Women's Health East
Investing in Equality and Wellbeing for Women

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Victorian LGBTIQ Strategy

Submission by Women's Health East – August 2020

Women's Health East's submission is endorsed by:

About Women's Health East

Women's Health East (WHE) applauds the Victorian Government's commitment to equality and welcomes the opportunity to provide input into Victoria's LGBTIQ Strategy.

Women's Health East is a regional women's health promotion agency working across the Eastern Metropolitan Region of Melbourne. The region covers seven local government areas which include Yarra Ranges, Knox, Maroondah, Manningham, Monash, Whitehorse and Boroondara. Working within a feminist framework, WHE addresses the social, cultural, economic, political and environmental factors impacting on the health, safety and wellbeing of women in the region.

Our vision is equality, empowerment, health and wellbeing for all women and our purpose is to drive action to build an equitable society. Guided by evidence and informed by women's lived experiences, we strengthen the capacity of the organisations to improve women's health and wellbeing.

Our key priorities are:

- Advance Gender Equality
- Prevent Violence against Women
- Improve Women's Sexual and Reproductive Health

Our work at WHE is underpinned by a social model of health which aims to address the broader influences of health with an intersectional approach to understand the intersecting and overlaying inequities individuals or communities experience in relation to a person's gender, race, ethnicity, income, Aboriginality, age, education and other factors. Building on this approach WHE ensures a primary prevention focus within our work. This is essential to allow equitable access to and experience of health for all through preventing ill-health or inequality before it occurs.

In 2019 Women's Health East published *Young & Queer in Melbourne's East*[1] to address issues of equity and inclusion for LGBTIQ young women accessing sexual and reproductive health services, and *(Re)shaping Respect: LGBTIQ young people talk healthy, equal relationships*[2], to better understand the dynamics of LGBTIQ young people's relationships with intimate partners and family members and the broader societal factors that influence these relationships. These research reports have given us valuable insights into the barriers and enablers to equitable health and wellbeing outcomes for LGBTIQ women and people.

Recommendations

After reviewing the discussion paper, Women's Health East recommends the LGBTIQ Strategy incorporates a more thorough assessment of power, privilege and oppression. While the discussion paper clearly articulates the health and wellbeing impacts of discrimination and abuse, it does little to analyse (or even acknowledge) how systems shape health outcomes. The development of the Strategy presents an opportunity to interrogate the structural production of discrimination and abuse (as by-products of homophobia, biphobia and transphobia) and put forward a framework that aims to transform the heteronormative, cisnormative and patriarchal systems that create power differentials.

To support this multilayered approach, Women's Health East recommends the Strategy:

- Promotes a clear and consistent application of intersectionality to underpin intersectional solutions
- Incorporates a primary prevention lens to address the underlying drivers of health and wellbeing outcomes and to align with leading strategies and frameworks
- Acknowledges and builds on existing work within the violence against women sector that challenges the overlapping drivers of violence against women and violence against LGBTIQ people and communities
- Recognises the historical and ongoing impacts of gender inequality and sexism on LGBTIQ women

These recommendations are consistent with those put forward in our 2019 research report *(Re)shaping Respect: LGBTIQ young people talk healthy, equal relationships*, which include:

- Address the drivers of LGBTIQ violence, heteronormativity and rigid binary concepts of gender and sex, and the condoning of violence against LGBTIQ people
- Undertake action to transform the norms, practices and structures that result in discrimination and violence against LGBTIQ people across our society
- Address gender inequality because patriarchal systems disadvantage everyone, including LGBTIQ people
- Continue to build evidence through well documented and evaluated programs and initiatives
- Fund LGBTIQ family violence prevention initiatives

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- Sustain prevention of violence against women partnerships, led by Women's Health Services across Victoria, to strengthen the focus on LGBTIQ women in regional action plans

Key areas for strengthening

Promote a clear and consistent application of intersectionality to underpin intersectional solutions

