CARE AUSTRALIA

Rapid Gender Analysis of COVID-19 in Australia

2 April 2020, Version 1

By My Linh Nguyen, Anuradha Mundkur, Tegan Molony, Athena Nguyen, Ratha Ra, and Trina Howley

care®

Author

My Linh Nguyen, Anuradha Mundkur, Tegan Molony, Athena Nguyen,
Ratha Ra, and Trina Howley – CARE Australia
www.care.org.au

Contents

Acronyms

AWAVA	Australian Women Against Violence Alliance
CALD	Culturally and Linguistically Diverse communities
CDC	Center for Disease Control (United States)
COVID-19	Novel coronavirus 2019
DPO	Disabled Persons Organisations
EAP	Employee Assistance Program
GBV	Gender-Based Violence
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Plus
MHPSS	Mental Health and Psychosocial Support Services
NACCHO	National Aboriginal Community Controlled Health Organisation
RGA	Rapid Gender Analysis
SRH	Sexual and Reproductive Health
WHO	World Health Organization

Executive Summary

First detected in China's Hubei Province in late December 2019, the novel coronavirus 2019 (COVID-19) has spread to 180 countries/regions, with 937,567 confirmed cases recorded. In Australia, as of 2nd April 2020, 4,976 confirmed cases were recorded.

The COVID-19 pandemic is not just a healthcare crisis but is having far-reaching impacts on the economy and the social fabric of countries. Australia is no different. While the proportion of COVID-19 cases in males and females is roughly equal, various groups are impacted differently. Women and people with disabilities and Aboriginal and Torres Strait Islander women who have poorer health outcomes are at a higher risk of infection. Barriers in accessing information and medical and other health services exacerbate this higher risk. Women make up almost 80 per cent of the health and social assistance industry, and this means more women than men will be on the frontline of the response to COVID-19, putting them at higher risk of exposure.

The COVID-19 pandemic has significantly impacted the Australian economy, with the Australian Government estimating one million people could be made unemployed. The impact on the economy is compounded by the destruction of local businesses and homes during the recent bushfire season. Four-fifths of employed Australians (80 per cent) work in industries providing services, such as health care, education, and retail. These sectors are the hardest hit by the economic impacts of COVID-19. Many part-time and casual workers, of which women comprise the majority, are most likely to be laid off or given shorter hours during the crisis and post-crisis. Unpaid caring labour falls more heavily on women because of the existing structure of the workforce and gendered social norms. Women are paid less and perceived to have more flexibility from doing casual or part-time jobs. As a result, women will be expected to undertake unpaid care work.

Key findings

The existing unequal division of labour in the household will be exacerbated as COVID-19 stretches healthcare systems. As a result, care responsibilities will fall to women and girls, who usually bear responsibility for caring for family members who are ill and the elderly.

Following global trends in other countries affected by COVID-19, the Australian Women Against Violence Alliance (AWAVA) has warned of a possible spike in family violence cases as an increasing number of people self-isolate at home. Evidence from previous public health crises indicates that there can be increased rates of child exploitation and abuse.

Quarantine, self-isolation, and increasing lockdown measures by federal and state governments have severely affected the mobility and access to all public services for everyone. However, these measures have had differential impacts on diverse genders and ages.

Key recommendations

The COVID-19 outbreak in Australia could disproportionately affect diverse genders and other marginalised groups in many ways, including adverse impacts on paid and unpaid care work, increased gender-based violence, and decreased access to health and public services. In Australia, women are the primary caregivers in the family. They are also critical frontline responders in the health care system, placing them at increased risk and exposure to infection. COVID-19 risks increase the workload of this already over-burdened sector; caring for children unable to attend school as schools close, and caring for the sick (both at home and as workers within the health system). Additionally, as with all crises, there is the potential for an increase in family violence. This RGA makes the following recommendations.

- Recommendation 1: Ensure availability of sex and age disaggregated data to inform COVID-19 response and recovery. COVID-19 impacts not only health but also economic and social wellbeing, and therefore data should be collected on impacts on livelihoods, physical and mental

wellbeing, gender-based violence, and child protection. This will enable better monitoring of these key issues and supports a holistic response to COVID-19.

- Recommendation 2: Ensure public health messages appropriately target women, including those most marginalised. It is highly recommended that multi-sector actors responding to COVID-19 consult representatives from indigenous communities, women's rights organisations, CALD communities, GBV service providers, LGBTQI+ organisations and disability organisations to tailor communication messaging and mediums to the needs and preferences of each group.

- Recommendation 3: Protect essential health services for women and girls, including sexual and reproductive health services. Provide priority support to diverse women on the frontlines of the response, for instance, by improving access to appropriate personal protective equipment and menstrual hygiene products for healthcare workers and caregivers, and flexible working arrangements for women with increased unpaid care workloads.

- Recommendation 4: Prioritise services for prevention and response to gender-based violence in communities affected by COVID-19. The government must support frontline agencies to resource and plan for maintaining continuity of care and scaling of service delivery.

- Recommendation 5: Tailored responses through targeted consultations. The National COVID-19 Coordination Commission (NCCC) must consult with diverse women's organisations to provide gender and socially inclusive advice on a response to COVID-19.

Introduction

Background information – COVID-19

First detected in China's Hubei Province in late December 2019, the novel coronavirus 2019 (COVID-19) has spread to 180 countries/regions, with 937,567 confirmed cases recorded by the Centre for Systems Science and Engineering at Johns Hopkins University as of 2nd April 2020.[1] The COVID-19 outbreak was declared a public health emergency of international concern on 30th January 2020 and subsequently a global pandemic on 11th March 2020 by the World Health Organization (WHO).

Although sex-disaggregated data for COVID-19 show equal numbers of cases between men and women, there appear to be differences in mortality and vulnerability to the disease.[2] Preliminary reports suggest that men may be slightly more at risk of contracting coronavirus than women—the risk increases by 2.5 times for those with two or more pre-existing medical conditions. China's Centre for Disease Control (CDC) reports the death rate for healthy individuals at 0.9 per cent, while for those with cardiovascular disease, it was 10.5 per cent.[3] China's CDC found that 106 men had the disease for every 100 women, while another earlier study of over 1000 COVID-19 patients in Wuhan found a greater imbalance, with 58 per cent of confirmed cases being men. The mortality rate for men is higher, at 2.8 per cent compared to 1.7 per cent for women, and could be attributed to the fact that men are more likely to have pre-existing conditions such as heart disease. However, current sex-disaggregated data are incomplete, cautioning against early assumptions.[4]

In Australia, as of 2nd April 2020, 4,976 confirmed cases were recorded.[5] The proportion of COVID-19 cases in males and females is roughly equal. The majority of cases are reported in those aged 20 to 69 years.[6] More women than men in the 20-29 age range have COVID-19, while more men in the 40-49 and 60-89 age ranges have been infected. Just six cases have been recorded in children under 10.[7] There are currently no known cases of the virus among Indigenous Australians.[8] The National Aboriginal Community Controlled Health Organisation (NACCHO) is working with state and federal health authorities to prevent or control any outbreaks.

