Improving condom access and availability in Melbourne’s West

Business case
Action for Equity: A Sexual and Reproductive Health Plan for Melbourne’s West 2013-2017

*Action for Equity* is a four year sexual and reproductive health promotion plan for Melbourne’s west that incorporates primary prevention initiatives that work to redress the social determinants of sexual and reproductive health in order to achieve health equity. The plan integrates long-term strategies across a range of settings and sectors to generate and maintain the social and cultural change needed to achieve optimal sexual and reproductive health through a regional partnership approach, the sharing of resources and knowledge, and a common planning framework.

**Improving condom access and availability in Melbourne’s West**

Improved condom access and availability by increasing the number of vending machines in public places is a key *Action for Equity* strategy. Condom access is a key public health consideration as using condoms and lubricant consistently and correctly can prevent the transmission of sexually transmissible infections (STIs) including chlamydia, gonorrhea, syphilis, HIV, blood borne viruses, and can protect against unwanted pregnancies.

Limited publically assessable and affordable condoms still presents a fundamental barrier to condom use for many young people and other population groups such as men who have sex with men, and street sex workers. Public toilets and parks throughout Melbourne’s west are commonly used as beats and for the solicitation of sexual services, and hence is an important site for STI and blood borne virus prevention initiatives.

This project is designed to create an enabling environment through supportive council policies that increase public access and availability to condoms. This project aims to redress social inequities by making condoms more available for marginalised populations who might not have access to these resources due to factors such as limited finances, lack of transport and other factors than impact on access. It also aims to increase knowledge about the importance of safe sexual practice, screening and treatment through a social marketing strategy implemented via social media.

**Why action is needed**

The following indicators illustrate why a condom access and affordability strategy is needed in Melbourne’s western region:

- Only 53 per cent of sexually active young people in the western region report that they practice safe sex by using a condom. This is lower than the reported Victorian rate of 58 per cent (DEECD, 2011)
- There was a 21 per cent increase in chlamydia notifications between 2010 and 2012, compared with a 20 per cent increase in Victoria (DH, 2013)
- Research shows an established street sex worker community in Footscray and surrounding suburbs and that men accessing these services aren’t practicing safe sex (Rowe, 2011)
- There has been a 41 per cent increase in gonorrhoea notifications between 2010 and 2012 (DH, 2012)
- Research in the West suggests that refugee and asylum seeker communities have a significant burden of communicable diseases and other health concerns that might be undiagnosed or untreated at the time of migration (Tiong et al, 2006)
- Aboriginal and Torres Strait Islander young people are far more frequently diagnosed with STIs and blood borne viruses than among their non-Indigenous counterparts (Ward et al, 2013)
- Two of Melbourne’s four designated ‘growth corridors’ are located in the region and have a comparatively high population of young people. The outer west of Melbourne’s population is forecast to increase by 42.1 per cent by 2022 (DH, 2011). This rapid growth exerts enormous pressure on service provision and health infrastructure.¹

**Economic modeling on the effectiveness of condom distribution interventions**

Research shows that the male condom is the single most efficient available technology to reduce the sexual transmission of HIV and other STIs. There is yet to be economic modelling produced in Australia or Victoria that relates to the social and economic burden associated with STIs. However, economic modelling conducted in the United States (US) shows that there are 20 million new infections in the US each year, costing the American healthcare system nearly $16 billion per year in direct medical costs alone (CDCP, 2013).

Economic modelling conducted in the US also found that the average annual cost per adolescent at risk of unintended pregnancy who does not practice safe sex is $1,267 - $1,079 for unintended pregnancy and $188 for STIs (Trussell et al, 1997). One year of savings associated with the use of the male condom was $946 in the private sector and $525 in the public sector (Trussell et al, 1997). Although such estimates aren’t directly transferable to Victoria, this research shows that increasing condom use leads to risk reduction within a range considered to be cost-effective when translated into health outcomes (Charania et al, 2011).

**Cost of condom vending machines**

Council will be required to fund an initial outlay for the purchase of condom vending machines that cost between $1500 and $2,000 per unit.

A condom vending machine distribution project conducted by the Centre for Excellence in Rural Sexual Health with three rural councils in the Hume region found that the outlay cost of machines can be recouped by councils within 18 months. This project also found that over a year, six publically accessible condom vending machines raised $2626.10 in revenue. This project did not receive any negative feedback from residents or negative reporting by the local media (Tomnay and Hatch, 2013).

Melbourne’s western region is three times larger than the Hume region; therefore it is likely that metropolitan councils will generate substantially more revenue associated with such a project.

¹ See appendix one for local government area breakdowns.
project. Once the initiation outlay of the machines is recouped, revenue is profit and as such, the project model is economically sustainable and can cover any future repair costs (Tomnay and Hatch, 2013).

**Evidence informing this project**

Research suggests that young people, particularly young men, prefer to access low-cost condoms from semi-private places such as local parks, school toilets and shopping malls (Sixsmith et al, 2006).

An international meta-analysis of 21 condom distribution programs found that increasing availability and accessibility to condoms in conjunction with community-based individual and group interventions that redress gender norms, knowledge, attitudes, skills and behaviours related to common use effectively:

- increase condom acquisition
- increase condom use
- delay sexual initiation among young people, and
- reduce incidence of STIs (Charania et al, 2011).