There are several examples within the discussion paper that demonstrate an inconsistent understanding of intersectionality and the interplay between social location and systems and structures of power. The discussion paper includes 'an overview of how multiple forms of systemic discrimination can create social inequality' (pg 4) and describes intersectionality as:

> *A theoretical approach that understands the interconnected nature of social categorisations — such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age — which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group* (pg 15)

These references to and definitions of intersectionality frame inequality as a result of factors, such as gender and sexual orientation, rather than 'the outcome of different social locations, power relations and experiences' based on those factors.[3,4] Suggesting it is the interconnected nature of social categorisations that create systems of discrimination or disadvantage obscures the order of events – it is in fact the systems designed to privilege some over others that assign social categorisations and attach to them unequal value, which in turn results in discrimination and disadvantage. It is imperative the Strategy acknowledge the imposition of the 'problem' and distinguish between the root causes of the 'problem' and the ways in which people and communities experience the 'problem.' Dr. Olena Hankivsky, Founder and Director of the Institute for Intersectionality Research and Policy at Simon Fraser University in Vancouver, Canada, puts forward the following definition of intersectionality:

> *Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., 'race'/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.*[3]

In a Strategy intended to promote and guide intersectional practice, it is vital to differentiate between identities, attributes and experiences and acknowledge how they are shaped and informed by the imposition of social categorisations and the value assigned to them at a point in time. An intersectional approach would ensure the issues are not presented as existing within and between 'marginalised' groups of people, as they currently are in the discussion paper:

> *LGBTIQ people of faith may experience trauma and rejection from within their faith communities, and unique struggles reconciling their sexual or gender identity with their faith* (pg 18)

> *Multicultural communities may have a poor understanding of LGBTIQ diversity and LGBTIQ communities may not adequately embrace cultural diversity* (pg 19)

LGBTIQ people with a disability may experience ableism by LGBTIQ communities and discrimination or prejudice based on their sexual orientation or gender identity by other people living with a disability (pg 20)

It is note-worthy that the only time ableism is mentioned in the discussion paper is to describe ableist attitudes within LGBTIQ communities (rather than included as an overarching analysis of systems of oppression). This approach is counter-productive to the aims of the Strategy and has several consequences, including:

Supporting deficit discourse

''Deficit discourse' refers to discourse that represents people or groups in terms of deficiency – absence, lack or failure. It particularly denotes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded'.[5] Evidence suggests problem-based narratives actually impact on health itself,[5] which has important implications for a strategy informed by 'do no harm' principles. The Strategy must find a balance between acknowledging the 'realities of disadvantage' and health disparities while also acknowledging the complexities of social context.

Shifting the focus away from the imposed structures of oppression that influence community understandings of diversity and culture

In 2015 Public Broadcasting Service (PBS) America released a map of gender-diverse cultures, highlighting that 'on nearly every continent, for all of recorded history, thriving cultures have recognised, revered and integrated more than two genders'.[6] The normalisation of the gender binary in Australia was the result of the colonial imposition and violent enforcement of heteropatriarchy and cisnormativity,[7] which is now deeply entrenched (along with white supremacy) after 200 years of dispossession. The Strategy must interrogate the structures of oppression that continue to normalise the gender binary and produce sexism, homophobia, biphobia and transphobia to coerce conformity.

Obscuring similarities and reinforcing differences between groups

In 2019 Karla McGrady, Senior Practice Advisory at Our Watch and proud Aboriginal woman, spoke at Women's Health East's AGM and made clear: 'The same system that creates inequality for women is the same system that racially discriminates, and is ableist, heteronormative and xenophobic.' The construction of social categories divides, rather than connects people over their shared relationships with power,[3] particularly when culture is weaponised and used to create fear.[8] Reinforcing points of difference can discourage and impede collaborative community action.[3]

Further perpetuating stereotypes by suggesting culture is something 'other people' have[4]

Everybody has culture, but positioning 'mainstream' Australian society as neutral fuels ethnocentrism and assumptions that underpin implicit biases, and can reinforce cultural stereotyping.