Graph 1: COVID-19 cases in Australia by gender and age (2nd April, 2020).
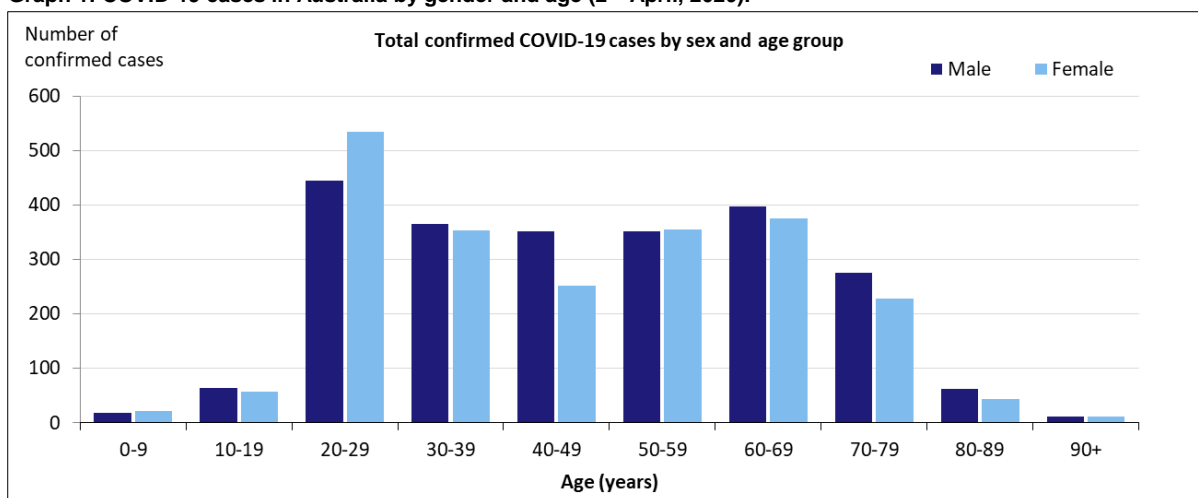
Source: Australian Government, Department of Health

The Rapid Gender Analysis objectives

This preliminary Rapid Gender Analysis has the following objectives:

- To analyse and understand the different potential impacts that COVID-19 potentially has on diverse genders in the Australian context and their current needs and capacities.
- To inform the response to COVID-19 in Australia based on the different needs of diverse genders and ages with a particular focus on (i) unpaid and paid care; (ii) gender-based violence; (iii) access to health and public services.

Methodology

This Rapid Gender Analysis (RGA) provides information on the different needs, capacities, and coping strategies of women, men, boys, and girls to the outbreak of COVID-19 in Australia. The purpose is to understand gender roles and relations and how they may change during the crisis. This RGA is based on an analysis of existing secondary data. The RGA was conducted from 23 March to 2 April 2020.

Demographic profile

Sex and Age Disaggregated Data

As of 30th September 2019, Australia's population was 25,464,116.[9] People aged 20 to 44 years comprise 38 per cent of the combined capital city population, compared with 30 per cent of the population in the rest of Australia. Older adults aged 45 years and above comprise a smaller proportion of the population in capital cities (37 per cent) compared to the rest of Australia (45 per cent).[10]

In 2018 there were 4.4 million Australians (17.7 per cent of the population) living with a disability. The prevalence of disability increased with age - 11.6 per cent of people aged 0-64 years had disabilities compared with 49.6 per cent of people aged 65 years and above. Disability prevalence was similar for males (17.6 per cent) and females (17.8 per cent).[11]

According to 2018 statistics, people aged 65 years and above made up 15.9 per cent of the total population (3.9 million). Many older Australians (persons aged 65 years and above) live in households (95.3 per cent), with 4.6 per cent living in cared accommodation. According to the 2016 census, there were 86 men, aged 65 and above, for every 100 women. For the 65 to 74 years age group, there were 95 men for every 100 women. This figure decreased with increasing age, with 85 men for every 100 women in the 75 to 84 years age group, and 59 men for every 100 women aged 85 years and over.[12]

The estimated resident Aboriginal and Torres Strait Islander population of Australia (2016) was 798,400 people (3.3 per cent of the total Australian population).[13] The estimated resident population of Aboriginal and Torres Strait Islander females was nearly 400,000 (3.2 per cent of the Australian female population), and they outnumber males in older age groups (122 Indigenous women for every 100 Indigenous men aged 65 or over).[14]

Aboriginal and Torres Strait Islander women experience poorer health than other Australian women as a result of dispossession, forced removals from family, racism, marginalisation, and exposure to violence.[15] With serious respiratory conditions, high heart problems, diabetes, circulatory and kidney diseases, and obesity, Aboriginal and Torres Strait Islander people, particularly women, are highly vulnerable to the outbreak of COVID-19. [16] Further, the close-knit nature of Aboriginal and Torres Strait Islander communities put them at particular risk of infection. However, the importance of interconnectedness to Aboriginal communities will place additional social and cultural strain on Indigenous communities if social distancing measures are required.[17]

Australian Government's responses to the pandemic

Australian Government's responses to the pandemic

The Australian Government has announced an AUD$2.4 billion health package (the COVID-19 National Health Plan) to protect Australians from the impact of the pandemic, including vulnerable groups such as the elderly, those with chronic conditions, and Indigenous communities.[18] The COVID-19 National Health Plan consists of measures for planning, preparedness, and access to testing and treatment. The Plan includes measures to support Australians living in remote communities, in particular, Aboriginal and Torres Strait Islander people, Australians living in aged care facilities, older people, and people with a chronic condition who are at greater risk of serious illness.

