" (21%). (53)

Medical Costs:

According to recent WHO statistics, 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. (54) Victims of domestic violence often suffer from severe physical injuries that require medical attention, 42% women report injuries as a consequence of this violence. (54) Medical costs associated with such injuries can put a significant financial strain especially on the economically disadvantaged groups among whom the incidence of domestic violence is even greater.

Education Disruption:

Lack of adequate education is a huge contributing factor to whether or not women are able to get higher paying jobs that allow them to support themselves. If domestic violence is preventing them from doing well in or finishing schools, their future choices may be more limited than they otherwise would have been. (55)

Work life disruption:

Employment is one of the most commonly used indicators of financial health and stability. Reduced work hours and lower educational attainment lead to significant income losses for those experiencing IPV and disrupt their ability, motivation and enthusiasm to work. (56)

Workplace Harrassement:

Many domestic violence survivors have also experienced sexual harassment or violence at work from either a co-worker or supervisor and this kind of harassment can cause victims to either lose their jobs or force them to leave their jobs, putting them at financial risk. Some abusive partners may try to stop women from working by calling them frequently during the day or coming to their place of work unannounced. Research indicates that about 50 percent of battered women who are employed are harassed at work by their abusive partners. (57)

Specific forms of abuse and their impact:

Financial Abuse:

Financial abuse is a lesser discussed tool used in abusive relationships. Abusers take money from the survivors of domestic violence against their will and this damages their credit which can prevent them from achieving financial independence in the future. (58)

Reproductive coersion:

Reproductive coercion is when an abuser tries to control over the reproductive health of a woman, which can mean sabotaging their birth control or forcing them to terminate a pregnancy. An
unplanned pregnancy can alter career plans and educational aspirations. Caring for a child is also incredibly expensive, which is another way that women may end up financially unstable. (59)

**Physical abuse:**

The effects on the physical health can be immediate and acute, long-lasting and chronic, and/or fatal. In addition to these, the negative health consequences can persist long after abuse has stopped. The consequences of violence tend to be more severe when women undergo more than one type of violence (physical and/or sexual) or multiple times. (4)

Acute or immediate physical injury is one of the most common injuries which women tend to suffer from. In the WHO multi-country study on women’s health and domestic violence, between 19% (Ethiopia) and 55% (Peru) of women who had ever experienced physical violence by their intimate partner reported being injured as a result. (60)

Chronic health problems in the form of headaches, chronic pelvic pain, back pain, abdominal pain, irritable bowel syndrome, and gastrointestinal disorders are often witnessed in women who have had a history of violence. Most of them after suffering from multiple acute injuries lead to chronic health problems. (61)

Fatality is a very common outcome as a result of domestic violence. It can be either due to the long standing chronic health problems and in multiple cases occurs as a result of femicide. It is estimated that of the 87,000 women who were intentionally killed in 2017 globally, more than half (50,000-58 per cent) were killed by intimate partners or family members, meaning that 137 women across the world are killed by a member of their own family every day. More than a third (30,000) of the women intentionally killed in 2017 were killed by their current or former intimate partner. (62)

**Sexual abuse:**

Gynaecological problems in women such as vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections are seen commonly in women who experience sexual violence. (63)

Even without sexual abuse, however, women who experience partner violence appear to have increased risk of gynaecological problems, though the reasons for this are not well understood. (64)

Sexual violence can also lead to unintended pregnancies, induced abortions, and sexually transmitted infections, including HIV. The 2013 analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who had not experienced partner violence. (54) The incidence of abortion also is twice in these cases. Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies. (54) The same 2013 study showed that women who experienced intimate partner violence were 16% more likely to suffer a miscarriage and 41% more likely to have a pre-term birth. (54)

**Psychological abuse:**

Threats and acts of intimidation can extend over time and take the form of mental harassment. In fact, 32.7 per cent of the respondents said they had been exposed to insistent and aggressive behaviour of a non-sexual nature. (65)

Both physical and sexual violence have been linked to a greater risk of adverse mental health outcomes among women. The most prevalent include depression (66), suicide attempts, post-traumatic stress disorder, other stress and anxiety disorders, sleeping or eating disorders and psychosomatic disorders. (63)(67)
The mental and the behaviour health is also largely impacted by psychological violence which mainly involves emotional abuse and controlling behaviour. (50)

**Intervention Targets:**

**Changing societal attitudes towards DV:**

Understanding the attitudes towards domestic violence around the world and the factors influencing these attitudes is a vital step in developing solutions to domestic violence.