The Strategy presents an opportunity to highlight learnings from intersectional work that challenges, rather than reinforces stereotypes. For example, the *Our Voices, Changing Cultures* project[9], delivered by Multicultural Centre for Women's Health in 2016, was open to same-sex attracted

women from culturally diverse migrant and refugee communities and used storytelling and theatre techniques to explore topics of visibility, the idea of coming out, the role of culture, and mental health and wellbeing. The aim was to gain insight into the specific cultural contexts through which these women experience their lives and sexualities to both support participants and to assist the youth and mental health sectors to better address the needs of same-sex attracted young women from culturally diverse migrant and refugee communities. The project promoted a sophisticated understanding of culture that understood its fluidity, diversity and rootedness in the social, political and economic structures relevant to a given context, and thereby rejected a simplistic deficit model of culture. Project participants citied culture as a 'grounding force.' This is in stark contrast to the discussion paper's representation of multicultural communities.

At the community level, *Our Voices, Changing Cultures* addressed the 'double trouble' of homophobia and transphobia within their cultures and racism and religious intolerance from within LGBT communities, but it is government's role at a systemic level to address the production of homophobia, biphobia, transphobia, racism and the overarching systems of oppression. *Safe Spaces, Inclusive Services: Support service access and engagement by LGBTIQ+ Muslims*,[10] a research project aimed at improving understanding of the unique service needs and delivery requirements for members of the Muslim LGBTIQ+ community, includes in its report:

> *While exploring how LGBTIQ+ Muslims address and manage stresses can provide practical insight into means of promoting resilience and encouraging the access of health and community services, it does not excuse or decrease structural and institutional responsibility and culpability.*

Incorporate a primary prevention lens to address the underlying drivers of poor health and wellbeing outcomes and to align with leading strategies and frameworks

Our understanding of primary prevention approaches to tackle complex social issues is largely informed by frameworks developed to guide the prevention of violence against women. The theoretical and evidence base for the primary prevention of violence against women was first introduced in 2007, when VicHealth released a framework for action[11] to support the government, community and corporate sectors to address the social and economic determinants of violence against women, with the aim of preventing violence before it occurred. In 2015 Our Watch built on this work to develop a national evidence-based framework for a consistent and integrated approach to preventing violence against women. *Change the story*[12] describes primary prevention as follows:

> *Primary prevention requires changing the social conditions, such as gender inequality, that excuse, justify or even promote violence against women and their children. Individual behaviour change may be the intended result of prevention activity, but such a change cannot be achieved prior to, or in isolation from, a broader change in the underlying drivers of such violence across communities, organisations and society as a whole. A primary prevention approach works across the whole population to address the attitudes, practices and power differentials that drive violence against women and their children.*

The socio-ecological model is often utilised to conceptualise the idea that individual behaviour and experiences both shape and are shaped by the social environment or context. We know that violence and abuse do not happen in a vacuum, and that family violence experienced by LGBTIQ people mirrors the violence LGBTIQ people experience in the broader community.[13] Rainbow Health's *Pride in Prevention: A guide to primary prevention of family violence experienced by LGBTIQ*

communities[14] identifies drivers of family violence experienced by LGBTIQ communities, but emphasises that they are 'likely better understood in the broader societal context of marginalisation and discrimination faced by LGBTIQ communities'.

Yet there is little in the discussion paper exploring how harmful behaviours are shaped by dominate norms (ideas, values, beliefs and attitudes) that are reflected in our institutional or community practices and reinforced by social structures. For example, in Australian society perceptions of the 'natural' way to marry, reproduce and parent continue to be informed by patriarchal, heteronormative and cisnormative ideologies, and the discussion paper misses an opportunity to explore a social context that led to 38.4% of Australians voting 'no' to marriage equality in 2017.[15] A context that hampers the LGBTIQ communities' ability to recognise, or acknowledge, or speak up about violence has serious implications for efforts to promote equal and respectful relationships.