The Australian Government has taken measures to ensure access to health services by expanding telehealth services programs to cover primary health care service providers. Telehealth services will be available to people isolating themselves at home on the advice of a medical practitioner, people who meet the testing guidelines for COVID-19, people aged over 70, Aboriginal and Torres Strait Islander people aged over 50, people with chronic health conditions or who are immunocompromised, and parents with new babies and people who are pregnant.[19] However, it is unclear how sexual reproductive health (SRH) and maternal and newborn health will be covered, especially for quarantined pregnant women[20]

and babies, and how emergency medical services for survivors of violence will be maintained.[21] Additionally, COVID-19 may disrupt SRH supply chains, including the supply of contraception.[22] This has been highlighted in reports concerning the forced shut down of Malaysia's Karex Bhd, the world's biggest condom producer, due to the lockdown in Malaysia.[23]

Australians living with a disability are a vulnerable population in the COVID-19 pandemic due to barriers in accessing information and medical and other health services, practicing preventative hygiene, and reliance on physical contact with the environment or support persons. Furthermore, people with disabilities may have pre-existing health (including respiratory) conditions related to their impairment resulting in a higher risk of not only contracting COVID-19 but also more developing serious illness or dying from COVID-19.[24] Nonetheless, the National Health Plan only has a targeted response for the aged care sector, but not the disability sector. However, "[b]oth sectors have many similarities including congregated settings, a precariously employed and inadequately trained care workforce, and families and carers who may face significant challenges meeting the care needs of people with disability in Australia."[25]

Although the national response includes a COVID-19 Remote Community Preparedness and Retrieval Plan,[26] Aboriginal and Torres Strait Islander health advocates have raised concerns about the under-resourced health services in remote areas. For example, remote areas in the Northern Territory rely on nursing staff from New Zealand, and new travel restrictions in Australia and New Zealand will exacerbate barriers to providing health services during the pandemic. The Chief Executive of the National Aboriginal Community Controlled Health Organisation (NACCHO), Pat Turner, has warned that "[i]f COVID-19 gets into our communities, we are gone."[27]

Findings and analysis

A crisis exacerbates existing gender inequalities, and COVID-19 is no different. With an increase in unpaid household and care work due to caring for the sick and for children whose schools have closed, coupled with a potential increase in paid care work,[28] COVID-19 places significant pressure on women. Additionally, as with all crises, there is the potential for an increase in family violence, as well as a potential diversion of healthcare and public services away from essential services for women and girls to address the crisis.

Unpaid and paid care

Before the outbreak of COVID-19

There is global evidence that at a household level, women are responsible for a bulk of unpaid household and care work.[29] Similarly, women in Australia spend nearly twice as long as men on primary activities associated with unpaid work.[30] According to the 2016 Census, 56 per cent of women in Australia were in paid employed, compared with 65 per cent of men.

On average, men spent nearly twice as long as women on paid work-related activities, while women spent nearly twice as long as men on primary activities associated with unpaid work. Women were also likely to spend more time on domestic activities (2 hours 52 minutes per day compared with 1 hour and 37 minutes per day for men) and childcare (59 and 22 minutes respectively per day).[31]

Employed women did more hours of unpaid domestic work such as housework, grocery shopping, gardening, and repairs than employed men. In 2016, over half of the employed men did nil or less than five hours per week of unpaid domestic work (60 per cent) compared with a third of employed women (36 per cent). Men were also less likely than women to do 15 hours or more per week of unpaid domestic work (8 per cent of men and 27 per cent of women). This pattern applied regardless of the number of paid work hours, even for those working more than 49 hours per week.[32]

For Aboriginal and Torres Strait Islander communities, women manage not only their own health but the health of their children, their partners, other relatives, and the community. Women who are healthy and health-literate are the single most important influence on the health of their communities.[33]

In 2012, 5.8 per cent of women and 2.6 per cent of men provided primary care to a person with a disability.[34] This gendered responsibility has increased. In 2018, women (12.3 per cent) were more likely to be carers than men (9.3 per cent).[35] There were 235,300 young carers (under the age of 25) in 2018. About 3.5 per cent of all Australians were primary carers, of which 71.8 per cent were women. Persons living with a disability were more likely than those without to provide this care (9.3 per cent women and 5.8 per cent men, compared with 4.9 per cent of women and 1.8 per cent of men with no disability).[36]

During the outbreak

This unequal division of labour in the household will be exacerbated as COVID-19 stretches healthcare systems, resulting in care work responsibilities falling to women and girls, who usually bear responsibility for caring for ill family members and the elderly.[37] Unpaid caring labour falls more heavily on women because of the existing structure of the workforce and gendered social norms. Women, who usually are paid less and are perceived to have more flexibility from doing casual or part-time jobs, are more likely to be expected to undertake unpaid care work.[38]

In addition to household and caring duties, the closure of schools will further increase the amount of unpaid care work as women and girls will be required to absorb the additional work toil of caring for children during what would have been school hours.[39]

Women are likely to feel the time stress more than men. On average, 42 per cent of Australian women feel they are always or often rushed or pressed for time compared to 35 per cent of Australian men. This is higher for those who provide care, rising to 46 per cent of men and 55 per cent of women. The main reasons women give for feeling rushed or pressed for time were trying to balance work and family responsibilities (31 per cent) and having too much to do and too many demands placed upon them (19 per cent).[40] There is also the added emotional labour – worrying about keeping children and ageing parents' safe and being supportive of partners/colleagues/friends who may have lost their jobs.[41]

The COVID-19 pandemic has significantly impacted the Australian economy, with the Government estimating that one million people could be made unemployed.[42] The impact is compounded by the recent bushfires with potentially devastating impacts upon regional businesses.[43] Four-fifths of employed Australians work in industries providing services, such as health care, education, and retail.[44] Women make up almost 80 per cent of the workforce in the health and social assistance industry.[45] This means that more women than men will be on the frontline of the response to COVID-19, putting them at greater risk of exposure. The education, retail and hospitality sectors will be the hardest hit by economic impact COVID 19. Many part-time and casual workers, of which women comprise the majority, are most likely to be laid off or given shorter hours during the crisis and post-crisis.[46]

Top four industries of employment

	Males	Females
TOP 1	Computer system design and related services — 122 529	Hospitals (except psychiatric hospitals) — 321 934
TOP 2	Cafes and restaurants — 115 279	Primary education — 197 671
TOP 3	Supermarket and grocery stores — 113 378	Aged care residential services — 177 219
TOP 4	Road freight transport — 110 581	Supermarket and grocery stores — 140 890

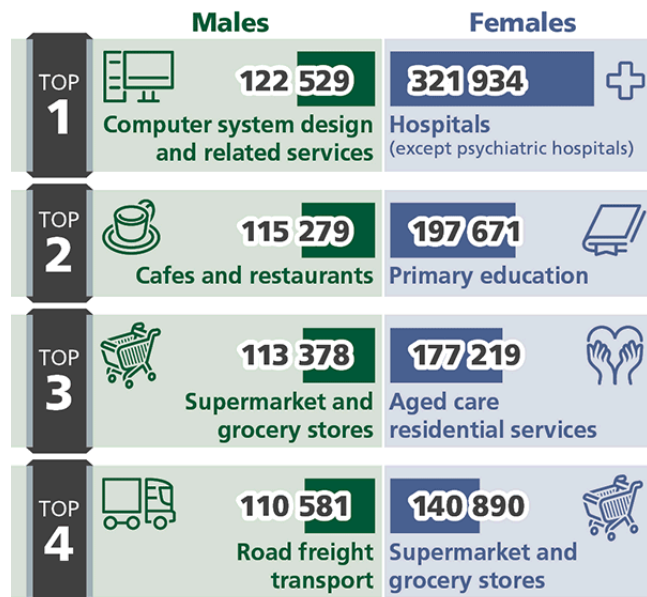Source: ABS, 2016 Census of Population and Housing