The perpetuation of domestic violence stems from societal attitudes towards domestic violence and sociocultural norms regarding patriarchal gender roles of male authority and female obedience, where physical abuse is the norm, all affect the levels of abuse seen in different settings. (46) This suggests that there is a need for a whole cultural shift in our society, if we are to truly defeat domestic abuse.

An international gendered analysis of the attitudes towards domestic violence in forty-nine low to middle income countries showed that one in three survey respondents justified domestic violence in at least one of the listed circumstances, and in thirty-six of the forty-nine countries sampled, many of these in Sub-Saharan Africa and South Asia, women were more likely to justify domestic violence than men. (46)

The study also highlighted a gendered divide in the drivers that influence men’s and women’s attitudes towards domestic violence. ‘Economic factors, poverty and education in particular had a greater influence on the societal acceptance of DV amongst women whilst political and government structures influenced men's justification of DV’. (46)

In contrast, a high literacy rate was the strongest protective factor against women’s acceptance of DV in society, whilst a democratic regime decreased acceptance rates towards domestic violence in men. (46)

In order to cleanse our social fabric from domestic violence we must build a society that has zero tolerance towards the issue. This can only happen by empowering survivors of domestic abuse and educating those who perpetrate it.

Management strategies can include interventions on an individual, family and community level, as well as national/public health strategies and legislation. These strategies must address key factors that contribute to domestic violence. (46)

**Working with parents and children:**

One of the factors is early childhood exposure to domestic violence. Parent education programs are one of the several strategies that have shown a promising potential to prevent child maltreatment.

As well as strategies targeting parents, it is important that children have access to appropriate emotional and social support, as any child who witnesses domestic abuse can be said to be experiencing emotional abuse. (68)

Strategies to help both parents and their child can involve providing children and family workers who can provide individualised practical and emotional support to women arriving in refugees together with children. Therapies can include conventional therapies, play therapy and activities such as the Hestia summer play scheme which provides activities in a safe, nourishing environment for the surviving parent and child to rebond and teach children to trust adults and their environment again. (69)

**Targetting excessive alcohol consumption:**
There is also mounting evidence suggesting a strong link between excessive alcohol consumption and acts of domestic violence. Numerous studies have explored how best to target domestic violence related to excessive alcohol use. In a study which compared standard perpetrator programmes combined with personalised brief alcohol interventions consisting of ninety minute motivational interviewing sessions with a standard programme that included one group therapy session related to substance abuse, the brief intervention strategy found initial reductions in alcohol consumption and violence, but unfortunately its impact subsided within 12 months. This may suggest the need for more long term therapies focusing on perpetrators.

Unfortunately, as well as there being limited evidence for the success of strategies targeted at the individual, there is also limited data to support those targeted at a relationship, such as couples-based alcohol interventions and at a community and population level, such as reduced hours of sale or increased price. Evidently, more research needs to be done in this area.

Education:

Education may also play a vital role in creating successful domestic violence prevention strategies. Both education that targets victims and perpetrators, and the education of medical students and healthcare professionals may play a vital part in improving existing domestic violence strategies.

In a UK study, it was found that most medical schools receive only a small amount of teaching on domestic violence and that a majority of respondents perceived this to be inadequate. Domestic violence is the leading cause of morbidity and mortality of women worldwide, so the fact that a majority of survey respondents only received 0-2 hours worth of teaching on domestic violence on one occasion throughout their medical schooling is appalling, when compared to time allocated to much less pertinent topics in medical education.

Recommendations arising from the study included case discussion, sessions with simulated patients and a need for a ‘structured approach to management’. The importance of adequately training medical students to deal with domestic violence is highlighted by the fact that survivors of domestic violence themselves believe that ‘their doctor is one of the few people they can disclose violence to and want them to respond appropriately’, showing that this is also a response focused on survivors actual wants and needs.

Themes highlighted in the study about why teaching in this area is still lacking included it ‘not [being] perceived as a medical problem’ and the ‘assumption that this knowledge can be picked up elsewhere’. This shows a gross misunderstanding of the nature of the issue and the need to also educate medical school faculty and key decision makers in order to rectify medical curricula.

Comprehensive sexuality education is also a key strategy in combating violence against women and girls and encompasses inclusive, non-stigmatising sex education which promotes gender equality. Schools have been shown to be a key place for prevention and changing social norms, and considering the high proportion of domestic violence that is sexual, this may be a key strategy.

Having comprehensive, fit for purpose strategies in place alone is not enough, and any policies or legislations must transcend from paper to tangible actions.