It is important for a whole-of-government strategy addressing discrimination, abuse and violence to reflect and align with the leading prevention frameworks and approaches. Our Watch's 2017 *Primary prevention of family violence against people from LGBTI communities: An analysis of existing research*[13] and Rainbow Health's 2020 *Pride in Prevention* both build on the drivers of violence introduced in *Change the Story* and draw links between individual behaviours and broader social attitudes:

> *Violence will fail to serve a function for the perpetrators if the prejudicial attitudes undergirding such violence are no longer supported by societal norms or by religious, legal and political doctrines.*[13]

These principles are reflected in other guiding frameworks. The vision of *Safe and Strong*,[16] Victoria's first Gender Equality Strategy, is a world in which all Victorians have 'access to equal power, resources and opportunities'. The *Equality Matters: Inclusion and Equity Statement*[17] acknowledges the power imbalances that drive violence, the overlapping nature of systems of oppression, and the attitudes, behaviours, policies and practices that hinder full and equal participation in society.

Addressing the structural drivers of violence against LGBTIQ people is one of the recommended guiding principles for all future prevention activities, put forward in Our Watch's *Primary prevention of family violence against people from LGBTI communities*:

> *This requires addressing gender structures, and heterosexism. Specifically designed prevention efforts to combat violence against LGBTI people must include an analysis of heterosexism and address the oppressive and institutional factors that generate and sustain harmful gender and sexuality stereotypes. This involves working at both the socio-structural level (such as through policy, legislation and institutional practices), and at the community or individual level (such as through direct participation or community mobilisation approaches).380 Importantly, this also requires a clear and explicit focus on the drivers of violence, that is, the structures, practices and norms that discriminate and oppress people with diverse sexualities and gender identities, rather than focusing on the identities of LGBTI people.*[13]

A focus on the norms, practices and structures as part of the social context would elevate the questions posed within the discussion paper, particularly as they relate to the groups of people identified on pages 16-23. For example, instead of focusing on LGBTIQ sex workers reluctance to access health, legal and policing services (pg 22) and their complex needs, the Strategy can investigate:

What is the lasting impact of laws and policies that have historically vilified LGBTIQ people and relationships?

How does trauma impact and shape people's engagement with the legal system and legal institutions today?

What are the consequences of multiple structures of oppression interacting?

What are the dominate social norms invalidating particular people and their experiences?

How has the system failed to protect people's right to autonomy and safety?

What organisational practices act as barriers to accessing health and support services?

Which protective factors in the broader community can be strengthened?

Applying a primary prevention lens to the Strategy would broaden its scope and sphere of influence without necessitating an exhaustive analysis of nuanced or unique experiences. By adopting a multi-layered 'systems' approach, rather than an 'issues' approach, the Strategy could focus on transforming at all levels the systems and structures from which inequity stems, while prioritising research to continue adding the evidence base to inform best practice.

It is critical the Strategy put forward measures that both mobilise the community from the bottom up while tackling the underlying drivers of violence from the top down. Primary prevention depends on a 'continuum of interdependent and interlinked strategies, where prevention efforts are integrated with early intervention and response initiatives'[12] to ensure equitable and respectful messaging is reinforced at every level and throughout every facet of society.

Acknowledge and build on existing work within the violence against women sector that challenges the overlapping drivers of violence against women and violence against LGBTIQ people and communities

Both feminism and queer theory question the dominant understanding and oppressive articulation of gender because it inherently positions women and LGBTIQ people and communities as inferior: 'Women and LGBTIQ communities are oppressed by the institutionalised sexism that underscores the supremacy of hegemonic masculinity (male, white, heterosexual, strong, objective, rational) over femininity (female, non-white, non-heterosexual, weak, emotional, irrational)'.[18]

Challenging the binary constructs of sex (women and men), gender (female and male) and sexuality (heterosexual and 'other') which underpin patriarchy and heterosexism is an essential part of challenging family violence experienced by cisgender, heterosexual people as well as LGBTIQ people. It is important for the Strategy to acknowledge evidence demonstrating the overlapping nature of the drivers of violence against women and violence against LGBTIQ people and communities and draw from and leverage the work of the women's health sector.

