Response to the Draft Sexual Offences Jersey Law

ACET (AIDS Care Education and Training) Jersey

Executive Summary

This paper summarises the concerns of ACET Jersey, an HIV/AIDS health awareness charity, over the risks associated with unprotected anal intercourse and the possible outcomes of lowering the age of consent to 16 for men who have sex with men.

It presents an overview of the prevalence of HIV, together with evidence that sex between men is the major transmission route for HIV in the UK. It highlights the lack of data currently available to map and monitor HIV prevalence and plan prevention programmes in Jersey and makes the following recommendations for implementation prior to any consideration of the lowering of the age of consent for sex between men:

1. **The urgent need for improved surveillance, including an Unlinked Anonymous Prevalence Monitoring Programme, coupled with research to establish a better understanding of the sexual networks, health seeking behaviour and risk behaviour of the homosexual/ bi-sexual community in Jersey.**

2. **The re-establishment of a multi-agency group to deliver an integrated programme of sexual health promotion and the development of an HIV and Sexual Health Strategy with a costed Action Plan.**

3. **A Public Information Campaign and expanded PSHE curriculum to warn adults and young people of the dangers of unprotected anal intercourse.**

4. **Targeted HIV prevention programmes for men who have sex with men.**

5. **The promotion of HIV testing to all sexually active people to improve early diagnosis of the virus and minimise the risk of infecting others coupled with a programme that encourages men who have sex with men to have an annual HIV test.**

Background

ACET Jersey has been delivering community-based HIV/AIDS prevention programmes in Jersey since 1994, with the aim of minimising the spread of HIV in the local community.

The charity is a member of the ACET International Alliance, a global network of independent agencies and church-based organisations responding to AIDS and related issues worldwide. ACET was founded in London by a young Christian doctor working in terminal care in the UK in 1980's when young homosexual men began to die from AIDS in a climate of ignorance, prejudice and fear, which was widespread at the time in both the medical profession and the wider community.

Dr Dixon actively campaigned for improvements in the humane treatment and palliative care of those dying in hospitals and established ACET in London to provide home care

and nursing services to enable those suffering in the late stages of HIV infection to live and die at home, if that was their wish.

ACET's care teams, which included specialist nurses and carers, provided a highly respected and valued service in the London area in the 1980's and 1990's. Sex between men has always been the major transmission route for HIV in Britain and the majority of people who benefited from ACET's care services in London were men who had acquired HIV through sex with other men.

The Prevalence of HIV in the UK

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. Each year, many thousands of individuals are diagnosed with HIV for the first time.

It is estimated there are about 58,300 HIV infected people alive in the UK and an estimated 19,700 who remain unaware of their infection and therefore undiagnosed. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed.

The number of people who are infected, but remain unaware of their HIV status, is calculated through a survey called the Unlinked Anonymous programme. This data is currently not available in Jersey, although it is generally accepted by health professionals that the situatuion in the UK is mirrored here in Jersey. For more details of HIV surveillance methodology see Annex A.

HIV remains a life-threatening condition. There is still no cure. The introduction of drug therapies has improved the lifespan of people living with HIV, but this has presented fresh and difficult challenges for those involved with their treatment, support and care.

HIV therapies are complex, expensive and extremely demanding on the patient. In addition the human costs for people living with HIV remain high. Many cannot work, and others can still suffer ill-informed prejudice and discrimination.

Men who have Sex with Men (MSM)

Sex between men remains the major transmission route for HIV in this country.

Anal intercourse has always been known to carry a health risk. Hepatitis B is spread easily by this route and many active homosexuals appear to have chronic low-grade infections of various kinds that may lower their resistance to HIV. The lining of the anus is fragile and the lining of the rectum is likely to bleed during anal intercourse, especially if a pre-sex douche (enema) or a dildo (artificial penis) is used. It is also possible that some cells in the rectum have surfaces particularly suited to HIV to latch on to and can become a reservoir for infecting the whole body.

A report published by the Health Protection Agency in November 2004 found that men who have sex with men remain the group at greatest risk of acquiring HIV infection within the UK, accounting for an estimated 84% of infections diagnosed in 2003 that were likely to have been acquired in the UK. The impact of HIV on MSM in the UK has been profound: 31,430 have been reported as HIV positive, of whom 9,693 have died.

Improved survival since the advent of effective anti-retroviral treatments in the past decade, with sustained numbers of new HIV diagnoses, has led to increasing numbers of MSM living with diagnosed HIV infection. In the UK in 2004 it was estimated that just under half (46%) of all adult HIV infections were amongst MSM. Furthermore, 26% were unaware of their infection; accounting for 45% of the 14,300 undiagnosed prevalent infections and could be inadvertently passing it on to others.[1]

The current figures for 2005 are subject to a reporting delay and will increase as further reports are received throughout 2006 of people who were diagnosed in 2005.