Gender-based violence

Family Violence

Following global trends in other countries affected by COVID-19, the Australian Women Against Violence Alliance (AWAVA) has warned of a possible spike in family violence cases as an increasing number of people self-isolate at home.[47] Globally, cases of gender-based violence tend to increase in times of disasters[48], and the COVID-19 pandemic is creating a number of triggers for violence such as financial pressures, close confinement of families, and narrowing of broader community contact.[49]

In Australia, 1 in 6 women and 1 in 16 men have been subjected, since the age of 15, to physical and/or sexual violence by a current or previous cohabiting partner.[50] This violence can repeatedly happen, with more than half (54 per cent) of survivors experiencing more than one violent incident. While men are more likely to experience violence from strangers and in a public place, women are most likely to know their perpetrator (often their current or a previous partner), and the violence usually takes place in their home.[51] According to Our Watch, one woman a week is killed by a current or former partner. Nine women have been murdered by men in Australia so far in 2020.[52] Family violence is also the leading cause of homelessness for women in Australia (approximately 44 per cent of homeless people in Australia are women).[53]

The incidences of family violence have the potential to increase further from this baseline as communities increasingly practice self-isolation, quarantine, or lockdown as part of the strategy to prevent the spread of COVID-19.

This coronavirus global health pandemic presents a new barrier to exiting abusive relationships, and increases the risk of pushing many Australian women and children to remain in violent and unsafe homes. In Australia, early reports indicate that there has been an increase in family violence. Liz Thomas, Chief Executive of Wayss, has reported an increase in support requests from 120 per week to 209 in the last week (as of 29th March 2020).[54] Cases reported to her service, Wayss, include perpetrators using COVID-19 as a means of further controlling their partner's movements and preventing them from leaving home, or threatening to infect women with COVID-19. This reflects similar trends from other crises in Australia, such as the 2009 Black Saturday bushfires, which saw in increase in family violence as people reverted to "strict gender norms during times of natural disaster and uncertainty such as men being the protectors and decision-makers and women being the carers."[55] This put women and children at risk of violence and dismissed or excused men's violence with statements such as "[h]e is just stressed."[56] Further, there are reports of perpetrators using COVID-19 as a form of abuse by telling their partners that they (the partners) have the virus; therefore, they cannot leave the house or inviting people into the house where the woman is self-isolating and saying to her that the visitor has COVID-19 and they are going to infect them.[57] Becoming infected with the virus may also prevent women from seeking help, as they are forced to self-quarantine and thereby unable to access walk-in support services.[58]

Women and girls living with disabilities are even more at risk as their social isolation, exclusion, and dependency may increase the extent of the abuse they are subjected to and can limit the actions they can take.[59] Studies show that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than women with no disabilities, and they also experience different forms of violence such as the denial of food or water, forced sterilisation, and medical treatment.[60] Those in same-sex relationships or from the LGBTIQ+ community also face increased risks of exclusion and violence, including increased rates of family violence, related to their marginalised status.[61] They may also face additional barriers to seeking support, such as discrimination, family violence, or related services being ill-equipped to provide adequate support or fear of reaching out to access services due to shame or stigma related to their sexual orientation or gender identity.

Resources for support services to address family violence were already tight before the COVID-19 pandemic. As recently as 6th March, federal and state women's safety ministers met in Canberra to discuss the need for major reform in handling the country's family violence crisis after over 80 organisations signed a letter by the AWAVA and Fair Agenda to call for "urgent and immediate changes to improve women's safety."[62] Budget cuts were a key concern with Fair Agenda's Executive Director, Renee Carr saying at the time, "[t]here are services that women are reaching out to right now that aren't sufficiently funded, and there are other services facing cuts."[63] The COVID-19 pandemic will put pressure on an already under-resourced system. It is vital that the family violence sector is deemed an essential service (as it has been in New Zealand) and that workers are supported and resourced to respond to survivors during the pandemic. This includes access to COVID-19 testing (as health workers have) and protective equipment to avoid transmission of the virus. Agencies need to activate contingency plans and share resources.

The system will be even further stretched as many health and social services, as well as the police, are likely to be diverted to respond to the COVID-19 crisis.[64] There will be increased demand on police personnel as they are deployed to enforced State-based containment measures, such as patrolling borders between States to monitor travel restrictions,[65] enforcing public health and ministerial orders including issuing fines,[66] and increasing their public presence to prevent the congregation of groups in communal areas. This will potentially reduce the police personnel and resources available to respond to family violence incidences or to undertake preventative community policing activities.

As a positive first step, on 29th March 2020, the Australian Government announced AUD$1.1 billion package to support more mental health, Medicare, and domestic violence services.[67] Of this, AUD$150 million will be dedicated towards family violence services and will support programs under the National Plan to Reduce Violence against Women and their Children including counselling, phone services such as 1800RESPECT and Mensline Australia, the Trafficked People Program, support for women and children experiencing violence to stay safely within their home or in a different home of their choice, and a new public communication campaign.

Child Protection

Evidence from previous public health crises indicates that there can be increased rates of child exploitation and abuse.[68] A recent *Technical Note on Protection of Children by the Alliance for Child Protection in Humanitarian Action* has documented some of the child protection risks observed in the current COVID-19 pandemic and some potential risks observed in previous infectious disease outbreaks.[69] Measures to contain COVID-19, such as restricted access to or closures of schools, kindergartens, childcare facilities and out-of-school care activities, confinement in homes, and increased

social and financial stress of carers, can have disproportionate impacts on children due to their increased vulnerability and dependency on caregivers. Child protection risks during a crisis can include physical and emotional maltreatment, gender and age-based violence; mental health and psychosocial distress; unaccompanied and separated children, and social exclusion.[70]

COVID-19 containment measures such as reduced school access or closures, restrictions on out-of-school activities, and general restrictions on movement can disrupt children's routines causing distress and impacting their education. In addition, for children who rely on those beyond the family for emotional or physical care, these measures will separate them from carers and support systems. Increased stress within the household – such as due to conflicting demands on carers to both work from home and undertake childcare responsibilities, or the stress of reduced or loss of employment - can impact the level of supervision and care children receive, including physical, social and emotional care. This may be compounded with other risk factors in the home, such as the increased risk of family violence (see above) or increased drug or alcohol consumption, which can exacerbate neglect, maltreatment, or violence.