Pride in Prevention identifies important insights from an analysis of literature and research relating to LGBTIQ family violence – inequality and power, gender dynamics, cisnormativity and heteronormativity and intersectionality – all of which are central to intersectional feminist approaches that have laid the groundwork for an equitable society for all.

Inequality and power

'Gender inequality is a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunities',[12] meaning gender and power are intrinsically linked. *Change the Story* identifies gender inequality as the primary driver of men's violence against women, but evidence suggests gender inequality and the privileging of heterosexual, cisgendered masculinity also drives violence against LGBTIQ people[13]: 'Intimate partner violence is intimately connected to male dominance and sexism even if an abuser is not male, because intimate partner violence occurs within a culture, created by men, that condones violence as a strategy for dominant people to control subordinate people'.[19]

Gender dynamics

Change the story identifies rigid gender roles and stereotyped constructions of masculinity and femininity as a gendered driver of men's violence against women, but we know gender role socialisation dictating the 'right' and 'wrong' ways to be a 'woman' or a 'man' has implications for cisgender heterosexual women and LGBTIQ people alike because violence can be used to reinforce or maintain rigid gender roles and binary notions of sex and gender to 'punish' all non-conformers. [12-14] Gender norms can also trivialise, invalidate and contribute to the invisibility of violence in lesbian intimate relationships, for example, when they reinforce myths and stereotypes such as 'girls don't hit other girls', 'lesbian relationships are inherently egalitarian', and girls don't fight for real, they 'cat fight'.[13]

Cisnormativity and heteronormativity

Research has consistently found that men who hold traditional, hierarchical views about gender roles and relationships and subscribe to traditional constructions of masculinity are more likely to condone, tolerate, excuse or perpetrate violence against women,[12] and adherence to rigid ideas of masculinity has been identified as a strong predictor of homophobia.[13] 'Heterosexism and cisgenderism are systems which adversely affect all individuals, irrespective of sex, gender identity and/sexuality'.[13] Homophobia and transphobia can be regarded as a 'weapons of sexism' and they are mutually reinforcing – 'homophobia and transphobia operate to maintain a binary system of gender and sexist social relations and sexism helps maintain homophobia, heterosexism and transphobia'.[20]

Intersectionality

Intersectionality is rooted in feminist history and was coined by Kimberle Crenshaw, who cations against a siloed approach to complex social issues: 'The failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women.'[21]

The women's health sector offers fundamental infrastructure in the prevention of violence against LGBTIQ women and LGBTIQ communities more broadly. A key recommendation of the *(Re)shaping Respect* report is to recognise the important role reginal prevention of violence against women partnerships, led by Women's Health Services Victoria, play in strengthening the focus on LGBTIQ people who identify as women in regional action plans. We strongly recommend the Strategy is open

to synergies with the women's health sector and leverages our expertise in advancing gender quality and the primary prevention of violence.

CASE STUDY

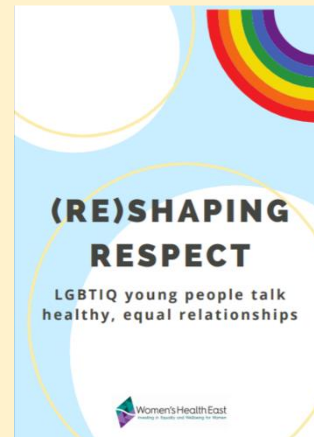
ADVOCACY WORK WTIHIN THE PREVENTION OF VIOLENCE AGAINST WOMEN SECTOR TO PROMOTE THE HEALTH AND WELLBEING OF LGBTIQ PEOPLE AND COMMUNITIES

Voices for Equality & Respect

The *Voices for Equality and Respect* project, funded by the Victorian Government, was undertaken by Women's Health East to better understand the dynamics of LGBTIQ young people's relationships with intimate partners and family members, and the factors that influence these relationships. Phase 1 of the project focused on exploring and improving LGBTIQ young people's knowledge and understanding of what creates an equal and respectful relationship, and to contribute to the evidence base about drivers of LGBTIQ family violence. Outputs of the project, including the *(Re)shaping Respect: LGBTIQ young people talk healthy, equal relationships* research report and the *Step Up: A guide for practice from the voices of LGBTIQ young people* resource are intended to support practitioners in promoting equal and respectful relationships among young LGBTIQ people.