A report published by the UK Health Protection Agency on 26 January 2006 predicts that new HIV diagnoses in 2005 are expected to exceed 7,750. It goes on to say that 'the continued rise in the number of new diagnoses between 2004 and 2005 is mainly due to a continued increase among men who have sex with men (MSM)'. Currently 1,712 new MSM diagnoses have been reported in 2005 but the HPA predicts that this will rise to approximately 2,453 when all reports are received.

In a Press Statement issued on 26 January Dr Valerie Delpech of the Health Protection Agency's HIV department said: ***'Sex between men remains the group in the UK at highest risk of acquiring HIV with evidence that transmission is continuing at a substantial rate.The rise in the number of new diagnoses reported is likely to be due to more HIV testing among MSM and ongoing transmission of HIV'.***

Rates of acute sexually transmitted infections amongst MSM have also been increasing, particularly since 1999. Rates of gonorrhoea among MSM in England and Wales doubled between 1999 and 2001, from 553/100,000 to 1140/100,000, and although a slight decrease was observed in 2002, this seems to have been restricted to men over 25 in London.[2] Unfortunately this decrease was not sustained in 2003; rates increased in all age groups.

In England, Wales and Northern Ireland, there have been large increases in rates of infectious syphilis amongst MSM since 1999 (616%), as a result of ongoing outbreaks in Manchester, Brighton, London and other parts of the UK.[3] Data from the Enhanced Syphilis Surveillance collected between April 2001 and September 2004 indicate that 53% (558/1048) of MSM diagnosed with syphilis in London were known to have co-infection with HIV.

Increases in genital chlamydia infections in MSM (183%) have also been observed since 1999.

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[1] Focus on Prevention: HIV and other Sexually Transmitted Infections in the United Kingdom in 2003. HPA November 2004

[2] Macdonald ND, Dougans S, McGarrigle CA, Baster K, Rice BD, Evans BG, *et al.* Recent trends in diagnoses of HIV and other sexually transmitted infections in England and Wales amongst men who have sex with men. *Sex Trans Infect 2004* (in press).

[3] Simms I, Fenton KA, Ashton M, Turner KME, Crawley-Boevey E, Gorton R *et al* The re-emergence of syphilis in the UK: the new epidemic phases. *Sex Transm Dis 2004* (in press).

Increasing high risk sexual behaviour

High-risk sexual behaviour remains the key determinant of STI transmission amongst MSM, and behavioural surveillance data have shown increases in rates of unprotected anal intercourse, particularly with HIV discordant or unknown status partners.[4]

Data from the second National Survey of Sexual Attitudes and Lifestyles (Natsal) show increases in the prevalence of male homosexual behaviour in general and increases in specific high-risk behaviours among homosexually active men[5]. Both factors would increase the overall 'at risk' population. The reasons for the change are unclear. However, continued liberalisation of attitudes towards homosexuality[6], and safer sex 'fatigue' in the era of ARV[7], coupled with increasing access to sites that facilitate partner acquisition (such as the internet and saunas)[8] may all contribute.

Increasing new diagnoses and incidence of HIV infection

Since 1999 the number of new diagnoses of HIV infection in the UK acquired through sex between men has been increasing, with 1,809 diagnoses reported in 2002, the largest annual total for 10 years.

HIV is the fourth most commonly diagnosed major STI among MSM in the UK today and the possible increase in HIV incidence predicted in the HPA annual report in November 2004 may result in a future rise in new diagnoses among this group.

A report issued by the European Commission in 2004 reveals that the number of newly reported cases of HIV infection in Europe has doubled over the past nine years and warns that the European Union and its neighbouring countires now face the threat of a new epidemic unless governments maintain prevention activities as a priority.[9]

Implications for prevention

Sexual health promotion for MSM faces considerable challenges. The English *National Sexual Health and HIV Strategy* [10] has prioritised a range of interventions including HIV/STI education and safer sex promotion, promotion of HIV testing, increasing the uptake of hepatitis B vaccination, and addressing the sexual health needs of HIV positive MSM.

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[4] Dodds J, Mercy D, *Sexual health survey of gay men-London 2003: Annual Summary Report.* London: Royal Free and University College Medical School 2004.

[5] Mercer CH, Fenton KA, Copas AJ, Wellings K, Erens B, McManus S, *et al.* Increasing prevalence of male homosexual partnerships and practices in Britain 1990-2000: evidence from national probability surveys. *AIDS 200:* **18:**1453-8

[6] Copas AJ, Wellings K, Erens B, Mercer CH, McManus S, Fenton KA, *et al.* The accuracy of reported sensitive sexual behaviour in Britain: exploring the extent of change 1990-2000. *Sex TransmInfect 2002;* **78:** 26-30

[7] Ostrow DE, Fox KJ, Chmiel JS, Silvestre A, Visscher BR, Vanable PA, *et al.* Attitudes towards highly active anti-retroviral therapy are associated with sexual risk taking among HIV-infected and uninfected homosexual men. *AIDS 2002;* **16:**775-80

[8] McFarlane M, Bull SS, Reitmeijer CA The internet as a newly emerging risk environment for sexually transmitted diseases *JAMA 2000;* **284: 443-6**

[9] European Commission working paper: A coordinated and integrated approach to combat HIV/AIDS within the European Union and its neighbourhood. September 2004.