In line with the evidence-base, this project will incorporate a social media strategy to promote safe sexual practices and inform communities within Melbourne’s west of the increased access of public condom vending machines. This project is also aligned with other Action for Equity community education strategies that work directly with young people and other population groups. This multipronged approach ensures that this project sits alongside other work that promotes opportunities for communities to gain the knowledge, skills and resources needed to ensure sustainable sexual and reproductive health outcomes.

**Project stages**

Stage one: Ensure by in and commitment from the seven local governments that make up Melbourne’s western region. This is important in ensuring that this project has reach across the West

Stage two: Develop evaluation strategy and work with partners to determine process, impact and outcome indicators

Stage three: Conduct mapping exercise via the use of the national public toilet map, which is an online tool that can support the mapping of public toilets throughout the western region

In some municipalities this work has been completed through the development of their public toilet strategies. This process will determine how many public toilets there are. An additional process of determining how many public toilets in the West currently have condom vending machines is also required. This will form part of the pre evaluation data

Stage four: Conduct consultations with participating councils to determine which council departments and plans this work needs to be embedding within e.g. operations, property and legal services and environmental health
Stage five: Conduct community consultations with population groups most in need of increased access and availability – young people, men who have sex with men in public parks and toilets and street sex worker community – to inform the location of condom vending machines.

Preference needs to be given to locations that are open 24 hours a day and easily accessible.

Stage six: Map access across the west to ensure equitable distribution and coverage. Once completed condom vending machines will be installed and monitored.

Stage seven: Develop and implement social media strategy to promote safe sexual practices and knowledge, STI screening and treatment among communities in the West.

Stage eight: It is also envisaged that this project include a strategy aimed at ensuring free access to condoms via venues such as community and women health services, youth services and secondary schools as appropriate.

Resources required

Women’s Health West is currently recruiting a student with a public health/health promotion background to conduct and support this project.

Women’s Health West on behalf of Action for Equity partnership is also exploring potential funding opportunities through a grant from the Helen Macpherson Smith Trust to support local councils to implement the project.

Councils will be required to provide in-kind staff support to enable the effectively and sustainable implementation of this project.

Next steps

WHW will distribute the condom vending machine business case to local governments in Melbourne’s West.

Once WHW receives in principle support from councils, WHW in partnership with councils, will develop a detailed project plan including a memorandum of understanding (MoU) and identify and potentially source project funding.

Local governments will then be required to sign MoUs and the project stages will commence. This work will be overseen by the Action for Equity regional reference committee.
References


Rowe, J. (2011) *Shantusi: Surveying HIV and need in the unregulated sex industry*, Inner South Community Health Service: Melbourne.


Appendix one

Proportion of sexually active adolescents who practice safe sex with a condom, 2009

Source: Adolescent Community Profile Series, DEECD, 2011.

### TABLE: STI notifications to the Victorian Communicable Disease and Surveillance Unit (for 2009 & 2011 period)

<table>
<thead>
<tr>
<th>STI</th>
<th>Wyndham 2009</th>
<th>Wyndham 2011</th>
<th>% increase over three years</th>
<th>Moorooduc 2009</th>
<th>Moorooduc 2011</th>
<th>% increase over three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>297</td>
<td>321</td>
<td>81.6%</td>
<td>291</td>
<td>337</td>
<td>16.5%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>34</td>
<td>68</td>
<td>106.6%</td>
<td>20</td>
<td>47</td>
<td>132.1%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>17</td>
<td>28</td>
<td>62.0%</td>
<td>10</td>
<td>14</td>
<td>20.3% (decrease)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STI</th>
<th>Melton 2009</th>
<th>Melton 2011</th>
<th>% increase over three years</th>
<th>Melbourne 2009</th>
<th>Melbourne 2011</th>
<th>% increase over three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>178</td>
<td>264</td>
<td>50.6%</td>
<td>728</td>
<td>893</td>
<td>17.2%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>23</td>
<td>23</td>
<td>0%</td>
<td>119</td>
<td>147</td>
<td>23.6%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>8</td>
<td>8</td>
<td>0%</td>
<td>81</td>
<td>50</td>
<td>0.8%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>STI</th>
<th>Maribyrnong 2009</th>
<th>Maribyrnong 2011</th>
<th>% increase over three years</th>
<th>Hastings Bay 2009</th>
<th>Hastings Bay 2011</th>
<th>% increase over three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>171</td>
<td>253</td>
<td>46.0%</td>
<td>203</td>
<td>267</td>
<td>31.5%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>29</td>
<td>65</td>
<td>150.7%</td>
<td>18</td>
<td>31</td>
<td>72.2%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>30</td>
<td>32</td>
<td>6.7%</td>
<td>17</td>
<td>19</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STI</th>
<th>Brimbank 2009</th>
<th>Brimbank 2011</th>
<th>% increase over three years</th>
<th>Western Region 2009</th>
<th>Western Region 2011</th>
<th>% increase over three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>361</td>
<td>502</td>
<td>31.3%</td>
<td>2,300</td>
<td>5,107</td>
<td>34.6%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>68</td>
<td>79</td>
<td>10.2% (decrease)</td>
<td>810</td>
<td>440</td>
<td>49.0%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>39</td>
<td>35</td>
<td>10.2% (decrease)</td>
<td>211</td>
<td>223</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Source: Department of Health, Communicable Disease Epidemiology and Surveillance Unit, 2012.