In Australia, there is likely to be reduced access to child protection services as State and Territory governments implement measures to curb the spread of COVID-19. For example, containment measures implemented with the Courts, including Children's Courts, may result in delays and backlogs, as Child Protection Practitioners will be required to conduct their work remotely and rely on the use of technology to file and progress their applications, despite the prioritisation of urgent cases.[71] In addition, children requiring protection will also be impacted by the redeployment of health care, social workers, and police personnel, as detailed above (see Family Violence).

The closure or reduced access to schools and increased confinement of children in the home may result in children spending more time online resulting from the move to online education services as well as caregivers juggling other responsibilities such as working from home or caring for multiple children, other family members, or ill people. Children are already at an increased risk online, with one in five young reporting being socially excluded, threatened, or abused online.[72] Child abuse perpetrators are able to exploit online forms of communication to gain access to children and young people, and children may have relatively easy access to adult or harmful content.[73] Children may also spend increased time connecting with friends and peers online, which, whilst healthy for maintaining social connection and support, can also become a forum for cyberbullying. Increased time on the internet, combined with a reduced capacity of caregivers to oversee their online activities, can exacerbate the risk that children face from online harm and abuse.

As the spread of COVID-19 progresses, children are also be at risk of becoming separated from their caregiver as their caregiver may be quarantined, become ill, pass away, or become unavailable for other reasons.[74] Separations expose children to a greater risk of exploitation and abuse, as well as psychosocial trauma.[75] Separation from caregivers may exacerbate existing physical or mental illness or conditions which children may have as they struggle to care for themselves or adapt to new caregivers. In addition, children rely on caregivers to provide them with guidance on limiting exposure to COVID-19. Public health messaging and news reporting on the pandemic might not be accessible to children, and children depend on caregivers to provide them with accessible and child-friendly explanations of appropriate protective measures to take, such as handwashing and social distancing.

Access to health and public services

Quarantine, self-isolation, and increasing lockdown measures by federal and state governments have severely affected the mobility and access to all public services for everyone. However, these measures have had differential impacts on diverse genders and ages.

Health Services

Gender norms affect help-seeking behaviour, including a willingness to access health services. Australian men are less likely to seek treatment from health professionals than women, and they are less likely to have in place the supports and social connections needed when they experience physical and mental health problems.[76]

When attempting to seek health services, the COVID-19 response may heighten existing social and economic inequalities, including gender inequalities, in treatment and care.[77] The Australian health system is recognised as one of the best in the world. Yet there are equity issues in the access to health services and information, particularly for the indigenous community, people in rural and remote areas, people from culturally and linguistically diverse (CALD) backgrounds, people from areas of socio-economic disadvantage, the LGBTQI+ community, and people living with disability.[78] The availability of

medical attention for ill persons within a strained healthcare system may require prioritisation of patients, with reports that an Italian medical association has issued guidelines to doctors to prioritise younger COVID-19 patients over older patients as they have a greater chance of survival.[79] Although hospitals in principle should regard every human life as equally valuable,[80] differentials in social and financial status may have serious implications for marginalised or vulnerable groups including elderly men and women, those with chronic conditions or weakened immune systems, those from lower socio-economic backgrounds, minority cultural or ethnic groups, LGBTIQ+ communities, women, children, and people living with disability.[81]

Women and girls in controlling relationships or from communities where they have limited decision making power within households may be restricted from accessing health services or may not have access to resources to travel to hospitals and health care facilities for testing and care. This may be exacerbated in the case of women and girls living with disability.

With the priority of reducing the spread of coronavirus, Canberra Health Services (CHS) has decided to reduce all non-urgent and non-essential non-admitted activity. This will include community-based services, medical outpatients, procedures, and treatments.[82] Health services of other states might follow this direction in the coming weeks, which might pose a risk of having low access to health services by violence survivors or others with healthcare needs deemed 'non-essential.'

Sexual and Reproductive Health (SRH) services

Evidence suggests that during past public health emergencies resources have been diverted from routine health care services toward containing and responding to the outbreak.[83] These reallocations could affect access to sexual and reproductive health (SRH) services, such as clean and safe deliveries, contraceptives, and pre- and post-natal health care, safe abortions, and provisions for clinical management of rape.[84]

SRH advocates in Australia have raised the following concerns: (i) a shortage in the availability of contraceptives as a result of panic buying;[85] (ii) likely increase in unplanned pregnancies and increased sexual violence;[86,87] and (iii) delays in later gestation abortions due to travel restrictions.[88]

Given the long hours of work expected from frontline responders as the crisis escalates, it will be important to ensure that they have easy access to menstrual hygiene management.[89]

Mental Health

Stress, anxiety, and depression are normal and expected in the context of this pandemic. For those who are predisposed to depression and anxiety, the unique and unprecedented threat of COVID-19 has the potential to exacerbated anxiety and depression for those living with psychosocial disabilities or mental health issues.[90] Regular access to mental health and psychosocial support services (MHPSS) has been disrupted by the crisis putting individuals using or needing these services at risk. Further, MHPSS caseloads will likely increase during the COVID-19 outbreak, as frontline health workers themselves,[91] as well as women and girls with caregiving burdens and community members fearful of becoming infected or infecting others, may all experience stress and trauma relating to the outbreak.[92] A 2019 report highlighted an increase in mental health issues for adolescents, with almost a quarter of young Australians facing mental health challenges. The report indicated that young women are twice as likely as young men to be grappling with psychological issues and that there are higher rates for Aboriginal and Torres Strait Islander young people.[93]

Out of the Australian Government's AUD$1.1 billion package, an initial AUD$74 million will be provided to support the mental health and wellbeing of all Australians, including a new national communications campaign, a dedicated COVID-19 support line delivered by Beyond Blue, increased support for services such as Lifeline and Kids Helpline, support for healthcare workers, and support for older Australians to reduce social isolations, education and training support for younger Australians, specific programs for Indigenous Australians, and those with mental health issues.[94]

Access to Information and Health Messaging

As in all emergencies, access to clear information about the crisis is essential. During quarantine, self-isolation, or lockdown, access to telecommunications, including phone and internet, can minimise isolation and be a source of information on support and available services, including for GBV and SRH. Inequities in access to mobile phones and adequate internet access have been raised[95] by media outlets in Australia. Socioeconomically disadvantaged Australians, including single mothers, those with a disability, and those from remote indigenous communities, are particularly disadvantaged.[96]

Health messaging and mediums used should be diverse and tailored to different groups, including elderly women and men, adolescent girls and boys, indigenous communities, CALD communities, and those with

disabilities. Community awareness-raising campaigns must ensure that all populations have access to information on prevention and safety during the pandemic, including measures to reduce the spread of the virus and how to reach support services in the event of infection. The potential for violence in stressful home quarantine situations means it is also important to have a communications strategy to ensure people in their homes access to information about available family violence services such as helplines and crisis support, and messaging targeting perpetrators and bystanders.