[10] Department of Health *the National Strategy for Sexual Health and HIV Implementation Action Plan* London: DH, 2002.

In his report for 2004, the UK Chief Medical Officer highlighted HIV as a key UK health prioroty and recommended that their should be an increase in activities to ensure early diagnosis and minimise the chance of infecting others. His recommendations for increasing HIV testing included the recommendation that all gay men should be encouraged to have an annual HIV test even if they have not had a sexually transmitted infection or have attended a sexual health clinic.

National studies investigating the current risk factors for HIV infection among MSM and the impact of the internet on their high risk sexual behaviour are currently underway and should provide evidence for the design of more effective prevention efforts in the future.

Costs

Poor sexual health costs the country a lot of money. Preventing poor sexual health has significant potential not just for better health, but also for the better use of finite resources. This should be a major consideration here in Jersey as we face considerable financial restraints in the years ahead.

The UK Department of Health calculated the costs of HIV infection in its strategy as follows: the average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000, and the monetary value of preventing a single onward transmission is estimated to be some where between £½ million and £1 million in terms of individual health benefits and treatment costs.

ACET's Recommendations to Reduce the Risks Associated with Anal Intercourse

1. **A Sound Evidence Base for Effective Local HIV/STI Prevention**

   Over the past year ACET has been increasingly concerned about the lack of data available to map and monitor the spread of HIV in the local community. In particular the delays in implementing the **Unlinked Anonymous Prevalence Monitoring Programme** recommended by the Misuse of Drugs Scrutiny Panel in April 2005. .

   Without this programme in place Jersey has no way of estimating the numbers of undiagnosed HIV infections in the island. This data is essential in order to target and evaluate health promotion programmes, to inform estimates of the numbers requiring treatment and care in the future, and to plan services for those affected by HIV/AIDS and chronic hepatitis. We believe the implementation of this programme coupled with regular reporting of the data is an essential pre-requisite to any move to lower the age of consent for men having sex with men.

   We also believe the other major research priority is to establish a better understanding of the sexual networks, health seeking behaviour and risk behaviour of the homosexual/ bi-sexual community in Jersey.

2. **An Integrated HIV and Sexual Health Strategy for Jersey**

   We are also concerned that the multi-agency **Sexual Health Strategy Group**, established by the former Medical Officer of Health to bring together all agencies concerned with the prevention of sexual ill-health, has been in abeyance since June 2004 and that there is currently no costed **HIV and Sexual Health Strategy and Action Plan** in operation.

The current state of affairs would imply that Jersey has yet to act on the warnings and recommendations to prioritise HIV prevention activities issued by the European Commission in 2004.

3. People Must be Provided with Clear Information About the Risks

We believe that the evidence clearly shows that anal intercourse carries a higher risk of HIV infection than vaginal intercourse and that it would be reckless on the part of the government to lower the age of consent for men who have sex with men to 16 without first implementing a public information campaign to warn of the dangers of unprotected anal intercourse.

We believe that young people are particularly vulnerable inasmuch as 'legal' is often equated with 'safe' in their minds. It is therefore essential that the government ensures that all young people receive clear and explicit information about the dangers of unprotected anal intercourse as part of the school PSHE curriculum.

4. Targeted Interventions for MSM

We believe that high priority must be given to HIV prevention for homosexual men including outreach services for those with undiagnosed HIV. The information must be based on evidence and credible with the target audience.

5. The Promotion of HIV Testing

We believe that there should be an increase in activities to ensure early diagnosis and minimise the chance of infecting others.

We believe HIV tests should be promoted and made more widely available to all sexually active people, in particular gay men, who remain the group at greatest risk of acquiring HIV within the UK (84%) and who carry the burden of 45% of undiagnosed prevelent infections, should be encouraged to have an annual HIV test even if they have not had a sexually transmitted infection or have attended a sexual health clinic.

Conclusion

The Board of ACET Jersey considers that it would be irresponsible for the States to pass and enact a change in the law governing the legal age of consent for MSM and anal intercourse without the realities of such a change being clearly recognised. This can only happen through the development of a States Sexual Health Strategy, together with a public information scheme and designated resources within the Ministry of Health and Social Services to cope, both with the existing HIV/AIDS situation in the island and with the likely increase in MSM that the lowering of the age of consent will bring. Only when such a costed and funded programme is in place should this proposed change in the law be accepted by the States.