The focus of Phase 2 was the dissemination of research findings and project learnings and included the following aims:

- Improve awareness and understanding among prevention of violence against women (PVAW) practitioners of LGBTIQ issues and existing gaps in research informing prevention efforts
- Improve awareness and understanding among PVAW practitioners of the link between gender inequality and LGBTIQ family violence
- Facilitate collaborations and partnerships for action on LGBTIQ issues at a primary prevention level
- Improve regional partner organisations' capacity to support LGBTIQ people



Two networks with existing infrastructure were identified to promote the relevance of this work in the prevention of violence against women space – the Victorian Women's Health Services (WHS) and the Together for Equality & Respect (TFER) Partnership. Victorian WHS is made up of state-wide, metro- and region-based women's health organisations with overlapping and coordinated strategic priorities (including prevention of violence against women). TFER is a platform for over 35 organisations in the Eastern Metropolitan Region to prioritise and work together on the primary prevention of violence against women. Partner organisations represent the family violence, community health legal and local government sectors and include DHHS, DET, PCP, PHN and VicPol.

(Re)shaping Respect findings and learnings were presented both at a WHS PVAW Network Meeting in March 2020 and a TFER Community of Practice (CoP) in June 2020. Eleven women's health organisations from across the state attended the WHS PVAW Network Meeting, including peak bodies Gender Equity Victoria and Women with Disabilities Victoria. To support our

presentation, the session featured presentations from Our Watch, Rainbow Health Victoria, and Women's Health Grampians, who provided an overview of their Equality for All program. Two Equality for All advocates also shared their experiences of intersectional discrimination as an LGBTIQ woman and an LGBTIQ woman living with a disability. An analysis of the evaluation data from the session revealed:

- 100% of respondents felt very equipped to take the *(Re)shaping Respect* learnings back to their respective regional partnerships as a result of the session
- On average, a 74% increase in understanding that the same harmful constructs of gender that drive violence against women also contribute to violence against LGBTIQ people (100% of respondents reported they have extensive understanding of the overlap as a result of the session)
- On average, a 34% increase in confidence to discuss the benefits of advancing gender equality to prevent violence against LGBTIQ women (100% of respondents reported they felt 'very confident' to discuss the benefits as a result of the session)
- On average, a 72% increase in likeliness to investigate opportunities for collaborative work in the LGBTIQ space (100% of respondents reported they were 'very likely' to investigate opportunities as a result of the session)

Interestingly, before the session, overall participants already felt confident discussing the benefits of advancing gender equality to prevent violence against LGBTIQ women. Also of note, the participants working with multicultural women (leaders in intersectional practice) demonstrated the highest 'before' knowledge and understanding of overlapping drivers of violence. When asked what further support participants required to promote this work among their regional partners, one participant answered, 'Having a regional LGBTIQA+ reference group to assist with co-designing programs or collaboration with LGBTIQA+ organisations in the region.'

Nineteen people participated in the TFER CoP, delivered via Zoom. Seventy-five percent of participants reported as a result of the session they had more confidence discussing with their colleagues the benefits of advancing gender equality to prevention violence against LGBTIQ women, while 100% of participants reported they were more likely to investigate opportunities to progress work in the LGBTIQ space as a result of the session.

Intersectional practice is part of the core work of the women's health sector, which provides a fundamental infrastructure for preventing violence against LGBTIQ women, and LGBTIQ people and communities more broadly by promoting gender equality.