Access to Basic Supplies

Panic buying and stockpiling seen recently in Australia's supermarkets is not an option for the economically vulnerable.[97] In Australia, more women than men live below the poverty line, and indigenous populations and people living with disability face elevated risks of poverty.[98] Stockpiling makes those already vulnerable, more vulnerable, potentially finding it difficult to sources supplies or having to pay more due to price surges. Women are also more vulnerable to long term negative economic impacts of the pandemic, as they are over-represented in casual employment without sick leave entitlements and also in industries likely to experience an economic downturn.[99] A part of the AUD$1.1 billion package announced by the Australian Government, AUD$200 million will be dedicated to supporting charities and other community organisations which provide emergency and food relief as demand surges as a result of coronavirus.[100]

Conclusions and Recommendations

The COVID-19 outbreak in Australia could disproportionately affect women, girls, and other marginalised groups in a number of ways, including adverse impacts on paid and unpaid care work, increased gender-based violence and decreased access to health and public services. In Australia, women are the primary caregivers in the family and are also the key frontline responders in the health care system, placing them at increased risk and exposure to infection. COVID-19 risks are increasing this already over-burdened workload adding caring for children unable to attend school and caring for the sick (both at home and as workers within the health system). Additionally, as with all crises, there is the potential for an increase in family violence.

Recommendation 1: Ensure availability of sex and age disaggregated data to inform COVID-19 response and recovery

There is currently limited sex-disaggregated data collected internationally on the impact of COVID-19. Of the 20 countries with the highest number of confirmed cases, only 13 have it available.[i] It is important to collect data that is disaggregated by sex, age, and disability (using Washington Group Questions[101]) and, if possible, also capture data on female-headed households, pregnant and lactating women, and people of diverse gender identities and expressions. COVID-19 impacts not only health but also economic and social wellbeing, and therefore data should be collected on impacts on livelihoods, physical and mental wellbeing, gender-based violence, and child protection. This enables better monitoring of these key issues and supports a holistic response to COVID-19.

Disaggregated data on health care workers who are infected with COVID-19 will provide information on whether they were infected at home or in a healthcare facility. Women who are healthcare workers tend to be primary caregivers at home as well, so a greater understanding of whether infections are acquired at home or in the healthcare setting is key to understanding transmission patterns.[102] Health facilities should have plans in place that reduce potential COVID-19 exposure to high-risk healthcare workers and reduce violence towards them.

Recommendation 2: Ensure public health messages properly target women including those most marginalised

It is highly recommended multi-sector actors responding to COVID-19 consult representatives from indigenous communities, women's rights organisations, CALD communities, GBV service providers, LGBTQI+ organisations and disability organisations to tailor communication messaging and mediums to the needs and preferences of each group.

Public health messages should be available in multiple languages, including indigenous languages. In those cases where self-isolation may not be possible, it is important to discuss with the community what culturally appropriate options are possible.

Public health messages provide an opportunity to promote the sharing of work and mutual support in a time of crisis. Communication campaigns need to ensure imagery depicts men and women working together to share household and caring work (cooking, cleaning, and caring for children) safely and hygienically to fight the spread of COVID-19.

Public health messaging around testing and the general health response must take into account diverse women and girls access to decision making power within households, restricted mobility, or lack access to resources to travel to hospitals and health care facilities for testing and care.

Recommendation 3: Protect essential health services for women and girls, including sexual and reproductive health services

It will be important for charity and community organisations to take into account gender and social dimensions in their provision of relief services.

Provide priority support to diverse women on the frontlines of the response, for instance, by improving access to appropriate personal protective equipment and easy access to menstrual hygiene products, and flexible working arrangements for women with increased unpaid care workloads.

To ensure access to safe abortions, mitigate emerging risks, maintain clinical operations, and ensure patient quality and safety, (i) abortion care should be considered an essential service throughout the pandemic, (ii) where possible, doctors and patients should be able to travel interstate or intrastate to deliver and access surgical abortion care , (iii) and Governments and non-government stakeholders must work collaboratively to ensure access to surgical abortion, particularly second trimester abortion, including shared care between private and community clinics and hospitals.[103]

It is vital the COVID-19 response includes mental health and psychosocial support (MHPSS) that is targeted to different and diverse groups in the community, including those who are living with the consequences of the pandemic (widows, widowers, etc.) as well as healthcare staff and frontline workers.

Disability support workers should be treated as an essential service and should be provided with personal protection equipment in order to continue providing services for people living with disabilities.

Recommendation 4: Prioritise services for prevention and response to gender-based violence in communities affected by COVID-19

The safety of women and girls must remain paramount during Australia's response to the COVID-19 pandemic. The Government must support frontline agencies to resource and plan for maintaining continuity of care and scaling of service delivery. Efforts should include maintaining continuity of care and scaling of service delivery, and governments must continue to support frontline agencies to resource and plan for this response. For example, safe crisis accommodation must remain available and accessible during the lockdown, protection orders must be maintained, and women and children must not be targeted by police or other enforcement agencies for defying self-isolation or quarantine orders in seeking safety. Ensure that emergency medical services for survivors of violence and all forms of crisis refuge accommodation are treated as essential services and will remain open. Keeping these services active will mean that State Governments will need to ensure staff managing these services have access to the required personal protection equipment.

While the announcement of AUD$150 million to be dedicated to family violence services is welcome, the adequacy of this funding needs to be assessed, and more dedicated funding needs to be allocated if the existing allocation is deemed insufficient. Further, dedicated allocation need to be sustained post-crisis as the economic and social impacts will continue to be felt once the pandemic has passed. Family violence services are already seeing a 20-30 per cent increase in demand for services. It is estimated AUD$180 million is required by the *Keeping Women Safe in their Home program* to meet Australia-wide demand. Urgent investment is also required in scaling up crisis accommodation, specialist outreach, and case management services so women can be supported to develop safety plans and set up safe living situations for themselves and their children. The shift to working online and phone support means that WESNET's safe phones program, which provides safe, smartphones, and tech safety advice to victims/survivors and frontline workers, is critical. Yet there is no guarantee that this service will continue beyond June 30th, 2020. Additionally, funding is required for disability support pensions, increasing refuge capacity, making women on temporary visas experiencing violence eligible for all health, services and income support, ensuring access to contraception and abortion, and ensuring victims/survivors can rely on civil protection orders. These critical issues must be addressed at the next COAG Women's Safety Council.[104]

There is a need for tailored responses for women with disabilities experiencing family violence, as women will be in isolation with abusive family members and reliant on them for their care. Further, the First Peoples Disability Network has drawn attention to the challenges of self-isolation and social distancing faced by people with disability, calling for urgent actions on three fronts – ensuring access to a specific outreach program, providing critical information provided in language and explained in an accessible way and scaling up access to disability equipment and supplies, particularly for regional and remote communities.