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Executive Director
AIDS Care Education and Training Jersey
30 January 2006

Surveillance

HIV is a chronic infection with a long latent period. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK. This means multiple sources of surveillance information are required to understand the nature of the epidemic in the UK.

1. New Diagnoses of HIV and AIDS

The main sources of information on newly diagnosed HIV/AIDS infection come from voluntary case reporting of HIV/AIDS from laboratory reports of newly diagnosed HIV infections by microbiologists and HIV/AIDS diagnoses by clinicians

For England Wales and Northern Ireland reports are made to the Health Protection Agency Centre For Infections. New diagnoses of HIV/AIDS in Scotland are reported to Health Protection Scotland (HPS). Paediatric infections are reported to the Institute of Child Health (ICH). Each quarter these data sources are pooled to make up the UK data set of newly diagnosed HIV/AIDS infections.

Reports of newly diagnosed HIV infections are subject to reporting delay. Summaries presented by year of diagnosis, or death may not include those infections or deaths that have occurred recently.

2. Survey of Prevalent HIV Infections Diagnosed (SOPHID survey)

This is a survey of those known to be HIV positive who attend for HIV related care in a year.

3. Unlinked Anonymous Prevalence Monitoring Programme (UAPMP)

This programme aims to estimate the prevalence of HIV by making use of residual sera from routine samples taken for other tests and irreversibly unlinked from patient identifiers before testing.

The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP), which began in 1990 and has tested nearly eight million samples, aims to measure the distribution of unrecognised (i.e. undiagnosed) infection, particularly HIV, in accessible groups of the adult population. In recent years, over 600 000 samples are irreversibly unlinked from patient identifying information and tested for HIV infection annually.

The programme provides estimates of the prevalence of HIV, hepatitis B and hepatitis C infection, among groups in whom a substantial proportion of infections are undiagnosed and therefore not ascertained by other surveillance systems. The data obtained are used to target and evaluate health promotion, to inform estimates of the numbers requiring treatment and care in the future, and to plan services for those affected by HIV/AIDS and chronic hepatitis.

Results from the UAPMP produces essential public health information that could not be obtained in any other way.

Programme Objectives:

- To monitor HIV, hepatitis B and hepatitis C infection prevalence, and associated risk factors, in accessible groups of behaviourally vulnerable adults, such as attendees at genitourinary medicine clinics and injecting drug users
- Through serosurveillance of accessible groups, to measure the impact of HIV infection on those who are behaviourally less vulnerable
- To monitor closely the prevalence of HIV infection in London and to recognise increasing prevalence elsewhere as early as possible
- To measure the effectiveness of antenatal and other voluntary confidential HIV testing strategies
- In combination with other data, to provide estimates of the national total of HIV-infected persons and to assist in estimating future numbers of persons with severe HIV disease who will require care
- To provide timely and useful information for the targeting of health promotion, the evaluation of preventive measures, and the planning of medical and social services for those affected by HIV

Recent findings in the UK

The 2005 annual surveillance report for the United Kingdom(UK) [11] describes a worrying situation with undiminished and high levels of transmission of HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM), a steady increase in the number of HIV-infected black Africans in the UK, limited but compelling evidence that heterosexual transmission of HIV within the UK is slowly rising, and continuing high transmission of other STIs, especially chlamydia among young people. The report summarises current surveillance information on HIV and STIs, as well as some of the behaviours underlying transmission, and shows the distribution of the problem across different areas of the country.

- By the end of 2004 there were an estimated 58 300 (range: 54 700 - 63 400) people living with HIV in the UK, of whom 34% (range: 29% - 39%) were unaware of their infection.
- During 2004 the incidence of HIV infection in MSM remained high at 3% per year. The prevalence of previously undiagnosed HIV infections was 4.7% among MSM attending sentinel GUM clinics in London and 2.8% among those aged under 25. Outside London, the prevalence of previously undiagnosed HIV infection among young MSM attending sentinel GUM clinics was 0.9%.
- The incidence of gonorrhoea also remained high among MSM in 2004, with 3977 infections diagnosed. More than a quarter of gonococcal isolates from MSM in 2004 were shown to be ciprofloxacin resistant, a stark increase from 11% in 2003. In addition, the syphilis epidemic among MSM continued to grow, and there has been a significant rise in the numbers of cases of a previously uncommon disease, lymphogranuloma venereum (LGV).

[11] Mapping the Issues HIV and other sexually transmitted Infections in the United Kingdom: 2005 The UK Collaborative Group for HIV and STI Surveillance

- Uptake of voluntary confidential testing (VCT) for HIV among MSM attending GUM clinics increased to 79% in 2004. Of those who could potentially have had their HIV infection diagnosed, 43% remained undiagnosed after leaving the clinic.