Effective police response:

An adequate police response to domestic violence is essential for enabling victims to leave domestic abuse and hold perpetrators to account. For example, a UK investigation found multiple gaps in the police response to domestic abuse, with 85% of those experiencing domestic violence calling the police five times before receiving effective support and on average living with domestic violence for three years. Fear about how the police will respond also means that four out of five victims of domestic abuse do not call in the first place.
Multiple factors have been suggested to contribute to this, including the reports of minimising the severity of calls and risk assessment, as well as poor data management which omits how effective responses are or the extent of the problem. (74) This suggests that improved training may be necessary for those in the police force, and that the police should be held accountable in their response to domestic violence and the positive role that they may play if they respond adequately.

Legal framework for DV:

There is also a need for laws and policies that empower the victims and hold perpetrators to account.

Worldwide, women have 75% the legal rights of men (75). Only fifty years ago, no countries worldwide guaranteed women legal protections from familial or domestic violence, deeming it a private matter not subject to external regulation. (75) More recently, beginning with the Arab Spring in the early 2010s, there has also been an increased trend of protecting women from violence, with more and more countries ratifying new laws and policies. (75) To build on this, there is a need to continue to implement policies which focus on the immediate separation of the perpetrator from the survivor, as the right to life without violence takes priority over the right to property. Increasing the number of shelters and safe accommodation is also of utmost importance, and we must continue to invest both monetary and human resources into domestic violence, and ensure that in times of recession and economic distress, this is not sidelined.

Several international conventions and declarations have been made since the Universal Declaration of Human Rights in 1948, that aim to foster equality within societies and protect the vulnerable. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) signed in 1979 is an example specific to protecting women against violence. (76) The Council of Europe Convention on preventing and combating violence against women and domestic violence is an example of a regional international effort to produce a legal framework to prevent, protect the victims and prosecute perpetrators of domestic violence. (77) The convention was opened for signatures in 2011 and has so far been signed by 45 countries. It has been in effect since 2014 and has been ratified by 45 countries. Although progress has been made, major states in the region including the United Kingdom still haven't ratified it. (78)

One example of best practice is New Zealand, where in 2018, the Domestic Violence Act of 1995 was replaced with the Family Violence Act 2018, which include ten days of paid leave for domestic violence victims to enable them to find new homes and protect themselves and their dependents. (79)

As of September 1, 2019, 155 economies worldwide have domestic violence legislation in place, including 30 of the 48 economies in Sub-Saharan Africa. Nevertheless, there are still 49 countries without laws against domestic violence, 45 without laws addressing sexualising sexual harassment, and in 112 countries, marital rape is still legal. (80)

This highlights how there are certain types of domestic violence which women are still particularly vulnerable to, due to lack of legal protection. On a global scale, over a billion women still lack legal protection against domestic sexual violence and 1.4 billion lack legal protection against domestic economic violence. (81) Although countries with laws against domestic violence increased from 71 to 76% between 2013 and 2017 (81), in more than one in three countries there are still no laws surrounding sexual violence experienced in the home, and for more than half, none surrounding domestic economic abuse (81).

Women are more likely to tolerate domestic abuse in countries with fewer legal provisions, so these laws are an essential component of eliminating domestic violence. (80)

Evidently, despite having come a long way in the past half of a century, there is still work to be done.

References:
8. United Nations Office on Drugs and Crime (UNODC), Global Study on Homicide: Gender Related Killing of Women and Girls 2018


65. Inter-Parliamentary Union (2016). Sexism, harassment and violence against women parliamentarians, p. 3


Bylaws Paragraphs concerning Policy

Bylaw Paragraph 17.2 Definitions

a. Policy statement: Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement includes neither background information, discussion related to the policy, a bibliography and nor does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.

b. Position paper: A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.

c. Policy Commission: A policy commission is composed of three people, with 2 representatives of the NMOs and one Liaison Officer. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
   i. They are responsible of the quality of the policy document with the approval of the proposer.
   ii. Ensuring the content is based on global evidence.
   iii. Collecting and incorporating NMO feedback after the call for input.
   iv. Coordinating the discussion during the General Assembly.

d. Policy Reviewing Committee: A policy reviewing committee is composed of Vice-President for External Affairs, with 3 representatives of the NMOs. A Policy Reviewing Committee shall submit a report to the Executive Board and the National Member Organizations according to Annex 1. A report shall include the review of all submitted policies and reasons behind the final recommendation.

Bylaw Paragraphs 17.3 -17.7 Adoption of policies

- A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer in accordance with Annex 1. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.

- The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.

- Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.

- A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires ⅔ majority.

- Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the timezone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require ¾ majority to pass.