Women on temporary visas experiencing violence must be provided access to Medicare, all relevant services and income support, including in the event their jobs are lost due to the pandemic, and to the economic support payments.[105]

Awareness-raising is also required among the community, particularly decision-makers and employers, that staying home to be 'safe' from COVID-19 may not be the safest option for all. As workplaces, schools, and communal areas, such as shopping areas, increasingly close, information must be made available on where women and children can seek support, services, and safety outside the home if needed. Employers with staff working from home also have a duty of care. They need to identify staff who may have concerns about working from home, implement safe alternatives, and support supervisors to check in with staff who are vulnerable. In cases where there is not a complete lockdown, employers could consider allowing some staff to work from the office. All communications about COVID-19 should remind staff about their Employee Assistance Program (EAP) (if these are available) and extend the number of sessions offered through EAP. Communications could encourage staff who feel unsafe to develop or review their safety plans and provide information on emergency hotline services. Employers could explore paying (full or part of the cost) for short term accommodations if someone is a very high risk. Finally, if an employer has a family violence policy, this would be a good time to review the policy as these are usually developed to respond to violence in the workplace – but the workplace now being the home, parts of such policies may need to be revised or updated.

It is also essential that community awareness-raising messages, which thus far have focused on preventing the spread of COVID-19 through measures such as handwashing, also increase awareness on how to manage stress, anxiety, and aggression during self-isolation and other measures to prevent family violence.

Recommendation 5: Tailored responses through targeted consultations

The Australian Government has set up a National COVID-19 Coordination Commission (NCCC) that will coordinate advice to the Australian Government on actions to anticipate and mitigate the economic and social effects of the global coronavirus pandemic. Of the eight commissioners appointed on two are women (that is less than the internationally recommended 33 per cent of women in decision-making positions). Further, there appears to be no representation from culturally and linguistically diverse women, indigenous women, or women with disabilities. The NCCC must consult with diverse women's organisations to provide gender and socially inclusive advice on a response to COVID-19.

References

[1] Center for Systems Science and Engineering (CSSE), Johns Hopkins University (2020) *Coronavirus COVID-19 global cases*

[2] Wenham, C., Smith, J., Morgan, R. on behalf of the Gender and COVID-19 Working Group (2020), *COVID-19: the gendered impacts of the outbreak,* Lancet, Vol. 395, p.846-848.

[3] Pearce, L. (2020) *Coronavirus: Who is most at risk broken down by age, gender and health*

[4] Wenham, C., Smith, J., Morgan, R. on behalf of the Gender and COVID-19 Working Group (2020) *COVID-19: The gendered impacts of the outbreak*, Lancet, Vol. 395, p.846-848.

[5] Australian Government, Department of Health (2020) *Coronavirus (COVID-19) current situation and case numbers*

[6] Australian Government, Department of Health (2020) *COVID-19 cases in Australia by gender and age*

[7] Lawson, K. (2020) *By the numbers: Coronavirus hits Australians in mid-life*

[8] Atkinson, S (2020) *Coronavirus: Why are Australia's remote Aboriginal communities at risk?*

[9] Australian Bureau of Statistics (2020) *Australian Demographic Statistics, Sep 2019*

[10] Australian Bureau of Statistics (2019) *Regional Population by Age and Sex, Australia, 2018*

[11] Australian Bureau of Statistics (2019) *Disability, Ageing and Carers, Australia: Summary of Findings, 2018*

[12] Australian Bureau of Statistics (2016) *Ageing Population*

[13] Australian Bureau of Statistics (2016) *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*

[14] Australian Institute of Health and Welfare (2019) *The health of Australian females*

[15] Burns, J., MacRae, A., Thomson, N., Anomie, Catto, M., Gray, C., Levitan, L., McLoughlin, N., Potter, C., Ride, K., Stumpers, S., Trzesinski, A. and Urquhart, B. (2013) *Summary of Indigenous women's health*.

[16] Australian Government, Department of Health (2009) *Aboriginal and Torres Strait Islander women*

[17] ABC (2020) *Indigenous leaders warn 'if coronavirus gets into our communities, we are gone'*

[18] Australian Government, Department of Health (2020) *Coronavirus (COVID-19): National Health Plan resources*

[19] Australian Government, Department of Health (2020) *Primary Care – Bulk billed MBS telehealth services*

[20] There is not currently information from published scientific reports about susceptibility of pregnant women to COVID-19. *Pregnant women experience immunologic and physiological changes which might make them more susceptible to viral respiratory infections, including COVID-19.*

[21] Smith, J. (2020) *Gender and the Coronavirus Outbreak*

[22] Purdy, C. (2020) *Opinion: How will COVID-19 affect global access to contraceptives-and what can we do about it?*

[23] The Guardian (2020) *Global condom shortage looms as coronavirus shuts down production*

[24] Information provided by email from Pacific Disability Forum, Fiji Disabled Persons Federation (FDPF) and CBM, March 2020

[25] Anne Kavanagh (2020) *An important message about people with disability and the COVID-19 Response*

[26] Australian Government, Department of Health (2020) *Primary Care – COVID-19 Remote Community Preparedness and Retrieval*

[27] McAlister, J. (2020) *Indigenous leaders warn 'if coronavirus gets into our communities, we are gone'*

[28] Owen, L. (2020) *Coronavirus: Five ways virus upheaval is hitting women in Asia*

[29] UN Women, *Redistribute unpaid work*

[30] Australian Bureau of Statistics (2016) *Work and family balance*

[31] Ibid

[32] Australian Bureau of Statistics (2018) *Employment in Australia – 2016 Census data summary*

[33] The National Aboriginal Community Controlled Health Organisation (NACCHO) (2017) *Indigenous women and the hidden health-gap*

[34] Australian Bureau of Statistics (2016) *Work and family balance*

[35] Australian Bureau of Statistics (2019) *Disability, Ageing and Carers, Australia: Summary of Findings, 2018*

[36] Australian Bureau of Statistics (2016) *Work and family balance*

[37] UN Women (2020) *The COVID-19 outbreak and gender: key advocacy points from Asia and the Pacific*,

[38] Lewis, H. (2020) *The Coronavirus is a Disaster for Feminism – Pandemics affect men and women differently*

[39] Ibid

[40] Australian Bureau of Statistics (2016) *Work and family balance*

[41] Andrea Flynn (2020) *Op-ed: The "All-Consuming" Emotional Labor Caused by Coronavirus—and Shouldered by Women*

[42] Worthington, B. (2020) *Centrelink offices due to coronavirus, Stuart Robert admits not anticipating MyGov demand*