Recognising the historical and ongoing impacts of gender inequality and sexism on LGBTIQ women

While our understanding of intersectionality has evolved to encompass the interplay between factors beyond gender, it is important to acknowledge that redressing the historical imbalance of power between traditionally constructed notions of 'women' and 'men' can exist within an intersectional framework that challenges the binary understanding of gender. In keeping with an approach that focuses on the imposing effects of systems of oppression, we strongly recommend the Strategy address the historical and ongoing impacts of patriarchal systems on women, including LGBTIQ women, to investigate compounded disadvantage.

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Manifestations of gender inequality for women in Australia[22]

- In Australia, women's superannuation balances at retirement are 47 percent lower than men's, and as a result are more likely to experience poverty in their retirement years and be far more reliant on the Age Pension
- Australia's current gender pay for full-time work is 15.3 percent
- Employers in women-dominated industries such as health care and social assistance are paid significantly less than employees in men-dominated industries
- Women are more likely to be in casual employment than men: 25.5 percent of all female employees in Australia are casual compared to 19.7 percent of male employees
- Victorian women are over-represented as part-time workers in low-paid industries and in insecure work, and continue to be underrepresented in leadership roles in the private and public sectors
- Women spend 64.4 percent of their average weekly working time in unpaid care work compared to men
- Raising children accounts for a 17 percent loss in lifetime wages for women

The global pandemic has amplified and exacerbated these existing gender inequities in alarming ways[22]:

- Women are disproportionately represented in sectors shut down by the pandemic, meaning more women have lost their jobs as a consequence of COVID
- Women are disproportionately represented in areas of the low paid service economy that have remained open, on the 'frontlines' (healthcare, education, social assistance, food retail)
- Women who have kept their jobs throughout the pandemic have experienced a greater reduction in hours worked than men who have kept their jobs
- Women were already more likely to assume unpaid caring roles (for children, older people, people with disabilities) and the closures of schools, support services, etc. in response to COVID has increased the burden for women
- Women are overrepresented in casual and insecure work and have therefore been more likely to both lose their jobs *and* be ineligible for support under the Government's Job Keeper package

Women are already more likely than men to live below the poverty line, meaning the economic response has serious implications for women, especially in light of Victoria's return to lock down. In addition, the Government's COVID recovery plan relies heavily on investments in male-dominated industries, further disadvantaging women in the long-term. Richard Denniss, Chief Economist and former Executive Director of the Australian Institute has highlighted the 'female employment multiplier' and redirecting stimulus spending to redress the existing imbalances that have only been exacerbated with the onset of COVID.[23]

The Strategy must explore the impact of intersecting systems of oppression – While women are more likely to live below the poverty line, we also know LGBTIQ people are three times more likely to be homeless than heterosexual people.[24] The Australian Longitudinal Survey of Women's Health found that lesbian women between the ages of 22 and 27 were less likely to have secure employment, more likely to have lower personal incomes, and more likely to lose a job than their heterosexual counterparts.[25] Furthermore, Rabelo and Cortina explored gender harassment and heterosexist harassment in LGBQ work lives and found that harassment experiences (gender

harassment – sexist, gender harassment – policing) rarely occurred absent of heterosexist harassment).[26]

In closing

We want to conclude by sharing further insights from (Re)shaping Respect, which was informed by the voices of young LGBTIQ people. Young people talked about the importance of increased visibility of LGBTIQ relationship and increased access to multiple and diverse models of healthy relationships, both queer and non-queer. We strongly encourage that instead of pointing to 'What LGBTIQ communities do well' (pg 25), which can inadvertently suggest LGBTIQ communities are not doing something well (especially when introduced in the discussion paper directly after pages of statistics quantifying disadvantage) that the Strategy also recognises and celebrates LGBTIQ people and relationships and queer culture. Rejecting sexist, heteronormative, cisnormative expectations and pressures is to be applauded, as one Voices for Equality and Respect project participant articulates:

> *In the women-loving-women community specifically, one of the wonderful perks that I find of relationships and friendships and more that I've had with women is the fact that, when we look at one another and we look at ourselves, we wouldn't hate an imperfection, a societal imperfection in the other person. Why should we hate it in ourselves? It's the most wonderful and beautiful freedom that we've discovered.*[2]

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