[43] ABC (2020) *A coronavirus cruise ship was about to dock in a bushfire-ravaged community until local doctors intervened*

[44] Australian Bureau of Statistics (2018) *Employment in Australia – 2016 Census data summary*

[45] Workplace Gender Equality Agency, *Health Care and Social Assistance within all industries*

[46] Davies, S. E., Harman, S., True, J., Wenham, C. (2020) *Why gender matters in the impact and recovery from COVID-19*

[47] O'Mallon, F. (2020) *Virus prompts domestic violence warnings*

[48] Inter-Agency Standing Committee (2015) *Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery*

[49] Casey, A. (2020) *Where do domestic violence victims go during the COVID-19 lock down?*

[50] Australian Bureau of Statistics (2017) *Personal Safety Survey: Key findings*

[51] Ibid

[52] Walton, K. (2020), *Australia urged to take action against rising violence against women*

[53] Australian Bureau of Statistics (2016) *Estimating Homelessness*

[54] Gearin, M. and Knight, B. (2020), *Family violence perpetrators using COVID-19 as 'a form of abuse we have not experienced before'*

[55] The Lookout (2020) *COVID-19 and Family Violence*

[56] Ibid.

[57] Gearin, M and Knight, B (2020) *Family violence perpetrators using COVID-19 as 'a form of abuse we have not experienced before.'*

[58] Ibid.

[59] Spratt., M. S. (2013) *A Deeper Silence The Unheard Experiences of Women with Disabilities – Sexual and Reproductive Health and Violence against Women in Kiribati, Solomon Islands and Tonga*. Suva, Fiji: UNFPA, Pacific Sub-Regional Office, https://pacific.unfpa.org/sites/default/files/pub-pdf/UNFPAReport-ADeeperSilenceA4PublicationLR3 per cent283 per cent29.pdf

[60] Ibid

[61] Thorne Harbour Health (2020) *LGBTI+ Health, Family Violence*,

[62] Walton, K. (2020) *Australia urged to take action against rising violence against women*,

[63] Ibid

[64] CARE International (2020) *Gender Implications Of COVID-19 Outbreaks In Development And Humanitarian Settings*

[65] Laschon, Eliza (2020) *New COVID-19 restrictions on travel within WA as big queues form on WA/SA border ahead of closure*

[66] SBS News (2020) *Heavy fines announced for breaching NSW virus orders*

[67] Office of the Prime Minister of Australia (2020), *Media Release 29 March 2020*

[68] UNICEF (2020) *COVID-19: Children at heightened risk of abuse, neglect, exploitation and violence amidst intensifying containment measures*

[69] The Alliance for Child Protection in Humanitarian Action (March 2019) *Technical note: protection of children during the coronavirus pandemic, version 1*

[70] Ibid

[71] Croxon, N., (2020) *COVID-19 leads to concerns about delays and backlog in Victoria's courts*

[72] eSafety Commissioner, *Cyberbullying*

[73] Australian Institute of Family Studies (April 2018) *Online Safety*

[74] The Alliance for Child Protection in Humanitarian Action (2020) *Guidance note: Protection of children during infectious disease outbreaks*

[75] International Committee of the Red Cross (2004) *Inter-agency guiding principles on unaccompanied and separated children*

[76] Ricciardelli, L. Mellor, D. and McCabe, M. (2012) *The quiet crisis: challenges for men's health in Australia*, InPsych, Vol. 34(4),

[77] UNFPA (2020) *COVID 19: A gendered lens, technical brief,*

[78] Australian Institute of Health and Welfare (2018) *Australia's Health 2018: In Brief*, https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/all-is-not-equal

[79] National Public Radio (2020) *us hospitals prepare guidelines for who gets care amid corona virus surge*

[80] Ibid.

[81] Sands, P. (2020) *COVID-19 threatens the poor and marginalized more than anyone*,

[82] ACT Government (2020) *Latest news on COVID-19 in the ACT*

[83] UN Women (2020) *The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific*

[84] Little is currently known about the effect of COVID-19 on pregnant and lactating women, making continued SRH services even more important. *See* UN Population Fund (UNFPA) (2020) *As COVID-19 Continues To Spread, Pregnant And Breastfeeding Women Advised To Take Precautions*

[85] ABC (2020) *Online sales halted, supermarket shelves stripped bare as shoppers prepare for coronavirus quarantine*

[86] AWAVA (2020) *OVID-19 and violence against women – Federal Government support needed*

[87] ABC (2020) *SA reproductive rights experts worried coronavirus is creating more barriers to abortion*

[88] The Guardian Australia (2020) *Later gestation abortions hit by Australia's coronavirus travel restrictions*

[89] BBC News (2020) *Coronavirus nurse describes 'heartbreaking' job*

[90] Safai, Y. (2020) *Anxiety and Depression Likely to Spike among Americans as coronavirus pandemic spreads*

[91] UNFPA (2020) *Technical Brief - COVID 19: A Gendered Lens*

[92] CARE International (2020) *Gender Implications Of COVID-19 Outbreaks In Development And Humanitarian Settings*

[93] Hall, S., Fildes, J., Perrens, B., Plummer, J., Carlisle, E., Cockayne, N., and Werner-Seidler, A. (2019) *Can we Talk? Seven Year Youth Mental Health Report - 2012-2018*. Mission Australia: Sydney, NSW.

[94] Ibid.

[95] Duffy, C. (2020) *Coronavirus opens education's Digital Divide, as COVID-19 forces schools into online learning*

[96] Thomas, J., Barraket, J., Wilson, CK., Cook, K., Louie, YM & Holcombe-James, I., Ewing, S., MacDonald, T. (2018) *Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2018*. RMIT University, Melbourne, for Telstra,

[97] Haddad, A. (2020) *COVID-19 is not gender neutral*

[98] Davidson, P., Saunders, P., Bradbury, B. and Wong, M. (2018) *Poverty in Australia, 2018*. ACOSS/UNSW Poverty and Inequality Partnership Report No. 2, Sydney: ACOSS,

[99] Haddad, A. (2020) *COVID-19 is not gender neutral*,

[100] Prime Minister of Australia (2020) *Media Release 29 Mar 2020, Prime Minister, Minister for Foreign Affairs and Women, Assistant Minister for Health, Minister for Families and Social Services*,

[101] Washington Group on Disability Statistics (n.d.)

[102] Twesiqve, G. (2020) *Thinking about gender while responding to an epidemic: Must have or nice to have*

[103] Marie Stope Australia (2020) *Sexual and Reproductive Health Rights in Australia*

[104] AWAVA (2020) *Media statement: Welcome initial funding needs to be followed with further investment in safety*

[105] AWAVA (2020) *COVID-19 and violence against women – Federal Government support needed*